



# Defense Health Agency

## PROCEDURAL INSTRUCTION

NUMBER 6490.03

December 17, 2019

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AD CS/PHD

SUBJECT: Deployment Health Procedures

References: See Enclosure 1.

1. **PURPOSE.** This Defense Health Agency-Procedural Instruction (DHA-PI), based on the authority of References (a) through (d), updates procedures from References (e) through (k), incorporates References (j) through (l), and in accordance with Reference (c), establishes the Defense Health Agency's (DHA) procedures to:

- a. Implement and monitor the execution of the DoD deployment health activities.
- b. Include procedures and guidance for deployment health activities in all phases of deployment.
- c. Incorporate and cancel the Defense Health Agency Director Memorandum, "Standardized Process Guidance for Completing, Approving, and Posting Periodic Occupational and Environmental Monitoring Summaries," dated September 12, 2014 (Reference (l)).

2. **APPLICABILITY.** This DHA-PI applies to:

- a. The OSD, the Military Departments (including the Coast Guard at all times, including when it is a Service in the Department of Homeland Security by agreement with that Department), the Office of the Chairman of the Joint Chiefs of Staff (CJCS) and the Joint Staff, the Combatant Commands (CCMD), the Office of the Inspector General of the Department of Defense, the Defense Agencies, the DoD Field Activities, and all other organizational entities within the DoD (referred to collectively in this issuance as the "DoD Components").
- b. Service members who are deploying, deployed, and returned-from-deployment (redeployed), as well as DoD civilian employees and DoD contractor personnel deploying with U.S. forces consistent with DoD policy (References (c) and (n) through (s)), and applicable DoD

Component guidance. DoD contractor personnel deploying with U.S. forces are included to the extent provided in the applicable contracts and pursuant to References (c), (n), (t), (u), and any applicable DoD Component policy. Reserve Component (RC) members include Army and Air National Guard members, consistent with the policies of the Adjutants General of the States, Territories, or the Commanding General of the District of Columbia, who are deploying, deployed, and returned from deployed, in a duty status pursuant to section 502(f) of Reference (m).

c. Shipboard operations when identified health risks indicate actions are necessary beyond the scope of shipboard occupational health programs, per the decision of the commander exercising operational control. Otherwise, shipboard operations that are not anticipated to involve operations ashore will report individual daily deployment locations but are exempt from other requirements of this issuance.

d. Deployments to enduring locations within operational areas, when identified health risks indicate actions are necessary beyond the scope of occupational and environmental health programs pursuant to References (c) and (v) through (x)), and other deployment health activities described in this DHA-PI, per the decision of the commander exercising operational control.

3. POLICY IMPLEMENTATION. To ensure uniform and effective implementation of DoD deployment health policy requirements across the DoD Components, pursuant to References (b) through (d):

a. The DoD Components will conduct key deployment health activities as described in Reference (c) and this DHA-PI. The DoD implements deployment health activities in order to deliver a medically ready force and protect the health of that force through individual medical readiness, occupational and environmental health practices, health assessments and health surveillance in accordance with References (q), (s), (v), (aa) and (ab). Deployment health activities will anticipate, recognize, monitor, evaluate, record, report, communicate, control, and mitigate health threats, to include their immediate and long-term effects. Measures outlined in this DHA-PI will be implemented to provide the necessary level of health protection before, during, and after deployment. DoD deployment health activities promote medical readiness and preserve the health of deploying Service members, DoD civilian employees, and military working animals throughout the spectrum of military operations.

b. Deployments lasting longer than 30 days outside the United States require the full range of deployment health activities described this DHA-PI. Deployments of shorter duration outside of the United States, and operations of any duration within the United States require the minimum deployment health activities described in this DHA-PI, plus any additional deployment health activities per the decision of the commander exercising operational control, as indicated by identified health risks.

c. DoD deployment health activities will be monitored, recorded, and used to promote individual medical readiness (IMR) and protect the health of all deploying U.S. military and DoD civilian employees.

