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Pamphlet 40-11

Medical Services

Preventive Medicine

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SUMMARY of CHANGE

DA PAM 40-11
Preventive Medicine

This new Department of the Army pamphlet, dated 22 July 2005--

- o Outlines the goals of Army preventive medicine (chap 1).
- o Introduces traditional preventive medicine topics including disease prevention and control (chap 2).
- o Covers field preventive medicine (chap 3).
- o Covers environmental health (chap 4).
- o Defines occupational health and the preventive medicine components of the Army Occupational Health Program and provides guidance for programs and services to support that Army program (chap 5).
- o Defines and provides health surveillance and epidemiology and procedures for deployment occupational and environmental health surveillance (chap 6).
- o Promotes soldier, family, community health, and health promotion (chap 7).
- o Describes preventive medicine toxicology (chap 8) and preventive medicine laboratory services (chap 9).
- o Defines and provides guidance for health risk assessment (chap 10) and health risk communication (chap 11).
- o Defines the programs and services within the medical functional area of preventive medicine throughout the publication.
- o Provides detailed instructions, guidance, and procedures and delineates the functions necessary for implementing the policies and responsibilities outlined in AR 40-5 where such information is not published in other Army publications throughout the publication.
- o Provides reference to other Army publications containing implementing instructions, guidance, and procedures related to Army preventive medicine throughout the publication.
- o Prescribes DA Form 3897 (Tuberculosis Registry).
- o Prescribes DA Form 5402 (Barber/Beauty Shop Inspection).
- o Prescribes DD Form 2493-1 (Asbestos Exposure, Part I-Initial Medical Questionnaire).
- o Prescribes DD Form 2493-2 (Asbestos Exposure, Part II-Periodic Medical Questionnaire).

Medical Services

Preventive Medicine

By Order of the Secretary of the Army:

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History. This publication is a new Department of the Army pamphlet.

Summary. This new pamphlet defines and establishes programs, services, functions, and procedures for implementing the essential elements of Army preventive medicine; it is to be used with AR 40-5.

Applicability. This pamphlet applies to all elements of the Army across the full spectrum of military operations from peacetime through major theater warfare. This pamphlet applies to all Army personnel to include the Active Army; the Army National Guard/Army National Guard of the United States and the United States Army Reserve personnel on active duty or

in drill status; the United States Military Academy cadets; the United States Army Reserve Officer Training Corps cadets, when engaged in directed training activities; foreign national military personnel assigned to Army components; and civilian personnel and nonappropriated fund personnel employed by the Army worldwide. Except for those preventive medicine services defined in Department of Defense Instruction 6055.1, for supporting Department of Defense contractor personnel during outside continental United States force deployments or specifically provided for in contracts between the Government and a contractor, this pamphlet does not generally apply to Army contractor personnel and contractor operations.

Proponent and exception authority.

The proponent of this pamphlet is The Surgeon General. The Surgeon General has the authority to approve exceptions to this pamphlet that are consistent with controlling law and regulations. The Surgeon General may delegate the approval authority, in writing, to an assistant surgeon general, the U.S. Army Medical Department Functional Proponent for Preventive Medicine, or the equivalent of a director within the Office of The Surgeon General in the grade of colonel or the civilian grade equivalent. Activities may request a

waiver to this regulation by providing justification that includes a full analysis of the expected benefits and must include formal review by the activity's senior legal officer. All waiver requests will be endorsed by the commander or senior leader of the requesting activity and forwarded through their higher headquarters to the policy proponent. Refer to AR 25-30 for specific guidance.

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

Distribution. This publication is available in electronic media only, and is intended for command level C for the Active Army, the Army National Guard/Army National Guard of the United States, and the United States Army Reserve.

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Glossary

Chapter 1 Introduction

1-1. Purpose

The purposes of this pamphlet are to—

- a. Define the programs and services within the medical functional area of preventive medicine.
- b. Identify Army publications that delineate functions and contain the detailed instructions, guidance, and procedures necessary for implementing the policies and responsibilities outlined in Army Regulation (AR) 40-5.
- c. Provide detailed preventive medicine functions, instructions, guidance, and procedures not published in other Army documents.

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 pamphlet are explained in the glossary.

1-4. Background

a. Army preventive medicine includes a broad set of capabilities, ranging from basic field sanitation techniques to comprehensive medical, behavioral health, and occupational and environmental health (OEH) exposure surveillance systems and procedures. These capabilities are focused on the medical readiness of the force to combat health threats across the full spectrum of military operations in the continental U.S. (CONUS) and outside the continental U.S. (OCONUS). They are also designed to promote and maintain the health and well-being of all personnel for whom the Army is responsible.

b. Army preventive medicine directly supports two of the three pillars of the Joint strategy for Force Health Protection (FHP), as described in the Joint capstone document, Force Health Protection - Healthy and Fit Force, Casualty Prevention, Casualty Care and Management (<http://www.dtic.mil/jcs/j4/organization/hssd/hssd.htm>).

(1) The first pillar of the Joint strategy, a healthy and fit force, is the necessary pre-condition for all other elements of FHP. Healthy and fit personnel are more resistant to disease, less prone to injury and the influence of stress, and better able to quickly recover should illness or injury occur. The process of creating a healthy and fit force begins at entry to service and continues through an individual's time in service.

(2) The second pillar of the Joint strategy for FHP, casualty prevention, protects the healthy and fit service member from occupational, environmental, and operational threats of disease and non-battle injury (DNBI). The sustainment of health and performance is essential throughout a service member's entire time in service, especially during pre-deployment, deployment, and post-deployment phases.

(3) The concept that a healthy and fit force and casualty prevention are the responsibility of both commanders and individual service members is an essential element of the Joint FHP strategy.

(4) Part of the mission statement of the U.S. Army Medical Department (AMEDD) is to project and sustain a healthy and medically protected force.

c. The goals of Army preventive medicine are—

(1) To ensure that deployable military forces in CONUS and OCONUS are in a state of optimal health and fitness, trained and equipped to protect themselves from DNBI.

(2) To sustain the health and fitness of forces deployed in CONUS and OCONUS and prevent casualties from DNBI.

(3) To ensure that Army units and personnel are trained, equipped, and capable of supporting the preventive medicine requirements of our forces across the full spectrum of military operations, CONUS, and OCONUS.

(4) To prevent and mitigate injuries and illnesses, improving and maintaining the health of all Army personnel, as defined in AR 40-5.

(5) To reduce the Army's medically related costs, in part by reducing demand for the more costly and less effective tertiary treatment services.

(6) To minimize the risks of long-term adverse health effects of military service.

1-5. Programs and services

a. Army preventive medicine consists of a broad-scope of clinical, installation, and field public health programs and services applied in a wide range of military settings. These specific programs and services include—

(1) Disease prevention and control.

(2) Field preventive medicine.

(3) Environmental health.

(4) Occupational health.

- (5) Health surveillance and epidemiology.
- (6) Soldier, family, community health, and health promotion.
- (7) Preventive medicine toxicology.
- (8) Preventive medicine laboratory services.
- (9) Health risk assessment.
- (10) Health risk communication.

b. A brief discussion of each of the Army preventive medicine programs and services is provided in AR 40-5, paragraph 1-7, and at the beginning of each chapter in this pamphlet.

1-6. Planning, programming, budgeting, and executing preventive medicine resources

a. The Army mission, goals, and objectives drive resource requirements for dollars and personnel. The Army identifies and articulates its resource requirements to the Department of Defense (DOD) through the DOD's Planning, Programming, and Budgeting System and the Army's Planning, Programming, Budgeting, and Execution System (AR 1-1).

b. The Army Management Structure is the official Army framework for interrelating programming, budgeting, accounting, and manpower control through a standard classification of all Army activities and functions. The Defense Finance and Accounting Service (DFAS)-Indianapolis Center (IN) Manual 37-100-FY, published annually, is the fiscal code manual that provides the coding structure for a wide variety of Army and DFAS users.

c. The first level of detail in the coding structure defined by DFAS-IN Manual 37-100-FY consists of 11 major programs for which the DOD programs resources by fiscal year (FY). A subset of the many program elements in Program 8 (Training, Medical, and other General Personnel Activities) reflects the various medical support missions of DOD and the resources related to those missions. The Army preventive medicine programs and services receive resources through the Congressional appropriations for the Operations and Maintenance, Army account; the Army Working Capital Fund; and the Defense Health Program (DHP).

(1) Military Public/Occupational Health is the medical program element in the DHP through which Army preventive medicine programs and services are provided resources. The program element code (also known as an Army Management Structure Code or AMSCO) for Military Public/Occupational Health is 847705. The definition of the Military Public/Occupational Health program element 847705 is provided in the DHP section of the DFAS-IN Manual 37-100-FY chapter on Office of the Secretary of Defense (OSD), DOD, and Other Agency Accounts.

(2) The DHP section of the DFAS-IN Manual 37-100-FY chapter on OSD, DOD, and Other Agency Accounts also breaks down the 847705 program element into an extensive list of subactivities or functions that are identified in the program element code by two-digit decimal numbers added to 847705. For example, Hearing Conservation is identified as 847705.24 and Environmental Health Engineering as 847705.30.

d. The AMEDD articulates medical funding requirements through the DHP Program Objective Memorandum process, managed by the Office of the Assistant Secretary of Defense for Health Affairs or OASD(HA). Funding for the DHP is provided from DOD through OASD(HA) directly to the services' medical departments.

e. A preventive medicine resource model exists to assist in determining local resource requirements. The model is a predictive, population-based and geographically based model of local mission requirements. The model relies on regulations, laws, and strategic and command guidance to identify the preventive medicine functions and tasks that must be performed. A series of formulas, relating to the functions and tasks, is used to estimate the dollars and personnel required to complete the preventive medicine mission.

f. Preventive medicine resource requirements and allocated funds are to be described and documented locally using the DHP activity structure and codes in DFAS-IN Manual 37-100-FY. The activity structure and codes provide a consistent structure for preventive medicine budget execution tracking and program analysis and review across the AMEDD.

Chapter 2 Disease Prevention and Control

Section I Communicable Disease Prevention and Control

2-1. Introduction

Communicable diseases can rapidly degrade the medical readiness of military units and their ability to carry out their mission. Communicable diseases can also cause significant suffering and excess utilization of military health care services among the beneficiary population. The prevention and control of communicable diseases are conducted

(a) Design and operate fixed laundry operations according to AR 210-50.

(b) Design and operate field laundry operations according to FM 42-414.

(c) Laundry operations should follow commercial laundry processes.

