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**23**

Army Regulation 40-3

Medical Services

# Medical, Dental, and Veterinary Care

Headquarters  
Department of the Army  
Washington, DC  
12 November 2002

**UNCLASSIFIED**

# SUMMARY of CHANGE

AR 40-3

Medical, Dental, and Veterinary Care

This revision--

- o Eliminates the Union List of Serials Report for SERHOLD to update library journal holdings (para 7-5n).
- o Converts DA Form 7397-R to DA Form 7397, available in electronic format only (chap 7 and app C).
- o Provides new guidance for the procurement of orthopedic footwear (chap 10).
- o In appendix A and throughout the regulation, updates publication and referenced forms.

This revision dated 28 January 2002--

NOTE: DA Form 7397-R (U.S. Army Medical Command Library Annual Report FY\_) (prescribed in AR 40-3) can no longer be found in the back of the electronic version of this regulation. An electronic version of this form is available on the Army Electronic Library (EM0001) and the USAPA Web site (<http://www.usapa.army.mil>). DA Form 7397-R will be converted to a totally electronic form at the next revision of this regulation.

- o Describes the method whereby Army flight surgeons become certified by the Federal Aviation Administration to become aeromedical examiners (chap 3).
- o Defines the distinction between specialists in aviation medicine (61N9C-A) and flight surgeons (61N9D) (chap 2).
- o Provides guidance relevant to the Remote Order Entry System for procuring hearing aid batteries (chap 4).
- o Augments current policy pertinent to active duty soldiers as living organ donors (chap 9).
- o Presents implementing policy for the DOD Basic Core Formulary and provides a classification system for medication errors (chap 11).
- o Provides new policy for newly appointed civilian emergency medical technicians (EMTs) who are not National Registry for Emergency Medical Technicians (NREMT)-certified (chap 13).

- o Revises supersession, history, summary, suggested improvements, and distribution statements in the front matter.
- o Revises policy on training of flight surgeons and specialists in AVMED (para 3-1).
- o Supersedes policy on Aviation Medicine Program responsibilities (para 3-2).
- o Supersedes policy on flight surgeon clinical duties (para 3-5).
- o Supersedes policy on flight surgeon non-clinical duties (para 3-6).
- o Supersedes policy on supervision of medical care for aviation personnel (para 3-7).
- o Adds policy on Federal Aviation Administration medical examinations and certificates (para 3-9).
- o Revises policy on auditory evaluation and hearing aids (chap 4).
- o Revises policy on nutrition care management (chap 8).
- o Supersedes policy on active duty (AD) members as donors (para 9-1d).
- o Revises policy on pharmacy management (chap 11).
- o Revises policy on emergency medical technician training (para 13-3c(4)).
- o Revises list of required publications (app A).
- o Revises list of referenced forms (app A).
- o Revises policy on inventory, control, and accountability of controlled substances (app B).
- o Revises glossary sections I and II.
- o AR 40-3 revision dated 30 July 1999-
- o Supersedes paragraphs 2-11 and 2-22 and chapters 9 through 12 and 17 through 19 of AR 40-3, dated 15 February 1985. AR 40-400 dated 12 March 2001 supersedes chapters 1, 3-8, 13-16, and all portions of chapter 2 except paragraphs 2-11 and 2-22 of AR 40-3, dated 15 February 1985.
- o Defines the Aviation Medicine Program and outlines responsibilities and duties of personnel associated with this program (chap 3).
- o Decentralizes hearing aid shipment and repair (para 4-5).
- o Implements Department of Defense Directive 6000.12, Health Services Operations and Readiness, dated 29 April 1996, for the Armed Services Blood Program Office (chap 5).
- o Adds policies on the Army Blood Program formerly contained in AR 40-2, chapter 12 (chap 5).

- o Delineates Army Blood Program responsibilities for U.S. Forces Command and U.S. Army Training and Doctrine Command commanders (para 5-2).
- o Prescribes DA Form 3982 (Medical and Dental Appointment), formerly prescribed by AR 40-2 (para 6-6e).
- o Updates information on Army Medical Department medical libraries formerly found in AR 40-2, chapter 10, and provides guidance on the Army Medical Department Medical Library and Information Network (chap 7).
- o Prescribes the use of a new form and reporting requirement, DA Form 7397-R (U.S. Army Medical Command Library Annual Report FY\_\_ ) (para 7--8).
- o Includes updated material on nutrition care management, formerly contained in AR 40-2, chapter 9 (chap 8).
- o Prescribes DD Form 2731 (Organ and Tissue Donor Card) (para 9-2b(2)).
- o Adds a requirement for a medical officer to test fit orthopedic footwear (para 10-5c).
- o Updates and adds policies on pharmacy management and controlled substances formerly contained in AR 40-2, chapters 7 and 8 (chap 11).
- o Prescribes the following forms formerly prescribed by AR 40-2: DA Form 2083 (New Drug Request) (para 11-6); DD Form 1289 (DOD Prescription) (para 11-12); DA Form 3875 (Bulk Drug Order) (para 11-12); DA Form 3862 (Controlled Substances Stock Record) (para 11-13); DA Form 3949 (Controlled Substances Record) (para B-5); and DA Form 3949-1 (Controlled Substances Inventory) (para B-5).
- o Adds new material on psychological test materials (chap 12).
- o Provides new standards for conducting emergency medical services (chap 13).
- o Delineates responsibilities for the operation of medical laboratories for Commander, U.S. Military Entrance Processing Command; Commander, Army Corps of Engineers; Commander, United States Army Medical Command; commanders, Regional Medical Commands; military treatment facility commanders; and Chief, Departments of Pathology or Laboratory Services (para 14-2).
- o Implements College of American Pathologists laboratory accreditation policy previously published in Health Services Command Supplement 1 to AR 40-2. Extends accreditation requirements to fixed military treatment facility laboratories in Europe and Korea. Clarifies Joint Commission on the Accreditation of Healthcare Organizations and Commission on Office Laboratory Accreditation requirements (para 14-4).
- o Contains personnel standards for the performance of minimal, moderate, and high--complexity laboratory procedures, including provider--performed microscopy. Clarifies laboratory director requirements (para 14-5).
- o Addresses the need for a laboratory quality control plan and the requirement for quality control data collection in the subspecialty of cytopathology (para 14-6).

- o Defines individuals authorized to order laboratory tests and provides guidance concerning self performance of laboratory tests by patients in medical treatment facilities (paras 14-9 and 14-10).
- o Rescinds the use of VA Form 21-8358 (Notice to Veterans Administration of Admission to Uniformed Services Hospital).
- o Deletes the coverage of medical care entitlements that are now contained in AR 40-400. Use of trademarked names does not imply endorsement by the U.S. Army but is intended only to assist in identification of a specific product.

Effective 12 December 2002

## Medical Services

### Medical, Dental, and Veterinary Care

By Order of the Secretary of the Army:

ERIC K. SHINSEKI  
General, United States Army  
Chief of Staff

Official:



JOEL B. HUDSON  
Administrative Assistant to the  
Secretary of the Army

**History.** This publication is a partial revision. The changed parts are listed in the summary of change.

**Summary.** This revision augments current policy pertinent to active duty (AD) soldiers as living organ donors. It describes the method whereby the Federal Aviation Administration certifies Army flight surgeons to become aeromedical examiners, and it defines the distinction between specialists in aviation medicine (61N9C-A) and flight surgeons (61N9D). This revision provides guidance relevant to the Remote Order Entry System for procuring hearing aids and batteries. It presents implementing policy for the (1111) Basic Care Boundary and provides

a classification system for medication errors. This regulation no longer implements quadripartite standardization agreement (QSTAG) 471. Finally, this revision provides new policy for newly appointed civilian emergency medical technicians who are not certified by the National Registry for Emergency Medical Technicians.

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

**Proponent and exception authority.** The proponent of this regulation is The Surgeon General. The proponent has the authority to approve exceptions to this regulation that are consistent with controlling law and regulation. Proponents may delegate the approval authority, in writing, to a division chief under their supervision within the proponent agency who holds the grade of colonel or the civilian equivalent.

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

**Supplementation.** Supplementing this

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

**Suggested Improvements.** Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) directly to Headquarters, Department of the Army (DASG-27), 5109 Leesburg Pike, Falls Church, VA 22041-3258.

**Committee Continuance Approval.** The DA Committee Management Officer (CMO) is the proponent of the Pharmacy and Therapeutics Committee and the Medical Library Committee.

**Distribution.** This publication is available in electronic media only (EMO) and is intended for command levels A, B, C, D, and E for Active Army, Army National Guard of the United States, and U.S. Army Reserve.

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### Glossary

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## **Chapter 1**

### **Introduction**

#### **1-1. Purpose**

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

#### **1-2. References**

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

#### **1-3. Explanation of abbreviations and terms**

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

#### **1-4. Responsibilities**

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

## **Chapter 2**

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

#### **2-1. Introduction**

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

#### **2-2. Responsibilities**

a. The military treatment facility (MTF) commander will provide operational guidance for implementation of the policies in this chapter.

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

#### **2-3. Policy**

a. A patient with decision-making capacity has the legal and moral right to participate in medical care decisions, including the right to refuse medical treatment at any time even if it is lifesaving.

b. Upon admission, all adult patients will be informed in writing of their right to participate in their health care decisions, including the right to accept or refuse medical or surgical treatment, and of their right to prepare advance directives.

c. An order to resuscitate is a standing order and resuscitation will be initiated unless there is a written DNR order to the contrary.

d. When a patient will not benefit from treatment, a decision to withhold or withdraw that modality, with the concurrence of the patient or appropriate surrogate decision-maker, may be justified and must be fully and accurately documented.

e. An abatement order (see Glossary) or an advance directive shall not affect other treatment decisions. Specific attention should be paid to making respectful, responsive, and competent care available for patients who choose to forego life-sustaining treatment. Therefore, orders for supportive care should be written separately. All efforts to provide comfort and relief from pain will be provided.

f. Only physicians with clinical privileges who are members of the medical staff may write an abatement order. Physicians in a graduate medical education status can transcribe a verbal order from a privileged physician.

g. Physicians will promptly inform others who are responsible for the patient's care, particularly the nursing staff, about the abatement decision. All who are responsible for the patient's care should clearly understand the order, its scope, its rationale, and its implications.

#### **2-4. Documentation**

a. *Advance directives.*

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**Table 13-1**

**Chief, emergency medical services—experience, training, and certification requirements**

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**EMS level:** Level I

**Requirements:** Successfully completed an accredited emergency medicine residency and applied for or successfully completed board certification in emergency medicine.

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**EMS level:** Level II

**Requirements:** Successfully completed an accredited emergency medicine residency or a primary care residency with 2 years experience working in EMS within the last 5 years, and current certifications in ATLS, ACLS, and PALS/APLS.

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**EMS level:** Level III

**Requirements:** Successfully completed an accredited emergency medicine residency or a primary care residency and with 6 months clinical experience in emergency medicine in the past 2 years with current ACLS, ATLS, and PALS/APLS certification.

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**Table 13-2**

**Emergency medical services staff physicians—experience, training, and certification requirements**

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**EMS level:** Level I

**Requirements:** There will be at least one full-time physician physically present in the EC 24 hours/day who successfully completed an accredited emergency medicine residency or is residency trained or board certified in a primary care specialty with current experience in emergency medicine and current ATLS, ACLS, and PALS/APLS certification.

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**EMS level:** Level II

**Requirements:** There will be at least one full-time physician physically present in the EC 24 hours/day who meets the same requirements as for Level I.

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**EMS level:** Level III

**Requirements:** There will be at least one full-time physician physically present in the EC 24 hours/day who meets the same requirements as for Level I or Level II or is residency trained in any clinical specialty and has extensive current emergency medicine experience (working more than 20 hours per week for the past 12 months) in similar or higher level emergency care institutions, and is currently certified in ACLS, ATLS, and PALS/APLS.

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## **Chapter 14**

### **Medical Laboratory Management**

#### **14-1. General**

*a.* This chapter further defines the implementation of the CLIP within the U.S. Army in accordance with policies and procedures contained in publications published separately.

*b.* Specific technical standards of CLIP and the minimal conditions that laboratories must meet to be certified to perform testing on human specimens are contained in publications that will be published separately.

#### **14-2. Applicability**

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

#### **14-3. Responsibilities**

*a.* The Commander, USAMEDCOM will—

(1) Establish corrective action procedures for clinical laboratory facilities whose proficiency testing or performance criteria fall outside the standards to the Tri-Service CLIP regulations.

(2) Establish standards and promulgate policy for implementation of quality clinical laboratory testing within all units assigned to the USAMEDCOM.

*b.* RMC commanders will—

(1) Provide medical laboratory, blood bank, and pathology staff assistance visits and technical consultation to

subordinate hospitals, occupational and health clinic laboratories, decentralized laboratories, blood donor centers, and departments of pathology throughout their region.

(2) Appoint regional laboratory consultant(s) to provide oversight of proficiency testing and technical consultation throughout the region concerning laboratory standards, laboratory accreditation, and laboratory business practices. Personnel should be appointed as regional consultants for the following specialties: RMC pathology consultant (board-certified pathologist), RMC laboratory consultant (laboratory manager-71E), RMC chemistry consultant (clinical chemist-71B), RMC microbiology consultant (microbiologist-71A), RMC blood bank consultant (71E8T or 61U), and RMC senior enlisted laboratory consultant (MOS 91K40/50).

(3) Analyze utilization of laboratory resources and assess laboratory performance indicators throughout the RMC region. Develop regional laboratory business plans that optimize use of laboratory resources, consolidate commercial reference laboratory testing contracts, and regionalize the purchase or lease of laboratory reagents or equipment.

(4) Ensure maximum utilization of blood resources within the RMC region by ensuring that blood and blood product inventories are kept at an acceptable medically indicated level, and cross-leveled throughout the region, as appropriate, to reduce outdating and wastage of a valuable resource.

(5) Support the laboratory readiness requirements of the Total Force throughout the RMC. Coordinate and take an active role in ensuring that readiness blood quotas for the ASWBPLs are met as directed from the USAMEDCOM. Coordinate laboratory-related professional filler system/medical filler system and individual mobilization augmentee training of personnel in the region.

(6) Assign qualified pathologists to act as a consultant, and, as required, the laboratory director of all medical laboratories in the region without director-qualified assigned medical personnel, or director-qualified civilian contract personnel.

(7) Provide technical expertise and guidance, on-site monitoring as necessary, and reference laboratory support for laboratories in the region that fail regulatory laboratory proficiency testing. Under a plan of corrective action, approve the decision to resume patient testing for failed analytes or subspecialties in all medical laboratories located within the region.

c. The MTF commander is responsible for the operation and CLIP registration of all medical laboratories within the MTF and all assigned clinics. CLIP registration is accomplished in accordance with guidance published separately.

(1) This includes centralized laboratories, such as the Department of Pathology, but also includes all decentralized medical laboratories including all places in the facility where medical laboratory tests are performed. Examples of common decentralized medical laboratories in MTFs include the following: medical laboratory tests performed in the intensive care unit, critical care unit, ICU, or other medical clinics, such as the physical examination clinic, or the occupational health clinic; in vitro medical laboratory tests performed by respiratory therapy or nuclear medicine; medical laboratory tests performed by ancillary staff on patient wards; and medical laboratory tests performed by preventive medicine personnel as part of medical screening programs or health fairs.

(2) The MTF commander determines the requirement and operational need for each decentralized laboratory assigned to the organization and is required to register all medical laboratories (minimal, moderate, or high complexity laboratories, or provider-performed microscopy (PPM) laboratories) with the CLIP office.

d. The Chief, Laboratory Services or Chief, Department of Pathology, depending upon the local designation, is charged with the duties of laboratory director as defined by the CLIP. The chief and his or her staff are responsible for providing quality medical laboratory services throughout the organization, keeping abreast of new or modern developments in the medical laboratory field, and for ensuring the MTF medical laboratory is in compliance with Federal laboratory accreditation standards defined by JCAHO, the College of American Pathologists (CAP), the CLIP, and standards of practice within the community. In doing so, the chief will be responsible for:

(1) Assisting and advising health care providers on the cost-effective use of timely, quality medical laboratory services to aid in the medical screening, prevention, and diagnosis or treatment of disease, including monitoring of therapy.

(2) Conducting and documenting inspections and assistance visits for all medical laboratories within the MTF, including medical laboratories in all outlying clinics assigned to the MTF and all troop medical clinics supported by the MTF. Recurring problems and trends not corrected by department or service chiefs will be referred to the appropriate person/group within the MTF's specific IOP structure.

(3) Maintaining adequate reference material (books, periodicals, atlases, computer-assisted instructional material, etc.) and knowledge-based information systems for use by laboratory personnel and other professional staff served by the laboratory.

(4) Providing technical expertise and guidance, on-site monitoring as necessary, and centralized laboratory support for MTF laboratories that fail regulatory laboratory proficiency testing. Under a plan of corrective action, approve the decision to resume patient testing for failed analytes or subspecialties in MTF medical laboratories.

(5) Disseminating information to the professional staff concerning advances in laboratory medicine, use of the laboratory services, laboratory input to clinical practice guidelines adopted by the MTF, and related matters. Appropriate media (for example, CHCS, electronic mail, memorandums, etc.) will be utilized to disseminate information concerning laboratory services available, acceptable specimen requirements, methods of obtaining service, the cost of

each laboratory test ordered, the reference ranges for all laboratory tests provided, and items of interest to the medical staff.

(6) Representing the laboratory services on various committees used by the MTF to improve information management, utilization management, and patient outcomes.

(7) Providing an adequate number of qualified, competent staff to perform the laboratory workload and to provide technical consultation and supervisory duties. The laboratory director also provides for orientation, in-service training, and continuing education for all personnel assigned to the clinical laboratory.

#### **14-4. Accreditation policies**

*a.* All eligible U.S. Army hospital clinical laboratories (Department of Pathology or Laboratory Service) located in fixed MTFs in the United States, Europe, or Korea will be accredited by the Commission on Inspection and Accreditation of the CAP. On-site accreditation inspections are required at least biennially.

