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DoD 6055.5-M

**OCCUPATIONAL
MEDICAL
SURVEILLANCE
MANUAL**

MAY 1998

**OFFICE OF THE UNDER SECRETARY OF DEFENSE
FOR ACQUISITION AND TECHNOLOGY**



OFFICE OF THE UNDER SECRETARY OF DEFENSE
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FOREWORD

This Manual is reissued under the authority of Department of Defense Instruction 6055.5 (reference (a)).

DoD 6055.5-M "Occupational Health Surveillance Manual," July 1982, is hereby canceled.

This Manual applies to the Office of the Secretary of Defense; the Military Departments, including the National Guard Bureau; the Chairman of the Joints Chiefs of Staff; the Combatant Commands; and the Defense Agencies (hereafter referred to collectively as "the DoD Components"). Its provisions encompass job-related medical monitoring of DoD military and civilian workers. This Manual does not apply to employees of contractors. However, it could be used as a model during contract negotiations.

The purpose of this Manual is to provide minimum standards for medical surveillance programs and to help occupational health professionals and others recognize and evaluate health risks associated with specific workplace exposures. Chapter 1 describes the general requirements for medical surveillance, types of examinations, and record keeping. Chapter 2 describes Occupational Safety and Health Administration (OSHA) related medical surveillance. Chapter 3 includes additional medical surveillance protocols endorsed by the Department of Defense where OSHA does not provide guidance. Medical surveillance protocols in Chapters 2 and 3 are grouped by chemical, physical, or biological stressors or by occupational groups.

This Manual is effective immediately. The heads of the DoD Components may issue supplementary guidance when necessary. This version of the Manual has been prepared by the DoD Occupational Health and Medical Surveillance Coordinating Committee of the DoD Safety and Occupational Health (SOH) Committee. This coordinating committee shall:

1. Periodically review this Manual and expeditiously recommend to the Assistant Deputy Under Secretary of Defense for Safety and Occupational Health Policy the necessary changes to ensure compliance with current scientific knowledge, professional practice, and OSHA standards.
2. When necessary, propose alternate or supplementary standards, as defined by Title 29, Code of Federal Regulations, Part 1960 (reference (b)), and DoD Instruction 6055.1 (reference (c)) for medical surveillance.
3. Report to the SOH Committee.

Send recommended changes to the Manual to:

Assistant Deputy Under Secretary of Defense
(Safety and Occupational Health Policy)
3400 Defense Pentagon, Room 3E792
Washington, DC 20301-3400

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C1. CHAPTER 1
GENERAL INFORMATION

C1.1. INTRODUCTION

C1.1.1. Purpose

C1.1.1.1. This Manual provides health professionals with information and references appropriate for developing occupational examination protocols for workers throughout the Department of Defense. Many occupational health problems can be prevented or their effects minimized if identified early. However, occupational medical examinations are preventive only if the workers at risk are properly identified and appropriately evaluated, and the results are used to modify exposure through work practices, process changes, engineering controls, administrative controls, personal protective equipment, or worker placement.

C1.1.1.2. The information in this Manual should be used to develop examination protocols for workers at risk of developing specific occupational health problems based on known work-related health risks. Developing and administering occupational medical examinations based on this Manual will satisfy the basic medical surveillance requirements prescribed in DoD Instruction 6055.5 (reference (a)) by identifying the known health risks associated with specific jobs, processes, and exposures.

C1.1.1.3. Occupational medicine specialists are available for consultation at the following centers of occupational health:

C1.1.1.3.1. U.S. Army -- Commander, U.S. Army Center for Health Promotion and Preventive Medicine, Aberdeen Proving Ground, MD 21-010-5422. (Telephone: (410) 671-4375; DSN 584-4375; Homepage: <https://www.denix.osd.mil/denix/Public/Redirect/redirect.cgi?url=http://chppm-www.apgea.army.mil/>)

C1.1.1.3.2. U.S. Navy -- Commanding Officer, Navy Environmental Health Center, 2510 Walmer Avenue, Norfolk, VA 23513-2617. (Telephone: (757) 363-5500; DSN 864-5500; Homepage: <https://www.denix.osd.mil/denix/Public/Redirect/redirect.cgi?url=http://www-nehc.med.navy.mil/>).

C1.1.1.3.3. U.S. Air Force -- U.S. Air Force Detachment One Human Systems Command/Occupational Medicine Division, Brooks Air Force Base, TX 78235. (Telephone: (210) 536-6048/5115; DSN 240-6048/5115; Homepage: <https://www.denix.osd.mil/denix/Public/Redirect/redirect.cgi?url=http://www.brooks.af.mil/AFRL/>)

C1.1.1.4. Should potentially hazardous agents not covered in this Manual be identified, promptly notify your respective center of occupational health to initiate appropriate hazard evaluation.

C1.1.1.5. Requirements for military deployment-related medical screening and surveillance for Military Services may include elements not included in this Manual. Additional information on joint medical surveillance for deployment may be found in references (f) and (g).

C1.1.2. Scope. This Manual is intended to assist medical practitioners in developing, performing, and interpreting the results of occupational medical examinations. The requirements in this manual apply to all DoD Components.

C1.2. REQUIREMENTS

C1.2.1. Workplace Exposures. Industrial hygiene surveys of workplaces must identify all potential exposures and other worker safety and health risks, and establish complete workplace exposure profiles. Documentation of these activities is required. See DoD Instruction 6055.5 (reference (a)) for additional guidance on industrial hygiene surveillance.

C1.2.2. Work-Related Health Risks. The health of hazard-exposed workers must be monitored to determine if work-related health problems are occurring. Through this portion of the DoD occupational safety and health program, the Department of Defense meets legal and regulatory requirements to assess the effects of work-related health risks on the workers' health status. Chapter 2 of this Manual summarizes existing mandatory occupational medical examination requirements of the OSHA standard for air contaminants, 29 CFR 1910.1000 (reference (d)). Chapter 3 includes other medical examination protocols, while not required by statute, have been endorsed by the Department of Defense.

C1.3. OCCUPATIONAL EVALUATION TYPES

C1.3.1. Preplacement or Baseline. These examinations are performed before placement in a specific job to assess (from a medical standpoint) if the worker will be able to perform the job capably and safely, to determine if the worker meets any established physical standards, and to obtain baseline measurements for future comparison. Ideally, these medical examinations should be done before commencement of work. However, if the individual already has started work, these examinations will be completed within 30 days of assignment when required by DoD Instruction 6055.5 (reference (a)), and within 60 days in other cases.

C1.3.2. Periodic. These examinations are conducted at scheduled intervals. Periodic examinations may include an interval history, physical examination, and/or clinical and biological screening tests. The scope of these examinations is determined locally after consideration of the information contained in this Manual, professional practice standards, regulatory guidance, and any other relevant factors.

C1.3.3. Termination. There are two kinds of termination examinations.

C1.3.3.1. Termination-of-Employment. These examinations are designed to assess pertinent aspects of the worker's health when the employee leaves employment. Documentation of examination results may be beneficial in assessing the relationship of any future medical problems to an exposure in the workplace. This is particularly applicable to those conditions that are chronic or that may have long latency periods. Some Federal regulations require termination of employment examinations (e.g., asbestos, 29 CFR 1910.1001, (reference (h))).

C1.3.3.2. Termination of Exposure. These examinations are performed when exposure to a specific hazard has ceased. Exposure to specific hazards may cease when a worker is reassigned, a process is changed, or the worker leaves employment. Termination of exposure examinations are most beneficial when the health effect being screened for is likely to be present at the time exposure ceases. Some Federal regulations require termination of exposure examinations (29 CFR 1910.120, reference (i)).

C1.4. OCCUPATIONAL MEDICAL EXAMINATIONS

C1.4.1. Background Information. The primary reasons for conducting occupational medical examinations are listed in the following sections. When performing an examination (or constructing an examination protocol), the practitioner must understand the reasons for obtaining each historical item, performing each physical

examination procedure, and ordering each laboratory test. This understanding is essential for the practitioner to know how to properly perform the examination, investigate abnormalities, and formulate appropriate medical recommendations.

C1.4.2. Fitness and Risk Determination. Fitness and risk determination examinations address the following questions:

C1.4.2.1. Is a specific individual, from a medical standpoint, capable of performing a specific job (set of tasks with or without necessary but reasonable accommodation)?

C1.4.2.2. Will performing the job place the individual at risk of significant health harm?

C1.4.2.3. Will allowing the individual to perform the job place someone else at risk or pose an unacceptable risk to public health?

C1.4.3. Occupational Medical Surveillance. Occupational medical surveillance examinations provide baseline and periodic measurements to detect abnormalities in workers exposed to work-related health hazards early enough to prevent or limit disease progression by exposure modification or medical intervention. Medical surveillance examinations are secondary prevention measures. They are effective only if useful screening techniques (history questionnaires, medical exams, or lab tests) are available to identify abnormalities in the target organ system at a stage when modifying exposure or providing medical treatment can arrest progression or prevent recurrence. Much of the information in this Manual is presented to assist health professionals in identifying known work-related health hazards, the target organ system, specific health effects, and useful screening tests.

C1.4.4. Personnel Policy Enforcement. Personnel policy enforcement examinations medically assess workers to determine if they meet established physical standards and conditions of employment. Examples of these programs include drug use screening and fitness for duty examinations (5 CFR 339, reference (j)).

C1.4.5. Employee Health Promotion. Employee health promotion examinations are non-occupational medical examinations given to workers as a benefit and are not addressed in this Manual.

C1.4.6. Regulatory Compliance. Regulatory compliance examinations provide medical data to meet legal and regulatory requirements. Chapter 2 addresses hazards with medical surveillance evaluation requirements specified by OSHA. Chapter 3 describes hazards with medical surveillance protocols endorsed by the Department of

Defense. Both chapters provide assistance to practitioners in identifying those hazards requiring medical examinations.

C1.5. OCCUPATIONAL MEDICAL EXAMINATION PROCESS

C1.5.1. Identifying Workers Who Need Occupational Medical Examinations

C1.5.1.1. There are three ways to identify workers at risk of work-related health problems: by job title, by workplace, and by individual exposure.

C1.5.1.1.1. Job Title. Job title and description characterize the basic tasks, hazardous exposures, and health outcomes likely to be experienced by the majority of workers in a specific occupational group. This type of grouping assumes all workers will have similar job demands, experience similar stresses, have the same exposures to hazardous agents, and suffer the same health effects.

C1.5.1.1.2. Workplace. Workplace characterizes the hazardous agents present in the workplace and assumes all workers assigned to that workplace are potentially exposed to the levels of hazards found at the time the workplace was evaluated.

C1.5.1.1.3. Individual Exposure. Individual exposure quantifies job demands, stresses, and hazardous exposures for each individual.

C1.5.1.2. Each method has limitations. Likewise, any standardized examination protocol developed using a single method to identify the workers at risk will be limited. To minimize these limitations, a combination of these methods is recommended.

C1.5.2. Determining Evaluation Content and Developing Protocols

C1.5.2.1. Installation occupational health and safety personnel are jointly responsible for identifying work areas where workers need medical examinations because of specific hazardous exposures. Local occupational medical personnel establish examination content and frequency based on an understanding of the job demands, exposures to the workers, the medical effects of specific exposures, the impact of specific medical conditions on job performance and safety, and legal and regulatory requirements.

C1.5.2.2. Examination protocols may include employee health promotion and personnel programs. Local medical personnel must be aware of collective bargaining

agreements and support agreements that entitle specific employee groups to health benefit programs or other medical benefits. If medical examinations are deemed inappropriate or of little value, documentation of the rationale used in making this decision shall be maintained locally.

C1.5.2.3. The following list summarizes factors to consider when determining examination content and developing examination protocols.

C1.5.2.3.1. Specific job tasks and/or requirements.

C1.5.2.3.2. Workplace risk factors (exposures).

C1.5.2.3.2.1. Physical agents.

C1.5.2.3.2.2. Chemical agents.

C1.5.2.3.2.3. Biological agents.

C1.5.2.3.2.4. Other.

C1.5.2.3.3. Personal risk factors (medical status).

C1.5.2.3.4. Target organ systems and potential health risks.

C1.5.2.3.5. Potential public health and safety impact.

C1.5.2.3.6. Legal and regulatory requirements.

C1.5.2.3.7. Employee health promotion and personnel programs.

C1.5.3. Performing the Evaluation

C1.5.3.1. The occupational medicine practitioner takes a targeted medical history based on complaints and risk factors, does a review of systems, and then performs selected physical examinations and laboratory tests to characterize the status of specific organ systems. In some cases, a standard examination protocol (historical questionnaire and lab tests) may be administered to a group of workers with similar specific health risks.

C1.5.3.2. Workers receiving occupational medical examinations can have health conditions that can affect their job performance or indicate a problem in the workplace. Determining a particular worker's fitness and risk for a particular job and identifying work-related medical conditions requires medical judgment by a practitioner knowledgeable of the worker's working conditions and job demands.

C1.5.4. Record Keeping (Documenting Examination Results). Occupational medical surveillance examinations shall be recorded and maintained in accordance with DoD Instruction 6055.5 (reference (a)) and the DoD Components' implementing directives. All results should be recorded in employees medical records. Standard or customized forms may be used or developed to aid in collecting and recording occupational medical information.

C1.5.5. Informing the Worker of Examination Results. All workers must be informed of the results of their occupational medical examination (even if all results are normal) as soon as possible following completion. Documentation of patient notification should be noted in the medical record. All personnel with significant abnormalities must be further evaluated or referred for evaluation as appropriate. One of the primary reasons for performing occupational medical examinations is to detect job-related abnormalities at an early stage to reverse or halt progression by modifying exposure. If abnormalities are not fully evaluated and reviewed, potential opportunities for prevention are lost.

C1.5.6. Counseling and Education Concerning Identified Health Risks. Medical personnel shall inform workers receiving occupational medical examinations of any specific health risks present in the work environment. The extent of the information provided to the worker will vary depending on the nature of the hazards and health status of the worker. This should not be interpreted as a requirement to establish formal education programs in the medical facility to inform every worker of their specific potential health risks. This may be appropriate in some cases. However, in most cases a short verbal explanation of the reasons for the examination and the types of health effects being screened for is sufficient.

C1.5.7. Medical Determinations and Recommendations

C1.5.7.1. A medical examination alone cannot determine an individual's ability to perform the essential duties of a particular position. The responsibility for making this determination rests solely with the appointing official. Employment-related decisions involving health are fundamentally managerial, not medical.

C1.5.7.2. Medical information may be an essential element in determining an individual's suitability for job tasks. However, management has the obligation to consider issues that are not strictly medical (e.g., reasonable accommodation or assessment of undue hardship on the operation of the Agency's operations).

C1.5.7.3. The role of occupational medical personnel in addressing employment decisions is limited to determining whether the individual meets the medical requirements of the position and can, from a medical standpoint, perform the job capably and safely.

C1.5.7.4. To assist managers in making employment and placement decisions, medical determinations should fall in one of the following three categories.

C1.5.7.4.1. Qualified -- The individual meets the medical requirements of the position and is (from a medical standpoint) capable of performing the required tasks. Allowing the individual to perform the job will not pose a significant risk to personal health and safety or the health and safety of others.

C1.5.7.4.2. Qualified with Restriction -- The individual meets the medical requirements of the position and is capable of performing the job without risk to personal health or others only with some accommodation or restriction. (When this determination is made, the practitioner should provide a list of recommended accommodations or restrictions and the expected duration of this requirement and therapeutic or risk-avoiding benefit.)

C1.5.7.4.3. Not Qualified -- The individual is incapable of performing essential tasks, will be unsafe, or fails to meet medical requirements for the job

C1.5.8. Recommended Disqualification Procedure

C1.5.8.1. A disqualifying or not-qualified medical determination is legitimate if:

C1.5.8.1.1. A medical condition prevents the worker from performing the essential functions of the job and no reasonable accommodation would enable the worker to perform the job.

C1.5.8.1.2. Allowing the worker to perform the job would endanger the health or safety of other workers or the public.

C1.5.8.1.3. Placing (or retaining) the individual in the job poses a significant risk to the worker's personal health or safety.

C1.5.8.1.4. The individual fails to meet a medical standard or physical requirement for placement in the position.

C1.5.8.2. The examining practitioner should prepare a case summary on all workers determined to be medically unsuited for their job and file this case summary in the workers medical record. The appointing official must be informed of the disqualifying recommendation. The case summary, as confidential medical information, should be provided to management only when necessary and authorized. The following information should be included in all case summaries:

C1.5.8.2.1. Diagnosis. The diagnosis must be justified in accordance with established diagnostic criteria.

C1.5.8.2.2. History. The history of the disqualifying condition(s) including references to findings from previous examinations, treatment, and responses to treatment.

C1.5.8.2.3. Clinical findings. The clinical findings including results of any laboratory tests, x-rays, or special evaluations performed.

C1.5.8.2.4. Prognosis. The prognosis must clearly state the medical basis for concluding that the individual is incapable or unsafe, plans or recommendations for future treatment, and an estimate of the expected date of full or partial recovery. If recovery is not expected this should also be clearly indicated. The prognosis must also include an explanation of the impact of the medical condition on overall activities both on and off the job, the reason(s) why restrictions or accommodations will not enable the individual to perform the job, and an explanation of the medical basis for any conclusions.

C1.5.9. Epidemiology (Reviewing Aggregate Data)

C1.5.9.1. The DoD Components shall accumulate appropriate data to allow trend analysis and early detection of job-related abnormalities that, if undetected and uncorrected, might lead to impairment, disability, or death.

C1.5.9.2. Methods should be developed to periodically analyze occupational medical surveillance examination results and local occupational injury and illness data to identify hazardous processes, operations, and work sites. Once identified,

appropriate targeted intervention programs should be developed to reduce the occurrence of occupational injury and illness.

C1.5.10. Changing Occupational Medical Surveillance Procedures. Certain occupational medical surveillance examination procedures (i.e., firefighters examinations) may be part of an installation or area-wide collective bargaining agreement between the Government and employee unions or organizations. Whenever changes are proposed in collective bargaining-agreed upon procedures, the responsible parties must be notified and allowed to accept or decline the changes. Your local or area-wide Civilian Personnel Office can provide information on collective bargaining required occupational medical surveillance and is the occupational medicine professionals point of contact for proposing any changes in examination procedures.

C3. CHAPTER 3

MEDICAL SURVEILLANCE ENDORSED BY THE DEPARTMENT OF DEFENSE

C3.1. INTRODUCTION

This chapter addresses hazards that OSHA has NOT identified for required medical surveillance. The Department of Defense Medical Surveillance Working Group selected these stressors and occupational groups because of their military uniqueness or common use in the Department of Defense workplace or operational setting.