1. Use bleach and/or chemical detergent/sanitizers for laundry with high potential levels of microorganisms, such as gym towels and clothing, and laundry from transient quarters, refugee camps, disaster relief operations, prisons, and field operations.

2. Design and test new field laundries to allow for the washing of field uniforms without the use of bleach. The medical commander or preventive medicine representative determines if chemical sanitizers/bleach are required for specific field laundry operations.

(8) *Confinement facilities.* Sanitary inspection requirements for Army detention and confinement facilities are outlined in AR 190-47.

(9) *Food service sanitation.*

(a) Provide quality food service at all levels of command. The scope of Army food service is defined by TB MED 530 to include all food operations within the Army and areas under its control.

(b) The essential elements for Army food service sanitation are described in TB MED 530. Additional guidance on field food service operations is presented in FM 4-02.56 and FM 21-10/MCRP 4-11.1D.

(c) Preventive medicine personnel provide sanitary inspections of Army food service operations, including cook-chill operations as defined in TB MED 530. Commissary and troop issue subsistence activities, including delicatessen operations in commissaries and storage of food in Army food service operations, are the responsibility of the supporting veterinary activity.

(10) *Sports facilities, gymnasiums, and fitness centers.* Sanitary requirements for sports facilities, gymnasiums and fitness centers can be found in appendix D.

(11) *Tattooing and piercing businesses.*

(a) Tattooing and application of permanent makeup is prohibited on Army installations.

(b) When these operations are legal and operating off the installation, the preventive medicine service coordinates with the local health department having jurisdiction and conducts joint inspections for safety, cleanliness and sterilization of needles, control of bloodborne pathogens and spread of infectious disease organisms including HIV and hepatitis.

(c) The preventive medicine service recommends the commander place "off-limits" any facility that presents a health risk to service personnel. Specific information can be obtained by contacting the USACHPPM (MCHB-CS-OSD), Aberdeen Proving Ground, MD 21010-5403.

Chapter 5 Occupational Health

Section I The Army Occupational Health Program

5-1. Introduction

a. The Army Occupational Health Program consists of occupational illness and injury prevention and control programs and services provided by a variety of professional disciplines. These programs and services are necessary to anticipate, identify, assess, communicate, mitigate and control occupational disease and injury threats to Army personnel. These threats may occur in a standard worksite or a deployed setting and may include chemical, biological, radiological, psychological and physical hazards. Occupational health services provided are tailored to the hazards that are anticipated or identified for the defined population with a focus on prevention.

b. The Army Occupational Health Program includes services that promote the health and safety of the individual, the unit, the workplace, and the community. Services may focus on education regarding hazards, or medical surveillance to facilitate early detection of adverse outcomes associated with the occupational environment. In the event that adverse injury or illness outcomes occur, services aim to restore health and productivity. These services may be individual, unit-based or population-based.

c. The Deputy Assistant Secretary of the Army for Environment, Safety, and Occupational Health provides policy, goals, guidance, and management oversight of the Army Occupational Health Program, as the Army component of the DOD Safety and Occupational Health Program.

d. The objectives of the Army Occupational Health Program are to—

(1) Ensure that Army personnel are physically, mentally, and psychologically suited to their work at the time of their assignment, and that physical and behavioral health are monitored to detect early signs of job-related injury or illness.

(2) Protect Army personnel from adverse effects of health and safety hazards in the work environment to include field operations, garrison, industrial, and administrative workplaces.

(3) Ensure proper medical care, rehabilitation, and return-to-duty programs for the occupationally ill and injured.

(4) Reduce loss (manpower and economic) caused by occupationally related injuries and illnesses of Army personnel.

(5) Prevent decreased combat readiness caused by occupational illness and injury of Army personnel throughout the full spectrum of military operations.

e. Programs and services include, but are not limited to—

(1) Medical surveillance examinations and screenings.

(2) Health hazard education.

(3) Surety programs.

(4) Reproductive hazards.

(5) Bloodborne pathogens.

(6) Hearing conservation and readiness.

(7) Vision conservation and readiness.

(8) Workplace epidemiological investigations.

(9) Ergonomics.

(10) Radiation exposure and medical surveillance.

(11) Industrial hygiene.

(12) Personal protective equipment.

(13) Respiratory protection.

(14) Asbestos exposure control and surveillance.

(15) Injury prevention and control.

(16) Occupational illness and injury prevention and mitigation.

(17) Work-related immunizations.

(18) Record keeping and reporting.

(19) Worksite evaluations.

(20) Other Federal programs.

(21) Evaluation of occupational health programs and services.

f. The control of exposures to known occupational hazards utilizes a hierarchy of control, with the use of personal protective equipment as the least preferable solution.

g. As the basis of Army occupational safety and health criteria, the provisions of the Occupational Safety and Health Act and the regulations, standards, and criteria promulgated by the Occupational Safety and Health Administration (OSHA) are followed. The Federal regulations promulgated by the NRC (10 CFR), the FDA (21 CFR) and the Department of Transportation (49 CFR) set additional standards and requirements for ionizing and nonionizing radiation. The current American Conference of Governmental Industrial Hygienists (ACGIH®) threshold limit values (TLVs®) are the criteria that apply within the Army when OSHA standards are less protective or no OSHA standards exist. AR 11-9 establishes the exposure standards for both ionizing and nonionizing radiation. When other alternate or supplemental criteria are necessitated by military uniqueness, existing standards and regulations are followed until justification is forwarded through command channels and OTSG approval is obtained.

h. ACGIH® and TLV® are registered trademarks of the American Conference of Governmental Industrial Hygienists, Cincinnati, Ohio.

5-2. Medical surveillance examinations and screenings

a. *Introduction.* The primary purpose for developing a medical surveillance program is to implement risk-based medical screening or examination for Army personnel. The primary focus is early detection of occupational diseases or illnesses that may be associated with work tasks or workplace exposures of a physical, chemical, biological, or radiological nature. Secondary purposes include—

(1) Documentation of occupational exposures for use as a part of the post-deployment and post-service medical assessments, medical studies, and health risk assessments.

(2) Evaluation of the effectiveness of protective and risk mitigation procedures.

(3) Provision of health risk information useful for commanders in deployed settings for assessing occupational health risks posed by military operations.

b. *References.* AR 40-5 directs the implementation of the DOD Occupational Health Manual (DOD 6055.5-M). Other references that provide policy, guidance, and information regarding job-related examinations are as follows:

(1) *Title 5 CFR 339.* Title 5 CFR 339 provides the requirements and procedures concerning medical qualification determinations, including medical standards, authority to require and offer examinations, medical evaluation programs, and waiver procedures.

(2) Title 5 CFR 930.108... Title 5 CFR 930.108 provides requirements and procedures for periodic medical evaluations.

(3) The U.S. Office of Personnel Management Operating Manual, section VI. This section provides a summary of the occupational series with medical requirements.

(4) Title 29 CFR 1910.

(5) AR 11-34.

(6) DA Pam 40-501.

(7) DA Pam 40-506.

(8) TB MED 509.

(9) TB MED 510.

(10) TB MED 523.

(11) TB MED 524.

(12) AR 11-9 (MEDCOM Regulation 40-42 for MEDCOM-specific guidance).

c. Procedures.

(1) The medical practitioner must know the person's job title, the type of work performed, and individual exposures. Components of the medical surveillance for any Army personnel are based on data characterizing the exposure, recommended or required items related to that hazard, and sound medical judgment. Industrial hygiene data is critical to separate potential exposures from actual exposures. The designated occupational health physician reviews the industrial hygiene data and regulatory requirements annually and when operations change to determine the scope and frequency of work-related medical examinations. Medical judgment synthesizes the total exposures, individual risk factors, job demands, and stresses.

(2) Determining evaluation content and developing protocols.

(a) 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.

(b) 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 the decision will be maintained locally.

(3) Industrial hygiene data is essential to determine potential and actual exposures. Occupational health personnel use such data in reviewing changes in operations. Occupational health personnel also use this data for their annual reviews of regulatory requirements and policies to determine the scope and frequency of work-related examinations.

(4) A follow-up system should be implemented for all health examination and screening programs to identify and report their effectiveness and to assure indicated counseling and referral.

(5) Termination examinations are provided on termination of assignment or termination of employment for all employees who have been included in a periodic job-related medical surveillance program, unless an examination has been conducted within the past 90 days. The 90-day exception does not apply in cases where the content of the periodic examination differs from the termination examination (for example, high-risk microwave or laser workers) or where a more stringent requirement exists.

(6) Military personnel will require further pre-assignment, periodic, pre- and post-deployment follow-up, and termination examinations that are specific for potential chemical, physical, biological, or radiological hazards, in addition to the routine entrance and periodic examinations prescribed by AR 40-501.

(7) Civilian employees assigned to positions requiring specific physical fitness standards are provided examinations in addition to pre-placement, job transfer, periodic, and termination examinations. If necessary, job-related examinations may be made a condition of employment. Employees not required to have pre-placement examinations should be scheduled for baseline health screening evaluations, if resources permit. The baseline examinations may include a health history, blood pressure determination, vision screening, and hearing tests.

(8) Fitness for duty and disability retirement examinations are accomplished following the guidance in 5 CFR 339. DA Pams 40-8 and 40-173 provide guidance for medical examinations for Army personnel potentially exposed to chemical surety materials.

(9) While not a requirement for civilian employees, health maintenance examinations are encouraged, subject to availability of health services resources. Such examinations may include single or multiple disease screening or more detailed medical evaluations, and can be offered on an age-related basis or to specific target groups.

d. Standards and criteria.

(1) Specific exposure standards and criteria are used for occupational health screening and medical examinations. OSHA permissible exposure limits (PELs) are used by the Army except when the current ACGIH® TLVs® are more stringent. Below is a list of governing bodies and organizations that publish standards and criteria with the name of the

respective standards or criteria. AR 11-9 provides exposure and screening standards for ionizing and nonionizing radiation that are based on Federal requirements.

(a) OSHA PELs, 29 CFR 1910.1000, Z-tables: PELs are 8-hour time-weighted averages (TWAs). Some chemicals have short-term exposure limits (STELs) and ceiling limits. More information is available at <http://www.osha.gov/>.

(b) ACGIH® TLVs®, current year TLVs® and biological exposure indices (BEIs®). TLVs® are 8-hour TWAs. Some chemicals have STELs and ceiling limits. (These criteria apply to the Army when more stringent than corresponding OSHA standards.) The current version of the TLVs® for chemical substances and physical agents as well as BEIs® can be ordered from the ACGIH®. Ordering information and costs can be found at <http://www.acgih.org/resources>.