*b.* All fixed MTFs, ambulatory care clinics, and troop medical clinics, including their assigned laboratories, will be accredited by and follow the laboratory guidelines of the JCAHO. The required biennial JCAHO survey of laboratories by a qualified medical technologist inspector will be waived if all laboratories (non-waived testing) assigned to the MTF have been inspected and accredited by CAP.

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

#### **14-5. Laboratory personnel**

*a.* The Chief, Laboratory Service or Chief, Department of Pathology will ensure that only properly qualified personnel whose competency has been assessed will perform and report the results of laboratory testing. Qualifications for testing personnel will be based on laboratory test complexity (minimal, moderate, or high complexity) and will meet the requirements of Section M of the CLIP.

*b.* Local, on-site training of military or civilian personnel to perform limited minimal or moderate complexity laboratory testing is permitted. In these cases, prior to analyzing patient specimens and reporting patient results, the personnel must be trained appropriately for the laboratory testing performed with a formal training program, not solely limited to on-the-job training. Documentation of training, skills, and competency assessment for these individuals will be maintained on file either within the laboratory, the MTF QA department, or the nursing education and training department. (Refer to AR 40-48.)

*c.* PPM, a special subset of moderately complex laboratory analyses, may be performed by privileged physicians, dentists, and mid-level practitioners (PAs, NPs, and certified nurse midwives) according to AR 40-48 when authorized by the MTF commander. In such cases, the PPM lab must be registered with CLIP, approved procedures for PPM tests must be instituted, and personnel authorized to perform PPM must be qualified and competency-assessed.

*d.* At installations that do not have an assigned pathologist, a qualified licensed physician will be assigned as the director of the laboratory. At inpatient facilities without an assigned pathologist, the commander will ensure that appropriate and timely professional pathology services are available to the staff and patients of the facility.

*e.* At all MTFs without an assigned civilian or military pathologist or without an equivalent contracted pathologist, the commander of the facility will appoint an appropriate regional military pathologist to the medical staff of the MTF as a consultant.

#### **14-6. Quality control**

*a.* Sound quality control systems in all MTF clinical laboratories, including decentralized laboratories, are essential to providing excellent services. Quality control systems must be designed to ensure medical reliability and timeliness of laboratory data. The goal of quality control is to achieve the most accurate test results and outcomes.

*b.* Each laboratory must have a written, defined, and approved quality control program that meets the standards of the CLIP and any applicable accrediting body. The quality control system must address pre-analytical, analytical, and post-analytical phases of laboratory testing and results reporting.

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

#### **14-7. Monetary collections for laboratory services**

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

#### **14-8. Improving organizational performance**

a. A laboratory's performance of important health care functions significantly affects the outcomes of the patients it serves, the costs to achieve these outcomes, and the patient's/customer's perceptions or satisfaction. The goal of IOP is to continuously improve the laboratory services that affect patient health outcomes.

b. The Chief, Laboratory Services will implement a collaborative and interdisciplinary performance improvement process that will demonstrate improvement in laboratory services. This process will be integrated with the MTF IOP structure and documentation will provide evidence of ongoing improvement processes.

c. Data will be collected on important laboratory processes and outcomes, including as a minimum: patient preparation, handling of specimens, communication processes, appropriateness of laboratory tests offered (utilization management), and the needs, expectations, and satisfaction of patients and other customers. Data on important processes and outcomes are also collected from risk management and quality control activities.

d. Data will be collected and reported through the RMCs to the Commander, USAMEDCOM (MCHO-CL-R), 2050 Worth Road, Fort Sam Houston, TX 78234-6010, for documentation of compliance with laboratory-related DOD Access Standards. Cervical cytological smear (Papanicolaou smear) screening results should be available to the patient within 14 days of specimen collection, except for isolated branch clinics and overseas locations where results shall be provided within 30 days.

#### **14-9. Individuals authorized to order laboratory tests**

a. The following categories of personnel are authorized to order laboratory tests:

(1) Uniformed and civilian physicians, dentists, veterinarians, optometrists, and podiatrists engaged in professional practice at uniformed services MTFs.

(2) Civilian physicians, dentists, optometrists, and podiatrists, not assigned to a uniformed services MTF but licensed in the jurisdiction of their practice and treating personnel eligible for care within the MHS.

b. The following personnel are authorized to order medical laboratory tests only for selected procedures as established under the provisions of AR 40-48 and/or approved by the local commander:

(1) Uniformed and civilian nurses, PAs, NPs, PTs, OTs, psychologists, and pharmacists engaged in professional practice at uniformed services MTFs and privileged to order medical laboratory tests.

(2) Civilian personnel, not assigned to a uniformed service MTF, but licensed within the jurisdiction of their practice and treating personnel eligible for care in the MHS, to the extent authorized by State law and by policies for equivalent staff non-physician health care providers.

(3) Other non-physician health care providers not listed above, but assigned to a uniformed service MTF and granted limited medical laboratory test ordering privileges by the local commander.

c. Requests for medical laboratory tests written by licensed civilian practitioners not assigned to a uniform services MTF for personnel eligible for care in the MHS, will be honored at Army MTFs according to AR 40-400 subject to the availability of space, facilities, the capabilities of the professional staff, and the following considerations.

(1) A policy relative to performing and reporting laboratory tests ordered by civilian practitioners will be established and announced by the local commander. This policy should coincide with policies regulating staff ordering of laboratory tests and must also include policies concerning the reporting of emergency or alert (panic) value laboratory results to civilian practitioners.

(2) Performance of a laboratory test requested by a civilian practitioner does not imply knowledge of or responsibility for a patient's medical condition. Under no circumstances will civilian laboratory test requests be countersigned or rewritten by military practitioners.

(3) A distance factor or geographic boundary limitation will not be the basis for denying laboratory testing services. MTFs may accept orders for laboratory tests electronically or in writing from civilian practitioners outside the MTF. Verbal orders should not be accepted from civilian practitioners outside the MTF.

(4) Orders for laboratory tests written by foreign licensed practitioners and brought into MTFs located within the United States may be honored in accordance with appropriate State law. In MTFs located outside the United States, the laws of the foreign country and the terms of the applicable treaty and/or administrative or Status of Forces Agreement between the United States and the foreign country concerned will be followed.

(5) Electronic transmittal of laboratory results, including patient identification data, is authorized utilizing direct modem communications without encryption to civilian practitioners. The Internet will not be used for transmittal of unencrypted laboratory results or patient demographic data which is subject to the Privacy Act.

#### **14-10. Self-performance of laboratory tests**

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

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

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

a. *Inspection.* Laboratory files and records will be subject to inspection by inspectors (accreditation organizations, other Government entities, and the CLIP) and higher echelon commanders at all times.

b. *Disposition.* Laboratory files, testing results, and other records maintained by the laboratory will be retained and disposed of according to AR 25-400-2. Any alternative method of storage and disposal must be approved by the MTF's records management officer.

### **Chapter 15 Veterinary Care**

#### **15-1. General**

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

#### **15-2. Veterinary services**

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

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

#### **15-3. Authorization of care**

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

#### **15-4. Provision of veterinary medical care**

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

a. *Animal categories.* The population and health needs of the different categories of animals provided veterinary care—

- (1) Military working dogs (MWDs), military working horses (MWHs), and GOA and POA health assistance animals (seeing-eye dog, and so forth).
- (2) Nonappropriated fund (NAF) animals (rental horses, and so forth).
- (3) Unit mascots authorized by appropriate orders (one per company-sized unit).
- (4) Non commercial POAs for authorized care.
- (5) Other GOAs in confinement (buffalo, deer, strays, and so forth).
- (6) Free ranging wild/feral animals (game animals, horses, and so forth).

b. *Acuteness of the condition.* The presentation of any animal with an acute, life-threatening condition has the highest priority for care. The provision of all other veterinary care is left to the professional judgment of the attending veterinarian consistent with the use of available resources and other factors as determined by the veterinary commander.

c. *Civilian veterinary care for MWDs and MWHs.* In certain circumstances, a military or NAF veterinarian may not be available to provide needed care for a GOA. In these cases, AR 40-330 provides for payment of civilian veterinary care if the following circumstances are met.

- (1) The care is authorized by AR 40-1.
- (2) The care needed is for an emergency or is requested at a time when an Army/NAF veterinarian is not available. The caretaker of the animal needing the care must have permission to utilize a civilian veterinarian. This permission can be obtained by—

(a) Calling the responsible military veterinarian or a delegated animal technician. This necessitates providing all veterinary customers with current emergency telephone/pager numbers and being available to answer calls.

(b) Using a roster of participating local veterinarians that has been previously distributed by the responsible military veterinarian who has specifically noted when he or she will not be available.



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**24**

Army Regulation 40-4

MEDICAL SERVICE

**ARMY  
MEDICAL  
DEPARTMENT  
FACILITIES  
ACTIVITIES**

Headquarters  
Department of the Army  
Washington, DC  
1 January 1980

**Unclassified**

# **SUMMARY of CHANGE**

AR 40-4  
ARMY MEDICAL DEPARTMENT FACILITIES ACTIVITIES

MEDICAL SERVICE

ARMY MEDICAL DEPARTMENT FACILITIES ACTIVITIES

By Order of the Secretary of the Army:

E. C. MEYER  
General, United States Army  
Chief of Staff

Official:

J. C. PENNINGTON  
Major General, United States Army  
The Adjutant General

History.

**Summary.** This revision changes the definitions of the United States Army Medical Center, United States Army Community Hospital, United States Army Medical Department Activity, and United States Army

Medical Clinics; provides guidance for establishment, closure, curtailment, or expansion of major medical services or capabilities within the United States; defines the United States Army Dental Activity; changes the title of various United States Army Medical Clinics to reflect current terminology; and describes the Armed Forces Regional Health Services System. This regulation may be supplemented at the major Army command level only. One copy of each supplement will be furnished to The Surgeon General, HQDA(DASG-HCD), Washington, DC 20310.

**Applicability.** This regulation applies to the Active Army, the Army National Guard, and the US Army Reserve.

**Proponent and exception authority.** The proponent agency of this regulation is the Office of The Surgeon General. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank

Forms) direct to HQDA (DASG-HCD-O)WASH DC 20310

**Army management control process.** Not applicable.

**Supplementation.** Not applicable.

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

**Suggested Improvements.** Not applicable.

**Distribution.** Active Army, ARNG, USAR: To be distributed in accordance with DA Form 12-9A requirements for AR, Medical Services—Applicable to Medical Activities Only—B

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\* This regulation supersedes AR 40-4, 27 September 1974, and so much of DA message, DASG-HCO-D, 071430Z December 1977, as pertains to AR 40-4.

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## Section I GENERAL

### 1. Purpose

This regulation sets forth organizational policy for Army Medical Department (AMEDD) facilities, activities, installations, and units. It also provides guidance for their establishment, designation, discontinuance, and other changes in status.

### 2. Applicability

This regulation applies to the Active Army, the Army National Guard, and the United States Army Reserve.

### 3. Organizational policy.

a. Commanders of US Army Medical Centers (MEDCEN), US Army Community Hospitals (USACH), US Army Medical Department Activities (MEDDAC), US Army Dental Activities (DENTAC), and other AMEDD medical and dental treatment facilities will organize their commands in a logical and functional manner. Guidelines for organizational structure are in DA Pam 570-557 and in US Army Health Services Command (HSC) regulations.

(1) All staff elements will be organized in the simplest structure possible. They will not contain excess layers of supervision.

(2) Organization and position titles will conform to the standards in AR 5-3, AR 570-4, and, where applicable, HSC regulations.

b. Major oversea commanders will use DA Pam 570-557 as a guide for organizing TDA Army medical treatment facilities set up under AR 310-49 and AR 220-5.

### 4. Memorialization criteria and guidance.

a. Normally, AMEDD facilities are named for deceased AMEDD members whose military contributions were distinguished and who met the memorialization criteria in AR 1-33.

b. Installation commanders are responsible for naming a facility on their installation.

c. Names chosen for memorialization will be selected from a list maintained by The Surgeon General.

d. Copies of orders naming a medical department facility will be sent to The Surgeon General.

### 5. Establishment, redesignation, or discontinuance of fixed AMEDD facilities, activities, and installations.

Requests to establish, redesignate, discontinue, or change the status of fixed AMEDD facilities, activities, and installations will be in accordance with AR 310-49 and AR 220-5. Changes in status requiring Headquarters, Department of the Army (HQDA) approval, as stated in AR 220-5, will be sent to The Surgeon General.

### 6. Establishment, closure, expansion, or curtailment of major medical services or capabilities within the United States.

a. *Proposals to open, close, expand, or curtail any health care service for 90 days or more.*

(1) Commanders will send such proposals through HSC to HQDA (DASG-HCZ) for review. HQ HSC will provide comments or recommendations for proposals to close or curtail care.

(2) All proposals will include the following documentation:

(a) Narrative description of services to be started, changed, or discontinued. Services to be curtailed will include impact on Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) and any specific beneficiaries. Also, state the degree of permanence and number of patients/dollars involved.

(b) Similar capabilities existing locally (40 mile radius) in other Federal and civilian facilities.

(c) Current efforts seeking shared service agreements and any associated costs. Such agreements include, but are not limited to, interservice or interagency agreements to improve the quality, availability, and accessibility of patient care considering patient comfort, convenience, and satisfaction. Also include the exploration of joint planning and sharing of scarce health resources with other Federal providers and with non-Federal health care institutions. Send copies

of correspondence seeking sharing agreements with Federal treatment facilities with the proposal.

(d) Other similar capabilities in Federal facilities within the DoD health services region. When distance is a significant factor, it will be so stated.

(e) Recommendations (based on telephonic surveys or formal meetings) of the Regional Review Committee of the Armed Forces Regional Health Services System. See section VI.

(f) Workload projections and how present workload is accomplished.

(g) Cost/benefit analysis, except in the case of curtailments.

(h) Fiscal and manpower resource requirements for establishment and expansion of services.

(i) Staffing projections and ratios.

(j) Cost of facility expansion or modifications.

(k) Cost of medical equipment needed to establish and expand services.

(l) Attempts to provide coverage through civil service hire, contract surgeon, or contractual services.

b. *Plans to curtail any health care service for less than 90 days.* Commanders will send these proposals through HSC to HQDA (DASG-HCZ). Appropriate comments/recommendations will be made by HQ HSC. There proposals will include the following documentation:

(1) Narrative description of services to be changed or discontinued.

(2) Recommendations or comments of the appropriate Regional Review Committee if the loss will—

(a) Cause curtailment or denial of services to specific beneficiaries.

(b) Impact on another military medical facility in the geographic area.

(c) *Public announcement of closure or curtailment.* Commanders will notify The Surgeon General before making any public announcements on closures or curtailment of services.

## Section II TYPE, DESIGNATION, AND GENERAL FUNCTIONS OF FIXED AMEDD FACILITIES, ACTIVITIES, AND UNITS

### 7. General

This section describes fixed AMEDD facilities, activities, and units as pertains to their identification, designation, and functions. Major oversea commanders who operate fixed medical facilities or activities with TOE units will adopt to the extent practicable, the provisions of this section. When oversea hospitals are designated as shown in paragraph 8, 9, or 14, follow the guidance below.

a. Medical holding unit, records of installed property, medical records and reports and mail, for patients will bear the name of the facility. For example, US Army Community Hospital, Frankfurt, Germany.

b. Records and mail for operating personnel will bear the designation of the operating unit. For example, 97th General Hospital.

c. Clinical records (AR 40-400) and certain medical reports (AR 40-418) will bear the name of the facility and the operating unit. For example, US Army Community Hospital, Frankfurt, Germany (97th General Hospital).

### 8. United States Army Medical Center (MEDCEN)

a. *Functions* A MEDCEN is a large hospital, staffed and equipped to perform the following:

(1) Provide health care for authorized persons. Such care includes a wide range of specialized and consultative support for all medical facilities within the assigned geographic area.

(2) Provide specialized medical care to other patients referred to the MEDCEN by appropriate authority.

(3) When designated, conduct post graduate education in health professions.

(4) Serve as a referral hospital, to include laboratory, for the Medical Department Activity (MEDDAC) within its Health Service Region (HSR).

(5) Conduct professional training programs as specified in its assigned mission.

(6) Provide administrative and logistical support, as required, to other TDA and TOE units satellited on the installation or post for support.

*b. TDA organization* In addition to the hospital facility, the MEDCEN TDA organization normally includes on and off post medical, dental, veterinary, and health and environment activities.

*c. Designations*

(1) *Memorially named MEDCEN* The designation of such a MEDCEN will contain the full or last name of the individual after whom the center is named, followed by "Army Medical Center." For example, Walter Reed Army Medical Center.

(2) *Unnamed MEDCEN* An unnamed MEDCEN will be designated "US Army Medical Center" and identified by adding the location. For example, US Army Medical Center, Fort Alpha, Fort Alpha, Utah. For official correspondence, hospital publications, and other administrative actions of the unnamed MEDCEN, repetition of the location may be deleted. For example, US Army Medical Center, Fort Alpha, Utah.

## 9. United States Army Community Hospital(USACH).

*a. Functions*

(1) A USACH is a health treatment facility which provides definitive inpatient care. It is staffed and equipped to provide diagnostic and therapeutic services in the field of general medicine and surgery, and preventive medicine services.

(2) A USACH may also discharge the functions of a clinic.

(3) When a MEDDAC has a hospital, the USACH is the primary medical treatment facility of that MEDDAC and is separately identified in the TDA of the MEDDAC.

(4) A USACH may serve as a specialized treatment or teaching facility when specified in its assigned mission.

*b. Designations*

(1) Memorially named USACH will contain the full or last name of the individual after whom the hospital is named, followed by "US Army Community Hospital." For example, Silas B. Hayes US Army Community Hospital, Fort Ord, California. Although US will be used in the TDA designation of the hospital, the abbreviation US may be deleted from official correspondence, hospital publications, and other administrative actions. For example, Walsen Army Community Hospital, Fort Dix, New Jersey.