C3.2. MEDICAL SURVEILLANCE

C3.2.1. Chemical Hazards

C3.2.1.1. Chemical Warfare Agents

C3.2.1.1.1. Chemical warfare agents include primarily nerve agents (GA, GB, GD, and VX), sulfur mustard agents (H, HD, and HT), Lewisite (L), and binary chemicals. Even though the toxicity of chemical warfare agents depends upon the nature and concentration of the agent and the route and duration of exposure, this group of chemicals must be considered highly hazardous. The binary chemicals are manufactured, transported, and stored as separate components of a final mixture. The separate components of sublethal toxicity are not mixed to obtain lethal toxicity until a chemical munition is directed toward an enemy target.

C3.2.1.1.2. Nerve agents are extremely potent inhibitors of acetylcholinesterase, an important enzyme in cholinergic neurotransmission. Mustard and Lewisite act as cytotoxic agents on all tissue surfaces contacted. Mustard has been shown to be mutagenic and carcinogenic in animals. The final mixture of current binary chemicals is a nerve agent. Component chemicals in the binary system have individual and quite varied toxicities.

C3.2.1.1.3. Routes of entry are through inhalation and skin and eye absorption. Ingestion is rare. Exposure may occur during manufacture, storage, transport, or destruction (demilitarization) of these agents. Exposure may also result with research, development, test, and evaluation (RDT&E) activities and during training with live agents. On rare occasions, exposure may occur during accidental excavation of unidentified chemical warfare agent burial sites.

C3.2.1.1.4. The Department of the Army is the executive agent for activities involving chemical warfare agents. Therefore, the Department of the Army, Office of The Surgeon General, is the proponent for medical surveillance guidance for workers with potential exposure. Details regarding medical examinations for these workers can be found in Department of the Army Pamphlets (DA PAM) 40-8, (reference (fff)) and 40-173 (references (ggg)). Further information on current guidelines may be obtained in the CDC "Recommendations for Protecting Human Health Against Long-term Exposure to Low Doses of Chemical Warfare Agents (reference (hhh)).

C3.2.1.2. Nitroglycerin

C3.2.1.2.1. Hazard Description. Nitroglycerin (CAS #55-63-0) in its pure form is a yellow oily liquid explosive that is usually handled as a component of a solid mixture that can produce dust. It is primarily used as a propellant for shells, rockets, and other ordnance. Exposure may be from the inhalation of dusts or vapors, or ingestion of dust, or through the skin. The primary sites of potential exposure are manufacturing plants in the United States, which are few in number. The risk of exposure to workers routinely involved with storage or operational delivery of weapons is far less.

C3.2.1.2.2. Exposure Limits. OSHA has substantially lowered the permissible exposures of nitroglycerin primarily because of cardiovascular effects, concerns of exposure to individuals with cardiovascular disease, and other health effects, such as headaches. Exposure limits for nitroglycerin carry a skin designation to emphasize that nitroglycerin can be absorbed through the skin. The reduction of skin exposure is to be achieved with any reasonable combination of controls, including engineering controls and personal protective equipment under 55 Federal Register No. 217, 26948-46950, Final Rule (reference (iii)).

C3.2.1.2.3. Target Organ(s) and Potential Health Effects. Nitroglycerin exposure is primarily manifested by symptoms in two organ systems:

C3.2.1.2.3.1. The cardiovascular system with symptoms such as palpitations and/or withdrawal angina; and

C3.2.1.2.3.2. The central nervous system with vasodilatation headaches.

C3.2.1.2.4. Criteria for Entry into Medical Surveillance Program.

Workers are recommended for placement into medical surveillance when they are exposed over the action level for more than 30 days a year or 10 days in any quarter.

C3.2.1.2.5. Surveillance Frequency. Workers identified for medical surveillance should receive pre-placement and annual examinations. Termination of exposure and/or employment medical surveillance examinations are not required. Emergency exposure examinations may be done to evaluate for acute effects.

C3.2.1.2.6. Medical and Occupational History. The history should include questions into the following areas:

C3.2.1.2.6.1. The occurrences and frequency of headaches (especially headaches occurring during exposure).

C3.2.1.2.6.2. History of heart disease (chest pain, myocardial infarctions, or abnormal electrocardiograms and/or history of chest pain when away from work -- "withdrawal angina").

C3.2.1.2.6.3. History of elevated blood pressure.

C3.2.1.2.6.4. History of elevated blood lipids (cholesterol and triglycerides).

C3.2.1.2.6.5. Use of medications (especially for hypertension and other cardiovascular diseases).

C3.2.1.2.6.6. Smoking history.

C3.2.1.2.6.7. History of previous exposure to nitroglycerin.

C3.2.1.2.6.8. History of other cardiovascular risk factors including a family history of cardiovascular disease (especially early age - less than age 55 cardiovascular disease events), diabetes mellitus and obesity.

C3.2.1.2.7. Physical Examination. The primary focus of the examination should be on the cardiovascular system including vital signs (especially blood pressure and pulse) and evaluation of the heart and lungs as indicated by the medical and occupational history.

C3.2.1.2.8. Laboratory. Additional studies should be done if indicated by history or physical examination and may include an electrocardiogram.

C3.2.1.2.9. Other Elements. The following areas should be addressed in counseling.

C3.2.1.2.9.1. Proper use of engineering controls and/or personal protective equipment to reduce exposure.

C3.2.1.2.9.2. Review of personal cardiovascular risk factors including the association of smoking and cardiovascular disease and education on the reduction of cardiovascular risk.

C3.2.1.2.9.3. Advising the patient of any health effects resulting from occupational exposure, including association of nitroglycerin exposure with an excess of ischemic heart disease in individuals under age 35.

C3.2.1.3. Organophosphate and Carbamate Pesticides

C3.2.1.3.1. Hazard Description. Organophosphate and carbamate pesticides are routinely used in a variety of pest control applications. These substances are grouped together because of a common mode of toxic action--the inhibition of the enzyme cholinesterase. Organophosphates, as a class, generally bind to the enzyme irreversibly while carbamates tend to bind reversibly. Human toxicity from these compounds can vary widely. Nearly all are readily absorbed from dermal contact, inhalation, and ingestion, making it essential for medical personnel to evaluate the exposure conditions and work practices of the applicators to assess the exposure hazards from multiple routes. Examples of compounds included in this category are: organophosphate pesticides--Dichlorvos (CAS # 62-73-7); Diazinon (CAS# 333-41-5); Chlorpyrifos (CAS# 2921-88-2); Malathion (CAS#121-75-9); and carbamate pesticides--Carbaryl (CAS# 63-25-2); Thiram (CAS#137-26-3); Propoxur (CAS#114-26-1); Ficam (CAS# 22781-23-1).

C3.2.1.3.2. Exposure Limits. Many organophosphate and carbamate pesticides have exposure limits (PEL) that are included in the OSHA-Z table. Exposure limits for these pesticides carry a skin designation to emphasize that they can be absorbed through the skin.

C3.2.1.3.3. Target Organ(s) and Potential Health Effects. The major target organs for organophosphate and carbamate pesticides are the peripheral and central nervous systems. Organophosphates and carbamates exert their toxic effects by

inhibiting cholinesterase in synapses. In acute exposures, initial hyperstimulation is followed by blockage of the affected synapses. Acute symptoms are excessive bronchial secretions, salivation, respiratory distress, incontinence, pinpoint pupils, fasciculations, abdominal cramps, tremors, cyanosis, and coma.

C3.2.1.3.4. Criteria for Entry in Medical Surveillance Program.

Personnel should be entered into medical surveillance if they are: exposed to airborne concentrations above the action level for 30 or more days per year; at significant risk of absorption from dermal exposure or ingestion; or performing an operation in an area where a worker has experienced toxicity related to pesticide exposure and exposure controls have not been in place long enough to assess their effectiveness. In addition, if a workplace survey identifies significant potential for dermal absorption or ingestion, appropriate hazard controls and work practice changes should be recommended. Medical surveillance may be used in these cases as an adjunct to industrial hygiene monitoring to determine if hazard controls are working. Medical monitoring should not be used as a substitute for industrial hygiene surveys.

C3.2.1.3.5. Surveillance Frequency. Workers identified for medical surveillance should receive pre-placement, periodic, and termination of exposure examinations. Cholinesterase determinations will be done during the maximum usage period of the pesticide application season. At locations where organophosphate pesticides are used year-round, the worker should receive at least quarterly cholinesterase determinations. All workers should be examined following any emergency over exposure. NOTE: Because reduced cholinesterase activity can be transient, medical surveillance should be performed during the period of time workers are engaging in operations using organophosphate and carbamate pesticides. Sampling workers at times when they are not exposed is of no value and may mislead workers into believing work practices and applications operations are not producing significant exposures.

C3.2.1.3.6. Medical and Occupational History. At each periodic evaluation, the workers history of use and exposure to pesticides and use of personal protective equipment should be reviewed and updated. A general medical history, along with a specific review of systems emphasizing symptoms of organophosphate/carbamate pesticide toxicity; i.e., headache, salivation, muscle twitching, should be updated or obtained at each evaluation.

C3.2.1.3.7. Physical Examination. When acute toxicity is suspected, the worker should have a complete neurologic exam (including evaluation of pupillary size and reactivity and observation for muscle fasciculations and tremor), auscultation of the chest for wheezing, and inspection for cyanosis. Routine periodic examinations during

the pesticide use season may be limited to the medical and occupational history and cholinesterase testing. Physical examinations for signs of mild exposures are not recommended.

C3.2.1.3.8. Laboratory. Serum (or plasma) and red blood cell (RBC) cholinesterase baseline levels should be done at preplacement or before exposure. This baseline value should be the average of two or more tests taken at least 72 hours, but not more than 14 days apart, and analyzed at the same laboratory. If two tests are done and the difference between them exceeds 15 percent, a third baseline test should be performed. The average of the two closest values should be considered the true baseline value. All baseline tests should be taken when the worker has had no exposure to cholinesterase inhibitors for at least 30 days. Since the interpretation of cholinesterase levels may be difficult, the following guidance is provided under the guidelines (reference (jjj)).

C3.2.1.3.8.1. Serum (or plasma) cholinesterase has a relatively short half-life whereas RBC cholinesterase has the same half-life as red blood cells (about 120 days). These two enzymes are structurally distinct and are inhibited differently by the various organophosphate and carbamate pesticides. For example, diazinon inhibits serum cholinesterase to a much greater extent than RBC cholinesterase under pesticides studied in man (reference (kkk)). Whereas diazinon inhibits both serum and RBC cholinesterase. The normal ranges for serum and RBC cholinesterase determinations are wide with marked interindividual variability and variability if different analytical methods or laboratories are used. For this reason, baseline pre-exposure measurements done by the same methodology, and preferably by the same laboratory, are extremely important. Individuals should be compared against their baseline levels rather than the "normal" range. A reduction in serum cholinesterase activity to 60 percent of baseline may occur before any symptoms appear and a drop to 20 percent of baseline activity is required before serious neuromuscular symptoms become apparent. A variety of medical conditions can depress cholinesterase activity.

C3.2.1.3.8.2. A drop in plasma or RBC cholinesterase levels to 80 percent of a worker's baseline or lower indicates the need for retesting. If the low value is confirmed, the employer should investigate the workplace for faulty work practices and take corrective measures. A drop in RBC cholinesterase level to 70 percent of baseline or lower, or a drop in plasma cholinesterase level to 60 percent of baseline or lower, indicates a need for immediate removal of the worker from all exposure to cholinesterase inhibitors until both parameters return to within 80 percent of the pre-exposure baseline or higher under the guidelines (reference (jjj)).

C3.2.1.3.8.3. In some cases, if exposure to a specific pesticide is suspected, tests for either the chemical or a metabolic product are available. Measurement of urinary organic phosphates is a helpful adjunct to cholinesterase determinations in workers suspected of significant organophosphate exposure. Total urinary organic phosphates in excess of 0.1 mg/L are evidence of significant exposure to organophosphate insecticides. Determination of urinary 1-naphthol is helpful in evaluating workers with suspected exposures to carbaryl. Urinary 1-naphthol levels, measured by colorimetry, greater than 4 mg/L represent significant exposures to carbaryl under 29 U.S.C. 651 *et seq.* and the guidelines (references (k) and (lll)). Reference (mmm) should be consulted for further information on agent specific biologic monitoring.

C3.2.1.3.9. Other Elements

C3.2.1.3.9.1. Removal from exposure if medically indicated (see subparagraph C3.2.1.3.8.2.).

C3.2.1.3.9.2. If respirators are used to protect workers from this hazard, the requirements of 29 CFR 1910.134 (reference (p)) should be applied to assess the worker's ability to safely use the respirator.

C3.2.1.3.9.3. Workers should receive education on the routes of exposure, and the particular importance of dermal exposure; the importance of hand washing and personal hygiene to minimize exposure; and of the symptoms that could represent absorption.

C3.2.1.3.9.4. A healthcare practitioner's written opinion indicating that the worker is qualified for work with organophosphate or carbamate pesticides may be used, if desired.

C3.2.2. Biological Hazards

C3.2.2.1. Biological hazards include microorganisms such as bacteria, viruses, fungi, protozoa, and rickettsiae. Transmission of microorganisms from humans to humans or from animals to humans, in the work setting, may produce occupationally associated infection or disease. Biological hazards may pose a significant risk to many workers in such fields as health care, medical research, public safety, child day care, education, grounds keepers, and animal care. Since most of the infectious diseases caused by biological hazards are not prevented or identified through medical surveillance, no routine medical surveillance is recommended in this section. Pre-placement or baseline medical history, physical examination and immunizations

may be appropriate for certain potential exposures. Subparagraphs C3.2.2.2. through C3.2.2.7. provide general comments on biological hazards and immunizations.

C3.2.2.2. As with chemical and physical hazards, primary prevention provides the best means of protecting workers from biological hazards. Exposure to biological hazards may be prevented or minimized through appropriate infection control methods, proper work practices, and use of personal protective equipment and Universal Precautions.

C3.2.2.3. Immunizations, which also provide primary prevention of disease, are available for many biological hazards. Table C3.T1. provides a reference list of recommendations for immunizations against some frequently encountered biological hazards. Immunization requirements for all military personnel and other applicable non military personnel can be found in the joint instruction Immunizations and Chemoprophylaxis (Air Force Joint Instruction 48-110, Army Regulation 40-562, BUMEDINST 6230.15, CG COMDINST M6230.4E of 1 NOV 95 (reference (nnn))).

C3.2.2.4. Many biological hazards do not produce a biologic marker or physiologic effect that can be readily detected prior to the development of disease. Therefore, secondary prevention by screening for early health effects is often less effective than it may be for many chemical and physical hazards. On the other hand *Mycobacterium tuberculosis* is one biological hazard that is associated with a practical screening measure. The tuberculosis (TB) skin test may be used to identify individuals with a previous TB exposure and latent TB infection. Medical surveillance for health care workers with potential exposure to tuberculosis is included in subparagraph C3.2.3.2.

C3.2.2.5. Hantavirus is a recently identified biological hazard that is spread to humans primarily through the inhalation of aerosolized rodent urine. Transmission through exposure of excreta to eyes and broken skin and the handling of rodents or rodent tissue, are also thought possible. Many types of rodents, including the deer mouse, pinon mouse, brush mouse, western chipmunk, and cotton rat have been identified as reservoirs for the virus and all geographic regions of the United States are considered at risk. The disease in humans presents like influenza and may rapidly progress to a life-threatening respiratory disease. Workers at highest risk are those employees who have contact with rodents, disturb rodent nesting, process soil, vegetation, or rodent tissue potentially infected with hantavirus, or have anticipated or suspected exposure when entering or working in facilities where there is a potential for exposure to hantavirus. Prevention of the disease involves education of workers and proper protective measures including use of personal protective equipment. For employees with a high potential for exposure, drawing and freezing pre-exposure,

baseline serum samples has been recommended. Serum samples retained for future comparison must be stored at -20 degrees C (reference (ooo)).

C3.2.2.6. Another recently recognized infectious disease is human ehrlichiosis caused by species of the genus *Ehrlichia*. The disease is usually an acute febrile illness and is associated with tick bites, much like Lyme disease. The disease may be diagnosed by the development of antibodies that cross react with the *Ehrlichia canis* antigen (*Ehrlichia canis* is not the cause of human disease). Frozen, serum samples may be helpful to recognize changes in serum antibody titers (reference (ppp)).

C3.2.2.7. Biological hazards associated with research, development, test and evaluation (RDT&E) may have special requirements. Guidance concerning immunizations and medical examinations for these programs may be found in Department of the Army Pamphlet (DA PAM) 385-69 (reference (qqq)).^{1,2}

Table C3.T1. U.S. Public Health Service Immunization Requirements^{1,2}

Subject	MMWR Publication ³
Hepatitis, viral B	1991;40(RR-13):1-25 (reference (rrr))
	1990;39(RR-2):1-26 (reference (sss))
Hepatitis, viral A	*
Influenza ⁴	1996;45(RR-5):1-24 (reference (ttt))
Measles	1989;38(s-9):1-18 (reference (uuu))
Mumps	1989;38:388-92, 397-400 (reference (vvv))
Poliomyelitis	1982;31:22-6, 31-4 (reference (www))
	1987;36:796-8 (reference (xxx))
Rubella	1990;39(RR-15):1-18 (reference (yyy))
Tetanus	1985;34:405-14, 419-26 (reference (zzz))
Typhoid	1994;43(RR-14):1-7 (reference (aaaa))
Varicella	1996;45(RR-11):1-36 (reference (bbbb))

¹ The Immunization Practices Advisory Committee (ACIP) periodically reviews recommendations on vaccination and prophylaxis. When recommendations are revised, they are published individually in the Morbidity and Mortality Weekly Report (MMWR) published by the Centers for Disease Control and Prevention (CDC).

² General information on immunization schedules and handling, storage and administration of vaccines can be found in MMWR document--"General Recommendations on Immunizations." MMWR 1994;(RR-1):1-39 (reference (cccc)).

³ The MMWR is available on the World Wide Web through the CDC Homepage (<http://www.cdc.gov>) or by subscription that can be purchased from the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402-9325.

⁴ Each year influenza vaccine recommendations are reviewed and amended to reflect updated information on influenza activity in the United States and to provide information on the vaccine available for the upcoming influenza season. These recommendations are published in the MMWR annually, usually in May or June.

* Current recommendations for hepatitis viral A immunizations are not available in the MMWR, but may be found in the Annals of Internal Medicine 1996;124:135-40 (reference (dddd)) or the New England Journal of Medicine 1997;336:196-204 (reference (eeee)).