(c) NIOSH-recommended exposure limits (RELs), Pocket Guide to Chemical Hazards. RELs are TWA concentrations for up to a 10-hour workday during a 40-hour workweek. Some chemicals have STELs and ceiling limits. NIOSH publications are available at <http://www.cdc.gov/niosh/>.

(d) American Industrial Hygiene Association (AIHA), workplace environmental exposure level (WEEL) guides, which are 8-hour TWAs. Some chemicals have STELs and ceiling limits. Purchasing information for current AIHA emergency response planning guidelines, WEEL guides, and related handbooks is provided through the publications and advertising link on the AIHA Web site: <http://www.aiha.org>.

(2) Additional guidance may be found in DA Pams 40-501, 40-503, and 40-506; TB MED 502/DLAM 1000.2 and TB MED 509; American National Standards Institute (ANSI) Z87.1; National Fire Protection Association (NFPA) standards (<http://www.nfpa.org/Codes/index.asp>); and other Federal standards such as EPA and U.S. Office of Housing and Urban Development standards (<http://www.hud.gov/>) for levels of lead dusts and health hazards.

(3) Clinical medical practices are guided by the CPGs of the American College of Occupational and Environmental Medicine (ACOEM). Purchasing information for ACOEM CPGs may be found through the publications link on the ACOEM Web site: <http://www.acoem.org>.

(4) AR 11-9 and 10 CFR 20 summarize the NRC's allowable level of intake and derived air concentrations to be used in assessing internal ionizing radiation exposures. AR 11-9 also provides guidance for monitoring potential ionizing radiation exposures in declared pregnant personnel.

(5) AR 11-9 summarizes nonionizing radiation exposure limits used in the Army. Personnel radiation exposure standards for lasers are in TB MED 524.

(6) DA Pams 40-8 and 40-173 provide exposure limits for chemical warfare agents.

(7) BEI® is a registered trademark of the American Conference of Governmental Industrial Hygienists, Cincinnati, Ohio.

5-3. Health hazard education

At a minimum, Army personnel must receive training and education in the following areas:

a. *Communication of hazard.* Federal regulations (10 CFR 19, 29 CFR 1910.1030, 29 CFR 1910.1200) and AR 11-9 require all personnel to receive, at a minimum, initial training regarding potential workplace hazards associated with chemicals, ionizing and nonionizing radiation, and bloodborne pathogens, as well as physical hazards associated with chemicals. The training also must include the protective measures to be taken and personal protective equipment to be used to control exposures.

(1) These regulations also require that such information be readily available to Army personnel in the form of MSDSs. If an Army installation is producing a chemical or hazardous material, that installation must provide the appropriate hazard information and communication. Preventive medicine personnel may assist in this training.

(2) Installation safety personnel normally provide hazard communication training. Preventive medicine personnel may assist in this training.

(3) The regulations require additional training when new hazards are introduced into the work environment.

(4) Occupational medicine personnel may assist in the communication of deployment-related hazards post-deployment.

(5) 10 CFR 19, 29 CFR 1910, 49 CFR 172, and NRC licenses have specific training requirements for ionizing and nonionizing radiation hazard communication.

b. *Hearing conservation.* As required by 29 CFR 1910.95, all personnel who work in noise-hazardous areas and operations receive initial and annual training on the effects of noise on hearing, the purpose of hearing protection, the advantages and disadvantages of various hearing protection devices, the mandatory requirement to wear assigned hearing protectors, and the purpose of audiograms. DA Pam 40-501 provides further guidance.

c. *Reproductive hazards.* Federal regulations (10 CFR 19 and AR 40-5) require that individuals (male and female) be informed of the potential adverse health effects (which includes reproductive effects) of exposures to hazards known to have such effects. Title 29, CFR 1910.1200, provides general requirements for hazard communication.

(1) AR 40-501 provides information on profiling pregnant soldiers, limitations to protect their health and the health of the fetus, and profiling postpartum soldiers.

(2) The NRC Regulatory Guide 8.13 and 29 CFR 1910 require that all pregnant personnel (those who officially declare their pregnancies in writing) are to be trained regarding the potential harmful effects of ionizing radiation on

the fetus. DA Pam 40-18/Defense Logistics Agency Instruction (DLAI) 1000.30 provides Army implementing guidance for this requirement.

(3) Title 29, CFR 1910.1025, mandates that training in the hazards of lead include information specific to adverse reproductive effects on both males and females.

(4) AR 40-562/AFJI 48-110/BUMEDINST 6230.15/CG COMDTINST M6230.4E requires counseling of females regarding the safety, benefits, and potential risks associated with immunizations during pregnancy.

(5) Title 29, CFR 1910.1030 addresses hazard communication requirements regarding potential exposure to blood-borne pathogens.

(6) Title 29, CFR 1910.1047 provides specific hazard communication requirements for ethylene oxide hazards, including reproductive hazards.

(7) Title 29, CFR 1910 provides training requirements in addition to general hazard communication information for specific chemicals that are known or potential carcinogens, many of which have been associated with reproductive hazards as well.

(8) Information to assist health care providers in identifying and understanding the reproductive hazards associated with a variety of waste anesthetic gases and hazardous drugs, such as cytotoxic drugs, in MTFs can be found at the following USACHPPM Web site: <http://chppm-www.apgea.army.mil/documents/TG/TECHGUID/TG149.pdf>. The information at this site may assist health care providers in complying with the general hazardous communication requirements of 29 CFR 1910.1200.

5-4. Surety programs

a. Chemical surety, biological surety, and nuclear surety are specialized programs designed to ensure that chemical and biological warfare materials and nuclear material and reactors are handled securely and that personnel working with these materials are protected appropriately. AR 50-5 prescribes the Army Nuclear Surety Program. AR 50-6 prescribes the Army Chemical Surety Program. AR 385-61 establishes and provides guidance for the Army's Chemical Agent Safety Program. AR 385-69 establishes and provides guidance for the Army's Biological Defense Safety Program.

b. The medical aspects of these programs include the Personnel Reliability Program, special handling and screening of medical records, and treatment of potential and actual casualties.

c. The Personnel Reliability Program supports the Army's surety programs. The goal of the Personnel Reliability Program is to ensure that those individuals who have access or control of surety program materials meet the highest standards of reliability and can safely perform their surety program duties. The components of the Personnel Reliability Program include—

(1) Initial screening of medical records.

(2) Evaluation of personnel for evidence of reliability.

(3) Continuing evaluation and periodic screening of personnel performing surety program duties.

d. Additional guidance related to the Army's surety programs may be found in DA Pams 40-8, 40-173, and 50-6.

5-5. Reproductive hazards

a. Both males and females are vulnerable to reproductive hazards. Some of the potential effects on the male reproductive system include sterility and sperm mutagenesis, both of which can cause infertility. All employees are to be informed about potential work area reproductive hazards. Pregnant employees and their fetuses may require special protection in the work environment. Females who breast-feed their infants and who are exposed to certain chemical hazards should be treated as pregnant employees. Key components of reproductive hazard surveillance and control include:

(1) Identifying work areas or occupations that present potential health reproductive hazards.

(2) Counseling all employees during pre-placement or periodic job-related examinations about the nature of any potential hazards to reproduction.

(3) Informing females about availability of job accommodation or transfer if indicated in the event of pregnancy, as long as the woman declares her pregnancy. Job accommodations, such as transfers, can only occur if the woman declares her pregnancy in writing to her supervisor.

(4) Instituting policy or procedure to ensure prompt notification to the health clinic by pregnant employees as soon as the pregnancy is known.

(5) Assessing the employee's job assignment and work environment when pregnancy is known.

(6) Providing recommendations to the profiling officer regarding job-related hazards to pregnant active-duty personnel.

(7) Providing periodic follow-up and counseling as indicated including pregnancy outcome evaluation.

b. The employee at risk must be informed and must understand that workplace hazards may include bloodborne pathogens (for example, hepatitis and HIV); airborne infectious diseases such as rubeola, rubella, and varicella-zoster; and other chemical or physical hazards not specified by OSHA. Vibration has been associated with abortions if in the

frequency range of 5 to 10 hertz (Hz). Exposure to the following substances has also been associated with spontaneous abortion:

- (1) Lead (inorganic).
- (2) Ethylene oxide.
- (3) Ionizing radiation.
- (4) Waste anesthetic gases.
- (5) Mercury.

c. Additional guidance may be found in AR 11-9, AR 40-501, TB MED 510, and 29 CFR 1910.

5-6. Bloodborne pathogens

a. The prevention and control of bloodborne pathogen exposure and infections is conducted according to the Federal regulations published in 29 CFR 1910.1030. These regulations apply to all employees with reasonably anticipated occupational exposure to blood and other potentially infectious materials. Exposure risk depends on an employee's job activities, not the physical place of employment. The Morbidity and Mortality Weekly Report (MMWR) from June 29, 2001, published recommendations for managing employees after an exposure. Additional technical information for Army preventive medicine personnel may also be found at the following USACHPPM Web site: <http://chppm-www.apgea.army.mil/documents/TG/TECHGUID/TG190.pdf>.

b. The goal of the program is to limit occupational exposure to blood and other potentially infectious materials that may result in the transmission of bloodborne pathogens that could lead to disease or death.

c. Prevention and control of bloodborne pathogen exposures is accomplished through—

(1) *Employee education and training.* The employer must provide an initial and annual training program to employees at risk of occupational exposure. Training is provided during working hours at no cost to the employee.

(2) *A written program to include an exposure control plan.* A written exposure control plan is required to be established and implemented with procedures aimed at eliminating or minimizing employee exposures.

(3) *Immunizations.* Federal standards require employers to make available the hepatitis B vaccine series to all employees who are at risk for occupational exposure, and provide post-exposure evaluation and follow-up to all exposed employees. Additionally, hepatitis B immunization is mandatory for Army medical and dental personnel hired after 1 January 1997 (Health Affairs Policy 97-006).

(4) *Response to exposures.* Following a report of occupational exposure to blood or body fluids, prompt and confidential medical evaluation with subsequent monitoring of the exposed employee is required. Medical evaluation should occur promptly after an exposure, since post-exposure prophylaxis against HIV and hepatitis B, if indicated, is most effective if administered promptly.

d. Timely reporting and accurate record keeping are necessary for preventing exposures, providing timely and appropriate responses to exposures, and analyzing outcomes and trends.