(2) Unnamed USACHs will be designated "US Army Community Hospital" and identified by adding the location. For example, US Army Community Hospital, Fort Carson, Colorado. For official correspondence, hospital publications, and other administrative actions of the USACH, repetition of the location may be deleted. For example, US Army Community Hospital, Fort Carson, Colorado.

## 10. United States Army Medical Department Activity (MEDDAC)

*a. Functions* A MEDDAC is an organization encompassing a USACH or designated US Army Health Clinic and the associated activities which are responsible for providing health services to authorized persons within an assigned Health Service Area (HSA). It normally has command and control over AMEDD facilities, activities, or units (other than TOE units) located within its HSA. The MEDDAC may also be tasked to provide administrative and logistical support to other AMEDD organizations over which it does not exercise command or operational control. These may include US Army Medical Laboratories or US Army Dental Activities.

*b. Designation* A MEDDAC will be designated "US Army Medical Department Activity" and identified by adding its location. For example, US Army Medical Department Activity, Fort Hood, Fort Hood, Texas.

## 11. United States Army Dental Activity (DENTAC)

*a. Functions* A DENTAC is a dental treatment organization which—

(1) Provides professional dental care and services to authorized persons.

(2) Supervises the preventive dentistry program

(3) Conducts educational programs.

(4) Supervises clinical investigations and research and development activities when needed.

*b. TDA, command, and support structures.*

(1) The DENTAC is included on the MEDCENMEDDAC TDA.

(2) The MEDCENMEDDAC does not command the DENTAC. The DENTAC is commanded by the major medical headquarters.

(3) Officer evaluation reports are rendered in accordance with AR 623-105.

(4) The supporting MEDCENMEDDAC will provide all administrative and logistical support to the assigned DENTAC.

*c. Designation* A DENTAC will be designated "US Army Dental Activity" and identified by adding its location. For example, US Army Dental Activity, Fort Hood, Fort Hood, Texas.

## 12. United States Army Regional Dental Activity(RDA)

*a. Functions* An RDA provides broad range dental support for patient care and treatment to all eligible persons within a specified geographic area. It is responsible for planning, coordinating, supervising, and performing dental laboratory support, research, and training for oral health services of the Army and, as directed, for other departments, agencies, and organizations. An RDA may be attached to a MEDCEN or MEDDAC for administrative and logistical support. TB MED 148 prescribes types of services and uses of RDA in CONUS and in overseas commands.

*b. Designations*

(1) Memorially named RDAs will comply with guidance in paragraph 3.

(2) If an RDA is not memorially named, it will be designated "US Army Regional Dental Activity" and further identified by its location. For example, US Army Regional Dental Activity, Fort Gordon, Georgia. In overseas areas the propriety of stating the location will be determined by the major overseas commander.

## 13. United States Army Dental Clinic

*a. Functions* A US Army Dental Clinic is a treatment activity or facility which provides diagnostic, preventive, and therapeutic outpatient dental services.

*b. Designations*

(1) A dental clinic located in a separate building may be memorially named. For example, Rhodes US Army Dental Clinic, Fort Sam Houston, Texas.

(2) If the dental clinic is not memorially named, it will be designated "US Army Dental Clinic" and further identified by its location. For example, US Army Dental Clinic, Fort Black, Texas.

(3) If there are two or more unnamed dental clinics located on the same installation, they will be further identified by number. For example, US Army Dental Clinic No. 1, Fort White, Texas.

(4) Dental clinics are the major element of a DENTAC. If they are located in a hospital as an integral part of a Department of Dentistry, they will not be separately identified.

## 14. United States Army Medical Clinics

Clinics are medical treatment activities that are staffed and equipped to provide emergency treatment and ambulatory services. They also perform nontherapeutic activities related to the health of the personnel served. These activities include physical examinations, immunizations, medical administration, and preventive medicine services. A clinic may be equipped with beds for observation of patients awaiting transfer to a hospital. The beds are also used for care of patients who cannot be cared for on an outpatient status, but do not require hospitalization. Such beds shall not be considered in calculating occupied bed days by hospitals. Normally, medical clinics will be elements of the Department of Primary Care and Community Medicine in a MEDCEN or USACH. In special cases, they may operate independently, but will be assigned to an appropriate MEDCEN-MEDDAC. US Army medical clinics are described in a through e below.

*a. US Army Troop Medical Clinic*

(1) *Functions*

(a) A Troop medical clinic is a medical treatment activity which performs sick call, provides limited treatment within the capability of the activity, and refers patients to a health clinic, hospital, or dental clinic when needed.

(b) Provides limited treatment, immunization services, medical examinations, physical profiling, and limited pharmacy dispensing services.

(2) *Designations*

(a) A troop medical clinic will be identified by its location. For example, US Army Troop Medical Clinic, Fort Black, New York.

(b) If there are two or more troop medical clinics located on the same installation, they will be further identified by number. For example, US Army Troop Medical Clinic, No. 1, Jones Arsenal, Missouri.

(c) Troop medical clinics operated by TOE units in oversea areas will bear the facility designation, followed by the operating unit designation. For example, US Army Troop Medical Clinic, Yongsan, Korea (548th Medical Detachment).

*b. US Army Health Clinic*

(1) *Functions* A health clinic is a medical treatment activity of facility designed, equipped, and staffed to provide ambulatory health services to eligible personnel.

(a) It normally has general radiology, laboratory, and pharmacy capabilities, and offers specialty care in one or more of the specialties of medicine. Services provided will depend on the availability of space and facilities and the capability of the assigned professional staff.

(b) It also provides medical administrative and logistical functions as directed by the MEDCEN or MEDDAC (USACH) to which it is subordinate when authorized by The Surgeon General.

(c) It may be equipped with beds (normally less than 25) for observation of patients to be transferred to a hospital. These beds are also used for care of patients who cannot be cared for on an outpatient status, but who do not require hospitalization. Such care normally will not exceed 72 hours.

(2) *Designations*

(a) Health clinics may be memorially named. For example, Andrew Rader US Army Health Clinic, Fort Myer, Virginia.

(b) If a health clinic is not memorially named, it will be designated "US Army Health Clinic" and identified by adding its location. For example, US Army Health Clinic, The Pentagon, Washington, DC. If there are two or more unnamed US Army Health Clinics located on the same installation, they will be further identified by number. For example, US Army Health Clinic, No. 1, Island Depot, Maine.

*c. US Army Occupational Health Clinic*

(1) *Functions*

(a) These health clinics are medical treatment activities which coordinate and implement the occupational health program (AR 40-3 and AR 40-5) for military and civilian employees of the Federal Government. They are equipped and staffed to treat on-the-job illness or injury and dental conditions requiring emergency treatment, to perform preplacement and work-related medical examinations, and to refer employees to private physicians and dentists. They carry on preventive activities related to health and industrial hygiene programs.

(b) Where possible, the functions of these clinics will be combined with a MEDCEN, MEDDAC (USACH), Troop Clinic, or Army Health Clinic.

(2) *Designation* Occupational health clinics will be identified as "US Army Occupational Health Clinic," followed by the location.

*d. General Outpatient Clinic* A General Outpatient Clinic is a medical treatment activity, integral to an Army Health Clinic or to the Department of Primary Care and Community Medicine of a MEDCEN or MEDDAC (USACH). It is designed to accomplish health screening, preliminary diagnosis and treatment of illness or injury, and referral of patients to specialty clinics within the medical

treatment facility or admission of the patient to the MEDCEN or USACH.

*e. Specialty Clinic* A Specialty Clinic is a medical treatment activity established as part of an Army Health Clinic or of a special department or service of a MEDCEN or MEDDAC (USACH).

**15. Veterinary Animal Disease Prevention and Control Facility**

A Veterinary Animal Disease Prevention and Control Facility is a veterinary treatment facility which provides veterinary medical support to Government-owned animals, control of animal diseases transmissible to man, and other veterinary services authorized by AR 40-1.

**Section III  
NONFIXED MEDICAL TREATMENT FACILITIES**

**16. General**

*a. Nonfixed medical treatment facilities normally are organized under MTOEs.*

*b. In CONUS the location will be added to all identifications, except when facilities are engaged in exercises that simulate combat conditions. During these exercises, the manner and propriety of stating the location is left to the discretion of the exercise commander.*

*c. In oversea areas, the propriety and manner of stating the location is left to the discretion of the major commander.*

*d. When using the designation and identification of a facility on medical department records, reports, and other patient administrative documents, the term "US Army" will be added. (This requirement implements NATO STANAG 2132 and ABCA QSTAG 470.)*

**17. Hospital**

*a. Functions* A hospital is a Medical Treatment Facility (MTF) primarily used to provide inpatient care. It is properly staffed and equipped to provide diagnostic, therapeutic, and support services. A hospital may also perform the functions of a clinic.

*b. Designation* A hospital will be designated and identified in the same manner as the operating unit. For example, 15th Field Hospital; 150th Evacuation Hospital.

**18. Convalescent center**

*a. Functions* A convalescent center is a unit which contains approximately 1,500 to 3,000 beds. It receives from hospitals within a theater of operations ambulatory patients needing no further hospital treatment but requiring further reconditioning. Such reconditioning must be under medical supervision, prior to return of patient to duty status.

*b. Designation* A convalescent center will be identified by numerical designation. For example, 890th Convalescent Center.

**19. Clearing station**

*a. Functions* A clearing station is an operating field medical facility established by a medical company which receives, sorts, and provides emergency or resuscitative treatment for field troops with minor illnesses, wounds, or injuries. Such treatment is given until the patient is evacuated.

*b. Designation* A clearing station will be designated "Clearing Station" and identified by the unit with operational responsibility. For example, Clearing Station, Company B, 12th Medical Battalion, 38th Infantry Division; 3rd Clearing Station, 314th Medical Company (Clearing)(Sep).

**20. Aid station**

*a. Functions* An aid station is a forward MTF where reception, sorting, emergency treatment, and disposition of the sick and wounded are performed by medical personnel.

*b. Designation* An aid station will be designated "Aid Station" followed by the unit designation. For example, Aid Station, 1st Battalion, 53d Field Artillery

## 21. Clinics

All MTFs previously referred to as "dispensary" will be redesignated as a "clinic." Specific wording for naming the clinic will be as described in paragraphs 13 and 14. Clinics operated by TOE units which have the word "dispensary" in the TOE title will be designated as follows: US Army Health Clinic, Fort Blank (operated by the 120th Medical Detachment (Gen Disp)).

## 22. Dental clinics

a. Dental clinics will be designated and identified by the Dental Service Detachment with operational responsibility. For example, Dental Clinic, 5th Medical Detachment (Den. Svc).

b. If there are two or more dental clinics operated by the same detachment, they will be identified by number. For example, Dental Clinic No. 1, 5th Medical Detachment (Den Svc).

## 23. Veterinary dispensary

a. *Functions* A veterinary dispensary is an animal treatment activity or facility which provides dispensary type veterinary medical services to Government-owned animals, control of animal diseases transmissible to man, and other veterinary services on an area basis.

b. *Designation* Veterinary dispensaries will be designated and identified by the Veterinary Service Detachment with operational responsibility. For example, Veterinary Dispensary, 2080th Medical Detachment (Veterinary Small Animal Dispensary).

## 24. Veterinary hospital

a. A veterinary hospital is a treatment activity or facility that provides surgery, definitive treatment and hospitalization for Government-owned animals, control of animal diseases transmissible to man, and other veterinary services on an area basis.

b. *Designation* Veterinary hospitals will be designated and identified by the Veterinary Service Detachment with operational responsibility. For example, Veterinary Hospital, 2075th Medical Detachment (Veterinary Small Animal Hospital).

## Section IV

### MEDICAL LABORATORY FACILITIES

## 25. General

The following are types of medical laboratory facilities within the Army:

- a. Clinical laboratories.
- b. US Army medical laboratories.
- c. Numbered medical laboratories.
- d. Research laboratories, facilities, and activities.

## 26. Clinical laboratory

A clinical laboratory is organic to an MTF and operates under the control of the facility commander. It may service other installations and facilities when proper support agreements have been made between the commanders concerned. To the extent of its capability, a clinical laboratory will assist in the detection and identification of biological, chemical, and radiological warfare agents. A clinical laboratory may refer examinations which it cannot perform to other laboratories.

## 27. United States Army Medical Laboratory

### a. Functions

(1) A US Army Medical Laboratory serves as a reference, consultation, and investigative laboratory for AMEDD and other Army installations and activities within a certain geographic area. These services may be furnished to other Armed Forces facilities and Federal agencies as prescribed in AR 40-441.

(2) The facilities and services of a US Army Medical Laboratory may supplement, but not be a substitute for, services normally performed by clinical or medical research and development laboratories, and the US Army Environmental Hygiene Agency.

### b. Organization

(1) The laboratory may be attached to a MEDCEN or MEDDAC for administrative and logistical support.

(2) When such a laboratory is established overseas, the major overseas commander will prescribe its functions and responsibilities. Normally, it will be operated by personnel of one or more TOE medical laboratories.

### c. Designations

(1) A laboratory overseas will be designated as "US Army Medical Laboratory." It will further be identified with the major command that it services. For example, US Army Medical Laboratory (operated by the 21st Medical Laboratory), Europe. The major overseas commander will determine the propriety of stating the geographic location.

(2) In CONUS, the laboratories will be designated "United States Army Medical Laboratory" and identified by adding its physical location. For example, United States Army Medical Laboratory, Fort Meade, Fort Meade, Maryland. For official correspondence, hospital publications, and other administrative actions of the laboratory, repetition of the location may be deleted. For example, United States (or US) Army Medical Laboratory, Fort Meade, Maryland.

## 28. Numbered medical laboratory

a. A numbered medical laboratory is a TOE unit assigned in support of corps areas and the communications zone in a theater of operations. In an overseas area, the commander of one of the numbered medical laboratories normally is appointed as consultant in pathology and laboratory services to the theater surgeon.

b. Numbered medical laboratories will be identified by their TOE numerical designation, followed by its geographical location if deemed appropriate by the theater commander. For example, 228th Medical Laboratory, Planceburgh, Germany.

## 29. Medical research and development laboratory

a. A medical research and development laboratory or unit performs specialized research functions prescribed by The Surgeon General.

b. Special medical research laboratories, facilities, and activities are established when authorized and at locations specified by HQDA.

c. Medical research and development laboratories are under the command jurisdiction of the Commander, US Army Medical Research and Development Command.

## Section V

### ARMY HEALTH SERVICE REGION AND HEALTH SERVICE AREA

## 30. Health Service Region (HSR)

a. The continental United States (CONUS) and certain overseas areas are subdivided into geographic regions. These are designated by the CG, HSC and overseas commanders. Each region is composed of a grouping of States or overseas commands. These regions are titled Health Service Regions.

b. The HSRs provide the CG, HSC and overseas commanders with needed supervision over the delivery of health care to eligible persons within CONUS and overseas.

c. Each HSR is subdivided into Health Service Areas. (See para 31.)

d. A regional coordinator will be named by the CG, HSC or the overseas commander. This person normally will be the commander of the MEDCEN within the respective HSR. The coordinator will maintain close liaison with the MEDCEN, MEDDAC, and other AMEDD activities, facilities, and units within the assigned HSR.

## 31. Health Service Area (HSA)

a. An HSA is a geographic area within CONUS or overseas, specified by counties or other political entities.

b. A single MEDCEN or MEDDAC provides designated health care services to authorized persons within an HSA.

c. The terms MEDCEN and MEDDAC refer to the TDA organization itself. HSA refers solely to the geographical area for which the MEDCEN or MEDDAC has designated responsibility (see AR 5-9).

d. The HSA assigned to a MEDCEN or MEDDAC will be as directed by the commander involved. Normally, there will be two or more HSAs assigned to an HSR.

e. An HSA will be named after the installation on which the MEDCEN or MEDDAC is located. For example, the HSA assigned to Madigan Army Medical Center, Fort Lewis, Washington, is Fort Lewis Health Service Area. The HSA assigned to the MEDDAC, Fort Dix, New Jersey, is Fort Dix Health Service Area.

## **Section VI ARMED FORCES REGIONAL HEALTH SERVICES SYSTEM**

### **32. Armed Forces Regional Health Services System (AFRHSS)**

a. The Department of Defense has established the AFRHSS as the principal means of coordinating the organization and management of health care delivery on an integrated tri-service basis within CONUS and certain oversea areas.

b. The Assistant Secretary of Defense and the Surgeons General of the Military Departments provide policy and guidance and coordinate implementation of the AFRHSS.

c. The basic goal is to assure continued availability of quality health care to the maximum number of beneficiaries.

d. The objectives of AFRHSS are as follows:

- (1) Identification and elimination of unnecessary duplication of services.
- (2) Improved planning and delivery of health services through regional cooperation.
- (3) Cost containment.
- (4) Effective and productive use of health professions manpower.
- (5) Development of cooperative arrangements for early acquisition of high cost advanced technology.

### **33. Military Medical Regions (MMRs)**

a. CONUS is divided into nine MMRs as shown in the appendix. The activities of each MMR are under the control of a Tri-Service Regional Review Committee. This committee reviews and assesses health services capability and operations for its MMR. In particular, it acts on requests for expansion or reduction of services, proposals to establish new services, and related manpower and major equipment requirements.

b. The committees are composed of senior representatives from each military Service. The Army's member normally is the commander of a MEDCEN. This function is performed as an adjunct to that of Army Health Service Region Coordinator.