C3.2.3. Occupational Groups

C3.2.3.1. Animal-handlers

C3.2.3.1.1. Hazard Description. Animal handlers who work with or around wild, domestic or laboratory animals may be at risk for a number of infectious diseases spread by or in association with animals. In addition to the infectious hazards, small proteins from animal danders or urine, may be the cause of allergic reactions in sensitized individuals. Work with or around animals can also expose the worker to biomechanical hazards associated with lifting cages or food bags and physical trauma secondary to bites and scratches from animals. Numerous infectious diseases can be spread through contact with animals, animal excretions or biologic material. Rabies is a well-known animal-related infectious disease, but other less well known diseases, such as Q-fever, brucellosis, and herpes B virus can be spread from animals to humans. Allergies to animals or animal products can produce a spectrum of allergic responses from common allergic conjunctivitis and rhinitis to life-threatening asthma (reference (ccc)).

C3.2.3.1.2. Exposure Limits. There are no exposure limits for this occupational category.

C3.2.3.1.3. Target Organ(s) and Potential Health Effects. The target organs and potential health effects will depend upon the hazards to which the employee is exposed. All infectious diseases can affect the immune and lymphatic system; sensitizing animal proteins can affect the respiratory system through the induction or

aggravation of allergic rhinitis and asthma; and the reproductive system or reproduction can be affected by the known teratogenic agents such as *Toxoplasma gondii*.

C3.2.3.1.4. Criteria for Entry into Medical Surveillance Program

C3.2.3.1.4.1. There are no mandatory criteria for entrance into medical surveillance programs for individuals exposed to animals. This program is designed for all DoD personnel who have occupational exposure to animals including: the direct care of animals or their living areas; or the direct contact with animals (live or sacrificed), their viable tissues, body fluids, or wastes. Typically animal workers are placed into three risk categories based upon the type of animals handled:

Risk Category 1: rodents, rabbits, aquatics

Risk Category 2: cats, dogs, livestock, ferrets

Risk Category 3: non-human primates

C3.2.3.1.4.2. The content of the medical surveillance program, including content of screening or requirements for immunizations, is based upon the Risk Category.

C3.2.3.1.5. Surveillance Frequency. Pre-placement evaluations are recommended for all animal handlers. The periodic examination frequency is based upon Risk Category and the need for immunizations. If periodic evaluations are necessary, they are generally done annually.

C3.2.3.1.6. Medical and Occupational History. The medical and occupational history should concentrate on those conditions or exposures that may place the worker at increased risk for infection. The following specific areas should be emphasized.

C3.2.3.1.6.1. History of medical conditions associated with suppression of the immune system, including underlying chronic medical conditions (i.e., chronic renal failure, diabetes mellitus), use of corticosteroids, and use of immune suppressive agents.

C3.2.3.1.6.2. Verification of immunizations, including tetanus.

C3.2.3.1.6.3. History of allergies, including atopy, dermatitis, allergic rhinitis, asthma, and sensitivity to latex products.

C3.2.3.1.6.4. Reproductive status of worker (specifically current pregnancy for female animal handlers).

C3.2.3.1.7. Physical Examination. Pre-placement examination requirements and annual medical screening for animal handlers may vary by Risk Category and job description. All risk categories should have vital signs and a review of their medical history. Additional requirements are listed in subparagraph C3.2.3.1.9.

C3.2.3.1.8. Additional Studies

C3.2.3.1.8.1. All Risk Categories: Tetanus immunization history and immunization update as indicated.

C3.2.3.1.8.2. Additional for Risk Category 2: toxoplasmosis titer for females of child-bearing age with exposure to cats; rabies prophylaxis if exposure warrants; and Q-fever titer if exposure warrants.

C3.2.3.1.8.3. Additional for Risk Category 3: influenza titer/immunization if exposure warrants; and tuberculosis screening by skin test if indicated.

C3.2.3.1.9. Other Elements

C3.2.3.1.9.1. Rabies Immunization. Individuals who should receive pre-exposure prophylaxis with human diploid cell rabies vaccine (HDCV) include: those working directly with rabies virus; those having direct contact with animals in quarantine; those having exposure to potentially infected animal body organs or performing post-mortem examinations on animals with a history of rabies; those with neurological disorders; those having the responsibility for capturing or destroying wild animals; or those having large animal (Risk Category 2) contact where a potential for exposure exists. Serological monitoring is performed annually on all HDCV recipients with the exception of the first year when the primary series is given. Booster doses are administered to employees with inadequate titers unless they have a history of a hypersensitivity reaction to the vaccine.

C3.2.3.1.9.2. Toxoplasmosis Titer. Women of child-bearing age who are occupationally exposed to cats and/or their waste should be screened for toxoplasmosis and receive appropriate health education regarding the risk of this disease during pregnancy. Every effort should be made to arrange temporary job reassignment while a susceptible employee is pregnant.

C3.2.3.1.9.3. Q Fever Titer. Employees at risk of exposure to Q fever include those with direct contact with *Coxiella burnetti* and those who handle or use products of parturition (placenta, amniotic fluid, blood, or soiled bedding) from infected sheep, goats or cattle. At the time of the pre-exposure examination, the individual should be assessed for the likelihood of developing chronic sequelae of Q fever should they acquire the disease. Individuals susceptible include those who are immunosuppressed and/or have valvular or congenital heart problems.

C3.2.3.1.9.4. Specific Immunizations. Other specific immunizations and antibody titers should be given or obtained on all animal-handlers working with specific agents or with infected or potentially-infected animals.

C3.2.3.1.9.5. Storage or banking of serum samples is not required except when determined to be appropriate and beneficial for the potential exposures encountered. If serum samples are stored, it is imperative that proper labeling and storage are available (reference (ppp)).

C3.2.3.2. Healthcare Workers

C3.2.3.2.1. Hazard Description. Healthcare facilities may present a number of hazards for healthcare workers (HCWs). Subparagraphs C3.2.3.2.1.1. through C3.2.3.2.1.4. provide a partial listing of possible hazards in the hospital worksite.

C3.2.3.2.1.1. Hazardous Drugs. Hazardous drugs are those drugs, whether considered cytotoxic or not, that have proven genotoxicity, carcinogenicity, teratogenicity or fertility impairment, or produce serious organ or other toxic manifestations at low doses in experimental animals or treated patients. Essentially all chemotherapeutic agents and a significant number of the anti-viral agents are included in this category. Worker exposure to these agents occurs during drug preparation, administration, and disposal under the OSHA Technical Manual Directive (reference (ffff)).

C3.2.3.2.1.2. Mycobacterium Tuberculosis. *Mycobacterium tuberculosis* (TB) is an aerosol-spread organism that is a known cause of human infection. Transmission of *M. tuberculosis* from individuals with respiratory infection is a known risk to patients and HCWs in healthcare facilities. Historically respiratory tuberculosis infections were treatable with anti-tuberculous medication. Recently the organism has developed resistance to standard anti-tuberculous medication and this resistant organism is referred to as MDR-TB (multi-drug resistant tuberculosis). This

emergence of drug-resistant organisms, along with the difficulty in identifying and diagnosing the tuberculosis infection, especially in individuals with other underlying diseases such as AIDS, has increased the risk of exposure to TB for HCWs under the guidelines (reference (gggg)). TB infection in humans can be categorized as "latent" or active. Latent TB infection is an asymptomatic condition characterized by a positive purified protein tuberculin (PPD) skin test. Individuals with latent TB may or may not have chest x-ray findings consistent with "old TB." On the other hand, active respiratory/pulmonary TB infection is usually characterized by cough, sputum production, fever, night sweats, and weight loss. Typically, if the infected individual has an otherwise intact immune system, the TB skin test is positive and the chest x-ray will reveal evidence of the infection. Prevention of the spread of TB is through the early identification and isolation of infected individuals and the use of respiratory protection by the HCWs. If the HCW is provided respiratory protection they must also be enrolled in the Respiratory Protection Program (see Chapter 2).

C3.2.3.2.1.3. Other Chemical and Physical Hazards. HCWs frequently encounter numerous other workplace hazards. The biomechanical hazards of lifting patients and pushing food and laundry carts are a common source of low-back pain and injury in the healthcare setting. Heat and noise hazards can also be found in mechanical spaces, laundries and kitchens. Many chemicals are used in the hospital environment. OSHA's HCS (29 CFR 1910.1200) covers only a few of the chemicals that workers are exposed to ethylene oxide and formaldehyde, but other common hospital chemicals, such as glutaraldehyde, are not covered by any specific regulation. A recent addition to the list of hospital workplace hazards is exposure to airborne latex particles from gloves and other products made from latex. These latex particles have been identified as a cause of allergic reactions in both patients and sensitized workers (reference (hhhh)).

C3.2.3.2.1.4. Blood-borne Pathogens. Requirements for the medical aspects of the blood-borne pathogens program, including vaccination against hepatitis B virus, are found in Chapter 2. The DoD hepatitis B immunization policy requires hepatitis B vaccination for all DoD medical or dental personnel hired or beginning healthcare worker activity after January 1, 1997 (reference (iiii)). See reference (iiii) for policy and exemptions.

C3.2.3.2.2. Exposure Limits. Not applicable.

C3.2.3.2.3. Target Organ(s) and Potential Health Effects. See subparagraph C3.2.3.2.1.

C3.2.3.2.4. Criteria for Entry into Medical Surveillance Program.

Criteria for entry into the medical programs for the OSHA-mandated Blood-borne Pathogens and Respiratory Protection programs are provided in Chapter 2. The OSHA Technical Manual chapter on controlling occupational exposures to hazardous drugs, recommends that those employees potentially exposed to hazardous drugs be enrolled in medical surveillance programs under the OSHA Technical Manual Directive (reference (ffff)). In 1994 the Centers for Disease Control and Prevention published, "Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Healthcare Facilities, 1994" (MMWR volume 43 RR-13, Oct 28, 1994, reference (gggg)). These guidelines outlined the tuberculosis program recommended for healthcare facilities and the requirements for TB skin testing in HCWs.

C3.2.3.2.5. Surveillance Frequency. Pre-placement evaluations are indicated for all HCWs with potential hazardous exposures. The frequency of follow-up evaluations is based upon type, duration and risk of exposure. Healthcare facilities at high-risk for tuberculosis exposure may need to conduct TB screening every 3-6 months, or as needed following known exposures. Otherwise, periodic screening is generally done annually. Examinations following acute exposures and at the termination of employment are also recommended for HCWs exposed to hazardous drugs. Recommendations for post-exposure prophylaxis for HIV exposed workers are provided in reference (jjjj).

C3.2.3.2.6. Medical and Occupational History. The medical and occupational history should be tailored to the type of HCW exposure.

C3.2.3.2.6.1. All HCWs should be asked about medical conditions that may suppress their immune system, including underlying chronic medical conditions (i.e., chronic renal failure, diabetes mellitus), use of corticosteroids, and use of immune suppressive agents.

C3.2.3.2.6.2. Verification of immunizations or documentation of antibodies to specific viruses is required of all HCWs. In addition to hepatitis B (see Chapter 2), immunization or immunity to rubella, measles, mumps and varicella (chicken pox) may be required or recommended (reference (vvv)).

C3.2.3.2.6.3. History of exposure to tuberculosis and history of results of prior TB skin testing.

C3.2.3.2.6.4. History of allergic dermatitis and specifically history of allergy to latex products.

C3.2.3.2.6.5. History of use or ability to wear respirator (TB and Respiratory Protection Program).

C3.2.3.2.6.6. Reproductive status (specifically for female HCWs--if they are currently pregnant).

C3.2.3.2.6.7. Physical Examination. The physical examination requirements, like the medical/ occupational history requirements, will need to be based upon the toxic effects of the potential exposure and the need for respiratory protection or other personal protective equipment. For HCWs with potential exposure to hazardous drugs, a complete examination with emphasis on the skin, mucous membranes, cardiopulmonary system, lymphatic system, and liver is recommended.

C3.2.3.2.6.8. Laboratory

C3.2.3.2.6.8.1. Immunizations, as indicated, or verification of immunity, if required.

C3.2.3.2.6.8.2. TB skin testing as recommended by CDC guidelines (reference (eeee)).

C3.2.3.2.6.8.3. Other laboratory testing as indicated by history and physical examination.

C3.2.3.2.6.8.4. Annual influenza vaccination for healthcare workers is recommended by the Centers for Disease (reference (ttt)).

C3.2.3.2.6.8.5. For HCWs with exposure to hazardous drugs, a complete blood count with differential, white blood cell count, liver function tests, blood urea nitrogen, creatinine, and urinalysis are recommended. The frequency of this testing may be from every year to every 3 years and should be determined by exposure, worker history, and discretion of occupational medicine physician under the OSHA Technical Manual (reference (ffff)).

C3.2.3.2.6.9. Other Elements. See Chapter 2 for requirements for the exposure to blood-borne pathogens. Appendix 5, Hepatitis B Vaccination Declination Form, should be completed and filed in the HCWs medical record if the HCW declines to receive the hepatitis B vaccination series. For Uniformed Service members, waivers are granted only in case of legitimate religious objections to immunization and are revoked if necessary to ensure the accomplishment of the military mission.

C3.2.3.3. Firefighters. DoD Instruction 6055.6 (reference (kkkk)) adopts the National Fire Protection Association (NFPA) Standard 1582, "Medical Requirements for Firefighters" (reference (llll)) as the medical surveillance guidelines for firefighters. These medical screening guidelines replace the medical qualification specifications for civilian firefighters (GS-081) specified by the Office of Personnel Management (reference (mmmm)). These standards are also applicable to full-time military firefighters, but not those assigned fire-fighting as an additional duty (e.g., shipboard fire fighting).

C3.2.3.3.1. Hazard Description. Firefighters are exposed to the chemical hazards of smoke and combustion products and the physical hazards of heat, climbing a ladder, carrying heavy equipment, and wearing a self-contained breathing apparatus. In addition to fighting fires, some firefighters serve as first responders for toxic chemical releases, hazardous material spills, confined space rescue, and for medical emergencies. To function as a firefighter, the individual must maintain a high level of physical fitness and have a healthy cardio-respiratory system.

C3.2.3.3.2. Exposure Limits. Not defined.

C3.2.3.3.3. Target Organ(s) and Potential Health Effects. The respiratory system is the primary target organ for inhalation exposures to smokes and fumes. The cardiovascular system must be able to respond to extremes of physical exertion and exposure to high ambient temperatures. The musculoskeletal system is also at risk from the requirement to climb ladders and carry loads.

C3.2.3.3.4. Criteria for Entry into Medical Surveillance Program. All firefighters are included in the program when they are hired to fight fires.

C3.2.3.3.5. Surveillance Frequency. All firefighters shall receive a medical evaluation annually to certify ability to continue participating in a training or emergency environment as a fire fighter. The medical evaluation shall include a physical examination according to the following schedule:

At time of placement
 Ages 29 and under - every 3 years
 Ages 30-39 - every 2 years
 Ages 40 and over - every year

C3.2.3.3.6. Medical and Occupational History. At placement, a complete medical and occupational exposure history shall be obtained. This history should be updated on each subsequent evaluation.

C3.2.3.3.7. Physical Examination. Height, weight, blood pressure, pulse rate and respirations are required. For physical examinations, completed by the schedule listed above, the required elements of the physical examination are:

C3.2.3.3.7.1. Vital signs.

C3.2.3.3.7.2. Height and weight.

C3.2.3.3.7.3. Examination of skin; eyes, ears, nose and throat; and cardiovascular, respiratory, gastrointestinal, endocrine/metabolic; musculoskeletal and neurologic systems.

C3.2.3.3.8. Laboratory

C3.2.3.3.8.1. Required tests are:

C3.2.3.3.8.1.1. Audiometry.

C3.2.3.3.8.1.2. Visual acuity and peripheral vision;

C3.2.3.3.8.1.3. Pulmonary function testing (spirometry).

C3.2.3.3.8.2. Additional laboratory tests or diagnostic imaging if clinically indicated from medical history or physical examination findings

C3.2.3.3.8.3. Other recommended, but not required, laboratory testing includes:

C3.2.3.3.8.3.1. Pre-placement chest x-ray;

C3.2.3.3.8.3.2. Baseline electrocardiogram;

C3.2.3.3.8.3.3. For firefighters age 40 and over--complete blood count, urinalysis, and chemistry profile (i.e., a focused chemistry panel such a cholesterol panel evaluating cardiovascular risk factors would be the most appropriate screen here as opposed to a generic blood chemistry panel). Consideration should be given to obtaining the above laboratory tests at placement for a baseline.

C3.2.3.3.9. Other Elements

C3.2.3.3.9.1. Civilian Firefighters. The NFPA Medical Requirements for Firefighters provides guidance on which medical conditions disqualify (Category A conditions) or may potentially disqualify (Category B conditions) an individual from being a firefighter. Each installation providing medical screening for firefighters should have access to the NFPA document and should refer to these requirements in developing their firefighter medical monitoring program. While NFPA Category A conditions are listed as medically disqualifying, it is prudent to follow the guidance in 5 CFR Part 339 (reference (i)), Medical Qualification Determinations for the evaluation and disposition of both Category A and B conditions. This guidance specifically addresses that care be used to consider each case on an individual basis, obtaining consultation on each case with the employee's private physician or with the relevant military medical specialists as appropriate. A determination should be made by the examining physician whether a disqualifying medical condition is temporary or permanent in nature and whether the employee's medical condition has reached maximum medical benefit. This information should be discussed with the employee's supervisor and employee relations representative (with care given not to divulge medical information that might be considered confidential). Guidance should be given to the supervisor on what accommodations might be possible for the employee to perform the minimum essential functions of his/her job. The final decision on whether an employee with a disqualifying medical condition is to be retained at work or accommodated is a managerial decision, not a medical decision.

C3.2.3.3.9.2. Military Firefighters. The NFPA medical monitoring requirements defined in NFPA Standard 1582 (reference (III)) shall be applied to full-time military firefighters. Medical fitness for duty procedures for military members shall follow Service-specific Medical Evaluation and Physical Evaluation Board procedures. Final determination of duty status for military members is a personnel action (similar to the case with civilian employees) defined by the Physical Evaluation Board process mentioned above.

C3.2.3.3.9.3. Reserve Force Firefighters. Medical surveillance requirements and fitness for duty evaluations for Reserve force firefighters shall address only those exposures or functional capabilities expected during active duty, including anticipated duties during deployment. The NFPA medical monitoring requirements defined in NFPA Standard 1582 (reference (III)) shall be applied to Reserve force firefighters. Fitness for duty procedures shall follow Service-specific medical evaluation and physical examination board procedures (identical to the active duty force). Medical monitoring requirements for exposures while employed by the

States or other non-DoD organizations, as well as fitness for duty evaluations arising from these activities, is beyond the scope of this Manual and will be addressed by those employers.