5-7. Hearing conservation and readiness

a. The Army Hearing Conservation Program is designed to protect hearing through the coordinated application of program elements, procedures, and guidelines published in DA Pam 40-501. The program is implemented through the Defense Occupational and Environmental Health Readiness System (DOEHRs)-Hearing Conservation (DOEHRs-HC) application. Program elements are delineated in DA Pam 40-501.

b. Hearing conservation program managers use the Hearing Conservation Program Evaluation Profile (<http://usachppm.apgea.army.mil/hcp/hcpep>) to annually assess and document the compliance of their local hearing conservation programs with regulatory requirements. The use of this tool supports compliance with 29 CFR 1960.79, subpart J, which requires all Federal programs to perform annual self-assessments of their safety and occupational health programs.

5-8. Vision conservation and readiness

An effective Army Vision Conservation and Readiness Program (VCRP) promotes and optimizes vision and optical readiness. The VCRP is essential to assure a safe and healthful working environment and applies to garrison, field training, and deployment environments. An effective VCRP is implemented and administered using the procedures, principles, and guidance provided in DA Pam 40-506 and 29 CFR 1910 and includes occupational vision, eye safety, and environmental vision components.

5-9. Workplace epidemiological investigations

a. Commonly accepted epidemiological methods and tools are used to investigate incidences of infectious diseases, occupational illnesses, and injuries presumed to be associated with the workplace. Such investigations address both the acute and short-term health outcomes as well as chronic health and reproductive health impacts.

b. Preventive medicine personnel conduct such workplace epidemiological investigations in coordination with safety personnel. These investigations are used to identify, assess, and document trends and analyze the occurrence and incidence of such illnesses and injuries. It is extremely important to determine whether the health outcomes are actual

or perceived. Situations that present an imminent danger to Army personnel are reported through Army safety officials according to AR 385-10.

c. Infectious diseases in workers can affect the incidence and severity of occupational and environmental exposure health outcomes. Consequently, infectious diseases in workers must be considered in analyzing potential OEH hazards as well as investigating noninfectious disease health outcomes. Infectious diseases in workers can also interfere with or mask efforts to detect clusters of noninfectious disease health outcomes. Some infectious diseases may actually be work-related.

d. Effective risk communication is a critical part of any epidemiological investigation of possible workplace infectious diseases, occupational illnesses, and injuries.

5-10. Ergonomics

a. In a memorandum signed on 4 February 1997, the Deputy Under Secretary of Defense (Environmental Security) established the Ergonomics Program interim requirements and procedures for the control of work-related musculoskeletal injury and illnesses. On 18 May 1998, the Deputy Assistant Secretary of the Army (Environment, Safety and Occupational Health) signed a policy memorandum outlining the Army's roles and responsibilities. These memorandums directed that, as a minimum, the Ergonomics Program would—

- (1) Interface with existing programs.
- (2) Include a written plan with goals and objectives.
- (3) Address the five critical program elements—workplace analysis, hazard prevention and control, health care management, education and training, and program evaluation. The degree of emphasis on each critical program element varies according to the hazards and concerns at each installation.

b. DA Pam 40-21 provides guidance and procedures for implementing the Army Ergonomics Program.

5-11. Radiation exposure and medical surveillance

a. Introduction.

(1) AR 11-9 provides policy and guidance for a comprehensive Army Radiation Safety Program. The program is directed at safeguarding personnel and property from ionizing and nonionizing radiation hazards.

(2) Radiation sources are identified and exposures prevented or controlled according to the guidance in AR 11-9, DA Pam 40-18/DLAI 1000.30, and TB MED 521. Specific guidance for MEDCOM personnel can be found in MEDCOM Regulation 40-42.

(3) Appendix G provides specific guidance on the control of radiation sources, protective clothing and equipment, radiation detection and measuring equipment, and radiologic facility shielding analysis. For additional standards, criteria, guidance, and procedures for controlling exposures to nonionizing radiation, refer to TB MED 523, TB MED 524, ANSI Z136.1, ANSI Z136.2, ANSI Z136.3, ANSI Z136.6, ANSI B11.21, and Military Handbook (MIL-HDBK)-828A.

b. Functions.

(1) In order to implement the prescribed policies and procedures in AR 11-9, an activity or installation commander who operates, maintains, or stores radiation-producing equipment—

(a) Designates a primary radiation safety officer (RSO) and alternate in writing as required by the applicable NRC license. Though not specifically required by all NRC licenses, designating an alternate RSO is an effective means to ensure program continuity and command and control of radiation sources in the absence of the primary RSO.

(b) Provides the RSO with training, equipment, and support staff commensurate with the extent of their responsibilities.

(c) Designates an on-site RSO for personnel under his or her command assigned to activities at non-Army locations that may involve radiation exposure. The on-site RSO's responsibilities include reviewing safety plans and safety procedures as well as ensuring that those personnel receive proper dosimetry and bioassay support.

(2) Commanders of medical activities with nuclear medicine services provide a full-time RSO who meets the training and experience requirements of 10 CFR 35.

(3) The RSO—

(a) Manages the Radiation Safety Program according to AR 11-9 and other applicable Federal and Army regulations, guidance, NRC licenses, and Army radiation authorization conditions.

(b) Maintains complete program files, including current records of radiation source inventories, SOPs, records of instructions for radiation source users, and all other records required for compliance with applicable Federal, state, and Army regulations.

(4) Commander, USACHPPM, provides technical assistance in the area of radiation safety, specifically to—

(a) Assist Commander, MEDCOM, in conducting triennial evaluations of each installation to ensure compliance with nonionizing radiation safety standards.

(b) Forward bioassay results and radiation dose assessments to the Ionizing Radiation Dosimetry Branch (IRDB),

U.S. Army Primary Standards Laboratory, Test, Measurement, and Diagnostic Equipment, Redstone Arsenal; the licensee (if applicable); the responsible RSO; and the MTF or occupational health clinic

- (c) Evaluate ionizing and nonionizing radiation sources.
- (d) Provide information and guidance regarding ionizing and nonionizing radiation safety.
- (e) Investigate alleged laser or radiofrequency radiation overexposures.
- (f) Maintain radiation safety reports and surveys.

c. *Licenses and authorizations.* Any organization requiring an NRC license or Army radiation authorization consults with the appropriate MACOM radiation safety staff officer and refers to AR 11-9.

d. *Ionizing radiation exposure surveillance.* Ionizing radiation exposure surveillance is conducted according to AR 11-9, DA Pam 40-18/DLAI 1000.30, and specific NRC license and Army radiation authorization requirements. Appendix G provides more specific guidance. The following Army procedures are necessary to implement established policies for exposure surveillance:

(1) All ionizing radiation exposure information is medical information that relates to the health status of Army personnel and is necessary for current and future health risk assessments. As such, this information will be treated according to AR 40-66.

(2) AR 11-9 provides guidance for determining when external ionizing radiation dosimetry is necessary, including specific guidance for declared pregnant females. Results of this dosimetry provide exposure estimates that are used for medical assessments of risk. The following procedures are necessary for standardized external ionizing radiation dosimetry across the Army.

(a) Army units must use the dosimetry services of the IRDB unless specifically exempted by TSG.

(b) TSG may grant exemptions (for periods up to two years) to use a laboratory or contract service, if the laboratory or contract service can demonstrate compliance with the technical requirements outlined in AR 11-9 and can be appropriately certified to conduct these measurements (for example, certified by the National Voluntary Laboratory Accreditation Program).

(3) AR 11-9 provides guidance for when bio-monitoring of internal ionizing radiation exposure is necessary, including specific guidance for declared pregnant females. The following are established as necessary procedures for standardized internal radiation exposure bio-monitoring across the Army.

(a) When not a regulatory or NRC license requirement, only a trained, privileged provider may approve sample collection for in-vitro bioassay analysis and interpret bioassay results.

(b) Trained medical personnel collect in-vitro bioassay samples according to proper medical sample collection procedures.

(c) In-vitro bioassay samples are sent to USACHPPM for analysis (specific technical information is available at <http://chppm-www.apgea.army.mil/documents/TG/TECHGUID/TG211.pdf>).

(d) TSG may grant exceptions (for periods up to two years) to use another laboratory if the laboratory can demonstrate the ability to perform the bioassay procedures specified in AR 11-9.

(e) All bioassay results (from in-vitro and in-vivo testing) must be placed in the patient's medical record and forwarded to the Army IRDB according to procedures outlined in AR 11-9.

(4) AR 11-9 requires the documentation of dosimeter use and occupationally related ionizing radiation exposure. See DA Pam 40-18/DLAI 1000.30 for detailed guidance on record retention, disposition, transfer and inspection.

(5) Specific items to be placed in personnel medical records include—

(a) Dosimetry and bioassay records as required in AR 11-9, paragraph 5-2.

(b) Results of ionizing radiation dosimetry monitoring. This includes the annual summary of external ionizing radiation exposure, results of in-vitro and in-vivo bioassays, and the assignment of administrative doses.

(c) A chargeout card can be placed in the medical records to indicate the location where current dosimetry records can be reviewed (that is, located in the office of records for the NRC licensee).

(6) The RSO ensures, through participation in the contracting process, that adequate provisions for proper exposure monitoring are included in any contract through which contractor personnel are at risk of radiation exposure.

(7) Contracting agencies that provide dosimetry and bioassay monitoring services for contract personnel provide copies of the results and records to the activity RSO.

e. *IRDB support of ionizing radiation exposure surveillance.* The IRDB provides capabilities essential to ionizing radiation dosimetry in the Army. The IRDB's information, archiving, search, and retrieval functions are the cornerstone of the Army's ability to archive and use ionizing radiation dosimetry data for health risk assessment, management, and communication. These capabilities include—

(1) Providing exposure histories on all Army and contractor personnel to comply with NRC archiving requirements as well as AR 11-9 reporting requirements during deployments and after deployments. The IRDB provides exposure histories when requested by a duly appointed RSO or a medical official when required for official business.

(2) Maintaining data with sufficient detail to allow reporting exposure by individual, by occupational code, and by unit of assignment.

(3) Interfacing with medical surveillance and medical reporting systems so that exposure data can be rapidly shared with medical authorities and authorized VA personnel.

(4) Providing external, internal and total exposure dosimetry and bioassay results. For bioassay results, the IRDB is able to provide the data upon which the exposure analysis is based. The IRDB also provides the basis for administrative doses when such doses are assigned.

f. Ionizing radiation medical surveillance. Routine medical examinations for individuals occupationally exposed to ionizing radiation are usually not necessary. A reported overexposure does not necessarily indicate the need for a medical examination. The circumstances associated with the reported overexposure and the estimated organ or whole-body dose should help determine the type and extent of any examination, as well as the types of laboratory or medical tests.