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**25**

Army Regulation 40-5

Medical Services

# Preventive Medicine

Headquarters  
Department of the Army  
Washington, DC  
15 October 1990

**UNCLASSIFIED**

# SUMMARY of CHANGE

AR 40-5  
Preventive Medicine

This revision--

- o Consolidates AR 40-5, AR 40-26, and AR 40-554.
- o Adds Responsibilities for commanders (chaps 1, 9, and 12) and preventive medicine personnel (chaps 1, 2, 4, 5, 6, and).
- o Adds information on the Preventive Dentistry Program, community health nursing activities, disease and climatic injury prevention and control, medical examinations, spirometry surveillance, community and family health, nonionizing radiation registry, sanitation, and field preventive medicine (chaps 2, 3, 4, 5, 6, 9, 12, and 14).
- o Deletes the appendix on ice manufacture sanitation in AR 40-5.
- o Rescinds RCS MED-292 (DA Form 3898-R (Report of Tuberculosis Detection and Control)).
- o Adds DD Form 2493-1 (Asbestos Exposure, Part I--Initial Medical Questionnaire).
- o Adds DD Form 2493-2 (Asbestos Exposure, Part II-Periodic Medical Questionnaire).
- o Adds DA Form 3897-R (Tuberculosis Registry).
- o Adds DA Form 5931 (Occupational Health Patient Form).
- o Adds DA Form 5932 (USAREUR Occupational Health Form).
- o Adds DA Form 5933 (Occupational Health Patient Form-Supplemental).
- o Adds DA Form 5934 (Korea Occupational Health Encounter Form).
- o Adds DA Poster 40-5 (Lyme Disease Warning).

Medical Services

Preventive Medicine

By Order of the Secretary of the Army:

CARL E. VUONO  
General, United States Army  
Chief of Staff

Official:



MILTON H. HAMILTON  
Administrative Assistant to the  
Secretary of the Army

**History.** UPDATE printing of November 1990 published a revision of this publication. This publication has been reorganized to make it compatible with the Army electronic publishing database. No content has been changed.

**Summary.** This regulation is a consolidation of several regulations that cover the Army's preventive medicine program. It establishes practical measures for the preservation and promotion of health and the prevention of disease and injury. This regulation implements Executive Order 12196 and DOD Instructions 6050.5, 6055.1, 6055.5, and 6055.12.

**Applicability.** This regulation applies to facilities controlled by the Army and to all elements of the Army. This includes military

personnel on active duty; U.S. Army Reserve or Army National Guard personnel on active duty or in drill status; U.S. Military Academy cadets; U.S. 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 employees who are employed by the Army on a worldwide basis.

**Army management control process.**

This regulation is subject to the requirements of AR 11-2. This regulation contains internal control provisions but does not contain checklists for conducting internal control reviews. These checklists are contained in DA Circular 11-88-7.

**Supplementation.** Supplementation of this regulation by the principal HQDA officials and major Army commands listed below is permitted. Supplementation is prohibited by all other elements without prior approval of HQDA (SGPS-PSP), 5109 Leesburg Pike, Falls Church, VA 22041-3258. If supplements are issued, one copy of each will be

furnished to HQDA (SGPS-PSP), 5109 Leesburg Pike, Falls Church, VA 22041-3258.

- a. Office of the Chief of Engineers.
- b. National Guard Bureau.
- c. Office of the Chief, Army Reserve.
- d. U.S. Army Training and Doctrine Command.
- e. Forces Command.
- f. U.S. Army Health Services Command.
- g. U.S. Army Materiel Command.
- h. U.S. Army, Europe.
- i. Eighth U.S. Army.
- j. U.S. Army South.

**Interim changes.** Interim changes to this regulation are not official unless they are authenticated by the Administrative Assistant to the Secretary of the Army. Users will destroy interim changes on their expiration dates unless sooner superseded or rescinded.

**Suggested Improvements.** The proponent agency of this regulation is the Office of The Surgeon General. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) directly to HQDA (SGPS-PSP), 5109 Leesburg Pike, Falls Church, VA 22041-3258.

**Distribution.** Distribution of this publication is made in accordance with the requirements on DA Form 12-09-E, block number 2058, intended for command level C for Active Army, Army National Guard, and U.S. Army Reserve (applicable to all Army elements); and command level A for Active Army and Army National Guard and D for U.S. Army Reserve (applicable to medical activities only).

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## Chapter 1 Introduction

### 1-1. Purpose

This regulation—

- a. Explains the Army Preventive Medicine Program.
- b. Prescribes a comprehensive disease prevention and environmental enhancement plan of action for the U.S. Army at fixed installations and in support of field forces.
- c. Establishes military occupational and environmental health standards.
- d. Defines the activities within the Preventive Medicine Program functional areas.
- e. Provides a basic guide for commanders, the installation medical authorities (IMAs), and other interested persons and agencies.
- f. Contains policy, guidelines, and procedures.
- g. Provides organizational structure guidance.
- h. Describes the functions and responsibilities of preventive medicine (PVNTMED) services at the U.S. Army medical department activity (MEDDAC) and U.S. Army medical center (MEDCEN) level.
- i. Identifies Department of the Army (DA) occupational safety and health (OSH) standards.

### 1-2. References

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

### 1-3. Explanation of abbreviations and terms

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

### 1-4. Responsibilities

a. The Assistant Secretary of the Army for Installations and Logistics, in addition to the responsibilities cited in AR 385-10, will—

(1) Provide executive leadership at the Army Secretariat level to ensure timely compliance with environmental, safety, and occupational health (OH) requirements.

(2) Establish goals and policies and monitor programs for environmental, safety, and OH.

b. The Surgeon General (TSG) is responsible for the overall development and oversight of DA policies and programs for the Army-wide Preventive Medicine Program, which includes—

(1) Disease and climatic injury control.

(2) OH.

(3) Community and family health.

(4) Health information and education.

(5) Nutrition.

(6) Health hazard assessment (HHA).

(7) Medical safety.

(8) Radiation protection.

(9) Pest and disease vector control.

(10) Environmental quality.

(11) Sanitation.

(12) Environmental laboratory services.

(13) Design review.

(14) Field PVNTMED.

(15) Toxicology.

c. The director, Army Safety, Office of the Army Safety Program, will carry out the responsibilities defined in AR 385-10.

d. The Chief, Preventive and Military Medicine Consultants Division, Office of the Surgeon General (OTSG) will—

(1) Formulate policies, standards, regulations, and directives to protect and promote health, improve effectiveness, and enhance the environment of Army personnel.

(2) Exercise staff supervision, program management (including Army Regulation (AR) proponenty), and provide consultative services on the Army-wide Preventive Medicine Program described in *b* above.

(3) Monitor and act as point of contact (POC) on health and welfare aspects of environmental quality.

(4) Advise and assist the Army staff in development of DA plans, policies, and regulations on health conservation and control of environmental quality.

(5) Provide international and interservice representation and liaison with professional organizations, Department of Defense (DOD), and other Federal agencies to exchange data on disease control, health maintenance, and environmental medicine.

(6) Determine appropriate preventive measures, pharmaceuticals, and biologics for disease control and initiate requests for supply actions to ensure availability.

(7) Coordinate with the DA Safety Office for compliance with Occupational Safety and Health Act health standards.

(8) Provide administrative support and staff supervision to the Armed Forces Epidemiological Board and the Armed Forces Pest Management Board (AFPMB).

(9) Evaluate and approve requests for epidemiology consultant (EPICON) assistance in the study of disease outbreaks.

(10) Be the OTSG reviewing authority for all environmental documents submitted by DA activities.

(11) Provide Preventive Medicine Program direction through the U.S. Army Health Services Command (HSC) to U.S. Army Environmental Hygiene Agency (USAEHA) and to U.S. Army Aeromedical Center (DA missions), through U.S. Army Japan to U.S. Army Pacific, Environmental Health Engineering Agency (USAPACEHEA), and through 7th Medical Command for 10th Medical Laboratory.

(12) Coordinate the mission services of USAEHA with appropriate elements of the DA staff and outside continental United States (CONUS) medical support organizations (see para 1-8c).

(13) Coordinate directly for USAEHA services provided in support of the DA-level PVNTMED mission.

(14) Provide professional advice concerning materiel and facilities requirements.

(15) Conduct HHA of medical and nonmedical materiel.

e. All major Army command (MACOM) commanders will establish a formal procedure to respond to the USAEHA, 10th Medical Laboratory, and USAPACEHEA report recommendations involving regulatory compliance. Further, the commanders will monitor compliance, and this procedure must provide for—

(1) Tracking the corrective actions involving regulatory compliance and target dates for completing planned action.

(2) Issuing copies of the installation's responses and planned corrective actions to the report originator (USAEHA, 10th Medical Laboratory, or USAPACEHEA) for review and comment.

(3) Reporting the status of uncorrected problems identified in USAEHA, 10th Medical Laboratory, or USAPACEHEA reports in annual environmental and OH management reports as prescribed by Headquarters, Department of the Army (HQDA).

f. The commanding general, HSC will—

(1) Provide health care services and resources for the Army within the continental United States (CONUS), Alaska, Panama, Puerto Rico, Hawaii, Johnston Island, Guam, and the trust territories of the Pacific.

(2) Plan, program, and budget resources for the USAEHA.

(3) Provide command guidance on the priorities, services, and direction of USAEHA.

g. Commanders at all levels will promote general health and safety and ensure occupational and environmental health within their commands. Commanders will—

(1) Support the Preventive Medicine Program.

(2) Provide adequate resources to implement the program.

(3) Take appropriate actions, based on recommendations of the IMAs, to protect all personnel under their jurisdiction from disease and injury.

(4) If DA Poster 40-5 (Lyme Disease Warning) is used, follow guidance in paragraph 10-18c.

h. Commanders of dental activities (DENTACs) will—

(1) Implement and monitor the Army Preventive Dentistry Program per AR 40-35.

(2) Forward a copy of the preventive dentistry report to the appropriate MACOM surgeon.

i. The IMAs are responsible to commanders for the following:

(1) Establishing and operating an effective Preventive Medicine Program. The program will be supported by adequate—

(a) Personnel.

(b) Funding.

(c) Office and laboratory space.

(d) Equipment and supplies.

(e) Transportation and communications.

(2) Recommending solutions for all PVNTMED problems.

(3) Providing PVNTMED guidance based on the functional areas described in this regulation.

j. Heads of installation civilian personnel offices will take the following actions to assist medical personnel with the medical evaluation:

(1) Identify employees expected to be absent from work for 2 weeks or more.

(2) Provide Army medical personnel with Department of Labor (DOL) Forms CA-16 (Authorization for Examination and/or Treatment) and CA-17 (Duty Status Report) (or equivalent medical documentation) for completion by the treating physician for those employees identified.

(3) Make arrangements with employees for examinations when necessary.

k. The commander, USAEHA will—

(1) Provide worldwide support of PVNTMED programs for the Army through consultations, supportive services, investigations, and training in the areas of environmental quality, occupational and environmental health, toxicology, disease prevention, surveillance, and control, radiation and environmental sciences, pest management, and laboratory services.

(2) Evaluate the responses to recommendations and resolve situations with MACOMs where responses to recommended corrective actions to USAEHA reports are considered unsatisfactory. When the MACOM and USAEHA cannot agree on proposed corrective actions, the matter with all associated correspondence will be referred to USAEHA through HSC, or the appropriate OCONUS medical support organization, to HQDA (SGPS-PSP), 5109 Leesburg Pike, Falls Church, VA 22041-3258. OTSG will coordinate with appropriate Army staff and provide a resolution to the MACOM.

(3) Review proposed environmental, safety, and health standards or standards criteria documents published for comment by regulatory agencies and consensus standard organizations. The commander also will provide written technical comment regarding content, feasibility of implementation, and applicability to Army operations. In addition, the technical input of the U.S. Army Safety Center and other DA organizations will be solicited as necessary to facilitate such review.

(4) Conduct the Army Preventive Medicine Residency Training Program in occupational medicine to meet accreditation requirements of the American Council on Graduate Medical Education and approval requirements of the American Osteopathic Association.

l. Commanders, 10th Medical Laboratory and USAPACEHEA will—

(1) Provide theaterwide support of PVNTMED programs for the Army through consultations, supportive services, investigations, and training in the areas of environmental quality, occupational and environmental health, toxicology, disease prevention, surveillance, and control, radiation and environmental sciences, pest management, and laboratory services, as staffing permits.

(2) Evaluate the responses to recommendations and resolve situations with MACOMs where responses to recommended correction actions to 10th Medical Laboratory or USAPACEHEA reports are considered unsatisfactory. When the MACOM and 10th Medical Laboratory or USAPACEHEA cannot agree on proposed corrective actions, the matter with all associated correspondence will be forwarded by 10th Medical Laboratory or USAPACEHEA to HQDA (SGPS-PSP), 5109 Leesburg Pike, Falls Church, VA 22041-3258.

OTSG will coordinate with appropriate Army Staff and provide a resolution to the MACOM.

m. Managers and supervisors are responsible for—

(1) Keeping informed of OII hazards and requirements in activities under their control.

(2) Training employees in appropriate health and safety practices.

(3) Enforcing the use of protective clothing and equipment.

(4) Providing the civilian personnel office with health and safety information necessary for effective job classification and placement actions.

#### 1-5. Program concept

DA policy is to conserve the fighting strength by controlling preventable disease and injury through command-oriented occupational, environmental, and personal protection programs. The individual's role in maintaining his or her own health and fitness will be emphasized.

#### 1-6. Liaison

a. Liaison will be established and maintained at all organizational levels with medical departments of other military services, and appropriate representatives of Federal, State, and local health and environmental protection authorities (AR 200-1).

b. Participation on Armed Forces disciplinary control boards and liaison with representatives of civil agencies concerned with health and welfare are prescribed in AR 190-24/MCO 1620.2/BUFERINST 1620.4/AFR 125-11/CCMDINST 1620.1.

#### 1-7. Recordkeeping

AR 25-400-2 establishes the Modern Army Recordkeeping System (MARKS). This system reorganized the files listed in The Army Functional File System by identifying each file by the number of the directive prescribing that those records be created, maintained, and used. Therefore, records required by this regulation should be filed under the file number 40-5. Refer to AR 25-400-2, appendixes B, C, or D for further guidance.

#### 1-8. Technical assistance

a. Commanders and IMAs at all levels may request technical assistance in matters pertaining to the Preventive Medicine Program through command channels.

b. CONUS requests should be addressed through the MACOM command channels of the activity requesting services to the Commander, USAEHA, Aberdeen Proving Ground, MD 21010-5422, with a copy furnished to Commander, HSC, ATTN: HSCL-P, Fort Sam Houston, TX 78234-6000.

c. OCONUS requests from the—

(1) U.S. Army, Europe (USAREUR) and Seventh Army areas of responsibility will be forwarded to Commander, 7th Medical Command, ATTN: AEMCL-PM, APO New York 09102.

(2) Pacific geographic areas of responsibility will be forwarded to Commander, USAPACEHEA—Sagami, APO San Francisco 96343.

(3) U.S. Army South areas of responsibility will be forwarded to Commander, U.S. Army South, ATTN: SOMD, APO Miami 34004.

d. If 7th Medical Command, USAPACEHEA, or U.S. Army South cannot provide the requested services, the requests will be forwarded to HQDA (SGPS-PSP), 5109 Leesburg Pike, Falls Church, VA 22041-3258.

## Chapter 2 Army Preventive Medicine Program

### Section I Background

#### 2-1. General

The Preventive Medicine Program is a comprehensive program, ranging from simple field sanitation procedures to extensive and

(2) *Hospital infection control officer.*

(a) This officer, appointed by the hospital commander and normally a nurse, will serve as liaison between the hospital infection control committee and all departments or services of the hospital to—

1. Facilitate clinical and environmental surveillance activities.
2. Foster an attitude of cooperation.
3. Enhance the effectiveness of the educational program.

(b) At the direction of the chairman, hospital infection control committee, the hospital infection control officer will coordinate all educational activities, and gather clinical data to determine the incidence of endemic infections (para 411) and manage epidemic events. This includes their epidemiological investigation and reporting.

(c) The hospital infection control officer can also serve as the hospital epidemiologist.

(3) *Clinical service representatives.* Representatives of the major clinical departments and services, including nursing personnel, may serve as members of the hospital infection control committee to provide the necessary interdisciplinary clinical input. Representation from the house staff, when applicable, is desirable and encouraged.

(4) *Environmental science officer (AOC 68N).* The environmental science officer is normally the principal adviser on matters relating to the hospital environment including waste management, ventilation, housekeeping, selection, and use of antiseptics and disinfectants, food sanitation, linen management, and environmental monitoring.

(5) *Administrative officer.* The hospital executive officer is normally the principal adviser on administrative matters and services.

(6) *Microbiologist.* The microbiology/serology section of the clinical laboratory should be represented to provide the necessary input on microbiological data and procedures.

(7) *Entomologist (AOC 68G).* When available, the entomologist will be the principal adviser on the potential for pest infestations that contribute to the spread of infectious agents and will also advise on the implementation of proper pest control measures. When an entomologist is not available, the environmental science officer will function in this role.

(8) *Other consultants.* Representatives of the pharmacy, food, and housekeeping services, as well as other consultants, should be available for infection control committee meetings when required.

*d. Functions.* Committee meetings will be held at least every 2 months or as often as necessary to accomplish the objectives. The committee will—

- (1) Describe standard criteria for defining nosocomial infections.
- (2) Establish written policies and procedures relating to isolation techniques, antiseptics, disinfection and sterilization techniques, waste management (para 116), and general sanitation.
- (3) Establish written policies and procedures concerning patient care techniques and measures for the prevention of infections in patients and personnel.
- (4) Ensure that policies and procedures developed for such activities as clinics, special care services, laboratories, and support services adequately address the potential for infections and their prevention.
- (5) Provide for a review, at least annually, of all hospital and clinic written policies and procedures related to infection control and to determine their applicability and to revise as appropriate.
- (6) Provide assistance in the development of the infectious disease aspects of the hospital employee health program. (See chap 5.)
- (7) Coordinate with the medical staff in its review of the clinical use of antimicrobial agents by analyzing and using significant surveillance data and antimicrobial susceptibility test data.
- (8) Recommend to the hospital commander actions that should be taken to control hospital outbreaks of infectious diseases.

*e. Education.* Provisions will be made by the hospital infection control committee for the orientation of all new hospital personnel to their responsibilities in the prevention and control of hospital-associated infections. Periodic inservice education in infection control will be provided in all departments and services and will be

documented. Information, including data supporting significant trends, will be reported to the MEDDAC or MEDCEN QA committee and be incorporated into departmental educational programs as well as in formal presentations of the most current prevention and control concepts to the medical staff (see AR 4068).