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Army Regulation 40-1

MEDICAL SERVICES

**COMPOSITION,
MISSION, AND
FUNCTIONS OF
THE ARMY
MEDICAL
DEPARTMENT**

Headquarters
Department of the Army
Washington, DC
1 July 1983

Unclassified

SUMMARY of CHANGE

AR 40-1

COMPOSITION, MISSION, AND FUNCTIONS OF THE ARMY MEDICAL DEPARTMENT

MEDICAL SERVICES

COMPOSITION, MISSION, AND FUNCTIONS OF THE ARMY MEDICAL DEPARTMENT

By Order of the Secretary of the Army:

JOHN A. WICKHAM, JR.
General, United States Army
Chief of Staff

Official:

ROBERT M. JOYCE
Major General, United States Army
The Adjutant General

History. This revision provides for the designation of The Assistant Surgeon General for Veterinary Services as Executive Agent for all DOD Veterinary Services; sets the policy pertaining to contract surgeons, to include justification for employment, duties, qualifications, full-time or part-time status, compensation and leave, contract negotiations, and contracts; sets the policy pertaining to off-duty employment of Army Medical Department (AMEDD) officers;

makes changes in processing procedures for applications for employment as social workers and psychologists; updates the composition of, and duties of, officers in all AMEDD Corps; makes changes in AMEDD warrant officer descriptions, to reflect Food Inspection Technicians (military occupational specialty 051A); and adds an appendix of required reference publications.

Summary. Not applicable.

Applicability. This regulation applies to—
a. The Active Army and Army National Guard (ARNG).

b. The US Army Reserve (USAR) when called to active duty.

Proponent and exception authority. Not applicable

Impact on New Manning System. This regulation does not contain information that affects the New Manning System.

Army management control process. Not applicable.

Supplementation. Supplementation of the

is regulation is prohibited unless prior approval is obtained from HQDA (DASG-HCD), WASH DC 20310.

Interim changes. Interim changes to this regulation are not official unless they are authenticated by The Adjutant General. Users will destroy interim changes on their expiration dates unless sooner superseded or rescinded.

Suggested Improvements. The proponent agency of this regulation is the Office of The Surgeon General. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) directly to HQDA (DASG-HCD), WASH DC 20310.

Distribution. Active Army, ARNG, USAR: To be distributed in accordance with DA Form 12-9A requirements for AR Medical Services-A. (Applicable to All Army Elements)

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*This regulation supersedes AR 40-1, 5 May 1976.

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Glossary

Chapter 1 INTRODUCTION

1-1. Purpose

This regulation—

- a. Prescribes the composition, mission, and functions of the Army Medical Department (AMEDD).
- b. Provides general information regarding the AMEDD, each AMEDD Corp, and civilian personnel employed by the department.

1-2. Applicability.

This regulation applies to—

- a. The Active Army and Army National Guard (ARNG).
- b. The US Army Reserve (USAR) when called to active duty.

1-3. References.

Required publications are listed in appendix A.

1-4. Explanation of abbreviations.

Abbreviations used in this regulation are explained in the glossary.

1-5. Concept.

a. The AMEDD encompasses those Army special branches that are under the supervision and management of The Surgeon General. Specifically, these special branches are the Medical Corps (MC), Dental Corps (DC), Veterinary Corps (VC), Medical Service Corps (MSC), Army Nurse Corps (ANC), and Army Medical Specialist Corps (AMSC).

b. The mission of the AMEDD is to—

- (1) Maintain the health of members of the Army.
- (2) Conserve the Army's fighting strength.
- (3) Prepare for health support to members of the Army in time of war, international conflict, or natural disaster.
- (4) Provide health care for eligible personnel in peacetime, concurrently with (3) above.

c. Accomplishment of this mission requires the following:

- (1) Development and execution of coordinated plans and programs to provide the best possible health service in war and peace to eligible personnel, within available resources.
- (2) Establishment of health standards.
- (3) Selection of medically fit personnel; disposition of the medically unfit.
- (4) Application of effective means of preventative and curative health services.
- (5) Execution of the approved medical research, development, test, and evaluation (RDTE) program.
- (6) Application of effective means of health education and management.

d. The AMEDD will provide health services for members of the Army and other agencies and organizations under AR 10-5. Each AMEDD component contributes to accomplishing the mission and functions of the AMEDD in its particular sphere of responsibility.

1-6. Responsibilities.

Responsibilities within the AMEDD are outlined below.

a. *The Surgeon General (TSG).* TSG is a general officer of the MC who has—

- (1) Overall responsibilities for development, policy direction, organization, and management of an integrated Army-wide health services system.
- (2) Direct access to the Secretary of the Army and the Chief of Staff, US Army (CSA) on all health and medical matters; these matters include the utilization of AMEDD professional personnel. (See AR 10-5.)

b. *Deputy Surgeon General.* The Deputy Surgeon General is a general officer of the MC who will—

- (1) Perform duties prescribed by TSG.
- (2) Serve as acting TSG in TSG's absence.

c. *Assistant Surgeon General for Dental Services.* The Assistant Surgeon General for Dental Services, a general officer of the DC, will make recommendations to TSG and through TSG to CSA on all

matters concerning dentistry and the dental health of members of the Army. All dental functions of the Army are under the direction of the Assistant Surgeon General for Dental Services.

d. *Assistant Surgeon General for Veterinary Services.* The Assistant Surgeon General for veterinary services, a general officer of the VC, will—

(1) Serve as the Executive Agent for all veterinary services within the Department of Defense (DOD).

(2) Advise, represent, and act for, as directed, TSG on all aspects of DOD veterinary functions.

e. *Officers commissioned in the MC, DC, VC, MSC, ANC, and AMSC.* Officers commissioned in these special branches of the AMEDD will carry out the duties outlined in chapter 2.

f. *Warrant officers of the AMEDD.* Warrant officers assigned to AMEDD specialties will carry out the duties outlined in chapter 3.

g. *Enlisted personnel assigned to the AMEDD.* Enlisted personnel assigned to AMEDD specialties will perform medically related technical and administrative functions prescribed in AR 611-201.

h. *Civilian personnel.* Civilian personnel assigned to the AMEDD will perform the duties shown in chapter 4. These civilian personnel include the following: Physicians, dentists, veterinarians, nurses, specialists in science allied to the practice of medicine, medical support and service personnel, contract surgeons, and professional consultants.

i. *Fee-basis physicians.* Fee-base physicians will perform duties set forth in AR 601-270.

1-7. Policy.

a. An AMEDD member may not be assigned to perform professional duties unless qualified to perform those duties. Assignments that involve professional expertise as recognized in the civilian sector must be filled by members of the AMEDD with equal, or similar, qualifications; however, emergency situations could cause exceptions. Qualifications may be met by education, training, or experience in a particular profession.

b. AMEDD members (including contract surgeons and other civilian employees) while on duty will not recommend to anyone authorized to receive health service in a Uniformed Services medical treatment facility (MTF) or at Army expense that this person receive health services from the member when off duty; this prohibition will include civilians associated in practice with the member. An exception would be that such health service would be provided without cost to the patient, the Government, or any other person or firm.

(1) Active members of the Army will not accept payment or other compensation for providing health services at any time or place to anyone authorized to receive health services in a Uniformed Services MTF, under AR 40-121 and AR 40-3 or at Army expense. Payment or other compensation will exclude military pay and allowances, and whether received directly or indirectly. Health services will include examination or consultation.

(2) AMEDD personnel who are active duty members or civilian employees are prohibited by Federal law from receiving additional US Government compensation of any nature, whether received directly or indirectly, for health services rendered to any person. Active duty members or civilian employees are defined in section 2105, title 5 United States Code; the Federal law cited above is section 5536, title 5, United States Code. Compensation of any nature also cited above will be other than ordinary pay and allowances.

c. The furnishing of testimony or production of records in civil courts by members of the AMEDD will be governed by AR 27-40 and guidance published in related technical bulletins.

(1) Testimony before civilian tribunals can involve State, Federal, or foreign courts, and many different situations. A member of the AMEDD in a nonduty status can appear in court on personal business not connected with the member's profession or official duties; usually, no official clearance will be required for this situation and appearance normally will be in civilian clothing. In cases where litigation is of interest to the United States, appearances and other

matters related to the litigation will be reported to The Judge Advocate General of the Army. A member of the AMEDD receiving an informal request or formal subpoena to give evidence or produce documents immediately will consult with the judge advocate or legal adviser of the member's command or agency.

(2) A member of the AMEDD whose official duties lead to appearance in court as a witness, or to furnishing testimony by deposition in litigation to which the Government is not a party, will not accept payment or compensation other than pay and allowance. Travel and subsistence expenses may be collected if the testimony is limited to matters observed in the performance of official duties. If the member's appearance in court is unrelated to his/her performance of official duties, and if he/she testifies as an expert on behalf of a State or the District of Columbia, or for a private individual, corporation, or agency (for example, other than the US Government) on matters outside the scope of his duties, he/she may accept pay as an expert witness. Further guidance may be obtained from the local Judge Advocate. However, all appearances by military personnel and civilian employees as expert witnesses require prior approval of TJAG under AR 27-40.

(3) No member of the AMEDD is authorized to give testimony against the Government except in the performance of official duty or under AR 27-40.

(4) If a member needs to take time off during normal duty hours because of something connected with his/her off-duty employment, duty or leave status is covered by AR 27-40.

d. No active duty member or civilian employee of the AMEDD, including contract surgeons, will accept appointments as, or act in the capacity of, a State or local official if contrary to Federal law or if included within the restrictions of AR 600-20. Before accepting appointment as, or acting in the capacity of, a State or local official, the advice of the local Judge Advocate will be sought. (See AR 600-50 for restrictions on other outside employment.)

1-8. Remunerative professional civilian employment.

a. A commissioned or warrant officer of the AMEDD on active duty will not engage in civilian employment without command approval. This will include the furnishing of testimony for remuneration. Active duty officers are in a 24-hour, 7-day duty status; their military duties at all times will take precedence on their time, talents, and attention. Subject to the limitations set forth in this regulation, members will not be restrained from employment during their normal off-duty hours. Permission for remunerative civilian professional employment will be withdrawn at any time by the commander when such employment is inconsistent with this regulation. In a case where such permission is withdrawn, the affected officer may submit to the commander a written statement containing views or information pertinent to the situation.

b. Before authorizing engagement in remunerative civilian professional employment, commanders will consider the following conditions of each case regarding the civilian community and the officer involved:

(1) The officer's primary military duty will not be impaired by civilian employment. Requests for civilian employment that exceed 16 hours a week usually will be denied. Commanders can grant exceptions if circumstances clearly show that the additional hours will not adversely affect military duties. Because of potential conflict with military obligations, AMEDD officers will not assume primary responsibility for the care of critically ill or injured persons on a continuing basis nor engage in private (solo) practice. Officer trainees (in graduate training programs) are prohibited from remunerative professional employment.

(2) The officer will not request, or be granted administrative absence for the primary purpose of engaging in civilian employment. However, ordinary leave may be granted to provide testimony in connection with authorized off-duty employment (para 1-7c), providing such absence does not adversely affect military duties.

(3) Civilian employment will not involve expense to the Federal Government nor involve use of military medical equipment or supplies.

(4) Individuals will advise employers that they will be subject to respond to alerts or emergencies that—

(a) May arise during non-duty hours.

(b) Could possibly delay the individual in reporting for civilian employment.

(c) Could require the individual to leave his or her civilian employment without warning.

(5) Civilian employment will be conducted entirely during non-duty hours and outside the Army MTF. Military personnel may not be employed by AMEDD officers in civilian employment.

(6) Except as indicated in (7) below, a demonstrated need must exist because of the relative lack of civilian physicians, veterinarians, nurses, or other professional personnel to serve the local community. A letter from the local professional society (or other responsible community agency) expressing no objection to such employment will be a required attachment to the request. This letter also must certify to the need and to the fact that such service is not available from any reasonable civilian source.

(7) AMEDD officers may engage in charitable civilian employment when voluntarily performed for, or for the benefit of, institutionalized persons and recognized nonprofit, charitable organizations; examples are the Boy Scouts and community clinics. (A letter to the benefiting institution or nonprofit organization should clearly state that the officer is performing charitable work as a private citizen and that the Government assumes no responsibility for the officer's actions.)

(8) Medical, nursing, dental, or veterinary officers prescribing drugs in civilian employment are subject to all the requirements of the Federal narcotic law. This will include Drug Enforcement Agency (DEA) registration and payment of taxes that are imposed upon other physicians, nurses, dentists, or veterinarians conducting private practice.

The responsibility for meeting local licensing requirements is a personal matter for officers who wish to engage in civilian employment. Similarly, malpractice insurance is a personal responsibility of the individual requesting permission to engage in civilian employment. The Army will not be responsible for officers' acts while they are engaged in off-duty employment.

d. Officers will submit written requests when they wish to engage in off-duty employment. The request will describe the position to be filled and the terms of employment; it will state that requester fully understands the provisions of this paragraph concerning off-duty employment; see appendix F. Commanders will approve or disapprove the request in writing and return a copy to the requester within 10 days. Approved requests will be reviewed at least annually by the commanders concerned.

e. Provided the provisions cited in b through d above are met (and authorized absence during normal duty hours does not adversely affect military duties) AMEDD officers—

(1) May, in isolated cases, provide remunerative advice or services to civilian practitioners in the diagnosis or treatment of patients not entitled to medical, dental, or veterinary care under AR 40-3. Employment must be authorized by their commanders; officers must be certified by an American Specialty Board or recognized by TSG as having achieved an equivalent level of professional ability.

(2) Will perform procedures necessary to save life or prevent undue suffering at any time in an emergency.

(3) May engage in teaching, lecturing, and writing as provided in AR 600-50.

1-9. Command positions.

a. The provisions of AR 600-20 apply in the designation or assumption of command; exceptions are shown in the modifications outlined below.

(1) *Health clinics.* Administrative directions of small outpatient health clinics may be vested in any qualified health care professional officer; this will be done without regard to the officer's basic health care profession. These clinics will be integral parts of the US Army Medical Center (MEDCEN) or medical department activity (MEDDAC) organization. In implementing this policy, due consideration will be given to the availability of qualified officers and the

size and mission of these outpatient facilities. In certain Army health clinics, the senior position is designated as commander. These commanders will provide for disciplinary control over personnel assigned to these clinics. The clinic will remain as an organizational element of the MEDCEN or MEDDAC to which assigned; the parent organization will be responsible for administrative control over personnel and financial resources. Professional direction of health clinics will come from the MEDCEN or MEDDAC commander, or an MC officer designated for this purpose.

(2) *Dental clinic.* Professional direction of dental clinics will come from the Director of Dental Services (DDS) or dental activity (DENTAC) commander.

b. MEDCENs, MEDDACs, community hospitals, and specific Army health clinics designated by HQDA(DASG-ZA) will be commanded by an MC officer qualified to assume command under AR 600-20. The MC officer will command, even though an officer of another branch may be the senior regularly assigned officer present.

c. DENTACs and dental units and detachments will be commanded by a DC officer qualified to assume command under AR 600-20. The DC officer will command, even though an officer of another branch may be the senior regularly assigned officer present.

d. When tables of organization and equipment (TOE) units normally commanded by MC, DC, or VC officers are in a training status, they will be commanded by the senior AMEDD officer qualified to assume command under AR 600-200, unless otherwise directed by HQDA.

1-10. Utilization of AMEDD officers.

a. AMEDD officers' duty time will be devoted, to the maximum extent possible, to actions and procedures for which they are specifically trained. They normally will be utilized in their primary occupational specialties.

b. Commanders of AMEDD units will establish local utilization policies for assigned members of their commands. These policies will include performance of additional duties. Policies will be based on—

- (1) Workload.
- (2) Assigned level of personnel.
- (3) General situation of the command.
- (4) Utilization guidance provided in subsequent chapters in this regulation for each AMEDD Corps and for AMEDD warrant officers.

Chapter 2 CORPS OF THE ARMY MEDICAL DEPARTMENT

Section 1 MEDICAL CORPS

2-1. Composition.

The Medical Corps (MC) consists exclusively of commissioned officers who are qualified doctors of medicine or doctors of osteopathy.

2-2. Duties of MC officers.

a. *Professional.* Professional duties are those directly related to—

- (1) Evaluation of medical fitness for duty of members and potential members of the Armed Forces.
- (2) Analysis of the medical and physical condition of patients.
- (3) Practice of preventive and therapeutic medicine.
- (4) Development and adoption of medical principles required for the—

(a) Prevention of disease and disability.

(b) Treatment of patients.

(5) Solution, through research and development (R&D), of medical professional problems in the—

(a) Prevention of disease and injury.

(b) Treatment and reconditioning of patients.

b. *Staff.*

(1) The senior MC officer present for duty with a headquarters (other than medical) will be officially titled—

(a) The "surgeon" of the field command.

(b) The "chief surgeon" of the oversea major Army command (MACOM).

(c) The "director of health services (DHS)" at the installation level.

These titles indicate the medical officer's staff position rather than qualifications.

(2) Duties of these individuals are advisory or technical: advisory as staff officers; technical in the supervision of all medical units of the command. These individuals—

(a) Advise the commander and members of the staff on all medical matters pertaining to the command.

(b) Take part in all planning activities dealing with military operations.

(c) Exercise complete technical control within a command over medical units in the maintenance of health, and in the care of the sick and wounded. This care will include those means of evacuation that are organic to the AMEDD.

(3) Except for direct coordination of professional and technical matters, coordination with staff counterparts at higher and subordinate headquarters is through command channels.

(4) When medical and nonmedical TOE units are stationed at installations where a DHS is authorized and assigned, the designated DHS, if other than the MEDDAC or MEDCEN commander, may retain the position, on approval of the installation commander (see AR 10-43), even though a senior MC officer is on duty with the TOE units.

(5) By mutual agreement between commanders, the appropriate medical staff officer may, as an additional duty, serve as the staff surgeon to other commands which do not have medical staff officers assigned.

(6) Specific duties of a medical staff officer are explained in AR 10-6 and AR 611-101.

2-3. Utilization of MC officers.

a. MC officers' duty time will be devoted, to the maximum extent possible, to actions and procedures for which they are specially trained. A minimum of time will be given to those duties that can be adequately performed under their direction by other AMEDD personnel

b. Except when regulations provide otherwise, such officers will not be—

(1) Detailed as members of—

(a) Courts-martial.

(b) Nonprofessional boards or committees.

(2) Assigned to other duties in which medical training is not essential.

To preclude requiring the personal appearance of MC officers as witnesses to present testimony, every effort consistent with due process of law will be made to use reports, depositions, or affidavits submitted by MC officers in connection with courts-martial and boards or committees.

2-4. Applicability of Federal and State licensing laws.

When duties are performed by MC officers under valid orders issued by lawful Federal authority, such officers are—

a. "Exempt officials," as explained by the DEA.

b. Not required to register and pay the Federal narcotics tax.

Section II DENTAL CORPS

2-5. Composition.

The Dental Corps (DC) consists exclusively of commissioned officers who are qualified doctors of dental surgery or dental medicine.

2-6. Duties of DC officers.

a. *Professional.* Professional duties will be those directly related to the science of dentistry as practiced by the dental profession.

These will include dental examinations, preservation and promotion of dental health, and execution of approved dental RDTE programs.

b. Staff.