(1) The supporting medical commander, in consultation with the RSO—

(a) Determines if a medical examination is necessary for individuals occupationally exposed to radiation.

(b) Refers any individual suspected of having received a radiation dose in excess of the limits specified in AR 11-9 to a physician.

(2) The supporting medical commander and the supporting occupational health physician—

(a) Determine the appropriate level of examination and treatment.

(b) Consider the following factors when determining an appropriate medical examination—

1. The total actual or suspected dose.

2. Types of radiation to which the individual was exposed.

3. Portion of the body exposed.

4. Target organ dose.

5. Time elapsed between the exposure and notification.

6. Other appropriate factors.

(c) Ensure that personnel potentially exposed to nonionizing radiation receive appropriate medical examinations as specified in DODI 6055.11 and TSG policy directives.

(d) Ensure that copies of reports documenting reported overexposures are forwarded to USACHPPM for archiving whether or not an actual overexposure occurred. Documenting a determination that a suspected overexposure did not occur is as important as documenting actual overexposures.

g. Nonionizing radiation medical surveillance.

(1) The medical commander and occupational health personnel ensure that personnel potentially exposed to nonionizing radiation receive appropriate medical examinations as specified in ANSI Z136.1, AR 11-9, MEDCOM Regulation 40-42, TB MED 523, and TB MED 524.

(2) No suitable personal dosimeters exist for measuring individual exposures to nonionizing radiation.

5-12. Industrial hygiene

Industrial hygiene consists of the anticipation, recognition, evaluation, and control of those environmental factors and stresses associated with work operations that may cause sickness, impaired health and well-being, or significant discomfort and inefficiency among workers or among the citizens of the community. Industrial hygienists function as a team with the occupational health staff, occupational medicine staff and installation safety. Refer to DA Pam 40-503 for detailed implementing instructions and guidance for industrial hygiene services for the Army.

5-13. Personal protective equipment

a. The use of personal protective equipment is an integral part of the local safety and occupational health program for all soldiers and civilian employees. Industrial hygienists and safety personnel determine when, where, and what type of equipment is used. Individuals who deliberately or carelessly violate regulations regarding the wearing of personal protective equipment may be subject to disciplinary action (AR 690-700).

b. Installation or activity safety personnel, with assistance from local industrial hygiene personnel—

(1) Designate areas requiring the use of personal protective equipment, such as eye-hazardous areas or areas requiring the use of a hard hat.

(2) Ensure that all personal protective equipment is used as required and stored and maintained properly.

c. Occupational health nurses (OHNS) and occupational medicine physicians evaluate the workers' ability to safely wear personal protective equipment.

5-14. Respiratory protection

A respiratory protection program involves much more than issuing a respirator to an employee. The preferred methods to reduce risk of exposure to airborne contaminants are reducing the air concentrations of hazardous substances by substitution with a less toxic substance and engineering and administrative controls. However, when respirators must be used to control exposures, the appropriate respirator must be selected according to the exposure, and must be appropriately fitted to the employee. Qualified medical and safety personnel are essential to an effective respiratory

protection program. The employee must be trained regarding how to use and properly maintain the respirator. Medical clearance is also an essential part of the respiratory protection program. The Army Respiratory Protection Program is described in detail in AR 11-34.

5-15. Asbestos exposure control and surveillance

The MTF commander ensures that occupational health personnel—

a. Administer medical questionnaires, such as DD Form 2493-1 (Asbestos Exposure, Part I-Initial Medical Questionnaire) and DD Form 2493-2 (Asbestos Exposure, Part II-Periodic Medical Questionnaire), to all employees who—

- (1) Are potentially or actually exposed to asbestos above the OSHA PEL or above the excursion limit.
- (2) May be engaged in or should engage in Class I, II, or III asbestos work, as defined in 29 CFR 1910.1001 and 29 CFR 1926.1101.
- (3) Participate in the installation asbestos management program as outlined in AR 200-1, AR 420-70, and TB MED 513.

b. Maintain these forms in the civilian employee's medical record and the military health record.

c. Perform health risk assessments of asbestos-containing building materials to determine the need for corrective action.

5-16. Injury prevention and control

Injuries and musculoskeletal illnesses are major causes of diminished readiness in the Army. A comprehensive Army injury prevention campaign can be waged against this preventable detriment to readiness and costs through improved fixed installation and deployment injury surveillance, population-based injury prevention analysis, identification of injury prevention "best practices" and tools, and education products.

a. *Functions.*

(1) The leadership and staffs of the Army Safety Center and the USACHPPM coordinate in supporting injury reduction planning and initiatives for the Army. The two organizations support each other with technical consultants in addressing workplace safety, risk communication, and investigation of accidents or incidents that cause injuries or other adverse health effects.

(2) Commanders, supervisors, and other leaders, assisted and advised by medical staff, are the first and critical line of defense in reducing impact from injuries through education and training of personnel, early recognition of symptoms of injury, and timely application of preventive measures.

(3) Commanders reduce the risk of injury and—

- (a) Publish a unit-level annual directive on the prevention of injuries.
- (b) Provide unit commanders an annual orientation class on the control of injuries using safety and medical personnel.
- (c) Ensure all newly assigned personnel are aware of the warning signs for injuries and ways to prevent injuries.

b. *Elements.*

(1) Successful installation injury prevention and control efforts include local policies, attentive case management, fraud investigation, light-duty assignments, position restructuring, and regular meetings of those involved in the local injury prevention and control program.

(2) Injury prevention and control efforts include—

(a) Cooperation at the local level between occupational health, safety, personnel, management and local Office of Workers' Compensation Program (OWCP) offices.

(b) Prompt provision of medical care for employees and soldiers afflicted with occupational injuries and illnesses on a priority basis per AR 40-400. Initial and follow-up care are provided for civilians as resources permit.

(c) Educational efforts to teach best practices in injury reduction, case management and related topics.

(d) Consultation with occupational health specialists for installations with particular problem areas.

(e) Use of medical surveillance and epidemiology tools to obtain relevant injury data, perform trend analysis, target specific interventions, and evaluate effectiveness of those interventions.

5-17. Occupational illness and injury prevention and mitigation

a. *Federal Employees Compensation Act Program.*

(1) The Federal Employees Compensation Act (FECA) provides monetary compensation, medical care and assistance, vocational rehabilitation, and reemployment rights to Federal employees who sustain disabling injuries as a result of their Federal employment. The Department of Labor (DOL) OWCP administers FECA claims.

(2) The FECA program is financed by the Employees' Compensation Fund, which consists of funds appropriated by Congress directly, or indirectly, through a charge back to the various agencies. Each year, the Secretary of Labor furnishes a statement to each DOD component regarding payments made from the Fund.

b. *Functions.*

- (1) The installation commander ensures that—

(a) Maximal effort is made to keep injured employees on the job, and that limited-duty positions are made available (DOD 1400.25-M, subchapter (SC) 810.3.4.4).

(b) Position restructuring is considered for employees who have been permanently partially disabled because of a job-related injury or illness (DOD 1400.25-M, SC 810.3.4.5).

(c) An installation FECA work group is established, if installation FECA claims exceed \$1 million (DOD 1400.25-M, SC 810.3.4.6).

(2) Those involved in the installation-level effort to prevent and mitigate injuries meet regularly as a group to review and analyze injury trends, causes, light-duty assignments, position restructuring, case management activities and outcomes, FECA costs, trends, and plans; and to develop cost containment initiatives (DOD 1400.25-M, SC 810.3.4.6).

(3) Occupational health clinics work with local commanders to reduce FECA costs by—

(a) Assisting organization and installation FECA coordinators with the medical aspects of case management, including *controversion* when appropriate.

(b) Coordinating with the installation safety office to identify and correct occupational safety and health problems (including ergonomic ones) that may cause further injuries or illnesses.

(c) Reviewing OWCP medical reports for appropriateness.

c. *Procedures to reduce civilian injury rates and FECA costs.*

(1) Effective management of FECA costs requires close coordination among supervisors, resource managers, personnel offices, installation safety, occupational health, FECA coordinators, and commanders. Most accidents and the claims that follow are preventable through strong hazard identification and abatement, safety education programs, enforcement of safety rules, and a progressive ergonomics program.

(2) Each installation should have a FECA work group tailored to the installation's needs (DOD 1400.25-M, SC 810.3.4.6).

(a) Department of the Defense policy requires a FECA work group on installations whose claims exceed \$1 million.

(b) The purpose of this work group is to review injury and claim trends, establish and track goals, and develop cost-containment initiatives to reduce FECA claims and costs to the command.

(c) Representatives from civilian personnel (usually the Installation Compensation Program Administrator (ICPA)), safety, occupational health, industrial hygiene, resource management and law enforcement (fraud investigation) should be included.

(d) Installation FECA work groups usually meet quarterly.

d. *Documenting and reporting occupational injury or illness for military personnel.* AR 385-40, chapter 2, requires that occupational injury or illness (fatal or nonfatal) of Army military personnel be documented and reported. AR 385-40, paragraph 2-10, prescribes the use of an installation log of occupational injuries and illnesses to record such injuries or illnesses to military personnel. Definitions of reportable occupational illness and injury are found in AR 385-40, chapter 2 and the glossary.

e. *The role of the occupational health clinic in injury cost reduction.* The occupational health clinics and local commanders work together to reduce costs by—

(1) Assisting supervisors in advising injured civilian employees that the installation MTF is available for examination and treatment of their injury or illness. Treatment at the installation MTF is not mandatory for the employee. Employees may choose to see a private physician. Supervisors ensure the safe transport of employees to the health care provider of choice.

(2) Offering emergency care to injured civilian employees who choose to see a private physician but cannot get an appointment on the day of the injury. Emergency care may be provided until the injured employee can see the private physician of choice.

(a) Selection of an on-site provider for emergency care does not constitute an employee's choice of physician.

(b) Any communication between occupational health clinic personnel and private physicians must be in writing with a copy furnished to the regional OWCP office. Occupational health personnel will not contact private providers directly or by telephone.

(3) Supporting an installation *light duty* program.

(a) An installation light duty program is designed to provide injured civilian employees with duties the employees can safely perform in order to reduce medical and compensation costs. Most injured workers can return to some form of useful work if the command makes it available.

(b) Coordination with the OHN and industrial hygienist to conduct a thorough job analysis to determine what accommodations are needed is an essential part of reducing FECA costs.

(4) Assisting the ICPA, when requested, with medical aspects of case management, including *controversion* when appropriate and meeting regularly with the ICPA when possible.

(a) Controversion of claims is the process by which an agency may object to paying continuation-of-pay for regulatory reasons.