#### 4-10. Technical assistance

On-site consultations and special studies should be requested from the hospital epidemiologist or hospital infection control officer at the relevant MEDCEN; for example, Fort Carson would contact the appropriate individuals at Fitzsimons Army Medical Center. The normal consultation routes will be as follows: MEDDAC to regional MEDCEN; regional MEDCEN to either TSG's physician or nurse consultant for hospital infection control. However, requests may also be made directly to OTSG.

#### 4-11. Reporting

*a.* An endemic nosocomial infection rate for the hospital will be consolidated into formal reports for presentation during medical staff conferences and for inclusion in CHR's. Nosocomial infections for a suitable period of time will be reported in CHR's at least three times a year by the total surveillance (incidence) or prevalence rate as follows:

(1) The total surveillance (incidence) rate equals—

(a) The number of nosocomial infections per unit of time.

(b) The number of patients discharged per unit of time.

(2) The point prevalence rate equals—

(a) The number of patients with nosocomial infection at the time of the survey.

(b) The number of patients in the hospital at the time of the survey.

(3) The number of patients with multiple nosocomial infections will be listed.

*b.* Coding of diagnoses on individual patient data system coding transcripts from inpatient treatment record cover sheets will always include any diagnosis representing a hospital infection (AR 4066).

*c.* Certain infections of high communicability as well as significant outbreaks of infection will be reported expeditiously by RCS MED16 (chap 3).

## Chapter 5 Occupational Health Program

### Section I General

#### 5-1. Background

This chapter prescribes the Occupational Health Program and services required under provisions of Executive Order 12196 and DOD Instructions 6050.5, 6055.1, 6055.5, and 6055.12 for DA military and civilian personnel.

#### 5-2. Objectives

The objectives of the Army Occupational Health Program are to—

*a.* Assure that all eligible personnel (military and civilian) are physically, mentally, and psychologically suited to their work at the time of their assignment, and that physical and mental health are monitored to detect early deviations from the optimum.

*b.* Protect employees against adverse effects of health and safety hazards in the work environment. This includes field operations as well as the industrial workplace.

*c.* Assure proper medical care and rehabilitation of the occupationally ill and injured.

*d.* Reduce economic loss caused by physical deficiency, sickness, and injury of civilian employees.

*e.* Prevent decreased combat readiness caused by occupational illness and injury of military personnel.

### 5-3. Army Occupational Health Program

a. The overall Occupational Health Program promotes health and reduces risk of illness arising from the individual's work environment. This encompasses special preventive measures for both military and civilian personnel who are exposed or potentially exposed to toxic materials, infectious agents, or other hazardous influences of the work environment.

b. Medical measures will be carried out according to professional standards in the field of OH.

c. Army occupational safety and health standards are noted in (1) through (5) below. When alternate or supplemental standards are necessary, documentation with justification will be forwarded through command channels to HQDA (SGPSPSP), 5109 Leesburg Pike, Falls Church, VA 220413258, to obtain appropriate approval authority.

(1) DOD and DA OSH standards for military and nonmilitary workplaces for which regulatory agencies either have or have not issued OSH standards. This includes DOD and DA pamphlets, circulars, technical bulletins, and messages.

(2) OSHA standards including emergency temporary standards with minor adaptation as necessary to conform with DA administrative practices.

(3) Alternate workplace standards based on publications relating to workplace exposure criteria. These standards may be used in lieu of existing OSHA standards or in which no OSHA standard exists. The current American Conference of Governmental Industrial Hygienists threshold limit values will be the standards used in DA military and civilian workplaces if—

(a) OSHA standards are less stringent.

(b) No OSHA standard exists.

(4) Other regulatory workplace standards issued under statutory authority by other Federal agencies (such as the Department of Transportation and the Environmental Protection Agency (EPA)).

(5) Special DA OSH standards developed for military-unique equipment, systems, and operations.

d. A viable Occupational Health Program requires continuing cooperation among managers, supervisors, personnel officers, and safety and medical personnel to include division surgeons, optometrists, industrial hygienists, audiologists, and safety personnel.

e. As a minimum, the Occupational Health Program will include the following elements:

(1) Inventory of chemical, biological, and physical hazards in the work environment of all installation activities, including MTFs and research and development activities.

(2) Job-related medical surveillance.

(3) Administrative medical examination.

(4) Employee education about job-related health hazards.

(5) Treatment of occupational illness and injury and emergency treatment of nonoccupational illness and injury.

(6) Hearing conservation.

(7) Occupational vision.

(8) Pregnancy surveillance.

(9) Job-related immunizations.

(10) Illness absence monitoring.

(11) Chronic disease surveillance.

(12) Epidemiologic investigations of occupational illness and injury.

(13) Maintenance of OH medical and administrative records and reports.

(14) Industrial hygiene surveys and safety and health inspections.

f. Other services that may be provided when adequate resources are available include but are not limited to—

(1) Group counseling on specific problems or habits affecting health.

(2) Disease screening.

(3) Voluntary periodic health examinations on an age-related basis.

### 5-4. Program functions

a. The installation commander will ensure that—

(1) Employees under his or her command are provided OH services required by this chapter.

(2) Supervisors at all levels are informed of and carry out their responsibilities in the program.

(3) Individual employees are informed of potential OH hazards and safe practices and procedures, and are instructed in the wearing of PPE.

(4) An Occupational Health Program administrator or coordinator will be designated at installations or activities that do not have an occupational health clinic.

(5) A program for the recognition, evaluation, and control of unhealthful working conditions is established. This program will include—

(a) Publishing a local regulation or supplement to an existing regulation that delineates the responsibilities of all installation OSH participants.

(b) Ensuring establishment of a safety and occupational health (SOH) advisory council (AR 38510).

(6) The installation Asbestos Management Program is established per TB MED 513 and other DA guidance.

b. Safety manager responsibilities are defined in AR 38510 and AR 38540.

c. Civilian and military personnel officers will provide support and guidance to ensure efficient accomplishment of the overall program (AR 6008 and Federal Personnel Manual (FPM) chaps 250, 290, 293, 294, 339, 792, and 810). This includes coordination with OSI personnel to ensure that—

(1) A suspense system is maintained to—

(a) Identify personnel in positions requiring specific standards of physical fitness and job-related medical surveillance.

(b) Schedule personnel for the indicated preplacement, change of position, periodic, fitness for duty, and termination examinations.

(2) Applicants and employees are advised regarding potential OH hazards, appropriate protective equipment, safety practices, and job-related medical surveillance requirements of their work assignments.

d. The commander of the MTF providing medical support will—

(1) Program resources to ensure provision of OH services required by this regulation.

(2) Ensure provision of physician support for OH services where there is no physician assigned.

(3) Appoint an audiologist, when available, to act as the hearing conservation officer and to participate as a member of the SOH advisory council. If an audiologist is unavailable, the IMA will designate an individual from the occupational medicine staff to act as the hearing conservation officer. (See the definition of occupational medicine staff in the glossary.)

(4) Appoint an individual to act as the industrial hygiene program manager according to TB MED 503.

(5) Project the impact of full-scale industrial mobilization on OH services and ensure provision of these services through the use of contingency contracts and on expanded mobilization TDA.

e. The chief, PVNTMED service, will—

(1) Provide overall technical guidance for the Occupational Health Program to appropriate supporting clinical services and to the tactical unit surgeons.

(2) Assure proper coordination with installation and MTF safety and personnel offices, hospital infection control personnel, and the division surgeon.

(3) Initiate, if appropriate, and assist in epidemiologic investigations.

(4) Ensure maximum use of the military occupational health vehicle, where applicable, to conduct monitoring audiometry.

(5) Support the installation Asbestos Management Program according to TB MED 513.

(6) Provide medical review of Federal Employees Compensation Act claims.

f. The SOH advisory council committee (as described in AR 38510) will—

(1) Consider matters involving OSH.

(2) Make recommendations to the installation commander.

(3) Perform such additional tasks as the commander or council

chairperson may direct. DOD components may exempt installations with a very small population from the requirement to establish a council.

(4) Review, discuss, and make comments on the installation OSH hazard abatement plan or schedule.

g. The OH representative of the SOH advisory council committee will provide input concerning specific health aspects of council responsibilities. The representative will—

(1) Provide information and make recommendations concerning required actions to implement applicable laws and regulations related to health.

(2) Provide advice, guidance, and/or coordination on required actions to comply with survey and inspection recommendations made by higher headquarters and other agencies.

(3) Provide the council with data regarding accident and illness trends and bring to the council's attention any problems related to employee participation in job-related health programs.

h. The OH nurse and the CHN, as deemed necessary by the chief of the PVNTMED service, will coordinate Occupational Health Program activities in the areas of epidemiology, educational programs, communicable disease programs, and use of community resources. The activities will include but are not limited to the following:

(1) Reviewing DA Form 3076 to detect illness and injury patterns.

(2) Providing advice, as needed, in matters pertaining to OH needs of soldiers.

i. The chief, OH, will—

(1) Plan, direct, supervise, and evaluate the Occupational Health Program according to specific installation needs and resources and requirements of this regulation.

(2) Coordinate with other MTF and installation staff (including labor relations advisers) and with the division surgeon to ensure—

(a) Provision of required OH services.

(b) Collection, review, and reporting of required OH data.

(3) Conduct or coordinate medical surveillance and health hazard training for military and civilian employees potentially exposed to OH hazards, and evaluate employees in positions requiring specific standards of physical fitness.

(4) Regularly visit work areas to keep informed about work operations and potential hazards and maintain working relationships with supervisors and employees.

(5) Conduct epidemiologic investigations of actual or suspected occupational illness.

(6) Provide advice and guidance to commanders and other concerned personnel (such as employee representatives) regarding OH matters.

(7) Participate in the installation SOH advisory council committee and quality control committee.

(8) Establish a light duty or limited duty program, in coordination with the installation commander, safety officer, and personnel officer, to facilitate an early return to work for employees injured on the job.

j. The industrial hygienist will—

(1) Develop and update annually industrial hygiene input into the Occupational Health Program document to clearly define goals and objectives in the industrial hygiene area.

(2) Establish and maintain the HHIM of the OHMIS.

(3) Develop an industrial hygiene implementation plan for the allocation and application of industrial hygiene resources.

(4) Perform industrial hygiene evaluations of workplaces, provide technical guidance and support for the hazard communication, asbestos abatement, and installation OSH programs, and perform other responsibilities as defined in TB MED 503.

k. The chief, DPCCM, will provide clinical support and coordinate with the chief, PVNTMED, and the chief, OH, to assure provision and reporting of required OH services for military and civilian employees.

l. The chief, optometry, MEDDAC, will serve or appoint an optometrist as the occupational vision officer who will—

(1) Assist OSH personnel in identifying eye-hazardous occupations, areas, tasks, or processes and in determining the type of protective eyewear required.

(2) Ensure that verification of prescription and proper fitting of industrial safety spectacles are accomplished.

(3) Ensure that industrial safety spectacles meet current American National Standards Institute (ANSI) Z87.1 criterion.

(4) Assist OH personnel in establishing and maintaining a vision screening program for workers in potentially eye-hazardous occupations and other vision screening programs when required.

(5) Provide professional vision evaluations and the necessary spectacle corrections for civilian employees referred under the Occupational Vision Program.

(6) Provide technical input and assistance for the Employee Health Hazard Education Program.

(7) Provide professional guidance regarding the wearing of contact lenses in the industrial environment. Contact lenses provide very limited industrial eye protection; therefore, proper protective eyewear should be used.

m. The chief, patient administration division, will act as technical adviser for patient administration aspects of the Occupational Health Program, to include collection and use of required OH reports data.

n. Managers and supervisors at all levels will—

(1) Keep informed about OH hazards and the medical and safety requirements in activities under their control.

(2) Train and educate employees regarding job health hazards and appropriate safety practices.

(3) Enforce the use of protective clothing and equipment.

(4) Advise the IMA of proposed or actual changes in work operations that may affect the health or safety of the worker.

(5) Provide the civilian and military personnel offices with the health and safety information necessary for effective job classification and placement actions.

(6) Assure that employees are referred for required job-related medical surveillance.

o. Employees will—

(1) Follow safe and healthful work practices.

(2) Use PPE when required.

(3) Make note of and report suspected unsafe or hazardous work situations.

(4) Comply with requirements of the Occupational Health Program.

## Section II

### Occupational Health Management Information System

#### 5-5. General

a. The purpose for OHMIS is to assist OH professionals in improving the effectiveness and economy of OH delivery through provision of accessible, timely, accurate data on both military and civilian employees, their workplace environment, and their health status. OHMIS is configured as a distributed network with installation level processing on microcomputers at each Army OH facility worldwide.

b. Three modules support the Army OH team:

(1) The Hearing Evaluation Automated Registry System will—

(a) Automate hearing testing to include automatic forms completion; reduce lost training and work time.

(b) Significantly reduce error rates.

(c) Allow hearing conservation officers to quickly and easily determine program participation and hearing loss incidence and prevalence.

(2) The HHIM will—

(a) Maintain workplace descriptions including workplace hazard inventories, employee exposures, engineering and personal protective controls, and exposure abatement efforts.

(b) Document individual exposure histories.

(3) The Medical Information Module (MIM) will—

(a) Automate access to present and past exposure information, both workplace and individual employee.

(b) Automate access, verification, and update of demographic and clinical encounter information.

(c) Generate exposure-based recommended health surveillance procedures and provide locally tailored appointment schedules.

c. All three modules combine to facilitate installation-level data base management, quality assurance, hazard communication and health education, resource management, and query and report preparation.

### 5-6. Functions

a. HSC is the designated Assigned Responsible Agency for operations, maintenance, and support of OHMIS after system deployment.

b. USAEHA is designated Proponent Agency for OHMIS. The OHMIS Coordinating Office has been established under the Director of Occupational and Environmental Health.

(1) The functional program manager will—

(a) Coordinate the separate module manager's efforts for the maintenance and update of reference files that reflect Army policy regarding OH surveillance, exposure monitoring, and exposure definitions.

(b) Evaluate the effectiveness of corporate and local OH programs and the conduct of corporate and local OH programs against established objective, discrete, measurable, and attainable performance standards adjusted for existing resources.

(c) Respond, as appropriate, to queries for information derivable from the OHMIS data base.

(2) The individual module managers will respond directly to queries from the field relating to use or function of the three modules.

c. The Fort Detrick Director of Information Management is designated as the Application System Developer for OHMIS. As such, the Director will provide technical systems administration. The information center will provide assistance to users with hardware and/or software.

d. At the installation level, the chief, PVNTMED services, will ensure systems administration security and the proper use of OHMIS.

### 5-7. Forms

a. The following occupational health patient forms are used to document both the workload requirements and activities of OH programs and the specific recipients of these activities:

(1) Occupational Health Patient Form, DA Form 5931.

(2) USAREUR Occupational Health Form, DA Form 5932.

(3) Occupational Health Patient Form—Supplemental, DA Form 5933 to be used in Panama, Puerto Rico, Guam, and the Virgin Islands, and Japan.

(4) Korea Occupational Health Encounter Form, DA Form 5934.

b. The data can be used to—

(1) Obtain the information required for summary or statistical reports.

(2) Help standardize Occupational Health Program elements and the services provided.

(3) Initiate epidemiologic studies.

(4) Increase program management efficiency.

(5) Serve as a tracer or audit trail for services.

c. Instructions for preparing these forms are found in MIM's Supplemental User's Instructions, available from the Commander, USAEHA, ATTN: HSHBMOF, Aberdeen Proving Ground, MD 210105422.

## Section III

### Occupational Health Services

#### 5-8. General

This section identifies the clinical and preventive medicine services authorized for military personnel and civilian employees within the Occupational Health Program.

#### 5-9. Medical examinations

a. *Job-related examinations.* Preplacement, job transfer, periodic, and termination examinations will be provided to all military personnel and civilian employees potentially exposed to health hazards in the work environment. Termination examinations will be 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. The chief, OH, or his or her representative, will review the HHIM (chap 5, sec II) annually and when operations change. Such a review is performed to determine the scope and frequency of job-related examinations for military personnel and civilian employees potentially exposed to health hazards. The medical surveillance matrix of the MIM will assist the OH care provider in making this determination by providing regulatory and recommended guidance for job-related examinations on each hazard in the matrix. The medical surveillance matrix is based on the hazards identified in the HHIM. The following documents will provide supplemental information:

(1) Part 1910, title 29, Code of Federal Regulations (CFR) (29 CFR 1910).

(2) National Institute for Occupational Safety and Health (NIOSH) Publication No. 81123.

(3) DOD 6055.5M.

(4) TB MED 500.

(5) TB MED 502.

(6) TB MED 506.

(7) TB MED 509.

(8) TB MED 510.

(9) TB MED 513.

(10) TB MED 523.

(11) TB MED 524.

(12) TB MEDs, DA pamphlets, and other documents concerning job-related medical surveillance requirements as they are developed and formally issued.

b. *Military.* In addition to routine entrance and periodic examinations performed under AR 40501, certain assignments will require further preassignment, periodic, and termination examinations that are specific for any potential chemical, physical, or biological hazards.

c. *Civilian.* In addition to job-related examinations required by a above, civilian employees assigned to positions requiring specific physical fitness standards will be provided examinations according to Office of Personnel Management (OPM) policy (FPM chap 339 and FPM chap 930). If necessary, job-related medical evaluations may be made a condition of employment. Employees not required to have preplacement examinations (FPM chap 339) should be scheduled for baseline health screening evaluations if resources permit. The baseline evaluations may include a health history, blood pressure determination, vision screening, and hearing tests.

d. *Other required examinations.* Fitness for duty and disability retirement examinations will be accomplished according to FPM chapter 339. Medical examinations for individuals potentially exposed to chemical surety materials will be accomplished per the applicable DA pamphlets.

e. *Health maintenance examinations.* While not a requirement for civilian employees, health maintenance examinations are encouraged, subject to availability of health 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.

f. *Follow-up.* A follow-up system should be developed and maintained for all health examination and screening programs to identify and report their effectiveness and to assure indicated counseling and referral.