(1) The primary duty of the senior DC officer present for duty with a non-DENTAC headquarters will be that of dental staff officer, except where designated as deputy commander. The title of a dental staff officer will be "dental surgeon."

(2) Individuals exercise complete technical control within the command over dental activities in the—

(a) Prevention of oral disease.

(b) Care of dental patients.

(3) Coordination with staff counterparts at high and subordinate headquarters is through command channels; an exception will be for direct coordination of professional and technical matters.

(4) By mutual agreement between commanders, the appropriate dental staff officers may, as an additional duty, serve as the staff dental surgeon to other commands that do not have a dental staff officer assigned.

(5) Specific duties of a dental staff officer are explained in AR 10-6 and AR 611-101.

2-7. Utilization of DC officers.

This applicable portions of paragraph 2-3 govern in the utilization of dental officers.

2-8. Dental organizations.

a. Dental personnel required by commands will be organized into DENTACs, as well as US Army Area Dental Laboratories (ADLs), and TOE units, as required. The DENTAC is part of the MEDCEN or MEDDAC table of distribution and allowance (TDA); however, the DENTAC is supported by, not commanded by, the MEDCEN or MEDDAC. The DENTAC receives complete administrative and logistical support from the MEDCEN or MEDDAC.

b. The dental care program is managed separately by the appropriate AMEDD command headquarters (for example, Headquarters US Army Health Services Command (HQ, HSC); Medial Command (TOE 8 111H?)) as a discrete, functionally managed program. On matters pertaining to the dental health of the command, the installation commander will communicate directly with the DDS, under AR 5-3.

2-9. Application of narcotic and licensing laws to DC officers.

Paragraph 2-4 applies.

Section III

VETERINARY CORPS

2-10. Composition.

The Veterinary Corps (VC) consists exclusively of commissioned officers who are qualified doctors of veterinary medicine.

2-11. Duties of VC officers.

a. The Assistant Surgeon General for Veterinary Services—

(1) Serves as executive agent for veterinary services for the DOD; see DODD 6015.5.

(2) Provides veterinary support to the DA, Department of the Navy and the US Marine Corps, the Air Force, all DOD agencies, and the US Coast Guard.

b. Professional duties of VC officers are discussed below.

(1) Provide consultative services to personnel performing food hygiene, safety, and quality assurance inspections. This will include advising the appropriate authority on the acceptability of food as follows:

(a) Food processing inspections incident to and following the procurement of foods of animal origin or other foods, when requested by proper authority.

(b) Sanitation inspection of establishments in which foods are produced, processed, prepared, manufactured, stored, or otherwise handled; excluded are food service facilities, such as dining facilities and snack bars.

(c) Inspections on receipt at destination for identity and condition of all foods of animal and non-animal origin.

(d) Perform professional functions in medical laboratories such as chemical, bacteriological, and radiological analyses of foods.

(e) Inspections to determine fitness for human consumption of all foods which may have been contaminated by chemical, bacteriological, or radioactive materials.

(2) Assist the senior medical staff officer or the MEDCEN or MEDDAC commander at all levels of command in discharging responsibilities for conducting a comprehensive preventive medicine program. This will include the prevention and control of diseases common to man and animals in areas of responsibility specified by the—

(a) Senior medical staff officer.

(b) MEDCEN or MEDDAC commander.

(3) Provide a comprehensive program for prevention and control if diseases or conditions that may—

(a) Be transmissible to humans or animals.

(b) Constitute a military community health problem.

(4) Provide veterinary service support—

(a) In AMEDD training programs.

(b) To medical and subsistence R&D programs and activities.

(5) Provide complete veterinary services for US Government public-owned animals. Morale support activities-owned animals will be provided veterinary services as time and resources permit.

(6) Collect and maintain data on—

(a) Food supplies and animal diseases that may affect the health of members to the Army.

(b) Animal diseases that may affect the health of public animals. In this respect, they will advise and make recommendations to the appropriate authority of existing or anticipated conditions that may be of military or civilian significance. Under applicable circumstances, these would include local, State, Federal, and comparable agencies.

(7) Provide technical consultation to the senior medical staff officer or the MEDCEN or MEDDAC commander. In this capacity the

(a) Identify unsanitary conditions associated with subsistence and animals.

(b) Make recommendations for correction of these unsanitary conditions.

(8) Assist, on request and when authorized, civilian authorities or other Federal departments in emergency animal disease control programs.

c. Specific duties of a veterinary staff officer are defined in AR 10-6 and AR 611-101.

2-12. Utilization of VC officers.

a. Applicable portions of paragraph 2-3 govern the utilization of VC officers.

b. As installation and activities where no VC officer is assigned required military veterinary service may be provided on an attending basis; this must be authorized by the Commanding General, US Army Health Services Command (CG, HSC) and the oversea MACOM commander for their areas of responsibility.

2-13. Title of VC officers.

a. The general officer in the VC may, when so designated by TSG, be called—

(1) The Assistant Surgeon General for Veterinary Services.

(2) Chief, Veterinary Services.

(3) Chief, VC.

b. The title of the senior VC officer assigned to a command, agency, or activity is "Veterinarian."

Section IV

MEDICAL SERVICE CORPS

2-14. Composition.

The Medical Service Corps (MSC) is authorized one officer in the grade of Brigadier General who serves as Chief of the MSC. The

MSC by law (section 3068, title 10, United States Code) is organized into four sections: Pharmacy, Supply, and Administration Section; Medical Allied Sciences Section; Sanitary Engineering Section; and Optometry Section. An officer is selected and certified by TSG and the Chief of the MSC to be Chief of each Section; each officer concurrently is designated an Assistant Chief of the MSC. These MSC sections are subdivided as follows:

a. Pharmacy, Supply and Administration Section.

- (1) Health care administration.
- (2) Field medical assistant.
- (3) Health services comptroller.
- (4) Biomedical information systems.
- (5) Patient administration.
- (6) Health services personnel management.
- (7) Health services manpower control.
- (8) Health services plans, operations, intelligence, and training.
- (9) Aeromedical evaluation.
- (10) Health services materiel.
- (11) Health facilities planning.
- (12) Pharmacy.

b. Medical Allied Sciences Section.

- (1) Microbiology.
- (2) Biochemistry.
- (3) Parasitology.
- (4) Immunology.
- (5) Clinical laboratory.
- (6) Physiology.
- (7) Podiatry.
- (8) Audiology.
- (9) Social work.
- (10) Clinical psychology.
- (11) Research psychology.

c. Sanitary Engineering Section.

- (1) Nuclear medical science.
- (2) Entomology.
- (3) Environmental science.
- (4) Sanitary engineering.

d. Optometry Section.

2-15. Duties of MSC officers.

a. Officers of the branch perform a wide variety of administrative, technical, scientific, and clinical duties within the AMEDD. These duties will be consistent with the officer's education, training, and experience. MSC officers will perform duty in branch immaterial assignments only when authorized by HQDA (DASG-PTZ).

b. See AR 10-6 and AR 611-101 for a more definitive explanation of duties of MSC officers.

2-16. Utilization of MSC officers.

a. MSC officers normally will be utilized in their primary professional specialty.

b. Applicable portions of paragraph 2-3 govern the utilization of those MSC officers who, in the performance of their assigned duties, provide patient care through either of the following:

- (1) Direct professional services on an appointment basis.
- (2) Preventative medicine functions.

c. Exceptions to *b* above are duties involving courts, boards, administrative officer of the day (AOD), or staff duty officer (SDO).

d. Provisions of paragraph 1-9d and the annually published HQDA Letter (MEDO Letter) govern MSC officers exercising command.

Section V ARMY NURSE CORPS

2-17. Composition.

The Army Nurse Corps (ANC) consists exclusively of the Chief, Assistant Chief, and other commissioned officers who are qualified, registered, professional nurses.

2-18. Duties of ANC officers.

a. Professional. Duties of ANC officers are those related to the theory and practice of nursing.

(1) The focus of the practice of nursing is on the assessment of individual, family, or group health care needs to—

(*a*) Promote health.

(*b*) Prevent illness.

(*c*) Provide assistance in coping with physical and psychological aspects of illness. This goal is accomplished by a variety of modalities, such as teaching, counseling, case-finding, and skilled supportive care.

(2) Nursing is based on recognized professional standards of practice. It has certain functions for which its practitioners accept responsibility. These include both independent nursing functions and delegated medical functions that may be either—

(*a*) Performed autonomously in coordination with other health team members.

(*b*) Delegated by the professional nurse to other persons.

(3) In US Army MEDCENs and MEDDACs the Department of Nursing is the administrative unit that provides the organization framework for nursing activities to accomplish the following:

(*a*) Define, design, and implement nursing care systems.

(*b*) Establish specific nursing care technologies, processes, and standards; develop mechanisms to insure that these standards are maintained.

(*c*) Collect and evaluate data concerning categories of patients and nursing resources.

(*d*) Assess and evaluate results of nursing actions on a continuous basis.

(*e*) Forecast and plan for requirements in money, materials, and personnel resources.

(*f*) Coordinate nursing actions with other health care providers.

(*g*) Establish a climate for and promote nursing research.

(*h*) Provide opportunities for continuing education for nursing personnel.

(*i*) Provide flexibility and modification of practice in response to technological advances and social changes.

b. Staff and other duties. Detailed duties, responsibilities, and titles of ANC officers are outlined in AR 40-6, AR 10-6, and AR 611-101.

2-19. Utilization of ANC officers.

a. ANC officers will be assigned to nurse-related professional, administrative, and staff duties that directly contribute to the accomplishment of the AMEDD mission. ANC officers will be considered appropriately assigned when performing duties related to their specialty skills identifier.

b. The applicable portions of paragraph 2-3 govern the utilization of ANC officers may be detailed as members of combatant boards of nonprofessional boards or committees when ANC officers or other nursing service personnel are involved in the proceedings.

c. ANC officers will not perform AOD, SDO, or other additional duties in which nursing professional education, training, and experience are not essential. Exceptions include serving—

(1) In an administrative headquarters (for example, HQ, HSC; HQDA; or Medical Group (TOE 8-122H)).

(2) As an administrative resident.

(3) As chief nurse in a TOE unit.

Section VI ARMY MEDICAL SPECIALIST CORPS

2-20. Composition.

a. The Army Medical Specialist Corps (AMSC) is composed of a Dietitian Section, Occupational Therapist Section, and Physical Therapist Section.

b. The AMSC consists exclusively of officers who are—

(1) Registered dietitians, certified occupational therapists, or licensed physical therapists.

(2) Eligible for membership in the American Physical Therapy Association.

(3) Taking part in AMSC professional education programs for the purpose of becoming qualified in one of the specialties cited in (1) or (2) above.

2-21. Duties of AMSC officers.

a. Duties of AMSC officers will be directly related to the specialties of dietetics, physical therapy, or occupational therapy, as practiced by the respective civilian professions. These will include development and adoption of principles and standards to meet the total needs of patients in these specialized fields.

b. See AR 10-6 and AR 611-101 for specific duties of AMSC officers.

2-22. Utilization of AMSC officers.

a. When AMSC officers are assigned to Army MTFs—

(1) The senior dietitian will be Chief of the Food Service Division.

(2) The senior physical therapist and senior occupational therapist will be chiefs of their respective sections.

b. The applicable portions of paragraph 2-3 govern the utilization of AMSC officers. An exception is that AMSC officers may be detailed as members of courts-martial boards or nonprofessional boards or committee when the following are involved in the proceedings:

(1) AMSC officers.

(2) Other food service, physical therapy, or occupational therapy personnel.

c. AMSC officers working regularly established clinic hours may perform AOD and SDO functions. Fair and equitable scheduling of those officers who work shifts or who are on weekend and holiday duty rosters within their sections must be evident.

d. AMSC officers will not be assigned to AOD or SDO or assistant AOD or SDO function when they are taking part in the following:

(1) The Army Dietetic Internship Program.

(2) The Army Occupational Fieldwork Program.

e. AMSC officers will not be assigned special administrative duties. These include, but are not limited to, additional duties; for example, line inventory, drug inventory, hospital inspection, and cash verification. The only exception would be those officers serving—

(1) In an administrative HQ.

(2) As administrative residents.

Chapter 3

ARMY MEDICAL DEPARTMENT WARRANT OFFICERS

3-1. Physician assistant, military.

a. *Composition.* Military physician assistants (PAs) are school-trained warrant officers who are qualified for and who have been awarded military occupational specialty (MOS) 011A.

b. *Duties.* Military PAs have the following duties:

(1) Provide general medical care for the sick and wounded under the supervision of designated physicians. Perform technical and administrative duties as—

(a) Indicated in AR 611-112.

(b) Assigned by supervisors in MTFs.

(2) Provide for preparation and maintenance of necessary records and reports.

(3) Supervise or assist in supervising enlisted specialists and comparable civilian employees in utilization, care, and maintenance of medical supplies and equipment.

(4) Assist in the training of enlisted specialists and comparable civilian employees in technical aspects of patient care and treatment.

c. *Utilization.* The provisions of paragraph 1-10 and AR 40-48 govern the utilization of military PAs.

(1) PAs will be utilized only within their MOS in troop medical

clinics, aviation medicine clinics, emergency rooms, physical examination sections, general outpatient clinics, family practice clinics, other primary care clinics, field medical units, and other medical facilities.

(2) Career management of military PAs is monitored by the MOS Career Activities Office, US Army Medical Department Personnel Support Agency, WASH DC 20324; this office comes under the direction of the Directorate of Personnel, Office of The Surgeon General (OTSG), HQDA.

3-2. Biomedical equipment repair technician.

a. *Composition.* Biomedical equipment repair technicians are warrant officers who are qualified for and have been awarded MOS 202A.

b. *Duties.* Biomedical equipment repair technicians perform specialized, equipment-oriented management functions; these include skills, knowledge, and abilities to manage programs for the maintenance of medical equipment. AR 611-112 prescribes the full range of duties performed by biomedical equipment repair technicians. Specific areas of responsibility are shown below.

(1) Planning and scheduling workload.

(2) Supervising and instructing subordinates.

(3) Administering a repair parts program.

(4) Recording maintenance performance and historical equipment data; coordinating with user and support activities.

(5) Developing and operating ancillary support programs.

(6) Advising on the layout of health care facilities as related to equipment and applicable installation requirements.

(7) Advising the commander and staff on maintenance-related matters.

c. *Utilization.* Provisions of paragraph 1-10 and AR 40-48 govern utilization of biomedical equipment repair technicians.

(1) Personnel with this specialty will be utilized only in their MOS; they normally will be assigned to TDA hospitals, MEDCENS, MEDDACs, or equivalent modifications TOE units. Some personnel also will be assigned for the following functions:

(a) Managing depot or combined maintenance operations.

(b) Performing as equipment specialists in varying assignments.

(c) Serving as instructors in service schools.

(d) Commanding TOE medical equipment maintenance detachments.

(2) Other personnel with this specialty also serve in successively higher levels of management with MACOMs and the National Maintenance Point.

(3) Career management of biomedical equipment repair technicians is monitored by the MSC Career Activities Office, US Army Medical Department Personnel Support Agency, WASH DC 20324; this office comes under the direction of the Directorate of Personnel, OTSG, HQDA.

3-3. Food inspection technician.

a. *Composition.* Food inspection technicians are school-trained warrant officers who are qualified for and have been awarded MOS 031A.

b. *Duties.* Food inspection technicians—

(1) Manage and direct personnel, facilities, and equipment required for military hygiene, safety, and quality assurance.

(2) Provide assistance in programs to—

(a) Prevent animal diseases.

(b) Control zoonotic and foodborne illnesses.

(3) Assist in animal control programs.

(4) Prepare reports relative to veterinary activities.

(5) Maintain liaison with Federal, State, and local health agencies.

(6) Assistant in the conduct of training of enlisted personnel and civilian employees.

(7) Other technical and administrative duties are performed as—

(a) Indicated in AR 611-112.

(b) Assigned by the technician's supervisor.

c. *Utilization.* The provisions of paragraph 1-10 govern the utilization of food inspection technicians. They will be utilized only

within their MOS in TOE units, TDA activities, MEDCENs or MEDDACs, and other DOD agencies and activities. Career management of food inspection technicians is monitored by the VC Career Activities Office, US Army Medical Department Personnel Support Agency, WASH DC 20324; this office comes under the direction of the Directorate of Personnel, OTSG, HQDA.

Chapter 4 ARMY MEDICAL DEPARTMENT CIVILIAN PERSONNEL

4-1. Civilian employees.

a. Composition. The civilian complement of the AMEDD consists of US citizens and direct- and indirect-hire local nationals employed under appropriate regulations issued by the US Office of Personnel Management, HQDA, and the AMEDD.

b. Duties. Civilian are employed in a wide range of occupational categories; these include physicians, nurses, those in other medical and allied specialties, and support and service personnel.

c. Utilization. General utilization policy of AMEDD civilian employees is outlined in AR 570-4.

d. Social workers and psychologists. Policy for employment of social workers and psychologists is contained in appendix E.

4-2. Contract surgeons.

a. Authorization. In an emergency, TSG may employ as many contract surgeons as may be necessary within applicable personnel limitations (section 4022, title 10, United States Code). An emergency may exist when utilization of the services of an MC officer or a graded Civil Service physician is not practicable or feasible for providing essential health services. Contract surgeons will not be employed as a means for circumventing general schedule pay scales (Civil Service) established for physicians employed by the US Government.

b. Justification for employment. Justification for employment of private physicians as contract surgeons in peacetime will be forwarded for approval through command channels to HQDA (DASG-PSC), WASH DC 20310, to arrive 60 days before the desired date of employment. When intermediate MACOM commanders do not concur with any part of the justifications, it will be returned to the originator with reasons for nonoccurrence. As a minimum, each justification submitted to HQDA will contain appropriate data with the following information:

(1) Workload data for the most recent 6-month period. This will include, for example, the number of visits (inpatient and outpatient, as appropriate) and the number of medical examinations, as pertains to areas in which a private physician will be employed.

(2) Projected workload data for period of contract. (See (1) above.)

(3) Number, by type of personnel (military, civil service, contract surgeon, or fee-for-service), presently authorized, required, and assigned in the work area where the contract surgeon is required.

(4) Other procurement actions taken to provide necessary services; an example is through the US Office of Personnel Management.

(5) Number of active duty medical officers programmed to fill existing or projected vacancies.

(6) Effective dates of contract.

(7) Activity or installation to be serviced by contractor.

(8) Compensation; hourly, daily, weekly, monthly, or yearly, as applicable.

(9) Hours, days, place of duty, and full-time or part-time; examples of place of duty are clinic or emergency room.

(10) Types of services to be provided; examples are sick call or emergency room.

(11) Types of personnel to be provided medical care; see AR 40-3 for eligibility for medical care. Specify as active duty Army, other active duty, dependents of US Uniformed Services personnel

(active duty and retired), retired US Uniformed Services personnel, or other personnel.