d. DoD deployment health activities, data, and information are coordinated and shared with relevant DoD component personnel accountability program activities described in References (ac) and (ad), with environment, safety, and occupational health program activities described in References (ae) and (af), and health surveillance activities described in Reference (q).

e. For deploying contract personnel, all pre-, during-, and post-deployment medical assessments, examinations, treatments, and preventive measures are the responsibility of the contractor unless otherwise stated in the contract, except that the Government will provide theater-specific immunizations and/or medications not available to the general public in accordance with Subparts 207.503, 252.225-7040 of Reference (u).

f. The definition of Deployment, as defined in Reference (ae), will be consistently used.

g. Individual location information is recorded, submitted, and archived according to Reference (c) and the procedures in this DHA-PI.

h. Health surveillance data and information will be matched to individuals by location. Health surveillance data and information include occupational and environmental health (OEH) and food protection data or documents recorded in the Defense Occupational and Environmental Health Readiness System-Industrial Hygiene (DOEHRS-IH) and the OEH and Chemical, Biological, Radiological, and Nuclear (CBRN) information in the Military Exposure Surveillance Library - Secret Internet Protocol Router (MESL (SIPR)).

4. RESPONSIBILITIES. See Enclosure 2.

5. PROCEDURES. See Enclosure 3.

6. INFORMATION COLLECTION REQUIREMENTS. The health surveillance data collected for the purposes of monitoring the individual and collective health of the military population (Service members and deployable DoD civilian employees) before, during, and following deployment operations are aligned with those in Reference (c).

7. RELEASABILITY. **Cleared for public release.** This DHA-PI is available on the Internet from the Health.mil site at: [www.health.mil/DHAPublications](http://www.health.mil/DHAPublications).

8. EFFECTIVE DATE. This DHA-PI:

a. Is effective upon signature.

b. Will expire 10 years from the date of signature if it has not been reissued or cancelled before this date in accordance with Reference (d).

## 9. FORMS

a. Standard Form 600, Chronological Record of Medical Care is available from [www.gsa.gov/reference/forms](http://www.gsa.gov/reference/forms).

b. The following DD Forms are available from [www.esd.whs.mil/directives/forms/](http://www.esd.whs.mil/directives/forms/):

(1) DD Form 1532, Pest Management Report

(2) DD Form 1910, Clearance Request for Public Release of Department of Defense Information

(3) DD Form 2341, Report of Animal Bite – Potential Rabies Exposure

(4) DD Form 2697, Report of Medical Assessment

(5) DD Form 2807-1, Report of Medical History

(6) DD Form 2808, Report of Medical Examination

(7) DD Form 2977, Deliberate Risk Assessment Worksheet

(8) DD Form 2978, Deployment Mental Health Assessment

c. The following DD Forms are available on the Service designated websites:

(1) DD Form 2795, Pre-Deployment Health Assessment

(2) DD Form 2796, Post-Deployment Health Assessment

(3) DD Form 2900, Post-Deployment Health Re-Assessment

d. DD Form 2766, Adult Preventive and Chronic Care Flowsheet, is a specialty form that can be ordered from <https://forms.documentservices.dla.mil/order/>.

e. The Vaccine Adverse Event Reporting System (VAERS) process mentioned in this DHA-PI is available from <https://vaers.hhs.gov/index.html>.

f. The DD Form 1532-1, Pest Management Maintenance Record, is available from <https://www.acq.osd.mil/eie/afpmb/>.