(b) The supervisor is responsible for controverting a claim on the U.S. Department of Labor (DOL) Form CA-1

(Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation) and submitting the detailed supporting information to the OWCP.

(c) The occupational health physician can review OWCP medical reports to provide an opinion to the ICPA as to whether second opinion and referee medical findings are consistent with employment restrictions recommended by the treating physician.

(5) Coordinating with the installation safety office to identify and correct occupational safety and health problems (including ergonomic ones) that may cause further injuries or illnesses.

f. Illness absence monitoring. Medical support of illness absence monitoring for civilian employees includes—

(1) Screening, treatment (see para 5-17g, below) and referral of employees who become ill during duty hours to the health care provider chosen by the employee.

(2) Evaluation of employee health status on return to duty after any absence due to job-related illness or injury that could impair job performance according to U.S. Equal Employment Opportunity Commission (EEOC) guidelines. (See EEOC Enforcement Guidance.)

(3) Recommendations regarding work limitations.

g. Medical directives. Comprehensive medical directives for emergency care and treatment of occupational and nonoccupational illnesses and injuries by the nursing staff are prepared, signed, reviewed annually, and revised by the responsible physician to—

(1) Assure proper handling of emergencies in the absence of, or prior to the arrival of, a physician.

(2) Direct the care to be given for minor incidents not requiring the personal attention of a physician.

(3) Authorize other activities by the nursing staff.

h. First aid. In general, the placement of first aid kits in work areas is discouraged. Exceptions can be made where work areas are geographically located distant from an MTF or where extremely hazardous exposures may occur and require immediate treatment for exposure. Local medical personnel approve first aid kits placed in work areas, their contents, intended use, and maintenance procedures. The only personnel approved for rendering first aid treatment are those who have completed approved first aid training. All first aid treatment rendered is reported to occupational health personnel.

5-18. Work-related immunizations

a. Appropriate immunizations are provided personnel with increased risk of infection related to potential job hazards or when required by official foreign travel. Other immunizations may be offered to civilian personnel to reduce absence due to sickness. Refer to AR 40-562/AFJH 48-110/BUMEDINST 6230.15/CG COMDTINST M6230.4E and CDC guidelines in the MMWR. The MMWR is available at <http://www.cdc.gov/mmwr>.

b. DA Pam 385-69 contains guidance concerning immunizations for workers in biodefense programs.

c. Civilians traveling under military sponsorship are provided appropriate immunizations and chemoprophylactic medications.

5-19. Record keeping and reporting

a. General instructions. While Civilian Personnel (Civilian Personnel Advisory Center or Civilian Personnel Operations Center) maintains accountability for employee records, the occupational health clinic, the industrial hygienist, the RSO, and the installation safety officer support this function. Title 29 CFR 1960, sections 66-74, establish uniform requirements for the collection and compilation of Federal employees' occupational safety and health records. AR 40-66 outlines medical record keeping, confidentiality, and reporting requirements. AR 40-68 outlines quality assurance procedures for records maintenance.

b. Special instructions for ionizing radiation exposures. AR 11-9 establishes special record keeping and reporting requirements for occupational exposures to ionizing radiation. Specific radiation exposure record keeping and reporting instructions for use by MEDCOM RSOs are found in MEDCOM Regulation 40-42. The following instructions pertain to the retention, disposition, information disclosure, transfer, and inspection of records pertaining to occupational exposures to ionizing radiation.

(1) *Record retention.*

(a) The automated dosimetry record (ADR) and bioassay results are permanent parts of the occupationally exposed individual's health record or civilian medical file. This includes all previous versions of dosimetry and exposure records. All previous copies of these records are retained in each occupationally exposed individual's health record or civilian medical file or with the dose records custodian. (AR 40-66 and AR 25-400-2 contain DA procedures.)

(b) If a DA or Defense Logistics Agency (DLA) civilian individual is not included in a Federal civilian occupational health service, the dose records should be kept in the individual's Official Personnel Folder.

(c) For a non-Federal worker (for example, contractor), the RSO ensures that records maintained at the IRDB are accurate.

(d) The IRDB permanently maintains all raw dosimeter readings obtained from personnel badges. The IRDB permanently retains, in the case of personnel threshold limit doses, the glow curve data for those threshold limit dose readings that require notification of OTSG. The IRDB should—

1. Retain this data on a media that can be processed by electronic data processing equipment.

2. Permanently maintain the databases containing the records of exposure of past and present employees of DA and DLA or Government-owned; contractor-operated employees in their entirety on a media that can be processed by electronic data processing equipment.

3. Microfilm paper records generated by the IRDB in providing dosimetry services; then dispose of the paper records according to AR 25-400-2.

(2) *Record disposition.*

(a) AR 40-66 and Civil Service regulations govern the disposition of "stray" exposure records for DA military and civilian personnel.

(b) Civilian personnel directives govern the disposition of these records for retired or separated civilian individuals.

(c) Dose records for retired or separated DA or DLA military personnel are placed in the individual's health records.

(3) *Disclosing information on records.*

(a) The RSO coordinates with the IRDB or custodian to provide each individual who required monitoring a written, annual report of the occupational dose, as required by 10 CFR 19 or 29 CFR 1910. Include the following in this report—

1. The name of the installation or activity at which the individual was provided personnel dosimetry.

2. The name of the individual and individual's social security number.

3. The individual's exposure information.

4. The following statement: "This report is furnished to you under the provisions of the Nuclear Regulatory Commission regulation 10 CFR 19 or Department of Labor regulation (29 CFR 1910). You should preserve this report for further reference."

(b) For instructions regarding reports upon employment termination, refer to DA Pam 40-18/DLAI 1000.30, paragraph 4-6.

(4) *Record transfer.*

(a) The RSO and the dose records custodian transfer records according to AR 25-400-2. Upon notification of an occupationally exposed individual transfer, the RSO and the dose records custodian—

1. Place the annual and current ADRs (and any previous versions of ADRs) and any bioassay results in the military health record or civilian medical file.

2. Prepare a copy of the above documents for the gaining installation or organization.

(b) The gaining organization ensures that the records are complete by reviewing them upon receipt. If the ADR and bioassay results are missing, the gaining organization's dose record custodian will request in writing that the losing organization's RSO, indicated on the chargeout record, forward these records.

(c) DD Form 877 (Request for Medical/Dental Records or Information) may be used to request these records from the MEDCEN, MEDDAC, or U.S. Army Dental Activity (DENTAC). See AR 40-66 for further information about the request and release of medical and dental records and information.

(5) *Record inspection.* The installation or activity commander has the authority to authorize inspecting officials to review dose records and bioassay results. Such inspecting officials must have a valid need to review such records. If these records are maintained in the military health records or civilian medical files, the document custodian provides access to these dose records.

5-20. Worksite evaluations

a. Worksite visits/evaluations are conducted annually by occupational health, industrial hygiene, and safety personnel. Additional worksite evaluations are conducted as operations change. Each visit is documented, and the worksite supervisor is provided a written report. At a minimum, these evaluations should include hazardous material identification, type of engineering controls needed if applicable, type of personal protective equipment required, and posting of appropriate signs needed (that is, noise-hazardous area, eye protection required). Appropriate entries should be made in the Health Hazard Information Module (HHIM) until DOEHRS-Industrial Hygiene (IH) is fielded. Appropriate entries are then made in DOEHRS-IH.

b. AR 385-10, DA Pam 40-503, and DODI 6055.1 contain additional guidance.

5-21. Other Federal programs

a. DA implements occupational safety and health standards by any of the following methods when there is no DA-published regulation or other guidance:

(1) Issuance of an OSHA standard.

(2) Publication of an OTSG policy letter providing guidance that incorporates the OSHA standard.

b. Additional guidance may be found in AR 385-10, chapter 3, and at the CDC Web site at <http://www.cdc.gov/niosh/>.

5-22. Evaluation of occupational health programs and services

a. Self-audits and external assessments of Army occupational health programs and services are essential tools in evaluating the outcomes and effectiveness of programs and services from both local and Army-wide perspectives. Such evaluations also assist installation commanders and local occupational health program managers in improving the quality of their occupational health programs and services.

b. The local occupational health program manager establishes local program goals and metrics and conducts an annual self-assessment of installation-level programs and services.

(1) The installation industrial hygiene program manager conducts an annual self-assessment of installation-level industrial hygiene programs and services.

(a) The assessment is completed and documented using the Industrial Hygiene Status Report self-assessment questionnaire, located on the DOEHRS secure Web site. Access to the Industrial Hygiene Status Report is restricted to account holders. Instructions for obtaining an account are provided through a link on the DOEHRS secure Web site homepage at <https://doehrswww.apgea.army.mil/dohrsdr>.

(b) The USACHPPM Industrial Hygiene Program sends an electronic notification letter annually to installation industrial hygiene program managers with instructions for completing the assessment on the DOEHRS secure Web site. The USACHPPM Industrial Hygiene Program analyzes the annual industrial hygiene assessments across the Army and distributes the analyses through the industrial hygienists at the regional medical commands (RMCs).

(2) The installation occupational health program manager completes and documents an annual self-assessment of installation-level occupational health programs and services.

(a) The assessment is completed using the self-assessment checklist in the Occupational Health Program Status Report Web-based application available at the following Web site: <https://echppm.apgea.army.mil/apps/ohsac>. Each Army occupational health clinic completes this self-assessment annually by 31 October, providing the results through the local MTF commander to the RMC preventive medicine service. Results are also sent electronically to USACHPPM. Results should be shared with the installation commander. The local MTF commander determines improvements to be made based on the self-assessment.

(b) The local occupational health program manager can access the Occupational Health Self-Assessment Checklist at the secure URL after obtaining an account in the USACHPPM extranet at <http://chppm-www.apgea.army.mil/extranet>. Extranet user guidance is available from the USACHPPM Deputy Chief of Staff for Information Management, Infrastructure Management Division.

(3) USACHPPM consolidates and analyzes these annual assessments to assist the Functional Proponent for Preventive Medicine in identifying Army-wide industrial hygiene and occupational health program strengths and weaknesses and planning systemic program improvements and problem resolution.

c. The local occupational health program can request consultative assistance as well as external audits and evaluations of the overall installation program or of individual services. USACHPPM can provide such external audits and evaluations when requested by the local occupational health program manager, the local medical commander, or the installation commander.

d. Each occupational health service completes a formal external evaluation using RMC, MEDCOM, or USACHPPM assets every three years at a minimum.