(12) Restrictions imposed or contemplated to be imposed upon the contractor.

(13) Proposed source and address.

(14) Monitoring headquarters; name and telephone (automatic voice network (AUTOVON)) of the individual conducting preliminary negotiations with the private physician.

(15) Statements that—

(a) Employment will be within all applicable personnel limitations and funding availability.

(b) The contractor will possess the applicable qualifications outlined in d below.

c. Duties. Professional and administrative duties of contract surgeons will be comparable to those which MC officers with similar training and experience normally would be called upon to perform. Contract surgeons are not eligible for detail on courts-martial boards, but may be detailed to serve on—

(1) Medical boards convened under AR 40-3.

(2) Administrative boards to which civilian employees may be appointed.

d. Qualifications.

(1) To be eligible as a contract surgeon within the United States, the contractor must be one of the following:

(a) A graduate of a medical school approved by the Council on Medical Education and Hospitals of the American Medical Association.

(b) A graduate of a school of osteopathy approved by the Bureau of Professional Education Committee in Colleges of the American Osteopathic Association.

(c) A holder of a permanent certification by the Educational Council for Foreign Medical Graduates.

(2) The candidate must—

(a) Have a full or unrestricted license to practice medicine in a State, the District of Columbia, the Commonwealth of Puerto Rico, or a territory of the United States.

(b) Be legally authorized to prescribe and administer all drugs and perform all surgical procedures in the area concerned.

(3) Oversea MACOM commanders will prescribe the qualifications for contract surgeons for their respective area of employment.

e. Full-time and part-time status.

(1) A full-time contract surgeon is one who is required to devote full time to the performance of duties under the contract; full time here means not less than 40 hours each calendar week.

(2) A part-time contract surgeon is one who is required each week to devote less than 40 hours to the performance of duties under the contract.

f. Compensation and leave.

(1) Pay and allowances for full-time and part-time contract surgeons will be as prescribed in Misc Publ 13-1.

(2) Pay of part-time contract surgeons may not exceed the monthly base pay of an officer, O3, with over 4, but less than 6, years of service.

(3) Part-time contract surgeons are entitled only to the travel and transportation allowances in the same amount and under the same conditions as allowed for commissioned officers.

(4) Special and incentive pays may not be included in the contract for either part-time or full-time contract surgeons.

(5) Contract surgeons are not entitled to officers' uniform allowances.

(6) Within the limitations prescribed above, oversea MACOM commanders are authorized to determine applicable compensation of part-time contract surgeons within the geographical limits of their commands. These rates will take in account—

(a) Comparable rates paid for similar services in the locality.

(b) Background, experience, and other qualifications of the contractor.

(c) Extent of service required under to contract.

g. Contract negotiation. Section 2304a(4) and 2304a(6), title 10, United States Code and Misc Pub 28-25, paragraph 22-102.1 contain authority for negotiation of contracts with private physicians.

On approval of justification by HQDA (DASG-PSC) (para 4-2b), commanders of installations and activities may enter into contracts for services of contract surgeons.

h. Contracts.

(1) *General.* The following provisions apply to both full-time and part-time contract surgeons:

(a) Contracts will be executed by the local contracting officer under applicable provisions of Misc Pub 28-24 and Misc Pub 28-25 (32 CFR 591 et seq.).

(b) The term of the contract will be for a specific period of time; it will not extend beyond the end of a fiscal year during which the available appropriated funds are authorized to be obligated.

(c) A contract will not be renewed automatically upon expiration. Justifications for re-employment of private physicians as contract surgeons for the ensuing fiscal year will be forwarded under paragraph 4-2b.

(d) One copy of each executed contract will be forwarded to HQDA (DASG-PSC), WASH DC 20310 within 10 working days after the effective date of the contract; the executed contract will be for initial employment or re-employment.

(2) *Contract format.*

(a) Contracts will conform to the format prescribed by Misc Pub 28-24 (para 16-102.2) and by Misc Pub 28-25 (app F 100-26).

(b) Each contract will contain a statement of work substantially as shown in appendixes B, C, or D. Modifications to these statements to meet local requirements are not prohibited; however, changes should be kept to a minimum.

4-3. Professional consultants.

a. General. This paragraph contains information and instructions regarding professional consultants (hereafter referred to as consultants). Those portions of this paragraph that deal with civilian consultants supplement CFR 4-4 and FPM Chapter 304. Unless otherwise specifically indicated, provisions of this paragraph are applicable to both military and civilian consultants.

b. Duties.

(1) Consultants will—

(a) Assist in the maintenance of high standards of professional practice and research.

(b) Further the educational program for the advancement of AMEDD officers in the medical, dental, nursing, and allied specialties.

(c) Provide close liaison with leaders in related professions.

(2) These consultants will assist TSG, the Commanding General, US Army Medical Research and Development Command (CG, USAMRDC), the CG, HSC, chief surgeons of oversea MACOMs, and commanders of AMEDD activities, particularly treatment and

(a) On matters pertaining to professional practice by providing advice on professional subjects.

(b) On new developments in prophylaxis, diagnosis, treatment, and technical procedures.

(c) By stimulating interest in professional problems and aiding in their investigation.

(d) By giving advice on RDTE programs.

(e) By encouraging participation in programs such as clinical and pathological conferences, ward rounds, and journal clubs.

(3) Proper performance of these duties involves an appraisal of all factors concerned with the prevention of disease and the professional care of patients. These include—

(a) Organization and program of professional services in medical installations.

(b) Quality, numbers, distribution, and assignment of specialty qualified professional personnel.

(c) Diagnostic facilities and availability and suitability of equipment and supplies for professional needs.

(d) Dental care, nursing care, and dietary provisions.

(e) Physical therapy and occupational therapy.

(f) Reconditioning and recreational facilities.

(g) Other ancillary services which are essential to the welfare and morale of patients.

(4) Execution of these duties involves periodic visits to MTFs and other types of AMEDD units concerned with health service or medical R&D activities.

c. Utilization categories. Utilization of consultants falls into the following categories:

(1) *OTSG.* In addition to AMEDD officers assigned or designated as consultants, other specialty qualified individuals may be utilized to—

(a) Provide TSG with professional advice or assistance, as required.

(b) Perform duties set forth in b above.

(2) *OTSG field operating agencies (FOAs).* OTSG FOAs are activities under the command jurisdiction of TSG.

(a) Consultants may be utilized to perform duties set forth in b above. Their services will be utilized, as required, for professional advice or assistance. (For further information regarding the educational program of the AMEDD in the medical, dental, nursing, and allied specialties, see AR 351-3.)

(b) In activities where intern or residency training programs are conducted, a representative consultant may be appointed to the Hospital Education Committee. This consultant may advise and recommend on all matters pertaining to graduate education. (For further information regarding AMEDD residency or intern training programs see AR 351-3.)

(3) *HSC.*

(a) Consultants may be utilized to perform duties set forth in b above. Their services will be utilized, as required, for professional advice or assistance.

(b) In hospitals conducting residency or intern training, a representative consultant may be appointed to the Hospital Education Committee. This consultant may advise and recommend on all matters pertaining to graduate education.

(4) *Oversea MACOMs.*

(a) Consultants may be utilized to perform duties set forth in b above. Their services will be utilized, as required, for professional advice or assistance.

(b) In hospitals conducting residency or intern training, a representative consultant in surgery, internal medicine, psychiatry and neurology, pathology, and dentistry may be appointed to the Hospital Education Committee. These consultants may advise and recommend on matters pertaining to graduate education.

4-4. Administrative procedures for professional consultants.

Before the initial appointment of consultants in the medical, dental, nursing, and allied specialties, the appropriate command or agency will conduct the following administrative procedures:

a. Appointment.

(1) *Military consultants.* In addition to AMEDD officers assigned as consultants, other specialty qualified individuals may be utilized to advise TSG, the CG, USAMRDC, the CG, HSC, and oversea MACOM commanders on major subjects and board problems connected with the following:

(a) Policy and practice in the prevention of disease.

(b) Care of patients.

(c) Health and environment activities.

(d) Evaluation and maximum utilization of specialized personnel.

(e) R&D program.

(f) Postgraduate education.

(g) Continuing education programs for AMEDD officers.

(h) Other important professional matters. TSG and MACOM commanders will appoint these designated individuals on appropriate military orders.

(2) *Civilian consultants.* TSG, the CG, HSC, the CG, USAMRDC, and oversea MACOM commanders may approve appointment of civilian consultants within their respective commands or agencies. Normally, civilian consultants will not be utilized for a period or periods exceeding 90 calendar days in 1 fiscal year. Prior approval by the appropriate approval authority must be obtained in

additional days of service are required during any fiscal year. In order to maintain a single pay account and to insure that consultants do not exceed the authorized maximum number of days in any fiscal year, civilian consultants will be carried in an appointive status on the rolls of only one command or agency. Short-term consultant appointments, not to exceed 6 months in total tenure, will be requested when individuals are required for brief periods of time to carry out special assignments; examples would be a trip overseas or giving a series of lectures.

(a) *Security requirements.* The security requirements established in the FPM, chapter 732 and CPR A-9, chapter 732 for assignment OT civilian positions in the competitive service will apply to civilian consultants. Nonsensitive positions require completion of National Agency Check and written inquiries with satisfactory results. These may be conducted as post-appointive actions.

(b) *Reappointment.* Civilian consultants will be reappointed by the employing command or agency at the end of each fiscal year instead of at the end of the service year, as specified in CPR A-9.

(c) *Roster.* To maintain a current roster of all AMEDD civilian consultants to the Army in an appointive status, each appointing command or agency will publish an annual roster no later than 15 July of each year. Addendum's will be published as required. Appointment data on consultants is provided through the DA Civilian Personnel Information System (CIVPERSINS). If needed, rosters may be obtained through CIVPERSINS channels.

b. *Joint utilization.* Consultants appointed by one command or agency may be used by another command or agency through agreements made between the commands or agencies concerned. Payment for services rendered by civilian consultants, plus travel and per diem for military consultants, will be made by the parent command from funds available for this purpose and cited by the using command. Transfer of funds between commands is not authorized.

c. *Civilian spaces incident to employment.* Approving authorities will determine the number of civilian spaces required for the employment of consultants in activities under their respective jurisdiction. Such spaces will be included in their overall manpower programs.

d. *Payment.* The rate of pay for each civilian consultant will be determined by the approving authority. However, consultants will not be paid more than the maximum rate per day stated in AT 40-330, paragraph 6.

(1) Consultants will be paid by the parent command or agency. For joint utilization (see b above), prior coordination will be made. Information concerning the consultant's visit must be forwarded to the appropriate command or agency on completion of the visit; such information will include the purpose, additional costs, funding cite, and services rendered.

(2) Funds available locally will be used for employment of professional consultants.

e. *Special services.* Purchase requests for consultant services will clearly state the specific services to be performed.

(1) When the services of a civilian consultant are desired on a one-time basis, a consultant appointment is not required. Services of these individuals may be obtained by contract under Misc Pub 28-24 and Misc Pub 28-25.

(2) A contract can be negotiated locally by the contracting officer when—

(a) The services required are non-personal.

(b) An end product is involved.

(3) Contracts for consultant services that are purely personal in nature will be submitted through contracting channels for advance approval under Misc Pub 28-25, paragraph 22-205. Determinations and findings will be prepared under Misc Pub 28-24, paragraph 22-205.

Appendix A References

Section I Required Publications

DODI 6015.5

Joint Use of Military Health and Medical Facilities and Services. Cited in paragraph 2-11a. This publication may be obtained from Commander, US Naval Publications and Forms Center (ATTN: Code 301), 581 Tabor Ave., Philadelphia, PA 19120.)

AR 5-3

Installation Management and Organization. Cited in paragraph 2-8b.

AR 10-5

Department of the Army. Cited in paragraphs 1-5d and 1-6a(2).

AR 10-6

Branches of the Army. Cited in paragraphs 2-2b(6), 2-6b(5), 2-11c, 2-15b, 2-18b, and 2-21b.

AR 10-43

US Army Health Services Command. Cited in paragraph 2-2b(4).

AR 27-40

Litigation. Cited in paragraphs 1-7c and c(2) (3), and (4).

AR 40-3

Medical, Dental, and Veterinary Care. Cited in paragraphs 1-7b(1), 1-8e(1), 4-2b(11), and 4-2c(11).

AR 40-4

Army Nurse Corps. Cited in paragraph 2-18b.

AR 40-48

Health Care Extenders. Cited in paragraph 3-1c and 3-2c.

AR 40-121

Uniformed Services Health Benefits Program. Cited in paragraphs 1-7b(1) and B-5a.

AR 40-330

Rate Codes and General Policies for Army Medical Department Activities. Cited in paragraph 4-4d.

AR 351-3

Professional Training of Army Medical Department Personnel. Cited in paragraphs 4-3c(2)(a) and (b).

AR 570-4

Manpower Management. Cited in paragraph 4-1c.

AR 600-20

Army Command Policy and Procedures. Cited in paragraphs 1-7d and 1-9a, b, c, and d.

AR 600-50

Standards of Conduct for Department of the Army Personnel. Cited in paragraphs 1-7d and 1-8e(3).

AR 601-270

Armed Forces Examining and Entrance Stations. Cited in paragraph 1-6i.

AR 611-101

Commissioned Officer Specialty Classification System. Cited in paragraphs 2-2b(6), 2-6b(5), 2-11c, 2-15b, 2-18b, and 2-21b.

AR 611-112

Manual of Warrant Officer Military Occupational Specialties. Cited in paragraphs 3-1b(1)(a), 3-2b, and 3-3b(7).

AR 611-201

Enlisted Career Management Fields and Military Occupational Specialties. Cited in paragraph 1-6g.

AR 630-5

Leave, Passes, Permissive Temporary Duty, and Public Holidays. Cited in paragraph B-4b.

Misc Pub 13-1

DOD Military Pay and Allowances Entitlements Manual. Cited in paragraphs 4-2f(1) and B-4b.

Misc Pub 28-24

Defense Acquisition Regulation. Cited in paragraphs 4-2h(1)(a) and (2)(a) and 4-4e(1) and (3).

Misc Pub 28-25

Army Defense Acquisition Regulation Supplement (ADARS). Cited in paragraph 4-2g and h(1)(a) and (2)(a) and 4-4e(1) and (3).

FPM, chapter 304

Federal Personnel Manual, US Civil Service Commission. Cited in paragraph 4-3a.

FPM, chapter 732

Federal Personnel Manual, US Civil Service Commission. Cited in paragraph 4-4a(2)(a).

CPR A-9

Employment of Experts and Consultants. Cited in paragraphs 4-3a and 4-4a(2)(a) and (b).

OPM HDBK X-118

Qualification of Standards for Position Under the General Schedule. Cited in paragraph E-2.

HQDA Ltr (Sngl Address to MACOMs) (Current FY)

Staffing Authorization and Utilization of Army Medical Department Personnel in Active Component MTCE Units of US Army Forces Command (FORSCOM) (Short Title: MEDO Letter). Cited in paragraphs 2-16d.

Section II

Related Publications

This section contains no entries.

Section III

Prescribed Forms

This section contains no entries.

Section IV

Referenced Forms

This section contains no entries.

Appendix B

SUGGESTED STATEMENT OF WORK FOR FULL-TIME CONTRACT SURGEON CONTRACT (DUTIES TO BE PERFORMED AT A GOVERNMENT FACILITY)

B-1. Scope of contract.

a. The contractor agrees, during the term of this contract, to perform for and on behalf of the Government the duties of a contract surgeon, US Army, under—

(1) The laws and regulations in effect on the execution of this contract, and as they may be amended from time to time.

(2) Duty assignments specified by the contracting officer or his or her duly authorized representative. Services rendered to eligible personnel will be at no expense to the individual.

b. b. The contractor will not, while on duty, advise, recommend, or suggest to persons authorized to receive medical care at Army expense that such persons should receive medical care from—

(1) The contractor when he or she is not on duty.

(2) A civilian associated in practice with the contractor. An exception will be unless such medical care will be furnished without cost to the patient, the Government, or any other person or firm.

c. The contractor is not prohibited, by reason of employment under this contract, from conducting a private medical practice, if the following prevail:

(1) No conflict with the performance of duties under the contract exists.

(2) Practice is not conducted during the regular hours established under this contract, during which the contractor is required to render services to the Government.

(3) The contractor makes no use of any Government facilities or other Government property in connection with this contract.

B-2. Duty hours.

The contractor will be on duty at _____

(name and location of medical facility)

on a full-time basis, 40 hours per week, for performance under this contract, in accordance with duties prescribed by this contract and a schedule mutually agreed upon between the contractor and the contracting officer. This schedule may be changed from time to time by mutual agreement.

B-3. Duties.

a. The contractor agrees to perform the service which a Medical Corps officer with similar training and experience normally would be called on to perform while in a similar duty assignment. The contractor's professional and administrative duties will consist of providing health services as specified in this contract, under the control and general supervision of the contracting officer or designated representative.

b. The contractor further agrees to be on call for emergencies at any time. Duty performed as a result of an emergency situation will be credited against the number of hours specified in the contract, when feasible; however, duty performed as a result of emergency situation, in excess of the number of hours specified in contract will not be the subject of additional compensation.

c. The contractor will maintain proper medical records on all military and dependent personnel to whom treatment is provided. The contractor will prepare such additional records and reports, when requested, as would be required of officers of the Army Medical Department charged with the same professional or administrative responsibilities.

d. Specific duties to be performed will include those shown below.

Note. Duties shown below are suggested for guidance. They may be modified, deleted, or supplemented as appropriate to the specific position.)

(1) Sick call service to military personnel on active duty at _____

(name and location of installation concerned)

(2) Sick call service to eligible dependents of such military personnel. (Only applicable when care is also furnished to military.)

(3) Pre-school and pre-athletic examinations, as required.

(4) Administration of vaccines and immunizing agents furnished by the US Government.

(5) Planning and administration of the Army Occupational or Industrial Health Program.

(6) Direction of special preventive medicine programs such as vision or hearing programs and chest X-ray surveys.

(7) Conducting sanitary inspections; submission of appropriate recommendations to concerned commanders.

(8) Other duties appropriate for performance by a contract surgeon as directed or assigned by the contracting officer or duly authorized representative.

B-4. Compensation.

a. For the satisfactory performance of the services required under this contract, the contractor will be paid the basic pay, basic allowances, and other allowances of a commissioned officer in pay grade O3 with over 4, but not more than 6, years of service, as authorized under section 421(a), title 37, United States Code. The contractor's entitlement to pay continues during periods of authorized leave. Special and incentive pays may not be included in the contracts for part-time or full-time contract surgeons.

b. The laws and regulations as to leave of absence for commissioned officers, as they will exist from time to time, will govern leaves and absences of the contractor. The contractor is not entitled to sick leave as such under AR 630-5. (This paragraph may be omitted if leave is not authorized. See Misc Pub 13-1, part four, chap 6.)

c. Subject to a above, the contracting officer will assure that payments are made monthly during the period at the rate of \$_____ per month on SF Form 1034 (Public Voucher for Purchases and Services Other Than Personal), directed to the finance and accounting officer. This contract must be presented at the time of payment for appropriate notation as to the payment made, together with a statement signed by the contracting officer that services have been satisfactorily rendered under terms of this contract.