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#### Enclosures

1. References
2. Responsibilities
3. Procedures

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ENCLOSURE 1

REFERENCES

- (a) DoD Directive 5136.01, "Assistant Secretary of Defense for Health Affairs (ASD(HA))," September 30, 2013, as amended
- (b) DoD Directive 5136.13, "Defense Health Agency (DHA)," September 30, 2013
- (c) DoD Instruction 6490.03, "Deployment Health," June 19, 2019
- (d) DHA-Procedural Instruction 5025.01, "Publication System," August 24, 2018
- (e) Assistant Secretary of Defense for Health Affairs Memorandum, "ASD(HA) Memorandum, "Clarification of the Requirement for Continuation of Semi-Annual Reporting of Results of Embedded Fragment Analyses," June 18, 2012<sup>1</sup>
- (f) Assistant Secretary of Defense for Health Affairs Memorandum, "Operation IRAQI FREEDOM/Operation NEW DAWN Depleted Uranium Bioassay Results - 16th Semi-Annual Report and Policy on Future Data Submissions," January 23, 2012<sup>2</sup>
- (g) Health Affairs Policy 07-029, Assistant Secretary of Defense for Health Affairs Memorandum, "Policy on Analysis of Metal Fragments Removed from Department of Defense Personnel," December 18, 2007<sup>3</sup>
- (h) Health Affairs Policy 04-004, Under Secretary of Defense (Personnel and Readiness) Memorandum, "Department of Defense Deployment Biomonitoring Policy and Approved Bioassays for Depleted Uranium and Lead," February 6, 2004<sup>4</sup>
- (i) Assistant Secretary of Defense for Health Affairs Policy Memorandum 03-012, "Policy for the Operation Iraqi Freedom Depleted Uranium (DU) Medical Management," May 30, 2003<sup>5</sup>
- (j) Office of the Chairman, Joint Chiefs of Staff Memorandum, "Procedures for Deployment Health Surveillance," Memorandum 0017-12, December 17, 2012
- (k) Assistant Secretary of Defense for Health Affairs Memorandum, "Guidance on Medications for Prophylaxis of Malaria," April 15, 2013<sup>6</sup>
- (l) Defense Health Agency Director Memorandum, "Standardized Process Guidance for Completing, Approving, and Posting Periodic Occupational and Environmental Monitoring Summaries," September 12, 2014 (cancelled)
- (m) United States Code, Title 32
- (n) DoD Directive 6200.04, "Force Health Protection (FHP)," October 9, 2004, as amended
- (o) DoD Directive-Type Memorandum 17-004, "Department of Defense Expeditionary Civilian Workforce," January 25, 2017, as amended
- (p) DoD Directive 1400.31, "DoD Civilian Work Force Contingency and Emergency Planning and Execution," April 28, 1995, as amended

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<sup>1</sup> Available on-line from the Health.mil website, from <https://health.mil/Reference-Center/Policies/2015/01/13/Embedded-Fragment-Analyses>

<sup>2</sup> Available on-line from the Health.mil website from <https://health.mil/Reference-Center/Policies/2012/01/23/Operation-IRAQI-FREEDOM-Operation-NEW-DAWN-Depleted-Uranium-Bioassay-Results---16th-Semi-Annual-Repo>

<sup>3</sup> Available on-line from the Health.mil website from <https://health.mil/Reference-Center/Policies/2007/12/18/Policy-on-Analysis-of-Metal-Fragments-Removed-from-Department-of-Defense-Personnel>

<sup>4</sup> Available on-line from the Health.mil website from <https://health.mil/Reference-Center/Policies/2004/02/06/Department-of-Defense-Deployment-Biomonitoring-Policy-and-Approved-Bioassays-for-Depleted-Uranium-an>

<sup>5</sup> Available on-line from the Health.mil website from <https://health.mil/Reference-Center/Policies/2003/05/30/Policy-for-the-Operation-Iraqi-Freedom-Depleted-Uranium--DU--Medical-Management>

<sup>6</sup> Available on-line from the Health.mil website from <https://health.mil/Reference-Center/Policies/2013/04/15/Guidance-on-Medications-for-Prophylaxis-of-Malaria>