Section II

Other Occupational Health-Related Programs and Services

5-23. Introduction

a. Army preventive medicine includes other occupationally related programs and services that are not part of the formal DOD Safety and Occupational Health Program or the formal Army Occupational Health Program. These programs and services include—

- (1) Army aviation medicine.
- (2) HHA of Army equipment and materiel.
- (3) Medical facility and systems safety, health, and fire prevention.
- (4) Nonoccupational injury and illness.

b. Army aviation medicine is considered to be a preventive medicine discipline focusing on improving and sustaining aviator health and performance.

c. The Army HHA Program provides system and materiel health risk assessments to prevent illness or injury once the system or materiel is fielded for Army use. This program is unique among the Services.

d. Preventive medicine services supporting medical facility and systems safety, health, and fire prevention are focused on MTF compliance with the JCAHO health and safety criteria.

e. Definitive diagnosis and treatment of nonoccupational illness and injury cases are not within the scope of the Army Occupational Health Program. There are exceptions in cases of emergencies, minor disorders, minor treatments, and cases of employees with substance abuse problems. Paragraph 5-27 provides additional information.

f. At the discretion of the MTF commander, a variety of occupational health-related, clinical and nonclinical health promotion and wellness services may be provided to civilian employees at Government cost. These services may include cholesterol testing; hypertension screening; and tobacco use cessation services such as clinical visits, group counseling, information, and medications.

5-24. Army aviation medicine

a. Introduction.

(1) Army aviation medicine applies to aircrew performing aviation or air traffic control duties in DA aircraft, aircraft leased by the DA, or in Army air traffic control facilities. This includes Active Army and Reserve personnel, DA civilians, contract civilians under employment by the DA, or firms under contract to DA.

(2) Aeromedical standards, policies, and procedures are provided in AR 40-501 and AR 40-3.

b. Functions.

(1) TSG is responsible for the Army Aviation Medicine Program and is the proponent for all aeromedical policies and standards. The aviation medicine consultant to TSG assists TSG in formulating policies and standards and provides technical supervision of all aspects of the Army Aviation Medicine Program.

(2) Medical commanders, command surgeons, and aviation unit commanders implement Army aviation medicine at the local level by providing trained personnel, equipment, and facilities for the proper conduct of the program.

(3) All aviation personnel are given ambulatory care or flight evaluations by or under the direct supervision of a flight surgeon if available. If such care is not available, other health care providers ensure that the requirements in AR 40-3 and the responsibilities in AR 40-501 are met.

5-25. Health hazard assessment of Army equipment and materiel

a. *Introduction.* The Army implements a formal HHA Program in support of the Army Materiel Acquisition Decision Process according to AR 40-10.

b. *Functions.* OTSG has the staffing, planning, programming, budgeting, and execution responsibilities for this program as prescribed in AR 40-10.

5-26. Medical facility and systems safety, health, and fire prevention

a. Introduction.

(1) AMEDD unit safety program management functions and responsibilities comply with AR 385-10.

(2) AMEDD unit accident reporting and record keeping procedures and responsibilities comply with AR 385-40.

(3) Electrical safety in fixed medical facilities complies with the criteria in JCAHO Comprehensive Accreditation Manual for Hospitals (CAMH) and Comprehensive Accreditation Manual for Ambulatory Care (CAMAC); NFPA Standards 70, 99, and 110; and 29 CFR 1910.

(4) Fire safety in fixed medical facilities complies with AR 420-90; CAMH; CAMAC; NFPA Standards 10, 13, 30, 72, 80, 82, 90A, 96, 101[®] (2000 edition) and 5000; MIL-HDBK-1008C, MIL-HDBK-1191, and 29 CFR 1910.

(5) General safety in fixed medical facilities complies with CAMH or CAMAC, 29 CFR 1910, and the AR-385 series.

(6) Environmental health in fixed medical facilities complies with the criteria in TB MED 2, TB MED 530, CAMH and CAMAC.

(7) Industrial hygiene in fixed medical facilities complies with the criteria in DA Pams 40-501 and 40-503; TB MEDs 266, 502/DLAM 1000.2, and 510; U.S. Department of Health and Human Services (DHHS) (NIOSH) Publications 75-137, 77-140, 77-200; and 29 CFR 1910.

(8) Radiation health in fixed medical facilities complies with the criteria in AR 11-9; TB MEDs 521, 523, 524, and 525; and 10 CFR 19, 20, 21, 30, and 35. Additional MEDCOM guidance is published in MEDCOM Regulation 40-42.

(9) Every attempt should be made to comply with the intent of codes and standards for fixed or mobile medical facilities.

(10) NFPA 101[®] is a registered trademark of the National Fire Protection Association, Quincy, Massachusetts.

b. Functions.

(1) The medical facility commander—

(a) Establishes and oversees a medical facility safety and occupational health advisory council (SOHAC).

(b) Approves and signs all written minutes of the SOHAC meetings.

(c) Verifies that the hospital has written safety policies that include procedures for the safety of patients and accident reporting procedures.

(d) Confirms that the hospital provides all employees with a safety orientation program.

(e) Formally authorizes the safety officer or safety manager to act upon hazardous conditions within the hospital.

(f) Communicates and enforces a written policy that bans smoking throughout the hospital and all its buildings. A licensed practitioner may, subject to the approval of the medical facility commander, authorize an exception to this policy for valid medical reasons:

(g) Confirms that the hospital has a written management plan for each of the seven disciplines required by the OSHA/CAHO (for example, safety, security, hazardous materials and waste, emergency preparedness, life safety, medical equipment, and utility systems) and that an evaluation of each discipline is submitted annually to the safety committee.

(2) The medical facility SOHAC—

(a) Consists of representatives from administration, preventive medicine service, medical staff, nursing staff, engineering and maintenance, housekeeping, and nutrition care.

(b) Meets at least annually and keeps written minutes of its meetings.

(c) Reports the findings of the committee and appropriate recommended corrective actions in its meeting minutes.

(d) Has all meeting minutes signed and approved by the hospital commander.

(e) Develops and provides a safety orientation program for all new employees.

(3) Preventive medicine service personnel coordinate with the installation/hospital safety office or manager and engineering and maintenance personnel to identify and eliminate hazards.

(4) Supervisors—

(a) Provide or coordinate and document safety education for all their employees.

(b) Instruct all employees regarding the hazards inherent in their jobs and the safety rules pertaining to their specific duties.

(c) Coordinate education related to job hazards with occupational health personnel, the safety manager or officer, and the infection control nurse when appropriate.

5-27. Nonoccupational illness and injury

Definitive diagnosis and treatment of nonoccupational illness and injury cases are not within the scope of the Army Occupational Health Program except for—

a. *Emergencies.* Employees are given the medical attention required to prevent loss of life or limb or relieve suffering until placed under the care of their personal physicians.

b. *Minor disorders.* First aid or palliative treatment may be given if the condition is one for which the employee would not reasonably be expected to seek attention from a personal physician, or to reduce absenteeism by enabling the employee to complete the current work shift before consulting a personal physician. Requests for repetitive treatment of nonoccupational disorders are to be discouraged.

c. *Minor treatments or services.* Examples of these include, but are not limited to, administering allergy treatments, monitoring blood pressure, and providing physiotherapy. These treatments or services may be furnished at the discretion of the responsible physician if resources are available. The employee's personal physician submits a request for such service in writing before such services are provided. The employee provides any required medications.

d. *Cases of employees with substance abuse problems.* Such employees are to be encouraged to seek assistance and counsel from local substance abuse program staffs. Occupational health personnel can provide initial counseling and referral of employees to treatment and counseling resources. AR 600-85 and DA Pam 600-85 provide additional guidance.

Section III

Workplace Violence Prevention

5-28. Introduction

a. Workplace violence is one type of violence that can occur in military communities. Some installations have active workplace violence prevention initiatives as part of their risk reduction strategies. Law enforcement, safety, and the chaplain's office are the principal participants in such installation programs. The following discussion presents guidance to help preventive medicine personnel support installation commanders in establishing and conducting effective workplace violence prevention activities.

b. Where installation workplace violence prevention programs exist, the five-step Army risk management process forms the context within which installation commanders work to identify and deal with individual high-risk behaviors. Those five steps, applied to behavioral risk reduction, are: identify risk behaviors; assess those behaviors; make a risk management decision (see AR 385-10, para 2-3d); implement controls; and supervise and evaluate outcomes.

c. Medical commanders and staff should support and participate in installation workplace violence prevention processes as well as provide such processes for the health care work environment.

d. Effective behavioral risk management in any work environment depends upon the following elements:

(1) Commander and supervisor commitment.

(2) An interagency coordinated approach.

(3) Soldier and civilian employee involvement.

(4) Worksite analysis.

(5) Hazard prevention and control.

(6) Safety and health training.

(7) Incident reporting.

(8) Emergency response.

(9) Follow-up and investigation.

(10) Record keeping.

e. Guidance for planning and implementing workplace violence prevention processes can be found in—

(1) Army Civilian Personnel Office guidance (<http://cpol.army.mil/library/permis/>).

(2) The U.S. Office of Personnel Management guide for agency planners for dealing with workplace violence (<http://www.opm.gov/ehs/workplac>).

(3) DOL-OSHA guidelines for preventing workplace violence for health care and social service workers (<http://www.osha.gov/SLTC/workplaceviolence/>).

5-29. Functions

a. Installation commanders, who choose to do so, establish local workplace violence prevention processes that reflect the unique demands of their military communities.

(1) A command-directed installation-wide workplace violence prevention strategy emphasizes command responsibilities, use of existing resources, and the application of the Army risk management process.

(2) Behavior leading to workplace violence may be categorized and addressed differently depending upon whether the employee is active-duty or civilian.

(3) The Army has some programs and agencies already in place to reduce the potential for workplace violence, such as the Army Substance Abuse Program, Army Community Services, installation and unit chaplains, and behavioral health services in MTFs.

b. The installation commander choosing to implement a local workplace violence prevention program should consider establishing an installation-level workplace violence prevention and response team to assist in identifying and assessing workplace violence indicators and implementing and evaluating prevention activities. This team can also provide effective management and information flow between commanders and their military communities.

c. The medical commander's support of an installation workplace violence prevention program can include the following:

(1) Representation on an installation workplace violence prevention team by occupational health nursing, behavioral health services, and social work services. Preventive medicine, occupational medicine, community health nursing, and other clinical services support may also be requested.

(2) Assistance with staff and victim education, staff mediation, consultation, referral, team building, and post-incident debriefings.

(3) A workplace violence prevention program and response plan for the health care work environment, especially for high-risk areas such as behavioral health clinics and wards.

d. Preventive medicine staff can assist medical commanders in establishing and implementing workplace violence prevention programs and response plans within the health care work environment.