#### 5-10. Illness and injury

a. *Treatment for civilian employees.*

(1) *Occupational illness and injury.* Diagnosis and treatment of injury or illness sustained in performance of official duties is authorized by AR 40-3 and under the Office of Workers' Compensation Program (FPM chap 810). Employees who request examination and treatment will be provided it at no cost at any Army MTF, other Federal MTF, or by a physician or hospital of his or her choice. If an Army dispensary, clinic, hospital, emergency room, or local facility under contract with the Army is available at the activity, locally prescribed procedures will require that the injured employee be initially referred to that MTF.

(2) *Nonoccupational illness and injury.* Definitive diagnosis and treatment of nonoccupational illness and injury cases are not responsibilities of the Occupational Health Program except—

(a) *In an emergency.* The employee will be given the attention required to prevent loss of life or limb or relieve suffering until placed under the care of the employee's personal physician.

(b) *For 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 will be discouraged.

(c) *Minor treatments or services such as administering allergy treatments, monitoring blood pressure, providing physiotherapy, and so forth.* These may be furnished at the discretion of the responsible physician if resources are available. A request must be submitted in writing by the employee's personal physician. Medications, if required, must be provided by the employee.

(d) *In cases of employees with an alcohol or drug abuse problem.* These employees should be encouraged to seek assistance and counsel from the alcohol and drug abuse prevention and control program. AR 600-85, FPM Supplement 792-2, and DA Pam 600-17 provide further guidance. OH functions in this program include initial counseling and referral of employees to treatment resources.

b. *Treatment for military personnel.* AR 40-3 authorizes diagnosis and treatment for both occupational and nonoccupational illness and injury for military personnel. All incidents of military noncombat job-related illnesses and injuries will be reported to the proper occupational health and safety officials. Definitions of reportable occupational illness and injury are found in AR 385-40, chapters 2 and 4, and in that publication's glossary.

c. *Medical directives.* Comprehensive medical directives for emergency care and treatment of occupational and nonoccupational illnesses and injuries by the nursing staff will be prepared, signed, annually reviewed, and revised (if necessary) 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 personal attention of a physician.

(3) Authorize other activities by the nursing staff.

d. *First aid.* In general, the placement of first-aid kits in work areas is discouraged. Exceptions should 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. If first-aid kits are placed in work areas, their contents, intended use, and maintenance will be approved by medical personnel. Personnel rendering first-aid treatment will have approved first-aid training. All first-aid treatment rendered will be reported to OH personnel.

#### 5-11. Epidemiologic investigations

Such investigations will be conducted after the occurrence of suspected or proven occupational illnesses. Identification of apparent excessive numbers of occupational injuries will be reported to safety personnel. Investigations will be made, in coordination with safety officials when indicated, of employee reports of unhealthful working

conditions. Situations that represent an imminent danger to Army personnel will be reported under AR 385-10.

#### 5-12. Immunizations and chemoprophylaxis

a. Appropriate immunizations will be provided personnel with increased risk of infection related to potential job hazards or when required for official foreign travel. Other immunizations may be offered to civilian personnel to reduce absence due to sickness. Immunizations offered to civilian personnel will be based on current recommendations published by the USPHS (AR 40-562/NAVMED-COMINST 6230.3/AFR 161-13/CG COMDTINST M6230.4D).

b. Civilians traveling under military sponsorship will be provided appropriate immunizations and chemoprophylactic medications.

#### 5-13. Illness absence monitoring

Medical support of the illness absence monitoring program for civilian employees will include—

a. Screening, treatment (para 5-10a(2)), and/or referral of employees who become ill during duty hours.

b. A medical evaluation in support of a claim controversy and for employees who are expected to be absent from work for 2 weeks or more due to a job-related illness or injury. Medical personnel will provide this evaluation by reviewing medical reports and/or performing an appropriate examination. Specialty consultation should be requested when indicated.

c. Evaluation of employee health status on return to duty after any absence due to job-related illness or injury.

d. Evaluation of employee health status on return to duty after absence due to illness not described in c above. The IMA and appropriate personnel officers will determine the duration of absence or types of illness or injury requiring such evaluation with the exception of food handlers and patient care personnel. Employees excepted will report to the OH service for evaluations after any absence due to illness.

e. Recommendations concerning work limitations.

#### 5-14. Chronic disease and handicapped personnel

Civilian employees with chronic diseases or disabilities can be productive members of the work force. The following employment guidelines will be used:

a. Medically evaluate their work capability as a basis for proper job placement.

b. Identify employees with chronic diseases or disabilities that may affect or be affected by the work assignment. Health records will be identified and will contain clinical data regarding the condition and current treatment and the name of the personal physician.

c. Provide periodic counseling to the employee and/or supervisor when indicated.

#### 5-15. Occupational vision

a. An occupational vision program oriented toward preservation of eyesight is an essential part of the Occupational Health Program. Guidance provided in TB MED 506 will be followed to develop and conduct the occupational vision program. An effective occupational vision program must include—

(1) Determination of which jobs or areas are eye hazardous.

(2) A job analysis to determine the visual skills required for optimal job performance.

(3) A visual assessment of workers, through use of an approved vision screening device, to determine whether they possess the required visual skills.

(4) Ocular surveillance (per OTSG Policy Letter 86-01.0) of personnel whose occupations are in the laser or microwave field and biennial vision screening for workers in all other potentially eye-hazardous job positions.

(5) Vision screening of individuals using video display terminals (VDTs) per Memorandum, U.S. Army Health Professional Support Agency, SGPS-PSP-O, 1 Sep 1988, subject: Policy for Use of Video Display Terminals (VDTs).

(6) Elective periodic vision screening for employees in noneye-

hazardous positions, resources permitting and not more frequently than triennially.

(7) Referral of employees not possessing the desired visual skills for a complete professional vision evaluation and necessary correction. Military personnel will obtain the examination at appropriate MTFs. Civilian employees in eye-hazardous positions as determined by the installation safety officer under TB MED 506 will be provided this service at Government expense, if they have not worn prescription glasses before or their present prescription is inadequate as determined by administrative vision screening. Employees not in eye-hazardous positions, as defined in AR 40-2, will obtain such professional examinations at their own expense.

(8) Supervision of the use of eye protection (industrial safety eyewear) and eye hygiene.

(9) First aid and care of occupational eye injuries and disease.

(10) Worker education on proper eye protection and benefits of the occupational vision program.

(11) Periodic surveys of work areas to promote adequate illumination and to evaluate other aspects of the work environment related to visual performance and eye safety.

(12) Review of contact lens use to assure their safe wear. Contact lens use will be prohibited during gas chamber exercises, field training, and combat. Personnel whose medical records document a medical requirement to wear contact lenses for medical reasons are not permitted to be in a prohibited environment with or without contact lenses. Personnel wearing contact lenses for medical reasons may apply for a waiver from this limitation. Waiver approval or disapproval is determined at the MEDCEN level. Individuals participating in research studies with approved protocols are exempt from these restrictions.

b. Industrial thickness spectacle lenses are recommended for all persons who have useful vision in only one eye (monocular individual). Active duty and retired military personnel will obtain eyewear per AR 40-63. Monocular civilian employees working in noneye-hazardous occupations will obtain such eyewear at their own expense.

c. Procurement of industrial safety spectacles both plano and prescription will be per AR 385-10. These spectacles will be provided to all military and civilian personnel working in potential eye-hazardous occupations and will meet the criteria of 29 CFR 1910.33 and ANSI Standard Z87.1.

#### 5-16. Hearing conservation

a. *General.* The hearing conservation program is designed to protect the employee from hearing loss due to occupational noise exposure. Implementation and maintenance procedures appear in TB MED 501.

##### b. *Program functions.*

(1) The installation commander will—

(a) Meet the hearing conservation program requirements according to this regulation and AR 385-10.

(b) Issue a command emphasis letter endorsing the installation's hearing conservation program.

(c) Include hearing conservation as an item of interest in the local command inspection program.

(2) The IMA will—

(a) Ensure that a physician determines the diagnosis of noise-induced hearing loss. (See TB MED 501.)

(b) Notify the civilian personnel officer of an individual sustaining a permanent hearing loss which creates a hazard to the individual and others.

(c) Maintain audiometric testing and noise exposure records. (See AR 40-66, AR 25-400-2, and TB MED 501.)

(d) Provide audiometric test records and exposure information on request. (See TB MED 501.)

(e) Report significant threshold shift. (See chap 3 and TB MED 501.)

(f) Provide health education materials on request. (See TB MED 501.)

(3) The flight surgeon will fit the SPH-4 aviator's helmet and inspect the helmet condition annually per AR 95-3.

(4) The safety officer (per AR 385-10) will—

a. Conduct inspections—

b. Include noise hazard abatement projects in the hazard abatement plan.

(5) The civilian personnel officer will—

(a) Ensure that OH is included on the inprocessing and out-processing checklists for new, transferring, or terminating personnel. (This alerts the IMA of the audiometric evaluations required for these personnel.)

(b) Include (per AR 385-10) in the job description, where applicable, the requirement to wear PPE (hearing protectors).

(c) Ensure (per AR 385-10) that the following responsibilities are included in a civilian supervisor's performance standards, where applicable—

1. Enforce the use of PPE.

2. Ensure that employees report for mandatory medical examinations.

(d) Notify supervisors when termination audiometric evaluations are required for individuals under their supervision. Include termination audiograms on the outprocessing checklists for noise-exposed personnel.

(e) Inform the IMA and safety officer of all workers' compensation claims for hearing loss.

(6) The director of engineering and housing will—

(a) Erect and maintain danger signs per AR 385-30 and AR 420-70.

(b) Implement, whenever feasible, acoustical engineering control measures when exposures to steady noise exceed the time-weighted criteria.

(7) The hearing conservation officer will manage and coordinate all aspects of the hearing conservation program outlined in this regulation. These responsibilities include—

(a) Drafting and staffing an installation standing operating procedure (SOP) detailing the hearing conservation program.

(b) Ensuring that medically trained personnel fit individuals with preformed earplugs, and then examine individuals at least annually to ensure proper earplug condition and fit.

(c) Requisitioning and maintaining a supply of preformed earplugs.

(d) Providing a pair of preformed earplugs and carrying case to all noise-exposed personnel.

(e) Ensuring that monitoring audiometry is performed per TB MED 501 and USAEHA Technical Guide (TG) No. 167.

(f) Providing health education annually.

(g) Conducting unannounced inspections of noise-hazardous areas.

(h) Evaluating program participation, quality assurance, and program effectiveness.

(8) The industrial hygiene program manager, per TB MED 503, will—

(a) Use approved and calibrated equipment, and survey all suspected noise-hazardous areas and equipment at least once and within 30 days of any change in operations.

(b) Establish a time-weighted average for all civilians working in noise-hazardous areas and soldiers working in noise-hazardous industrial type operations.

(c) Maintain a current inventory of all noise-hazardous areas using DD Form 2214 (Noise Survey) until HHIM can accommodate noise information.

(d) Provide the names of noise-exposed personnel and the magnitude of their noise exposure to the—

1. Hearing conservation officer.

2. Unit commander or supervisor of the individual.

(e) Establish risk assessment codes (per AR 385-10) and forward the noise survey results, which indicate a violation, to the designated safety and occupational health official for inclusion in the violation inventory log.

(f) Establish appropriate contours and advise unit commanders or supervisors how to properly post these contours.

(9) Unit commanders or supervisors of noise-hazardous areas will—

(a) Appoint a unit hearing conservation manager and ensure that this individual inspects helmets and/or noise muffs and requisitions hearing protectors to ensure an adequate supply.

(b) Prepare a unit SOP detailing the hearing conservation program.

(c) Purchase new equipment that generates the lowest noise levels feasible.

(d) Notify the IMA of any suspected hazardous-noise levels or changes in hazardous-noise levels in their work areas.

(e) Endorse a command emphasis letter explaining the importance of hearing conservation.

(f) Provide appropriate hearing protectors free of charge to their noise exposed personnel per AR 385-10.

(g) Ensure that noise-exposed personnel under their supervision—

1. Are provided appropriate audiometric evaluations.
2. Attend annual health education briefings.
3. Follow recommendations from audiometric examinations, medical evaluations, and noise surveys.
4. Wear hearing protectors.
5. Report for scheduled medical examinations.
6. Are notified of their exposure measurements.
7. Are allowed to choose from the appropriate approved hearing protectors.

(h) Ensure that all soldiers and noise-exposed civilians under their supervision retain a pair of preformed earplugs as an item of individual equipment.

(i) Require noise-exposed soldiers (per AR 670-1) to wear earplugs and carry the earplug carrying case as part of the battle dress uniform when appropriate.

(j) Provide copies of regulations, technical bulletins, and other hearing conservation documents to employees, or their representatives, on request.

(k) Ensure that noise-hazardous areas and equipment are marked with proper danger signs and decals.

(l) Post 29 CFR 1910.95 in noise hazardous workplaces.

(m) Monitor the use of engineering controls.

(n) Refer any personnel under their supervision to the MTF for any hearing problems or complaints associated with the wearing of hearing protectors.

(o) Initiate disciplinary action when appropriate.

(10) Noise-exposed personnel will—

(a) Correctly wear approved and properly fitted hearing protectors when exposed to hazardous-noise levels.

(b) Report for all scheduled medical examinations and health education briefings concerning hearing conservation.

(c) Report any hearing problems or difficulties associated with hearing protectors to their supervisor.

(d) Maintain hearing protectors in a sanitary and serviceable condition.

(e) Wear noise dosimeters to evaluate noise exposure, when requested.

(f) Keep hearing protection in their possession.

#### 5-17. Occupational health counseling

a. OH counseling is concerned with two major areas: health implications of the work environment and general health promotion and maintenance. This includes—

(1) The 29 CFR 1960 mandates counseling for employees during job-related health screening or assessment that incorporates appropriate annotation in the health record. This requires coordinated action of OSH staff and supervisors.

(2) Employee orientation to the available OH services.

(3) Supervisor orientation and guidance regarding responsibilities for employee health.

b. The elements of an occupational health education (OHE) program are defined in paragraph 5-18.

#### 5-18. Occupational health education

a. The Occupational Health Education Program is an integral part of the Occupational Safety and Health Program.

b. The objectives are to—

(1) Ensure that employees (civilian and military) are aware of the actual and potential hazards of their workplace.

(2) Identify, evaluate, and modify those work practices that can be changed through OHE.

#### 5-19. Chemical and/or nuclear surety

OH support will be provided to all workers involved in chemical and/or nuclear surety operations. The exact services will depend on the onsite exposures, but will include all medical aspects of the chemical and nuclear surety programs as described in AR 50-5, AR 50-6, and DA Pam 40-8.

#### 5-20. Reproductive hazards

a. The reproductive hazards program assures that—

(1) Male and female employees are informed about potential work area reproductive hazards.

(2) The pregnant employee (military and civilian) and her fetus are not endangered by the employee's work assignment.

b. The program will include—

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

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

(3) Informing females about availability of job accommodation or transfer in the event of pregnancy (FPM chap 630 and AR 40-501).

(4) Instituting policy or procedure to ensure prompt notification to the OH 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. When justified, specific job limitations should be recommended after consultation with the person's physician. Limitations due to pregnancy will be treated like any other medically certified temporary disability (FPM chap 630, AR 40-501, and AR 635-100).

(6) Providing periodic follow-up and counsel as indicated, including pregnancy outcome evaluation.

#### 5-21. Records and forms

a. Obtain a health history from each permanent civilian employee upon employment and initiate a medical record. Records will be maintained by the appropriate MTF and kept confidential according to AR 40-66. They will be disposed of under AR 25-400-2. Entries into medical records will meet the requirements of AR 40-66. Medical records of civilian employees who are also military medical beneficiaries will be cross-coded to identify this dual status.

b. Results of atmospheric sampling affecting the employee conducted under the Occupational Health Program will be included in the military or civilian medical records and retained per AR 25-400-2. Documentation of sampling, even for negligible results, is important in assessing the present and past exposure history and in meeting legal obligations. (Atmospheric sampling results and recommendations will be posted in the work area to notify the employee and the supervisor.)

c. The following forms are available for use by the OH service.

(1) Outpatient treatment record forms authorized by AR 40-66.

(2) DD Form 689 (Individual Sick Slip).

(3) DD Form 1141 (Record of Occupational Exposure to Ionizing Radiation).

(4) DD Form 2215 (Reference Audiogram).

(5) DD Form 2216 (Hearing Conservation Data).

(6) Office of Workers' Compensation Program Forms under FPM chapter 810.

(7) SF 78 (United States Civil Service Commission Certificate of Medical Examination).

(8) SF 93 (Report of Medical History).

d. Nonmedical forms that may be filed in the employee medical record to provide supplementary medical data include—

(1) OF 345 (Physical Fitness Inquiry for Motor Vehicle Operators).

(2) SF 177 (Statement of Physical Ability for Light Duty Work).

e. Overprints of standard forms may be used when approved under AR 40-66 to meet specific needs; such as, a hazard specific health history check list overprinted on SF 600 (Health Record—Chronological Record of Medical Care).

#### 5-22. Reports

a. DA Form 3076 (RCS MED-20). RCS MED-20 will be submitted biannually by each MTF according to paragraph 3-12.

b. DA Form 3075. DA Form 3075 will be used according to paragraph 3-12 to assist in compiling data for RCS MED-20.

c. Log of Federal Occupational Injuries and Illnesses (unnumbered OSHA form). (See AR 385-40, 29 CFR 1960.67, and OSHA 2014 for use.) Coordination with the safety officer is required to assure complete collection and appropriate review and use of report data.

### Section IV Industrial Hygiene

#### 5-23. General

Industrial hygiene is an integral part of the DA OSH programs.

#### 5-24. Essential elements of the installation industrial hygiene portion of the Occupational Safety and Health Program

The essential industrial hygiene elements to be implemented at each installation are specified in TB MED 503.