- (q) DoD Directive 6490.02E, "Comprehensive Health Surveillance," February 8, 2012, as amended
- (r) Office of the Secretary of Defense memorandum, "Policy Guidance for Provision of Medical Care to Department of Defense Civilian Employees Injured or Wounded While Forward Deployed in Support of Hostilities," September 24, 2007
- (s) DoD Instruction 6490.07, "Deployment-Limiting Medical Conditions for Service Members and DoD Civilian Employees," February 5, 2010
- (t) DoD Instruction 3020.41, "Operational Contract Support (OCS)," December 20, 2011, as amended
- (u) Code of Federal Regulation, Title 48, Subparts 207.503, 252.225-7040
- (v) DoD Instruction 6055.05, "Occupational and Environmental Health (OEH)," November 11, 2008, as amended
- (w) DoD Instruction 4715.05, "Environmental Compliance at Installations Outside the United States," November 1, 2013, as amended
- (x) DoD Instruction 4715.06, "Environmental Compliance in the United States," May 4, 2015, as amended
- (y) DoD Directive 6400.04E, "DoD Veterinary Public and Animal Health Services," June 27, 2013, as amended
- (z) DHA-Procedural Instruction 6025.18, "Animal Access to Facilities," May 21, 2019
- (aa) DoD Instruction 6025.19, "Individual Medical Readiness (IMR)," June 9, 2014
- (ab) DoD Instruction 6200.06, "Periodic Health Assessment (PHA) Program," September 8, 2016
- (ac) DoD Directive 5124.02, "Under Secretary of Defense for Personnel and Readiness (USD(P&R))," June 23, 2008
- (ad) DoD Instruction 3001.02, "Personnel Accountability in Conjunction with Natural or Manmade Disasters," May 3, 2010
- (ae) DoD Directive 4715.1E, "Environment, Safety, and Occupational Health (ESOH)," March 19, 2005, as amended
- (af) DoD Instruction 6055.01, "DoD Safety and Occupational Health (SOH) Program," October 14, 2014, as amended
- (ag) "DoD Dictionary of Military and Associated Terms," current version
- (ah) DoD Instruction 6200.05, "Force Health Protection Quality Assurance (FHPQA) Program," June 16, 2016, as amended
- (ai) Defense Health Agency Procedural Instruction 6200.05, "Force Health Protection Quality Assurance (FHPQA) Program", May 2, 2018).
- (aj) DoD Instruction 6040.45, "DoD Health Record Life Cycle Management," November 16, 2015, as amended
- (ak) DoD Manual 5200.01, Volume 2, "DoD Information Security Program: "Marking of Classified Information", February 24, 2012, as amended
- (al) Joint Publication 4-02, "Joint Health Services," December 11, 2017, as amended
- (am) Joint Publication 5-0, "Joint Planning," June 16, 2017
- (an) NTRP 4-02.9/AFTTP 3-2.82\_IP /ATP 4-02.82, "Occupational and Environmental Health Site Assessment," April 2012
- (ao) Assistant Secretary of Defense for Health Affairs Memorandum, "Clinical Practice Guidance for Deployment-Limiting Mental Disorders and Psychotropic Medications," October 7, 2013

- (ap) DHA-Procedural Instruction 6200.02, "Comprehensive Contraceptive Counseling and Access to the Full Range of Methods of Contraception," May 13, 2019
- (aq) DoD Instruction 6205.02, "DoD Immunization Program," July 23, 2019
- (ar) DoD Instruction 6200.02, "Application of Food and Drug Administration (FDA) Rules to Department of Defense Force Health Protection Programs," February 27, 2008
- (as) Assistant Secretary of Defense for Health Affairs Memorandum, "Guidance Memorandum on use of Primaquine during Primaquine Shortages," August 2, 2012<sup>7</sup>
- (at) Assistant Secretary of Defense for Health Affairs Memorandum, "Guideline for Tuberculosis Screening and Testing," April 20, 2012<sup>8</sup>
- (au) DoD 6055.05-M, "Occupational Medical Examinations and Surveillance Manual," May 2, 2007, as amended
- (av) DoD Instruction 6055.12, "Hearing Conservation Program (HCP)," December 3, 2010, as amended
- (aw) Army Public Health Command Circular 40-1, "Worldwide Directory of Sanitarily Approved Food Establishments for Armed Forces Procurement," June 27, 2014, or current version<sup>9</sup>
- (ax) Military Standard 3041, Department of Defense Standard Practice "Requirements for Food and Water Risk Assessments (FWRA)," May 15, 2013
- (ay) Military Handbook 3041, Department of Defense Handbook "Guidelines for Conducting Food and Water Risk Assessments (FWRA)," May 15, 2013
- (az) Technical Bulletin Medical 530/NAVMED P-5010-1/AFMAN 48-147\_IP, "Tri-Service Food Code," March 1, 2019
- (ba) DoD Instruction 6025.18, "Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule Compliance in DoD Health Care Programs," March 19, 2019
- (bb) DoD Manual 6025.18, "Implementation of the Health Insurance Portability And Accountability Act (HIPAA) Privacy Rule in DoD Health Care Programs," March 13, 2019
- (bc) DoD Instruction 8580.02, "Security of Individually Identifiable Health Information in DoD Health Care Programs," August 12, 2015
- (bd) DoD Instruction 5230.29, "Security and Policy Review of DoD Information for Public Release," August 13, 2014, as amended
- (be) DoD Instruction 6490.13, "Comprehensive Policy on Traumatic Brain Injury-Related Neurocognitive Assessments by the Military Services," September 11, 2015, as amended
- (bf) DoD Instruction 5154.30, "Armed Forces Medical Examiner System (AFMES) Operations," December 29, 2015, as amended
- (bg) DoD Instruction 6480.04, "Armed Services Blood Program Operational Procedures," August 13, 2012, as amended
- (bh) DoD Instruction 6465.01, "Erythrocyte Glucose-6-Phosphate Dehydrogenase Deficiency (G6PD) and Sickle Cell Trait Screening Programs," July 17, 2015
- (bi) DoD Instruction 3000.12, "Management of U.S. Global Defense Posture (GDP)," May 6, 2016