(1) Violence within the health care work environment can come from co-workers, patients and other customers, relatives of patients, and strangers. The health care work environment includes outreach activities in which health care providers, such as social workers, CHNs, environmental science officers, and preventive medicine technicians, can be at significant risk of violence while performing their duties outside of the MTF.

(2) Preventive medicine personnel should work closely with MTF safety personnel and with installation safety and law enforcement staff in workplace violence hazard anticipation, identification, control, and the education of managers and employees.

(3) Guidance for preventing workplace violence for health care workers can be obtained from the OSHA Web site referenced in 5-28e(3), above. This guidance includes—

(a) Case histories of health care workplace violence.

(b) Categories of violence that present the greatest threats in health care workplaces.

(c) Factors that may increase a health care worker's risk for workplace violence.

(d) Core elements of an effective violence prevention program.

(e) Worksite analysis and risk assessment procedures.

(f) Development and deployment of installation prevention programs and response plans.

(g) Training and education instructions.

(h) Record-keeping and program evaluation methods.

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SUPERSEDED
DEPARTMENT OF THE ARMY
U.S. ARMY MEDICAL DEPARTMENT ACTIVITY
FORT DRUM, NEW YORK 13602-5004



REPLY TO
ATTENTION OF

FD MEDDAC Regulation No. 40-1

29 March 1988

Medical Services
REPORTING OF COMMUNICABLE DISEASES

1. **PURPOSE.** To prescribe the mechanism for reporting communicable diseases and other conditions of public health and command significance.

2. **APPLICABILITY.** This regulation applies to health care providers at all MEDDAC treatment facilities, Fort Drum, New York.

3. **GENERAL.**

a. Reportable conditions are:

(1) Diseases of major public health concern because of their epidemic potential.

(2) Conditions of Command concern because of their occupational relationship. These conditions are listed in Appendix A and B.

b. All suspected or confirmed cases will be telephonically reported to the Preventive Medicine Service as soon as possible by the health care provider who initially makes the diagnosis.

4. **RESPONSIBILITIES.**

a. **MEDDAC Commander:** Appoint a physician to act as consultant and provide direct assistance with investigation of all suspected foodborne/waterborne outbreaks.

b. **Health Care Providers.** Report to Preventive Medicine Service all cases of conditions listed in Appendix A and B which they have diagnosed and documented in the patient's record. All health care providers are encouraged to notify the Preventive Medicine Service of any cases or conditions listed in Appendix A and B that they suspect have not been reported.

c. **Chief, Preventive Medicine Service.**

(1) Contact all reported cases.

(2) Obtain pertinent information.

SUPERSEDED

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29 March 1988

(3) Conduct epidemiological investigation, when appropriate.

(4) Identify disease contacts and arrange for prophylaxis if required.

(5) Provide consultation upon request.

(6) Forward reports as required to County and State Health Departments, the Centers for Disease Control, and to the Patient Administration Division for submission of MED-16 to higher headquarters, as appropriate.

c. Chief, Patient Administration Division.

(1) Prepare RCS MED-16 (R4), Special Telegraphic Report of Selected Condition, as received from Preventive Medicine Service and forward to appropriate headquarters as required by AR 40-400.

(2) Forward information copy of RCS MED-16 (R4) to Chief, Preventive Medicine Service.

(3) Screen clinical record cover sheets, retrieve those with a diagnosis of a reportable condition and forward a copy to the Preventive Medicine Service.

5. PROCEDURES.

a. To report a case, call the Preventive Medicine Service at 772-6968/6404/6984, operating hours are from 0730-1600, Monday through Friday. The report should include the following information:

(1) Inpatient: Name, sponsor's SSAN, sex, age, ward, hospital, diagnosis, status (e.g., active duty, dependent, civilian) and name of primary medical care provider.

(2) Outpatient: Same as above plus home telephone number.

b. If information concerning the condition or its control is required, the caller should request to speak to the Chief of Preventive Medicine, Chief of Community Health Nurse or the NCOIC of Preventive Medicine.

c. The Preventive Medicine Service will prepare and submit the following reports as indicated:

(1) New York State Communicable Disease Report forms and forward to local County/State office.

29 March 1988

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(2) RCS Med-3 (R7) Morbidity Report (Appendix C) submitted monthly with the Command Health Report to FORSCOM and HSC Headquarters.

(3) DA Form 2789-2-R (Medical Summary - Section III) (Appendix D) submitted to Patient Administration Division monthly with the Med-302 (R4) Report.

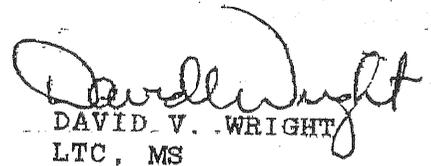
(4) RCS Med-16 (R4) submitted as necessary to Patient Administration Division.

6. REFERENCES.

- a. AR 40-5, Preventive Medicine, 30 August 1986.
- b. AR 40-400, Patient Administration, 11 February 1972.
- c. New York State - Reportable Diseases.

The proponent of this regulation is Chief, Preventive Medicine Service, U.S. Army MEDDAC, Fort Drum, New York. Users of this regulation are invited to send comments and suggestions on DA Form 2028 (Recommended changes to Publications) through channels to Commander, U.S. Army MEDDAC, ATTN: HSID-IM, Fort Drum, New York 13602-5004.

FOR THE COMMANDER:



DAVID V. WRIGHT
 LTC, MS
 Deputy Commander of Administration

DISTRIBUTION A

29 March 1988

APPENDIX A

Military Reportable Conditions
and Outbreaks

A. Reportable Conditions

1. AIDS/HIV
2. Anthrax
3. Botulism
4. Brucellosis
5. Cholera
6. Coccidioidomycosis
7. Dengue
8. Diphtheria
9. Guillain Barre Syndrome
10. Infectious Encephalitis/Arthropodborne
11. Legionnaires Disease
12. Leishmaniasis
13. Leprosy
14. Leptospirosis
15. Malaria
16. Measles (Rubeola)
17. Melioidosis
18. Meningococcal Infection
19. Penicillinase
20. Plague
21. Poliomyelitis
22. Psittacosis
23. Q Fever
24. Rabies
25. Relapsing Fever
26. Rift Valley Fever
27. Rocky Mountain Spotted Fever
28. Rubella
29. Schistosomiasis
30. Smallpox
31. Tetanus
32. Trypanosomiasis
33. Tularemia
34. Typhoid Fever
35. Typhus
36. Viral Hemorrhagic Fever
37. Yellow Fever
38. Heat and Solar Injuries
39. Cold Injuries
40. Non-ionizing/Ionizing Radiation
41. Attempted Suicide/Suicide

APPENDIX B

New York State Reportable Diseases

Amebiasis	Lyme Disease	Tetanus
Anthrax	Lymphogranuloma venereum	Toxic Shock Syndrome
Babesiosis	Malaria	Tularemia
Botulism	Meningitis	Tuberculosis
Campylobacteriosis	Aseptic	Current disease (specify site)
Chancroid	Hemophilus	Typhoid
Chickenpox	Meningococcal	Typhus
Cholera	Other (specify type)	Yellow Fever
Diphtheria	Meningococcemia	Yersiniosis
Encephalitis	Mumps	
Giardiasis	Pertussis (whooping cough)	
Conococcal	Plague	
Granuloma inguinale	Polioyelitis	Specimen must be submitted to an approved laboratory.
Hemophilus Influenza (invasive disease)	Psittacosis	
Hepatitis (A, B, NonA, NonB)	Rabies	
Histoplasmosis, new cases	Reyes Syndrome	

B. Reportable Outbreaks

1. Food/Water-borne Outbreaks
2. Hepatitis Outbreaks
3. Acute Respiratory Disease Outbreaks/Viral Exanthems
4. Case clusters/Asceptic Meningitis
5. Rash Illnesses
6. Fevers
7. Nosocominal Infections
8. Occupationally related illnesses

29 March 1988

FD MEDDAC Reg No. 40-1

New York State Reportable Diseases (Con't)

Hospital-associated infections

Kawasaki Syndrome

Legionellosis

Rocky Mountain spotted fever

Rubella/Congenital Rubella Syndrome

Salmonellosis

Shigellosis

MORBIDITY REPORT
(Rates and Number of Cases)

For use of this form, see HSC Suppl 1 to AR 40-5; proponent agency is DCSCS.

FEEDER REPORT
 RCS: MED-3 (R7)

MONTH _____
 INSTALLATION _____
 MILITARY STRENGTH _____

DATE PREPARED _____
 PREPARER _____
 TELEPHONE NUMBER _____

Rate (and number of cases)¹
 Hospitalized and Non-Hospitalized
 Active Duty Army

DIAGNOSIS	Current Month	Previous Month	Corresponding Month Previous Year
Acute Respiratory Disease	()	()	()
Gonorrhea	()	()	()
Syphilis	()	()	()

Number of Cases²
 Hospitalized and Non-Hospitalized
 Active Duty Army

Active Pulmonary TB (new cases)	()	()	()
TB Skin Test Convertors	()	()	()
Acute Respiratory Infections	()	()	()
Leishmaniasis	()	()	()
Leptospirosis	()	()	()
Malaria	()	()	()
Meningococcal Infections	()	()	()
Cold Injuries	()	()	()
Heat Injuries	()	()	()

Number of cases³
 Hospitalized and Non-Hospitalized
 Active Duty Army, dependents, retirees, others

Acquired Immune Deficiency Syndrome	()	()	()
Hepatitis A	()	()	()
Hepatitis B	()	()	()
Hepatitis Non-A, Non-B	()	()	()
Measles (Rubella)	()	()	()
Rubella	()	()	()
Penicillinase-Producing Neisseria Gonorrhea	()	()	()
Animal Bites - On Post	()	()	()
Animal Bites - Off Post	()	()	()
Animal Bites - Anti-Rabies RX Rqr	()	()	()

OUTBREAKS (Provide details in CHR narrative)

Aseptic Meningitis	()	()	()
Fevers of Unknown Origin	()	()	()
Food- or Water-borne Gastroenteritis	()	()	()
Influenza	()	()	()

Nosocomial Infections⁴

%

%

9

Remarks:

- All rates expressed as number of Active Duty Army cases per 1000 military strength per month (no. mil cases in month x 1000) / military population
- Report only number of Active Duty Army cases.
- Report number of cases Active Duty Army, dependents, retirees, others.
- Nosocomial infections (%) expressed as number of hospital-acquired infections during the month per 100 discharges during month.