B-5. Exclusions.

This contract does not include—

a. Medical and surgical care of dependents of military personnel who are hospitalized, or receiving treatment, under conditions that provide a basis for separate reimbursement in accordance with the dependents' medical care under AR 40-121.

b. Routine medical and surgical care of dependents or military personnel involving house calls, furnishing medication, or other care which is considered to be other than office or sick call service.

c. Provision of medicines or medical supplies other than those—

(1) Normally furnished as part of office or sick call treatment.

(2) For which no additional charge is made, unless otherwise provided for by contract.

Appendix C SUGGESTED STATEMENT OF WORK FOR PART-TIME CONTRACT SURGEON CONTRACT DUTIES TO BE PERFORMED AT A GOVERNMENT FACILITY

C-1. Scope of contract.

See paragraph B-1.

C-2. Duty hours.

The contractor will be on duty for the medical treatment of eligible military personnel and their dependents at _____ from _____

(name and location of medical facility)

hours to _____ hours on _____

(days of week)

C-3. Duties.

a. See paragraph B-3a

b. The contractor further agrees to be on call for emergencies in situations when no other physician employee is available. Duty performed as a result of an emergency situation will be credited against the number of hours specified in the contract, when feasible; however, duty performed as a result of an emergency situation, in excess of the number of hours specified in the contract, will not be the subject of additional compensation.

- c. See paragraph B-3c.
- d. See paragraph B-3d.

C-4. Compensation.

a. The Government will pay the contractor the sum of \$_____ for the satisfactory performance of services described in and required by this contract. (Compensation is limited under AR 40-1, para 4-2f.) Special and incentive pays may not be included in the contracts for part-time and full-time contract surgeons.

b. Same as paragraph B-4c.

C-5. Exclusions.

See paragraph B-5.

**Appendix D
SUGGESTED STATEMENT OF WORK FOR
PART-TIME CONTRACT SURGEON CONTRACT
DUTIES TO BE PERFORMED OUTSIDE
GOVERNMENT FURNISHED FACILITY**

Note. The statement of work will follow the suggested format in app C for a part-time contract surgeon who performs at a Government facility. Exceptions and additions are shown below.

<paratext>

D-1. Duty hours.

Add to the end of paragraph C-2, duty hours, the address at which at which the contractor will be on duty for the purpose of this contract.

D-2. Duties.

Under paragraph C-3d, Duties, those duties to be performed by the contractor will be specified in detail, since supervision by the Government will not be feasible.

D-3. Additional provisions.

The following additional provisions will be included as a separate subparagraph to paragraph C-3, Duties:

- a. A requirement for furnishing drugs and medications or medical supplies from Government sources. Restrictions as to types and quantities of such items will be clearly set forth and procedures for resupply specified.
- b. Methods established to determine eligibility for care.
- c. Instructions for referral of patients to service medical treatment facilities for further evaluation or hospitalization.

**Appendix E
PROCESSING PROCEDURES FOR APPLICATIONS
FOR EMPLOYMENT AS SOCIAL WORKERS AND
PSYCHOLOGISTS**

E-1. General.

a. To insure uniformity of professional standards and a high degree of professional competency, this appendix provides procedures for the processing of applications of civilian personnel for employment or placement in the position of Social Workers, GS-185, or Psychologists, GS-180. These will include those whose duties will be concerned, all or in part, with research activities.

b. Civil Service personnel employed as social workers and psychologists will be under the direction and responsibility of the commander of the installation or MTF on whose TDA the position is authorized. They will be guided in their utilization by overall policies established by TSG.

E-2. Qualifications.

The qualification standards for the position of Social Worker and

Psychologist as set forth in OPM HDBK X-118, will be observed. These are minimum standards: fullest efforts will be made to locate candidates who, for the position of social worker, hold a master's degree in social work. For the position of psychologist, individuals must hold an acceptable doctoral degree in clinical or counseling psychology with an American Psychological Association (APA)-approved internship in clinical psychology if they are to do clinical work. If they do research work they must hold a doctoral degree in psychology in an appropriate specialty. The degree in clinical, counseling, or other sub-specialties of psychology must be from a school accredited by the APA or otherwise acceptable to TSG or the regional psychology consultant (when specifically designated for that purpose).

E-3. Procedure.

Applications for Civil Service positions in social work and psychology will be screened by the commander of the installation or MTF on whose TDA to position is authorized. After determination of the best qualified applicants, and before employment and placement in positions as social workers and psychologists, an appraisal of professional qualifications and an approval of the appointments will be obtained from HQDA(DASG-PSC), WASH DC 20310. For positions that are on medical TDA within the continental United States (CONUS), Alaska, Hawaii, Panama, 7th Medical Command, and 8th Medical Command (Provisional), approval will be obtained from the medical command social worker or psychology consultant, when specifically authorized by OISG, together with HQDA(DASG-PSC), WASH DC 20310. Forwarded recommendations will be accompanied by—

- a. Complete SF 171 (Application for Federal Employment).
- b. Official transcript of all graduate work completed by the applicant toward professional training.
- c. Written appraisal of the applicant's professional performance by at least three former supervisors or employers familiar with the applicant's work. Letters should contain relevant and specific information regarding individual's qualifications for the position to be filled.

**Appendix F
SUGGESTED REQUEST FOR OFF-DUTY
REMUNERATIVE PROFESSIONAL CIVILIAN
EMPLOYMENT**

FROM: _____ GRADE: _____
name (last, first, middle)
BRANCH: _____ SERVICE: _____
TO: COMMANDER _____

(activity)
SUBJECT: Request for Off-Duty Remunerative Professional Civilian Employment

F-1. In accordance with AR 40-1, paragraph 1-8, I request permission to engage in remunerative professional civilian employment apart from my assigned military duties. I have attached a statement from the local medical, dental, or other applicable association indicating no objection to my professional employment in the community

- a. Type of employment and nature of work: _____
 - b. Beginning date: _____
 - c. Hours per day: _____ Number of days per week: _____
- TOTAL hours per week: _____
- d. Location of work: _____

(name and address of employer)
Telephone number at place of employment: _____

F-2. I understand the provisions of AR 40-1, paragraph 1-8 concerning off-duty employment and I agree to conduct any off-duty employment activities in accordance with those provisions. Further, I understand that—

a. It is my obligation to inform my commanding officer in writing of any deviation in my off-duty employment from my proposal, as set forth in this letter, before the inception of such change.

b. No outside responsibilities will be assumed that will in any manner compromise the effective discharge of my duties as an officer in the US Army Medical Department, both as to number of hours devoted to outside work and my individual limit and capacity.

c. A copy of this proposal may be forwarded to the Office of The Surgeon General of the US Army, HQDA(DASG-PSZ), WASH DC 20310.

F-3. I recognize that I am prohibited from, and cannot in good conscience assume, the primary responsibility as an individual practicing health care, provide for the care and critically ill or injured patients on a continuing basis as this will inevitably result in the compromise of my responsibility to the patient on the one hand, or the primacy of my military obligation on the other hand.

requester (signature)

date

1st Ind

FROM: Commander

TO: Requester

Subject request is _____ approved

_____ not approved Reasons: _____

signature (commander)

(date)

Glossary

Section I Abbreviations

ADL

Area Dental Laboratory

AMEDD

Army Medical Department

AMSC

Army Medical Specialist Corps

ANC

Army Nurse Corps

AOD

administrative officer of the day

ARNG

Army National Guard

AUTOVON

automatic voice network

CG

Commanding General

CIVPERSINS

Civilian Personnel Information System

CPR

Civilian Personnel Regulation

DC

Dental Corps

DDS

Director of Dental Services

DEA

Drug Enforcement Agency

DENTAC

dental activity

DHS

Director of Health Services

DOD

Department of Defense

FPM

Federal Personnel Manual

HSC

US Army Health Services Command

HQ

Headquarters

HQDA

Headquarters, Department of the Army

MACOM

major Army command

MC

Medical Corps

MEDCEN

US Army medical center

MEDDAC

medical department activity

MOS

military occupational specialty

MSC

Medical Service Corps

MTF

medical treatment facility

NAC

National Agency Check

OTSG

Officer of The Surgeon General

PA

physician assistant

R&D

research and development

RDTE

research, development, test, and evaluation

SDO

staff duty officer

SSI

specialty skills identifier

TDA

table of distribution and allowances

TJAG

The Judge Advocate General

TOE

table of organization and equipment

TSG

The Surgeon General

TSAR

US Army Reserve

VC

Veterinary Corps

Section II

Terms

This section contains no entries.

Section III

Special Abbreviations and Terms

This section contains no entries.

Unclassified

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Army Regulation 40-3

Medical Services

Medical, Dental, and Veterinary Care

Headquarters
Department of the Army
Washington, DC
30 July 1999

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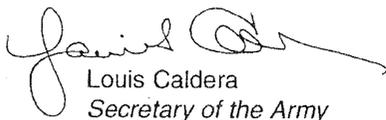
Headquarters
Department of the Army
Washington, DC
30 July 1999

*Army Regulation 40-3

Effective 30 August 1999

Medical Services

Medical, Dental, and Veterinary Care



Louis Caldera
Secretary of the Army

History. This printing publishes a revision of this regulation. Because the publication has been extensively revised, the changed portions have not been highlighted.

Summary. This regulation has been extensively revised. It contains policies for management of selected programs; medical care entitlement and patient administration are now addressed in AR 40-400. This regulation implements quadripartite standardization agreement (QSTAG) 471 and Department of Defense Directive 6000.12.

Applicability. This regulation applies to the Active Army, the Army National Guard, and the U.S. Army Reserve. It also applies to medical department activities, medical centers, dental activities, veterinary activities, and other Army Medical Department organizations. This publication is applicable during mobilization.

Proponent and exception authority. The proponent of this regulation is The Surgeon General. The proponent has the authority to approve exceptions to

this regulation that are consistent with controlling law and regulation. Proponents may delegate the approval authority, in writing, to a division chief under their supervision within the proponent agency who holds the grade of colonel or the civilian equivalent.

Army management control process. This regulation contains management control provisions and identifies key management controls that must be evaluated.

Supplementation. Supplementing this regulation is prohibited without prior approval from The Surgeon General (DASG-HSZ), 5109 Leesburg Pike, Falls Church, VA 22041-3258.

Suggested improvements. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) directly to The Surgeon General (DASG-ZA), 5109 Leesburg Pike, Falls Church, VA 22041-3258.

Committee establishment approval. The DA Committee Management Officer concurs in the establishment of the Pharmacy and Therapeutics Committee and the Medical Library Committee.

Distribution. Distribution of this publication is made in accordance with initial distribution number (IDN) 092057, intended for command levels B, C, D, and E for Active Army, Army National Guard of the United States, and the U.S. Army Reserve.

***Supersession.** This regulation, together with AR 40-400, supersedes AR 40-3, dated 15 February 1985, and supersedes AR 40-2, chapters 7, 8, 9, 10, 11, and 12 and appendix B, dated 3 March 1978. It rescinds VA Form 21-8358, dated February 1980.

AR 40-3 • 30 July 1999

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Summary of Change

AR 40-3

Medical, Dental, and Veterinary Care

This revision—

- Supersedes paragraphs 2-11 and 2-22 and chapters 9 through 12 and 17 through 19 of AR 40-3, dated 15 February 1985. The newly revised AR 40-400 (to be published concurrently with this regulation) supersedes chapters 1, 3-8, 13-16, and all portions of chapter 2 except paragraphs 2-11 and 2-22 of AR 40-3, dated 15 February 1985.
- Defines the Aviation Medicine Program and outlines responsibilities and duties of personnel associated with this program (chap 3).
- Decentralizes hearing aid shipment and repair (para 4-5).
- Implements Department of Defense Directive 6000.12, Health Services Operations and Readiness, dated 29 April 1996, for the Armed Services Blood Program Office (chap 5).
- Adds policies on the Army Blood Program formerly contained in AR 40-2, chapter 12 (chap 5).
- Delineates Army Blood Program responsibilities for U.S. Forces Command and U.S. Army Training and Doctrine Command commanders (para 5-2).
- Prescribes DA Form 3982 (Medical and Dental Appointment), formerly prescribed by AR 40-2 (para 6-6e).
- Updates information on Army Medical Department medical libraries formerly found in AR 40-2, chapter 10, and provides guidance on the Army Medical Department Medical Library and Information Network (chap 7).
- Prescribes the use of a new form and reporting requirement, DA Form 7397-R (U.S. Army Medical Command Library Annual Report FY__) (para 7-8).
- Includes updated material on nutrition care management, formerly contained in AR 40-2, chapter 9 (chap 8).
- Prescribes DD Form 2731 (Organ and Tissue Donor Card) (para 9-2b(2)).
- Adds a requirement for a medical officer to test fit orthopedic footwear (para 10-5c).
- Updates and adds policies on pharmacy management and controlled substances formerly contained in AR 40-2, chapters 7 and 8 (chap 11).
- Deletes regulatory requirements as to which personnel may be given medical examinations and issued Federal Aviation Agency medical certificates (previously chap 11, AR 40-2).
- Prescribes the following forms formerly prescribed by AR 40-2: DD Form 2081 (New Drug Request) (para 11-6); DD Form 1289 (DOD Prescription) (para 11-12); DA Form 3875 (Bulk Drug Order) (para 11-12); DA Form 3862 (Controlled Substances Stock Record) (para 11-19); DA Form 3949 (Controlled Substances Record) (para B-5); and DA Form 3949-1 (Controlled Substances Inventory) (para B-5).
- Adds new material on psychological test materials (chap 12).
- Provides new standards for conducting emergency medical services (chap 13).

- Delineates responsibilities for the operation of medical laboratories for Commander, U.S. Military Entrance Processing Command; Commander, Army Corps of Engineers; Commander, United States Army Medical Command; Commanders, Regional Medical Commands; military treatment facility commanders; and Chief, Departments of Pathology or Laboratory Services (para 14-3).
- Implements College of American Pathologists laboratory accreditation policy previously published in Health Services Command Supplement 1 to AR 40-2. Extends accreditation requirements to fixed military treatment facility laboratories in Europe and Korea. Clarifies Joint Commission on the Accreditation of Healthcare Organizations and Commission on Office Laboratory Accreditation requirements (para 14-4).
- Contains personnel standards for the performance of minimal, moderate, and high-complexity laboratory procedures, including provider-performed microscopy. Clarifies laboratory director requirements (para 14-5).
- Addresses the need for a laboratory quality control plan and the requirement for quality control data collection in the subspecialty of cytopathology (para 14-6).
- Defines individuals authorized to order laboratory tests and provides guidance concerning self-performance of laboratory tests by patients in medical treatment facilities (paras 14-9 and 14-10).
- Rescinds the use of VA Form 21-8358 (Notice to Veterans Administration of Admission to Uniformed Services Hospital).
- Deletes the coverage of medical care entitlements which are now contained in AR 40-400.

Use of trademarked names does not imply endorsement by the U.S. Army but is intended only to assist in identification of a specific product.

Chapter 1 Introduction

1-1. Purpose

This regulation establishes policies, procedures, and responsibilities pertaining to selected Army Medical Department (AMEDD) programs and initiatives. If any policy or procedure contained in this regulation changes current conditions of employment of civilian bargaining unit employees, the servicing Civilian Personnel Office/Civilian Personnel Advisory Center will be contacted to determine if there are bargaining obligations with recognized unions.

1-2. References

Required and related publications and prescribed and referenced forms are listed in appendix A.

1-3. Explanation of abbreviations and terms

Abbreviations and special terms used in this regulation are explained in the Glossary.

1-4. Responsibilities

Responsibilities specific to subject areas addressed in this regulation are delineated in individual chapters and pertain only to policies and procedures described in that chapter.

Chapter 2

Advance Directives, Do-Not-Resuscitate, and Withhold/Withdraw Orders

2-1. Introduction

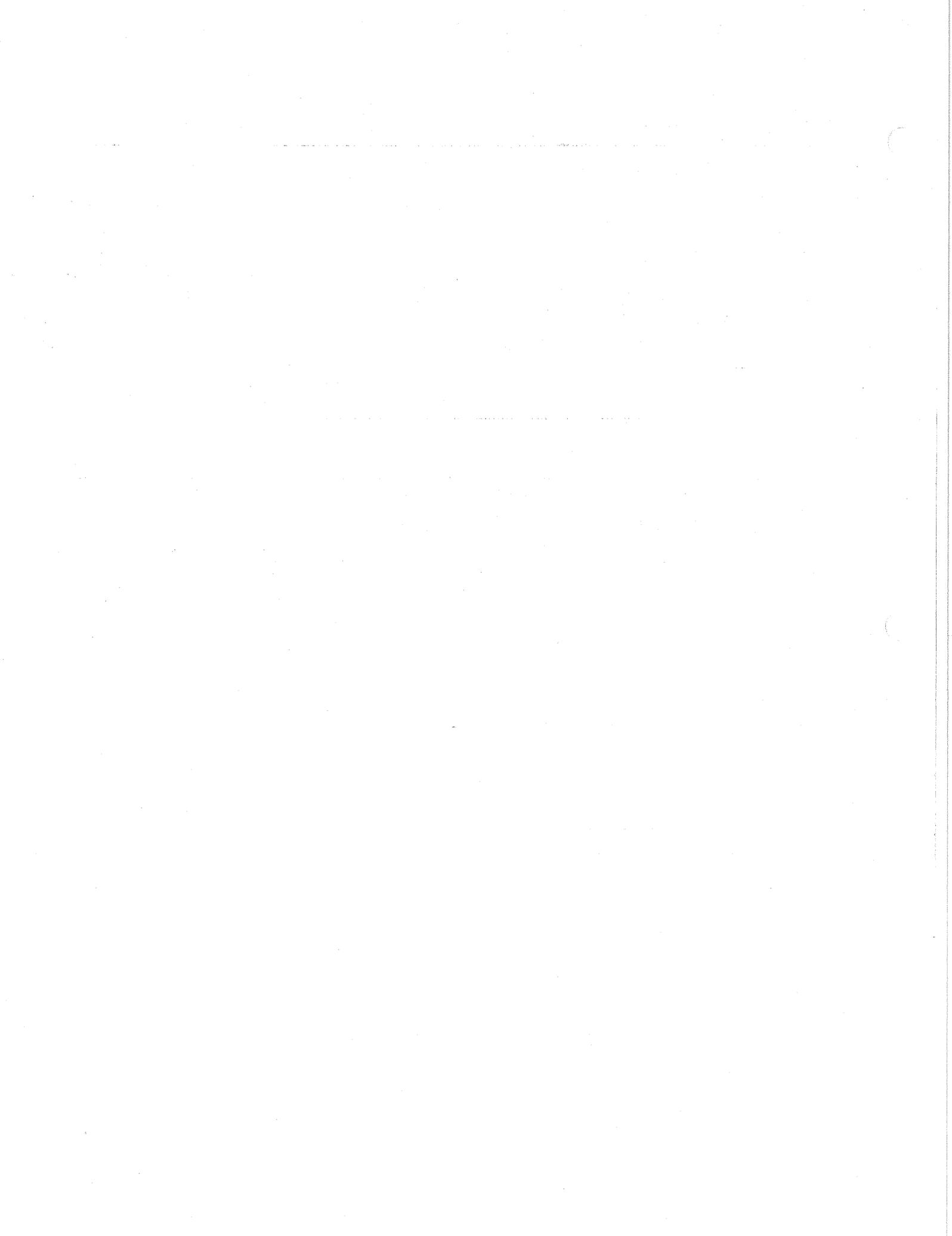
This chapter sets policy and procedures for the implementation of advance directives and for the initiation of orders to suspend cardiopulmonary resuscitation (do-not-resuscitate (DNR) orders) or to withhold or withdraw life-sustaining treatment.