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<sup>7</sup> Available on-line from the Health.mil website, from <https://health.mil/Reference-Center>

<sup>8</sup> Available on-line from the Health.mil website, from <https://health.mil/Reference-Center/Policies/2012/04/20/Guideline-for-Tuberculosis-Screening-and-Testing>

<sup>9</sup> Available on-line, from <https://phc.amedd.army.mil/topics/foodwater/ca/Pages/DoDApprovedFoodSources.aspx>

- (bj) DoD Directive 3000.10, "Contingency Basing Outside the United States," January 10, 2013, as amended
- (bk) Armed Forces Pest Management Board (AFPMB) Technical Guide No. 36, "Personal Protective Measures against Insects and Other Arthropods of Military Significance," September 2012, as amended
- (bl) DoD Instruction 4150.07, "DoD Pest Management Program," May 29, 2008, as amended
- (bm) Armed Forces Pest Management Board (AFPMB) Technical Guide No. 24, "Contingency Pest Management Guide," September 2012
- (bn) Armed Forces Pest Management Board (AFPMB) Technical Guide No. 3, "Feral Animal Risk Mitigation (FARM) in Operational Areas," January 2017
- (bo) Army Regulation 40-905/SECNAVINST 6401.1B/AFI 48-131, "Veterinary Health Services," August 29, 2006, effective September 29, 2006
- (bp) DoD Instruction 6495.02, "Sexual Assault Prevention and Response Office (SAPR) Program Procedures," March 28, 2013, as amended
- (bq) DoD Instruction 6490.05, "Maintenance of Psychological Health in Military Operations," November 22, 2011, as amended
- (br) Joint Theater Trauma System Clinical Practice Guidelines, "Clinical Practice Guidelines for Military Working Dogs," September 13, 2018,<sup>10</sup>
- (bs) Army Public Health Command Technical Guide 230, "Environmental Health Risk Assessment and Chemical Exposure Guidelines for Deployed Military Personnel," 2013
- (bt) Defense Health Agency Memorandum, "Armed Forces Reportable Medical Events Guidelines and Case Definitions," June 17, 2017<sup>11</sup>
- (bu) Armed Forces Health Surveillance Division (AFHSD) in collaboration with: U.S. Air Force School of Aerospace Medicine, Army Public Health Center, and Navy and Marine Corps Public Health Center, "Armed Forces Reportable Medical Events Guidelines and Case Definitions," July 17, 2017, or current version<sup>12</sup>
- (bv) DoD Instruction 6025.27, "Medical Ethics In the Military Health System," November 8, 2017
- (bw) Chairman Joint Chiefs of Staff Instruction 3150.25G, "Joint Lessons Learned Program," January 31, 2018
- (bx) DoD Instruction 1241.01, "Reserve Component (RC) Line of Duty Determination for Medical and Dental Treatments and Incapacitation Pay Entitlements," April 19, 2016
- (by) DoD Instruction 6040.46, "The Separation History and Physical Examination (SHPE) for the DoD Separation Health Assessment (SHA) Program," April 26, 2016
- (bz) United States Code, Title 5
- (ca) Code of Federal Regulations, Title 32
- (cb) USAPHC Technical Guide 317, "Technical Guide for Collection of Environmental Sample Data Related to Environmental Health Site Assessments for Military Deployments," February 2009<sup>13</sup>
- (cc) DoD Instruction 4715.19, "Use of Open-Air Burn Pits in Contingency Operations," November 13, 2018