### Section V Personal Protective Equipment

#### 5-25. General

The use of PPE is an integral part of the Occupational Safety and Health Program for all soldiers and civilian employees and requires input from both medical and safety personnel who are qualified in determining when, where, and what type of equipment will be used. Individuals who deliberately or carelessly violate regulations regarding the wearing of personal protective equipment and clothing will be subject to disciplinary action under AR 690-700, appendix A, and the Uniform Code of Military Justice (UCMJ).

#### 5-26. Functions

a. Installation, activity, and/or unit commanders will provide PPE to persons who, by the nature of their jobs, are required to wear this equipment (AR 385-10).

b. Installation and/or activity safety personnel, with assistance from MEDDAC or MEDCEN industrial hygiene personnel, will—

(1) Designate areas requiring the use of PPE (such as eye-hazardous areas or areas requiring the use of a hard hat).

(2) Ensure that all PPE is stored and maintained properly.

(3) Ensure that all PPE is used as required.

c. MEDDAC and/or MEDCEN industrial hygiene personnel will—

(1) Conduct the OH hazard evaluation (para 5-24) to identify areas where potential exposures may require the use of PPE such as protective eyewear, respirators, or hearing protectors.

(2) Evaluate the adequacy of the following:

(a) Safety glasses and other eye-protective equipment.

(b) Earplugs and other hearing protective equipment according to paragraph 5-13 and TB MED 501.

(c) Provide technical assistance for the installation respiratory protection program per AR 11-34 and TB MED 502. Medical fitness requirements for respirator use are addressed in TB MED 509.

(d) Provide technical assistance and guidance within the installation hazard communication program.

(e) USAEHA will provide assistance to MEDDACs and/or MEDCENs and installation commanders in the selection of approved PPE upon request.

### Section VI Asbestos Monitoring

#### 5-27. Medical surveillance

Medical questionnaires must be administered to all employees who—

a. Are exposed to asbestos, tremolite, anthophyllite, actinolite, or a combination of these minerals above the action level.

b. Will therefore be included in the medical surveillance program according to TB MED 513.

#### 5-28. Forms

a. DD Form 2493-1 (Asbestos Exposure, Part I—Initial Medical Questionnaire) must be obtained for all new employees who are provided preplacement medical examinations according to TB MED 513. This initial questionnaire must also be obtained on all employees currently enrolled in the asbestos medical surveillance program if they have not previously completed the form.

b. DD Form 2493-2 (Asbestos Exposure, Part II—Periodic Medical Questionnaire) must be obtained for all employees who are provided annual medical examinations according to TB MED 513.

c. These forms will be filed in the civilian employee's medical record and the military health record.

### Chapter 6 Community and Family Health

#### 6-1. General

Community and family health programs are intended to improve the level of health and increase the potential for self-sufficiency for servicemembers, their families, and other members of the military community. The cornerstone of the programs is a comprehensive community assessment that includes evaluation of health needs, based on actual or potential health problems, identification of and coordination with resource agencies, and prioritization of specific program elements. A program document developed by the community health nursing section of PVNTMED service will describe the community and list nursing objectives and goals designed to promote, protect, and restore health.

#### 6-2. Goals

The goals of the community and family health programs are to—

a. Discover and assess actual and potential health problems of persons and families.

b. Assist persons and families in understanding their health problems and how to cope with them.

c. Assist persons and families in changing their behavior or their environment to promote health and safety.

d. Provide or secure health care and other services that persons or families may need, but cannot provide for themselves.

e. Provide or secure support for persons and families in times of stress as an interim measure while they learn to resolve or accept their situation.

f. Coordinate with and use community resources for individual families to conserve and achieve maximum use of Army CHN resources.

g. Provide continuity in health care by planning and supporting the transition from hospital to home care.

#### 6-3. Functions

a. MEDDAC and/or MEDCEN commanders. MEDDAC and/or MEDCEN commanders have overall responsibility for the health care of persons or families in the military community.

b. Chief, PVNTMED. The chief, PVNTMED, through the CHN, assists in the overall responsibility as the principal health adviser

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**26**

Army Regulation 40-5

Medical Services

# Preventive Medicine

Headquarters  
Department of the Army  
Washington, DC  
22 July 2005

**UNCLASSIFIED**

# **SUMMARY of CHANGE**

AR 40-5

## Preventive Medicine

This regulation is a comprehensive and substantive revision of the 1990 policy and responsibilities relating to preventive medicine. Specifically, this major revision, dated 22 July 2005--

- o Redefines preventive medicine and preventive medicine services (chap 1, section II).
- o Requires the incorporation of health threats into the Army's operational risk management process (chap 1, para 1-5e).
- o Revises the list of the preventive medicine components of the Army Occupational Health Program (chap 1, para 1-7d).
- o Incorporates the concepts of the Joint Staff's Force Health Protection strategy (chaps 1 and 2).
- o Adds medical surveillance and occupational and environmental health and exposure surveillance policies and responsibilities (chaps 1 and 2).
- o Incorporates measures to decrease the risk and improve the management of communicable disease outbreak on an installation (chaps 1 and 2).
- o Implements Department of Defense Directive 6490.2 and Department of Defense Instruction 6490.3 policy and procedures for medical surveillance (chaps 1 and 2).
- o Implements Department of Defense Instruction 6055.1 policy and procedures for ergonomics (chaps 1 and 2).
- o Requires the addition of programs and services for vision conservation and readiness, deployment occupational and environmental health threat management, health risk assessment, medical and occupational and environmental health surveillance, surety programs, ergonomics, population health management, and health risk communication (chaps 1 and 2).
- o Redefines responsibilities for preventive medicine programs and services (chap 2).
- o Adds additional Army Secretariat and Army Staff responsibilities (chap 2).
- o Incorporates the U.S. Army Medical Department Functional Proponent for Preventive Medicine and the Proponency Office for Preventive Medicine (chap 2, para 2-8b).
- o Requires the use of the Reportable Medical Events System (chap 2).

- o Identifies responsibilities for commanders of regional medical commands (chap 2).
- o Provides guidance and responsibilities for using the Defense Health Program activity structure and codes for preventive medicine budget execution tracking and program analysis and review (chap 2).
- o Establishes an installation-level ergonomics subcommittee and a vision conservation and readiness team (chap 2).
- o Rescinds Requirement Control Symbol, Medical-3 (RCS MED-3) command health report requirement, DA Form 3075 (Occupational Health Daily Log), and DA Form 3076 (Army Occupational Health Report (RCS MED-20)).
- o No longer prescribes DD Form 2215 (Reference Audiogram) and DD Form 2216 (Hearing Conservation Data), which are now prescribed by Department of the Army Pamphlet 40-501.
- o No longer prescribes DD Form 2493-1 (Asbestos Exposure, Part I-Initial Medical Questionnaire) and DD Form 2493-2 (Asbestos Exposure, Part II-Periodic Medical Questionnaire), which are now prescribed by Department of the Army Pamphlet 40-11.
- o No longer prescribes DA Form 3897-R (Tuberculosis Registry), which is now prescribed by Department of the Army Pamphlet 40-11.
- o No longer prescribes DA Form 5402-R (Barber/Beauty Shop Inspection), which is now prescribed by Department of the Army Pamphlet 40-11.
- o Eliminates the term "installation medical authority" and replaces it with "medical commander" throughout this regulation.
- o Removes detailed roles, functions, procedural guidance, and technical standards and criteria throughout this regulation for inclusion in other appropriate Army publications.

Effective 22 August 2005

## Medical Services

### Preventive Medicine

By Order of the Secretary of the Army:

PETER J. SCHOOMAKER  
General, United States Army  
Chief of Staff

Official:

  
SANDRA R. RILEY  
Administrative Assistant to the  
Secretary of the Army

**History.** This publication is a major revision.

**Summary.** This regulation has been revised to update the policies and responsibilities for preventive medicine. It establishes practical measures for the preservation and promotion of health and the prevention of disease and injury. This regulation implements Executive Order 12196; Department of Defense 1400.25-M; Department of Defense 6055.5-M; Department of Defense Directives 1000.3, 1010.10, 4715.1, 6000.12, 6050.16, and 6490.2; Department of Defense Instructions 1322.24, 4150.7, 6050.5, 6055.1, 6055.5, 6055.7, 6055.8, 6055.11, 6055.12, 6060.2, 6060.3, 6205.2, 6205.4, and 6490.3, and Presidential Review Directive 5.

**Applicability.** This regulation applies to all elements of the Army across the full spectrum of military operations from peacetime through major theater warfare. This regulation applies to all Army personnel to include the Active Army; the Army National Guard/Army National Guard of the United States and United

States Army Reserve personnel on active duty or in drill status; United States Military Academy cadets; 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 regulation does not generally apply to Army contractor personnel and contractor operations. This regulation is applicable during mobilization.

**Proponent and exception authority.** The proponent of this regulation is The Surgeon General. The proponent has the authority to approve exceptions to this regulation that are consistent with controlling law and regulations. The proponent may delegate the approval authority, in writing, to a division chief within the proponent agency or its direct reporting unit or field operating agency, in the grade of colonel or the civilian 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.

**Army management control process.** This regulation contains management control provisions and identifies key management controls that must be evaluated (see app B).

**Supplementation.** Supplementation of this regulation and establishment of command and local forms by major Army commands are prohibited without prior approval from HQDA (DASG-PPM-NC), 5109 Leesburg Pike, Falls Church, VA 22041-3258.

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

**Committee Continuance Approval.** The Department of the Army Committee Management Officer concurs in the establishment of an installation-level ergonomics subcommittee.

**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.

\*This regulation supersedes AR 40-5, dated 15 October 1990; and HQDA Ltr 40-04-1, dated 14 July 2004; and rescinds DA Form 3075, dated March 1985; and DA Form 3076, dated March 1985.

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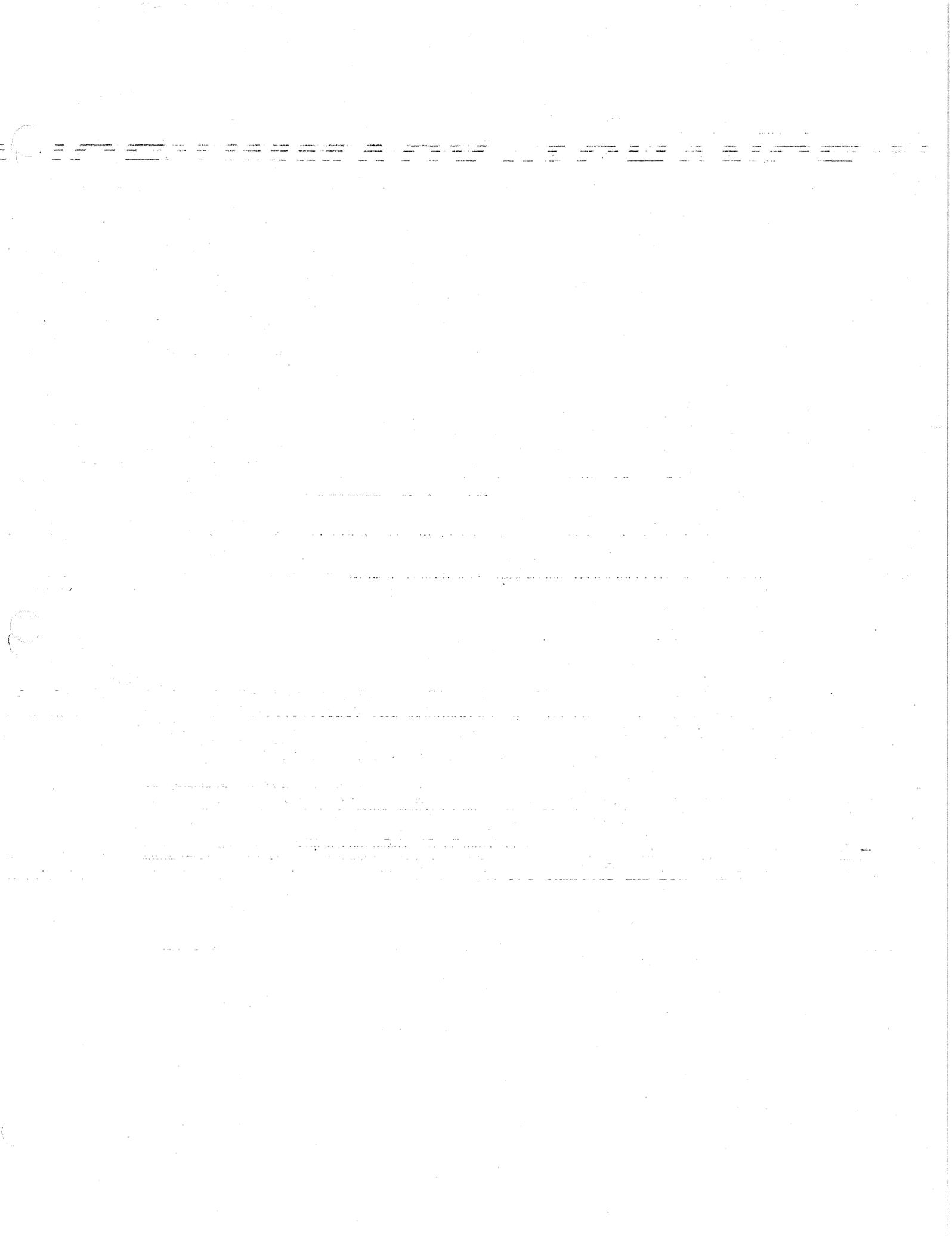
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**Glossary**



## Chapter 1 Introduction

### Section I General

#### 1-1. Purpose

This regulation—

- a. Establishes policies for preventive medicine.
- b. Defines preventive medicine and directs the establishment of preventive medicine programs and services.
- c. Assigns responsibilities for—
  - (1) Improving and sustaining health throughout the Army and across the spectrum of military operations, including joint and combined operations.
  - (2) Developing and implementing preventive medicine programs and services.
  - (3) Providing preventive medicine resources, services, and technical support.
  - (4) Providing preventive medicine guidance, strategy, doctrine, and oversight.
  - (5) Conducting comprehensive, coordinated military health surveillance activities to include medical surveillance and occupational and environmental health (OEH) surveillance for Army personnel throughout their time in service.
  - (6) Identifying or developing military-unique OEH standards, criteria, and guidelines.
  - (7) Implementing Department of Defense directives (DODDs) and Department of Defense instructions (DODIs), including those listed in appendix A.

#### 1-2. References

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

#### 1-3. Explanation of abbreviations and terms

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

#### 1-4. Responsibilities

Responsibilities are listed in chapter 2.

#### 1-5. Preventive medicine policies

The Army will—

- a. Enhance and sustain optimal levels of health and fitness of all Army personnel by applying the principles of population medicine to promote health and prevent and minimize the impacts of diseases and injuries as defined in paragraph 1-7, below.
- b. Protect all Army personnel from exposures to ionizing and nonionizing radiation, biological warfare agents, vector-borne disease agents, chemical warfare agents, environmental pollutants, toxic industrial materials (TIMs), psychological stressors, and physical agents.
- c. Adhere to Federal, state, and host nation laws, regulations, and guidance governing OEH during peacetime in nondeployed situations and during training exercises, except for uniquely military equipment, systems, and operations as authorized in Executive Order 12196. These statutes and regulations also apply during military operational deployments and war unless specifically exempted by appropriate authority based on the tactical situation. Contractors whose personnel are using Government-furnished facilities will similarly adhere to Federal, state, and host nation laws, regulations, and guidance governing OEH.
- d. Strive to adhere to peacetime U.S. or host nation health standards, whichever are more stringent, during military operational deployments. However, when the mission or the overall health of deployed personnel warrant risk decisions that may require overriding the peacetime health standards, such decisions must be made by the first general officer in the chain of command as far as possible and practicable or as specified in the operational plans and orders. These decisions must be based on a complete consideration of operational as well as health risks and available contingency guidance and criteria so that the total risk to our Soldiers and civilians is minimized. This decisionmaking will be deliberate, documented, and archived.
- e. Use the operational risk management process to minimize the total health threat and risk to personnel in garrison, training, contingency operations, and war. Army health policies are intended to allow commanders to execute the full spectrum of military operations while minimizing the total health risk to Soldiers and civilian employees, according to applicable Department of Defense (DOD)/Army policies, implementing instructions, and regulations.
- f. Have Army leaders make informed risk decisions about OEH risks and consider, in all risk decisions, health risks to personnel arising from short-term and long-term exposures across the full spectrum of operations.
- g. Operate a system of medical, behavioral, and OEH surveillance to—

- (1) Provide preventive medicine assessments supporting operational risk management decisionmaking.
- (2) Identify health threats to Army personnel and other military health system beneficiaries.
- (3) Monitor and assess the health status of all Army personnel throughout their service.
- (4) Report the health status of Army units and the impact on readiness.
- (5) Archive data for future analyses.
- h.* Incorporate preventive medicine requirements into medical information management systems.
- i.* Inform Army personnel and co-located contractor personnel of health threats, risks, and appropriate unit and individual preventive countermeasures using health risk communication techniques.
- j.* Provide pre-placement, job transfer, periodic, and termination medical examinations for military personnel and civilian employees potentially exposed to health hazards in the work environment.
- k.* Ensure all preventive medicine laboratories are accredited or abide by accepted quality assurance procedures to guarantee the accuracy and quality of the data.
- l.* Ensure all new equipment and materials acquired by the Army are subjected to a health hazard assessment (HHA).
- m.* Ensure that all new chemicals and materials being added to the Army supply system have a toxicity clearance.
- n.* Procure and use in any military operation within the continental U.S. (CONUS) and outside the continental U.S. (OCONUS) only those pesticide active ingredients that are not cancelled by the U.S. Environmental Protection Agency for use within the U.S.
- o.* Acquire, archive, and store health-related data acquisition using only approved military health information systems that will comply with Part 201 et seq., Title 42, United States Code (42 USC 201 et seq.), and the Act's regulations, Parts 160, 162, and 164, Title 45, Code of Federal Regulations (45 CFR Parts 160, 162, and 164).