2-2. Responsibilities

- a. The military treatment facility (MTF) commander will provide operational guidance for implementation of the policies in this chapter.
- b. The entire health care team (including physicians, nursing personnel, administrators, attorneys, chaplains, social workers, and patient representatives) will provide assistance with the formulation of advance directives and will help patients and their families participate in their health care decisions. The physician primarily responsible for the patient's care is ultimately responsible for ensuring that the patient has adequate information on which to base his or her decision and that the patient's wishes are honored so far as possible.

2-3. Policy

- a. A patient with decision-making capacity has the legal and moral right to participate in medical care decisions, including the right to refuse medical treatment at any time even if it is lifesaving.
- b. Upon admission, all adult patients will be informed in writing of their right to participate in their health care decisions, including the right to accept or refuse medical or surgical treatment, and of their right to prepare advance directives.
- c. An order to resuscitate is a standing order and resuscitation will be initiated unless there is a written DNR order to the contrary.



Chapter 14 Medical Laboratory Management

14-1. General

- a. This chapter further defines the implementation of the CLIP within the U.S. Army in accordance with policies and procedures contained in publications published separately.
- b. Specific technical standards of CLIP and the minimal conditions that laboratories must meet to be certified to perform testing on human specimens are contained in publications that will be published separately.

14-2. Applicability

This chapter applies to all fixed Army MTFs worldwide that operate a clinical laboratory. (See Glossary, section II.) This chapter applies to AD, Reserve, and National Guard components and to clinical laboratories operated under the executive agency of the U.S. Army (United States Military Entrance Processing Command and the U.S. Army Corps of Engineers). This chapter does not apply to facilities that perform testing only for forensic purposes; research laboratories that test human specimens but do not report patient-specific laboratory results for the diagnosis, prevention, or treatment of any disease, or the assessment of health for individual patients; or laboratories that perform solely drug-of-abuse testing under DODI 1010.1 and AR 600-85.

14-3. Responsibilities

- a. The Commander, USAMEDCOM will—
 - (1) Establish corrective action procedures for clinical laboratory facilities whose proficiency testing or performance criteria fall outside the standards to the Tri-Service CLIP regulations.
 - (2) Establish standards and promulgate policy for implementation of quality clinical laboratory testing within all units assigned to the USAMEDCOM.
- b. RMC commanders will—
 - (1) Provide medical laboratory, blood bank, and pathology staff assistance visits and technical consultation to subordinate hospitals, occupational and health clinic laboratories, decentralized laboratories, blood donor centers, and departments of pathology throughout their region.
 - (2) Appoint regional laboratory consultant(s) to provide oversight of proficiency testing and technical consultation throughout the region concerning laboratory standards, laboratory accreditation, and laboratory business practices. Personnel should be appointed as regional consultants for the following specialties: RMC pathology consultant (board-certified pathologist), RMC laboratory consultant (laboratory manager—71E), RMC chemistry consultant (clinical chemist—71B), RMC microbiology consultant (microbiologist—71A), RMC blood bank consultant (71E8T or 61U), and RMC senior enlisted laboratory consultant (MOS 91K40/50).
 - (3) Analyze utilization of laboratory resources and assess laboratory performance indicators throughout the RMC region. Develop regional laboratory business plans that optimize use of laboratory resources, consolidate commercial reference laboratory testing contracts, and regionalize the purchase or lease of laboratory reagents or equipment.

- (4) Ensure maximum utilization of blood resources within the RMC region by ensuring that blood and blood product inventories are kept at an acceptable medically indicated level, and cross-leveled throughout the region, as appropriate, to reduce outdating and wastage of a valuable resource.
 - (5) Support the laboratory readiness requirements of the Total Force throughout the RMC. Coordinate and take an active role in ensuring that readiness blood quotas for the ASWBPLs are met as directed from the USAMEDCOM. Coordinate laboratory-related professional filler system/medical filler system and individual mobilization augmentee training of personnel in the region.
 - (6) Assign qualified pathologists to act as a consultant, and, as required, the laboratory director of all medical laboratories in the region without director-qualified assigned medical personnel, or director-qualified civilian contract personnel.
 - (7) Provide technical expertise and guidance, on-site monitoring as necessary, and reference laboratory support for laboratories in the region that fail regulatory laboratory proficiency testing. Under a plan of corrective action, approve the decision to resume patient testing for failed analytes or subspecialties in all medical laboratories located within the region.
- b. The MTF commander is responsible for the operation and CLIP registration of all medical laboratories within the MTF and all assigned clinics. CLIP registration is accomplished in accordance with guidance published separately.
- (1) This includes centralized laboratories, such as the Department of Pathology, but also includes all decentralized medical laboratories including all places in the facility where medical laboratory tests are performed. Examples of common decentralized medical laboratories in MTF facilities include the following: medical laboratory tests performed in the intensive care unit, critical care unit, EC, or other medical clinics, such as the physical examination clinic, or the occupational health clinic; *in vitro* medical laboratory tests performed by respiratory therapy or nuclear medicine; medical laboratory tests performed by ancillary staff on patient wards; and medical laboratory tests performed by preventive medicine personnel as part of medical screening programs or health fairs.
 - (2) The MTF commander determines the requirement and operational need for each decentralized laboratory assigned to the organization and is required to register all medical laboratories (minimal, moderate, or high complexity laboratories, or provider-performed microscopy (PPM) laboratories) with the CLIP office.
- d. The Chief, Laboratory Services or Chief, Department of Pathology, depending upon the local designation, is charged with the duties of laboratory director as defined by the CLIP. The chief and his or her staff are responsible for providing quality medical laboratory services throughout the organization, keeping abreast of new or modern developments in the medical laboratory field, and for operating the MTF medical laboratories in compliance with Federal laws, accreditation standards defined by JCAHO, the College of American Pathologists (CAP), the CLIP, and standards of practice within the community. In doing so, the chief will be responsible for—

- (1) Assisting and advising health care providers on the cost-effective use of timely, quality medical laboratory services to aid in the medical screening, prevention, and diagnosis or treatment of disease, including monitoring of therapy.
- (2) Conducting and documenting inspections and assistance visits for all medical laboratories within the MTF, including medical laboratories in all outlying clinics assigned to the MTF and all troop medical clinics supported by the MTF. Recurring problems and trends not corrected by department or service chiefs will be referred to the appropriate person/group within the MTF's specific IOP structure.
- (3) Maintaining adequate reference material (books, periodicals, atlases, computer-assisted instructional material, etc.) and knowledge-based information systems for use by laboratory personnel and other professional staff served by the laboratory.
- (4) Providing technical expertise and guidance, on-site monitoring as necessary, and centralized laboratory support for MTF laboratories that fail regulatory laboratory proficiency testing. Under a plan of corrective action, approve the decision to resume patient testing for failed analytes or subspecialties in MTF medical laboratories.
- (5) Disseminating information to the professional staff concerning advances in laboratory medicine, use of the laboratory services, laboratory input to clinical practice guidelines adopted by the MTF, and related matters. Appropriate media (for example, CHCS, electronic mail, memorandums, etc.) will be utilized to disseminate information concerning laboratory services available, acceptable specimen requirements, methods of obtaining service, the cost of each laboratory test ordered, the reference ranges for all laboratory tests provided, and items of interest to the medical staff.
- (6) Representing the laboratory services on various committees used by the MTF to improve information management, utilization management, and patient outcomes.
- (7) Providing an adequate number of qualified, competent staff to perform the laboratory workload and to provide technical consultation and supervisory duties. The laboratory director also provides for orientation, in-service training, and continuing education for all personnel assigned to the clinical laboratory.

14-4. Accreditation policies

- a. All eligible U.S. Army hospital clinical laboratories (Department of Pathology or Laboratory Service) located in fixed MTFs in the United States, Europe, or Korea will be accredited by the Commission on Inspection and Accreditation of the CAP. On-site accreditation inspections are required at least biennially.
- b. All fixed MTFs, ambulatory care clinics, and troop medical clinics, including their assigned laboratories, will be accredited by and follow the laboratory guidelines of the JCAHO. The required biennial JCAHO survey of laboratories by a qualified medical technologist inspector will be waived if all laboratories (non-waived testing) assigned to the MTF have been inspected and accredited by CAP.

- c. Decentralized laboratories (point-of-care testing, separate health clinics or troop medical clinics, or Military Entrance Processing Stations, etc.) will be inspected biennially and accredited by either CAP, JCAHO, or the Commission on Office Laboratory Accreditation (COLA).

14-5. Laboratory personnel

- a. The Chief, Laboratory Service or Chief, Department of Pathology will ensure that only properly qualified personnel whose competency has been assessed will perform and report the results of laboratory testing. Qualifications for testing personnel will be based on laboratory test complexity (minimal, moderate, or high complexity) and will meet the requirements of Section M of the CLIP.
- b. Local, on-site training of military or civilian personnel to perform limited minimal or moderate complexity laboratory testing is permitted. In these cases, prior to analyzing patient specimens and reporting patient results, the personnel must be trained appropriately for the laboratory testing performed with a formal training program, not solely limited to on-the-job training. Documentation of training, skills, and competency assessment for these individuals will be maintained on file either within the laboratory, the MTF QA department, or the nursing education and training department. (Refer to AR 40-48.)
- c. PPM, a special subset of moderately complex laboratory analyses, may be performed by privileged physicians, dentists, and mid-level practitioners (PAs, NPs, and certified nurse midwives) according to AR 40-48 when authorized by the MTF commander. In such cases, the PPM lab must be registered with CLIP, approved procedures for PPM tests must be instituted, and personnel authorized to perform PPM must be qualified and competency assessed.
- d. At installations that do not have an assigned pathologist, a qualified licensed physician will be assigned as the director of the laboratory. At inpatient facilities without an assigned pathologist, the commander will ensure that appropriate and timely professional pathology services are available to the staff and patients of the facility.
- e. At all MTFs without an assigned civilian or military pathologist or without an equivalent contracted pathologist, the commander of the facility will appoint an appropriate regional military pathologist to the medical staff of the MTF as a consultant.

14-6. Quality control

- a. Sound quality control systems in all MTF clinical laboratories, including decentralized laboratories, are essential to providing excellent services. Quality control systems must be designed to ensure medical reliability and timeliness of laboratory data. The goal of quality control is to achieve the most accurate test results and outcomes.
- b. Each laboratory must have a written, defined, and approved quality control program that meets the standards of the CLIP and any applicable accrediting body. The quality control system must address pre-analytical, analytical, and post-analytical phases of laboratory testing and results reporting.

- c. For the subspecialty of cytopathology, a written quality control program must be in place to measure, assess, and improve quality in cytology addressing the accuracy of both positive and negative findings. Each cytopathology service will be directed by a pathologist or other physician qualified in cytology who will maintain the quality of the service through direct supervision and adequate oversight. Annual statistical reports will be produced by each facility performing cytopathology testing. The reports will be collated by each RMC and forwarded to the Commander, USAMEDCOM (MCHO-CL-R), 2050 Worth Road, Fort Sam Houston, TX 78234-6010, for consolidation for the U.S. Army.

14-7. Monetary collections for laboratory services

The laboratory will not serve as a monetary collection agency for medical laboratory test services. However, laboratory personnel will assist the command's TCP office in billing third party insurers for laboratory tests authorized under the TCP.

14-8. Improving organizational performance

- a. A laboratory's performance of important health care functions significantly affects the outcomes of the patients it serves, the costs to achieve these outcomes, and the patient's/customer's perceptions or satisfaction. The goal of IOP is to continuously improve the laboratory services that affect patient health outcomes.
- b. The Chief, Laboratory Services will implement a collaborative and interdisciplinary performance improvement process that will demonstrate improvement in laboratory services. This process will be integrated with the MTF IOP structure and documentation will provide evidence of ongoing improvement processes.
- c. Data will be collected on important laboratory processes and outcomes, including as a minimum: patient preparation, handling of specimens, communication processes, appropriateness of laboratory tests offered (utilization management), and the needs, expectations, and satisfaction of patients and other customers. Data on important processes and outcomes are also collected from risk management and quality control activities.
- d. Data will be collected and reported through the RMCs to the Commander, USAMEDCOM (MCHO-CL-R), 2050 Worth Road, Fort Sam Houston, TX 78234-6010, for documentation of compliance with laboratory-related DOD Access Standards. Cervical cytological smear (Papanicolaou smear) screening results should be available to the patient within 14 days of specimen collection, except for isolated branch clinics and overseas locations where results shall be provided within 30 days.

14-9. Individuals authorized to order laboratory tests

- a. The following categories of personnel are authorized to order laboratory tests:
 - (1) Uniformed and civilian physicians, dentists, veterinarians, optometrists, and podiatrists engaged in professional practice at uniformed services MTFs.
 - (2) Civilian physicians, dentists, optometrists, and podiatrists, not assigned to a uniformed services MTF, but licensed in the jurisdiction of their practice and treating personnel eligible for care within the MHS.
- b. The following personnel are authorized to order medical laboratory tests only for selected procedures as established under the provisions of AR 40-48 and/or approved by the local commander:

- (1) Uniformed and civilian nurses, PAs, NPs, PTs, OTs, psychologists, and pharmacists engaged in professional practice at uniformed services MTFs and privileged to order medical laboratory tests.
 - (2) Civilian personnel, not assigned to a uniformed service MTF, but licensed within the jurisdiction of their practice and treating personnel eligible for care in the MHS, to the extent authorized by State law and by policies for equivalent staff non-physician health care providers.
 - (3) Other non-physician health care providers not listed above, but assigned to a uniformed service MTF and granted limited medical laboratory test ordering privileges by the local commander.
- c. Requests for medical laboratory tests written by licensed civilian practitioners not assigned to a uniform services MTF for personnel eligible for care in the MHS, will be honored at Army MTFs according to AR 40-400 subject to the availability of space, facilities, the capabilities of the professional staff, and the following considerations.
- (1) A policy relative to performing and reporting laboratory tests ordered by civilian practitioners will be established and announced by the local commander. This policy should coincide with policies regulating staff ordering of laboratory tests and must also include policies concerning the reporting of emergency or alert (panic) value laboratory results to civilian practitioners.
 - (2) Performance of a laboratory test requested by a civilian practitioner does not imply knowledge of or responsibility for a patient's medical condition. Under no circumstances will civilian laboratory test requests be countersigned or rewritten by military practitioners.
 - (3) A distance factor or geographic boundary limitation will not be the basis for denying laboratory testing services. MTFs may accept orders for laboratory tests electronically or in writing from civilian practitioners outside the MTF. Verbal orders should not be accepted from civilian practitioners outside the MTF.
 - (4) Orders for laboratory tests written by foreign licensed practitioners and brought into MTFs located within the United States may be honored in accordance with appropriate State law. In MTFs located outside the United States, the laws of the foreign country and the terms of the applicable treaty and/or administrative or Status of Forces Agreement between the United States and the foreign country concerned will be followed.
 - (5) Electronic transmittal of laboratory results, including patient identification data, is authorized utilizing direct modem communications without encryption to civilian practitioners. The Internet will not be used for transmittal of unencrypted laboratory results or patient demographic data which is subject to the Privacy Act.

14-10. Self-performance of laboratory tests

- a. Patients should not be required to self-perform laboratory tests within the MTF. When current medical practice indicates that a patient may routinely monitor their condition or treatment using an FDA-approved laboratory test for home use, health care providers assigned to the MTF may train the patients on the use and interpretation of the FDA-approved home laboratory test.

- b. Laboratory tests performed within the MTF will be performed only by qualified personnel. The results of all laboratory tests performed in the MTF will be entered in the appropriate patient record according to AR 40-66.

14-11. Inspection and disposition of laboratory files and records

- a. *Inspection.* Laboratory files and records will be subject to inspection by inspectors (accreditation organizations, other Government entities, and the CLIP) and higher echelon commanders at all times.
- b. *Disposition.* Laboratory files, testing results, and other records maintained by the laboratory will be retained and disposed of according to AR 25-400-2. Any alternative method of storage and disposal must be approved by the MTF's records management officer.

Chapter 15 Veterinary Care

15-1. General

This chapter provides guidance for the delivery of veterinary medical care within the United States Army. AR 40-905/SECNAVINST 6401.A/AFI 48-135 addresses veterinary responsibilities and functions to all DOD agencies and the services. The veterinary commander is responsible for delivery of effective and efficient veterinary care. Veterinary medical care provided will be consistent with accepted professional standards.

15-2. Veterinary services

The United States Army Veterinary Corps, as DOD Executive Agent for veterinary services, provides veterinary services to all branches of the DOD. Veterinary services include, but are not limited to—

- a. Veterinary medical care for GOAs.
- b. Control of zoonotic diseases.
- c. Food safety and QA programs.
- d. Veterinary medical care for POAs.

15-3. Authorization of care

The senior area veterinarian will establish the extent and priority to which veterinary medical care is provided to GOAs and POAs within the area of the veterinary commander's scope of responsibility.

15-4. Provision of veterinary medical care

Veterinary commanders will determine how best to employ available resources to provide authorized veterinary medical care taking into consideration the following factors:

- a. *Animal categories.* The population and health needs of the different categories of animals provided veterinary care—
 - (1) Military working dogs (MWDs), military working horses (MWHs), and GOA and POA health assistance animals (seeing-eye dog, etc.).
 - (2) Nonappropriated fund (NAF) animals (rental horses, etc.).
 - (3) Unit mascots authorized by appropriate orders (one per company-sized unit).
 - (4) Non commercial POAs for authorized care.
 - (5) Other GOAs in confinement (buffalo, deer, strays, etc.).