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<sup>10</sup> Available on-line from [https://jts.amedd.army.mil/index.cfm/PL\\_CPGs/cpgs](https://jts.amedd.army.mil/index.cfm/PL_CPGs/cpgs)

<sup>11</sup> Available on-line from <https://health.mil/Reference-Center/Policies/2017/07/17/Revised-Armed-Forces-Reportable-Medical-Events-Guidelines-and-Case-Definitions>

<sup>12</sup> Available on-line from <https://health.mil/Reference-Center/Publications/2017/07/17/Armed-Forces-Reportable-Medical-Events-Guidelines>

<sup>13</sup> Available on-line from [https://iphc.amedd.army.mil/sites/EHE/EHRAD/ORAOEH/Visioning/DOEHS/Operations and Processes/TG 317 \(Technical Guide for Collection of Enviro Sampling Data Related to Enviro Health Site Assessments\).pdf](https://iphc.amedd.army.mil/sites/EHE/EHRAD/ORAOEH/Visioning/DOEHS/Operations%20and%20Processes/TG%20317%20(Technical%20Guide%20for%20Collection%20of%20Enviro%20Sampling%20Data%20Related%20to%20Enviro%20Health%20Site%20Assessments).pdf)

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- (ce) U.S. Army, “Uranium Aerosol Doses and Risks: Summary of U.S. Assessments,” October 2004
- (cf) John S. McCain National Defense Authorization Act for Fiscal Year 2019
- (cg) DoD Instruction 6490.11, “DoD Policy Guidance for Management of Mild Traumatic Brain Injury/Concussion in the Deployed Setting,” September 18, 2012, as amended
- (ch) DoD Instruction 6490.08, “Command Notification Requirements to Dispel Stigma in Providing Mental Health Care to Service Members,” August 17, 2011
- (ci) DoD Instruction 6055.07, “Mishap Notification, Investigation, Reporting, and Record Keeping,” June 6, 2011, as amended
- (cj) Army Regulation 40-562/BUMEDINST 6230.15/AFJI 48-110/CG COMDTINST M6230.4F, “Immunizations and Chemoprophylaxis,” current version
- (ck) Assistant Secretary of Defense for Health Affairs Memorandum, “Human Rabies Prevention During and After Deployment,” November 14, 2011

ENCLOSURE 2

RESPONSIBILITIES

1. DIRECTOR, DHA. Under the authority, direction, and control of the Under Secretary of Defense for Personnel and Readiness, through the Assistant Secretary of Defense for Health Affairs (ASD(HA)), the Director, DHA, will:

a. Recommend and advise on health-related policy, requirements development, and implementation of DoD issuances.

b. Publish standardized deployment health implementation procedures developed in collaboration with the other DoD Components in accordance with References (b) and (c).

c. Establish procedures for collecting deployment health performance measures, metrics, and goals for monitoring the effective implementation of this publication, and procedures, to monitor quality assurance (QA), in accordance with Reference (ah) in coordination with all DoD Components that deploy personnel.

d. Establish standardized deployment health surveillance data, information collection, documentation and reporting methods to facilitate deployment-related health risk management and longitudinal recordkeeping. Recordkeeping systems include, but are not limited to, the DOEHRS-IH, MESL (SIPR), Defense Medical Surveillance System (DMSS), and other systems that support deployment health surveillance such as the DoD Health Record, DoD Veterinary Health Record, and personnel record systems.