## Section II

### The Preventive Medicine Functional Area

#### 1-6. Background

*a.* Preventive medicine is one of the functional areas of Army health care delivery for which The Surgeon General (TSG) is the Army functional proponent. It is the application of many of the principles of public health and preventive medicine practice to military situations and populations. A component of force health protection, preventive medicine is the anticipation, prediction, identification, surveillance, evaluation, prevention, and control of disease and injuries. These include—

- (1) Communicable diseases.
- (2) Vector-, food-, air-, and water-borne diseases.
- (3) OEH-related diseases and injuries.
- (4) Disease and non-battle injuries (DNBIs).
- (5) Training injuries.

*b.* Core public health functions as applied to military preventive medicine include assessment, policy development, and assurance. Assessment includes the key capabilities of general health assessment of the beneficiary populations, investigation of outbreaks, and determination of risk factors and causes of major disease and injury syndromes. Policy development includes advocacy, prioritization of needs, development of plans and policies, and provision of resources to implement programs, plans, and policies. The assurance function includes the direct provision and assurance of delivery of services; it entails implementing programs, plans and policies; management of resources; and monitoring outcomes. A key aspect of all public health practice is effective communication and education with all affected populations.

*c.* Preventive medicine supports the concept of population health management within the military health system. Population health management is the intentional and proactive use of a variety of individual, organizational, and population interventions to help improve patterns of disease and injury burdens, health status, and the health care demand of defined populations. Preventive medicine support includes individual and community health risk and needs assessments, surveillance, program planning, defined responses, and health outcome evaluation for the entire beneficiary community.

*d.* Effective preventive medicine will meet the following objectives:

- (1) Improvement in beneficiary health.
- (2) Reduction in short- and long-term health risks.
- (3) Reduction of health care costs due to chronic disease and conditions caused by injury.
- (4) Improved performance through reduced morbidity.

*e.* The process for providing effective preventive medicine services consists of the following actions:

- (1) Identification of requirements and objectives.
- (2) Allocation of resources to accomplish objectives.
- (3) Development of policies, plans, and implementing guidance.
- (4) Accomplishment of objectives.

(5) Demonstration of accomplishments using process and outcome measurements.

f. Knowledge and application of the principles of obtaining and executing resources through the Military Planning, Programming, Budgeting, and Execution System are essential skills for Army preventive medicine personnel. Without such skills, preventive medicine personnel responsible and accountable for obtaining and executing resources will not be able to perform those functions.

### 1-7. Preventive medicine programs and services

This paragraph broadly describes the components and scope of the Army preventive medicine functional areas. It directs the development and implementation of a wide range of specific preventive medicine programs and services. Health surveillance and epidemiology; toxicology and laboratory services; health risk assessment; and health risk communication are foundation components of Army preventive medicine that directly support and must be integrated into the other components of preventive medicine. The detailed implementing guidance and instructions for each of the required programs and services in this regulation are provided in Department of the Army Pamphlet (DA Pam) 40-11. The publication of new Army documents with guidance and instructions specific to any of the required individual programs and services is authorized. The following describe the Army preventive medicine functional areas:

#### a. Disease prevention and control.

(1) Primary care, preventive medicine, and other health care providers in both tables of distribution and allowances (TDA) and tables of organization and equipment (TO&E) medical organizations deliver disease prevention and control services. These services, delivered in clinical and nonclinical settings, are initiated to prevent the occurrence and reduce the severity and consequences of diseases in individuals and populations. Examples include screening and monitoring procedures for early detection of disease (using a variety of clinical examinations and laboratory tests), immunizations to prevent disease, chemoprophylaxis for individuals exposed to infectious diseases, infection control, and preventive medicine counseling.

(2) Disease prevention and control programs and services will be provided according to the detailed implementing instructions and guidance published in DA Pam 40-11, chapter 2. Specific programs, services, and capabilities will be established and provided for the following areas:

#### (a) Communicable disease prevention and control to include—

##### 1. Immunization and chemoprophylaxis.

2. Acute respiratory disease.

3. Meningococcal infection.

4. Malaria.

5. Viral hepatitis.

6. Sexually transmitted diseases.

7. Rabies.

8. Tuberculosis.

9. Biowarfare threat.

#### (b) Travel medicine.

#### (c) Population health management.

#### (d) Hospital-acquired infection control.

#### b. Field preventive medicine.

(1) The principles and practices of Army preventive medicine will apply to all Army individuals and units in all field-training environments and across the full spectrum of military operations. Field preventive medicine services will focus on the health and fitness components of force medical readiness and on the operational management and effective communication of health risks.

(2) The overall objectives of field preventive medicine are to provide commanders with healthy and fit deployable forces; to sustain the health and fitness in any military operation; and to prevent casualties from DNBI and stress reactions.

(3) Field preventive medicine services will include capabilities from the following U.S. Army Medical Department (AMEDD) functional areas, as described in Field Manual (FM) 4-02, chapter 5:

#### (a) Preventive medicine services.

#### (b) Veterinary services.

#### (c) Combat and operational stress control.

#### (d) Dental services (preventive dentistry).

#### (e) Laboratory services (those supporting the above four AMEDD functional areas).

(4) Field preventive medicine services will be provided according to Army doctrine published in FM 4-02, FM 4-02.17, FM 4-02.18, FM 4-02.19, FM 4-25.12, FM 8-51, FM 8-55, and their supporting references, as well as in DA Pam 40-11, chapter 3.

(a) Soldiers will apply the basic individual preventive medicine measures prescribed in FM 8-55, paragraph 11-5, and FM 21-10/MCRP 4-11.1D, chapter 2. Unit leaders will motivate, train, and equip subordinates prior to and during

field training exercises and all deployments to defeat the medical threat through the use of individual and unit preventive measures as described in FM 4-25.12, chapters 1-2 and appendixes A-D; and FM 21-10/MCRP 4-11.1D, chapters 2-4 and appendix A.

(b) Company-sized units will establish and employ manned, trained, and equipped unit field sanitation teams (FSTs), according to the Army doctrine published in FM 4-02.17, chapter 2 and appendix A, and FM 4-25.12, chapters 1-2 and appendixes A-D.

(c) Medical and OEH surveillance will be provided for each Soldier from accession through the entire length of each Soldier's service commitment. Such surveillance will be provided according to the doctrinal principles defined in FM 4-02.17, chapters 3, 4, 6 through 9, and appendixes A, C, E, and F. Additional guidance can be found in DA Pam 40-11, chapter 6.

(d) Field preventive medicine information management needs will be met using standard military medical and nonmedical information and communication systems, and tactics, techniques and procedures prescribed by doctrine (for example, FM 4-02.16, chapters 1-5 and appendixes A-H).

(e) Health risk communication will be provided in the field through planning and implementation using proven processes and tools.

*c. Environmental health.*

(1) In Army preventive medicine, environmental health consists of those capabilities and activities necessary to anticipate, identify, assess, and control risks of immediate and delayed-onset DNBI to personnel from exposures encountered in the environment. These exposures include risks from chemical, biological, radiological, and physical hazards. These risks will be evaluated using standardized risk assessment principles and procedures.

(2) Environmental health programs and services will be provided according to the detailed implementing instructions and guidance published in DA Pam 40-11, chapters 3 and 4. Environmental health programs, services, and capabilities will be established and provided for the following specific areas:

- (a) Drinking water.
- (b) Recreational waters.
- (c) Ice manufacture.
- (d) Wastewater.
- (e) Pest and disease vector prevention and control.
- (f) Solid waste.
- (g) Hazardous waste.
- (h) Groundwater and subsurface release of hazardous constituents.
- (i) Regulated medical waste.
- (j) Waste disposal guidance.
- (k) Spill control.
- (l) Air quality.
- (m) Environmental noise.
- (n) Climatic injury prevention and control.
- (o) Sanitation and hygiene, including the following topics:
  1. Troop housing sanitation.
  2. Barber and beauty shops.
  3. Dry cleaning operations.
  4. Mobile home parks.
  5. Child development services facilities.
  6. Recreational areas.
  7. Laundry operations.
  8. Confinement facilities.
  9. Food service sanitation.
  10. Sports facilities, gymnasiums, and fitness centers.
  11. Tattooing and piercing businesses.

*d. Occupational health.*

(1) In Army preventive medicine, occupational health consists of those capabilities and activities necessary to anticipate, identify, assess, communicate, mitigate, and control occupational disease and injury threats. This includes management of the risks to personnel from exposures encountered at their worksite in garrison and field settings. Occupational health hazards include risks from chemical, biological, radiological, physical, and psychological threats. These risks will be evaluated using standardized risk assessment methodologies.

(2) The Army Occupational Health Program's medical components will be developed and provided consistent with the Defense Safety and Occupational Health Program and implemented according to the detailed instructions and

guidance published in DA Pam 40-11, chapter 5. Occupational health programs, services, and capabilities will be established and provided for the following specific areas:

- (a) Medical surveillance examinations and screening.
- (b) Health hazard education.
- (c) Surety programs.
- (d) Reproductive hazards.
- (e) Bloodborne pathogens.
- (f) Hearing conservation and readiness.
- (g) Vision conservation and readiness.
- (h) Workplace epidemiological investigations.
- (i) Ergonomics.
- (j) Radiation exposure and medical surveillance.
- (k) Industrial hygiene.
- (l) Personal protective equipment.
- (m) Respiratory protection.
- (n) Asbestos exposure control and surveillance.
- (o) Injury prevention and control.
- (p) Occupational illness and injury prevention and mitigation.
- (q) Work-related immunizations.
- (r) Recordkeeping and reporting.
- (s) Worksite evaluations.
- (t) Other Federal programs (for example, Department of Labor (DOL), Office of Workers' Compensation).
- (u) Evaluation of occupational health programs and services.

(3) Other occupational health-related programs and services that are not listed above will also be provided according to the detailed instructions and guidance published in DA Pam 40-11, chapter 5. These programs and services will include—

- (a) Army aviation medicine.
  - (b) HHA of Army equipment and materiel.
  - (c) Medical facility and systems safety, health, and fire prevention.
  - (d) Nonoccupational illness and injury.
- (4) Where local commanders establish and resource a command prevention of violence in the workplace program, preventive medicine will assist upon request.

*e. Health surveillance and epidemiology.*

(1) Health surveillance is defined to be those capabilities and activities necessary to effectively collect, analyze, report, and archive information pertaining to the—

- (a) Health status of Army personnel throughout their time in service.
- (b) Health hazards, risks, and exposures to Army personnel.
- (c) Preventive medicine and health risk communication measures necessary to counter those hazards and reduce risks.
- (d) Diseases, injuries, and behavioral problems that result from those hazards.

(2) Epidemiology will consist of those capabilities and activities necessary to effectively identify Army populations at risk of disease, injury, or behavioral difficulties and the associated risk factors to—

- (a) Identify and characterize morbidity and mortality in Army populations.
- (b) Identify the causes of occupational, environmental, and infectious diseases.

(3) Health surveillance and epidemiology programs and services are critical to the success of preventive medicine activities in disease prevention and control; field preventive medicine; occupational health; environmental health; and Soldier, family, and community health, and health promotion. Programs and services will be developed and implemented according to the detailed implementing instructions and guidance published in DA Pam 40-11, chapter 6. Health surveillance and epidemiology programs, services, and capabilities will be established and provided for the following specific areas:

- (a) OEH surveillance in deployment, training, and in garrison.
  - (b) Defense Occupational and Environmental Health Readiness System (DOEHRs).
  - (c) Occupational Health Management Information System.
  - (d) Medical surveillance.
  - (e) Epidemiology.
- f. Soldier, family, community health, and health promotion.*

(1) Soldier, family, and community health programs and services address community health needs across a continuum of home, school, and work environments as well as specific communicable and chronic disease prevention and control activities. Soldier readiness is a priority in the development and execution of these programs. They are intended to address and improve the level of population health. The cornerstone of these programs and services is a comprehensive community health needs assessment. This assessment is the basis for a program document that plans, implements, evaluates, and prioritizes local health needs, resource agencies, and program implementation.

(2) Soldier, family, and community health programs and services will be developed and implemented according to the detailed implementing instructions and guidance published in DA Pam 40-11, chapter 7. Community health programs, services, and capabilities will be provided to support the following areas:

- (a) Soldier medical readiness.
- (b) Soldier dental readiness.
- (c) Community health support of Army operations.
- (d) Communicable disease prevention and control.
- (e) Community health needs assessment.
- (f) Community health referrals.
- (g) Chronic disease prevention and control.
- (h) Case management.
- (i) Child and youth services.
- (j) Health of school-age children.
- (k) Childhood lead poisoning prevention.
- (l) Spousal and child abuse.
- (m) Family safety.
- (n) Women's health.
- (o) Health risk appraisal.
- (p) Tobacco use cessation.
- (q) Nutrition.
- (r) Stress management.
- (s) Alcohol and substance abuse prevention and control.
- (t) Suicide prevention.
- (u) Spiritual health and fitness.
- (v) Oral health.

(3) Health promotion is concerned with the promotion of wellness through health education and related activities designed to facilitate behavioral and environmental changes that will improve and maintain health as prescribed in AR 600-63, chapters 1-5.

(4) AMEDD health promotion services to support the Army Health Promotion Program will be developed and implemented according to the detailed instructions and guidance published in DA Pam 40-11, chapter 7.

*g. Preventive medicine toxicology and laboratory services.*

(1) Preventive medicine toxicology and laboratory services provide for the analytical needs of all elements of preventive medicine.

(2) Toxicology programs and services will be developed and implemented according to the detailed instructions and guidance published in DA Pam 40-11, chapter 8. Toxicology programs, services, and capabilities will be established and provided for the following specific areas:

- (a) Toxicological assessments of potentially hazardous materials.
- (b) Toxicity clearances for Army chemicals and materiel.
- (c) Toxicologically based assessments of health risks.

(3) Laboratory programs and services will be developed and implemented according to the detailed instructions and guidance published in DA Pam 40-11, chapter 9. In addition to the necessary analytical capabilities, laboratory programs and services will be established and provided for the following specific areas:

- (a) Certification and accreditation.
- (b) Quality control and quality management.
- (c) DOD Cholinesterase Monitoring Program.

*h. Health risk assessment.*

(1) Health risk assessment is those capabilities and activities necessary to identify and evaluate a health hazard to determine the associated health risk (probability of occurrence and resulting outcome and severity) of potential exposure to the hazard.

(2) Health risk assessment programs and services will be developed and implemented according to the detailed implementing instructions and guidance in DA Pam 40-11, chapter 10. Health risk assessment programs, services, and capabilities will be established and provided for all preventive medicine programs and service areas.

*i. Health risk communication.*

(1) Health risk communication is defined to be those capabilities and activities necessary to identify who is affected by potential or actual health and safety threats; to determine the interests and concerns those people have about the threats, and to develop strategies for effectively communicating the complexities and uncertainties associated with the scientific processes of determining risk. Effective risk communication can only be accomplished through building and maintaining relationships that provide a framework of credibility for the message and the messenger.

(2) Health risk communication programs and services will be developed and implemented according to the detailed implementing instructions and guidance in DA Pam 40-11, chapter 11. Health risk communication programs, services, and capabilities will be established and provided for all preventive medicine program and service areas.

#### **1-8. Technical assistance**

Technical assistance will be available through preventive medicine units, U.S. Army medical centers (MEDCENs), U.S. Army medical department activities (MEDDACs), regional medical commands (RMCs), and U.S. Army Center for Health Promotion and Preventive Medicine (USACHPPM). All technical assistance will be coordinated with the appropriate commands. Consultative assistance may be obtained from command surgeons, the U.S. Army Medical Department Center and School (AMEDDC&S), U.S. Army Medical Research and Materiel Command (MRMC), veterinary commanders, and U.S. Army Dental Command (DENCOM).

## **Chapter 2 Responsibilities**

### **2-1. The Assistant Secretary of the Army (Installations and Environment)**

The Assistant Secretary of the Army (Installations and Environment) (ASA(I&E)) will—

a. Provide executive leadership at the Army Secretariat level to ensure timely—

- (1) Integration of DOD directives and policies concerning Army OEH with Army policies, doctrine, and guidance.
- (2) Compliance with the Army OEH requirements.

b. Establish goals, policies, priorities, and oversight for Army OEH.

c. Provide Army OEH input to the defense planning guidance and the defense medical planning guidance in coordination with the Assistant Secretary of the Army (Manpower and Reserve Affairs) (ASA(M&RA)).

d. Provide policy, goals, guidance, and management oversight of the Army Occupational Health Program, as the Army component of the DOD Safety and Occupational Health Program.

### **2-2. The Assistant Secretary of the Army (Manpower and Reserve Affairs)**

The ASA(M&RA) will—

a. Provide executive leadership at the Army Secretariat level—

(1) To ensure timely integration of DOD directives and policies concerning health and fitness with Army policies, doctrine, and guidance.

(2) For the development and implementation of Army health and fitness policies.

b. Oversee the integration of Army health and fitness policy with Army activities, operations, policies, and doctrine.

c. Provide preventive medicine input to the defense planning guidance and the defense medical planning guidance in coordination with the ASA(I&E).

### **2-3. The Assistant Secretary of the Army (Acquisition, Logistics, and Technology)/The Army Acquisition Executive**

The Assistant Secretary of the Army (Acquisition, Logistics, and Technology)/Army Acquisition Executive (AAE) will plan, program, and budget for the integration of preventive medicine factors with the Army's acquisition programs. This includes but is not limited to—

a. The HHA of Army materiel and systems throughout the full life cycle of these items (see AR 40-10, para 2-1; AR 70-1, para 2-10; AR 200-1, para 1-8; and AR 385-16, para 4a(2)).

b. The development of nonmedical material (such as instruments, equipment) in conjunction with the AMEDD to rapidly identify and assess the short- and long-term health risks to Army personnel presented by deployment OEH threats.

c. The establishment of procedures to assure that program managers and other individuals authorized to add chemicals and chemical-based materiel to the Army supply system request toxicity clearances for those products.

### **2-4. The Deputy Chief of Staff, G-1**

The Deputy Chief of Staff, G-1 will—