e. Coordinate with the Director, Defense Human Resources Activity, who establishes standardized procedures and systems to track the duty locations of Service members, DoD civilians, and DoD contractor personnel during deployment in accordance with References (c), (ac) and (ad). Ensure that associations can be made between health surveillance information and deployed forces by location and date/time in accordance with References (c), (ah) and (ai).

f. Develop implementing guidelines for existing and emerging technologies and programs that fully support the range of deployment health activities. These technologies and programs include validated deployment exposure biomarkers and individual dosimeters, the refinement of deployment-related health assessments to detect changes in health indicators, and the monitoring of other programs to assess the health and wellbeing of the deploying, deployed, and redeployed force. These technologies, such as new and emerging analytic methods, and these programs, such as an individual longitudinal exposure record and joint health risk management initiative, will share data and information with systems of record as appropriate (e.g., such as the DoD Electronic Health Record (EHR), DOEHRS-IH, MESL (SIPR), DMSS, Veterinary EHR, and personnel record systems as appropriate).

g. Support the development and fielding of biomonitoring and other health surveillance capabilities, such as individual dosimeters to assess individual exposures in order to support risk management (or operational risk management), health risk management and the joint health risk management initiative, medical surveillance, Force Health Protection (FHP), individual longitudinal exposure records, and the timely diagnosis and treatment of exposure-related conditions.

2. ASSISTANT DIRECTOR (AD), COMBAT SUPPORT (CS). Under the authority, direction, and control of the Director, DHA, the AD, CS will:

a. Provide strategic guidance, goals, and objectives for the development of deployment health policy and uniform implementation among the DoD Components.

b. Monitor the implementation of DoD deployment-related health assessments to ensure procedures are facilitated through the Deployment-Related Health Assessment Working Group and coordinated with the DoD Components, in accordance with Reference (c), and this DHA-PI.

3. CHIEF, PUBLIC HEALTH DIRECTORATE (PHD). Under the authority and direction of the AD, CS the Chief, PHD will:

a. Recommend changes to deployment health policy and requirements to the Deputy Assistant Secretary of Defense for Health Readiness Policy and Oversight.

b. Develop procedures for deployment health activities in collaboration with the DoD Components.

c. Direct and oversee the Deployment-Related Health Assessment Working Group to provide subject matter expertise regarding policy and its uniform implementation among the DoD Components.

d. Manage the Food and Water Risk Assessment (FWRA) Program in accordance with Reference (y) and, in collaboration with the DoD Components, develop the associated publications.

e. Prepare requested reports to the AD, CS and establish regular feedback processes with the DoD Components.

4. DoD COMPONENT HEADS AND COMMANDANT, U.S. COAST GUARD. The DoD Component Heads and the Commandant, U.S. Coast Guard, will:

a. Coordinate with the ASD(HA) and Director, DHA, in promulgating deployment health DHA publications and will identify a primary action officer to serve as the point of contact for such coordination.

b. Appoint members or representatives to DHA committees and work groups, as appropriate, and provide subject matter expertise in Component-specific aspects of deployment health to the Chief, PHD, through the Director, DHA.

5. DIRECTOR, DEFENSE MANPOWER DATA CENTER (DMDC). The Director, DMDC will identify a primary action officer to serve as the point of contact for coordination of individual deployment health location information with the Office of the ASD(HA) and DHA.

ENCLOSURE 3

PROCEDURES

1. DEPLOYMENT HEALTH PROCEDURES OVERVIEW. Adequate measures to provide the necessary level of health protection for deployed personnel will be implemented. The procedures contained in this DHA-PI pertain to actions to be taken pre-deployment, during deployment, and post-deployment. For purposes of this publication, deployment is not limited to contingency deployments, and is defined in Reference (ag).

a. Deployment health procedures apply to the DoD Components, as specified in the Applicability statement.

b. Specified minimum health activities apply to all deployments. Additional health activities for deployments of 30 days or less outside the United States or for operations of any duration within the United States are based on health risk (see Appendix 1), and the decisions of the combatant commander (CCDR), Service component commander, or commander exercising operational control. For deployments of greater than 30 days outside the United States, all deployment health activities apply.

c. Medical resources required for health risk assessments and other deployment health activities during all phases of the deployment should be identified during the planning process. These resources and activities should be included in operational staffing requirements and communicated to the supporting DoD Components.

d. Commanders ensure health risks are included in the overall operational risk summary evaluation, risk management decisions are documented, and this information is communicated to subordinate units for inclusion into their unit-level planning.

e. The risk management process will be institutionalized and be an inherent part of all deployment health activities (before, during, and after deployment) to address health threats in deployed environments. Health risk management anticipates, identifies, and assesses health threats; develops controls and countermeasures; makes risk management decisions; and implements controls to mitigate health threats.

f. Health risk assessments inform health risk management. Deployment health risk assessments will be conducted as part of risk management during all phases of deployment.

g. Health risk assessments use information from OEH risk assessment sources such as the Preliminary Hazard Assessment (PLHA) or Occupational and Environmental Health Site Assessment (OEHSA) or, industrial hazard assessments, environmental baseline surveys, plus medical surveillance and other health surveillance findings, FWRAs, medical intelligence products, after action reports (AARs), lessons learned, and other available data for the deployment area.



h. Health risk communication plans shall be developed, implemented, and updated as part of the health risk assessment and risk management process before, during, and after deployments. Deployment health threats and countermeasures briefings will be disseminated to deployers before, during, and after deployment.

i. Deployment-related health assessments are conducted, when required, at specific intervals throughout the deployment cycle. This includes the DD Form 2795, Pre-Deployment Health Assessment), DD Form 2796, Post-Deployment Health Assessment, DD Form 2900, Post-Deployment Health Re-Assessment, and DD Form 2978, Deployment Mental Health Assessment. These assessments may be combined, conducted concurrently, or completed as part of the Annual Periodic Health Assessment when established requirements are met (see Appendix 5).

j. Medical evaluations and any biomonitoring, personal dosimetry, or other measures of individual exposure are documented in the individual's DoD Health Record using the designated DoD EHR and other specified systems in accordance with Reference (aj).

k. Data and information from occupational and environmental health surveillance (OEHS) and Incident Reports (OEHS or CBRN incidents) are recorded in DOEHRS-IH in addition to any DoD Component-specific data collection system. Any classified OEHS and Incident Reports, are recorded in the classified MESL (SIPR) in addition to any DoD Component-specific classified data collection system in accordance with Reference (ak). To ensure appropriate classification and declassification, classified information will include reference to the applicable security classification guidance (or other guidance issued by the original classification authority) and/or original classification authority.

l. Medical surveillance data and information, such as reportable medical events (RMEs) and deployment-related health assessments, are documented in the individual's DoD Health Record and submitted separately to DMSS in addition to any DoD Component-specific data collection system. Population-level data and health surveillance summaries, such as periodic occupational and environmental monitoring summaries (POEMS), should not be included in the individual's DoD Health Record.

m. The same deployment medical and dental screenings required for Active Component (AC) members are required for RC members.

n. Individual deployment locations are recorded at least daily in the system of record specified by the DoD Component and submitted to DMDC.

o. The Military Services train, equip, and provide health services support to conduct and apply the full range of deployment health activities including OEHS, POEMS, health risk assessments, QA, retrospective analysis, and other health surveillance activities in accordance with this DHA-PI, and References (c), (j), (q), (ah), and (ai), using the Department of Defense Health Record, Disease Reporting System internet (DRSi) to transmit to the DMSS, DOEHRS-IH, and MESL (SIPR) as well as DoD Component or command-designated systems.

p. Procedures include line and medical coordination that ensure health risk assessments and risk management decisions are available, applied, documented, and periodically reevaluated.

2. PRE-DEPLOYMENT. Pre-deployment health activities (see Table 1), are based on DoD policies, DoD Component policies and the decision of the commander exercising operational control, informed by the health risk assessments for the area of operations and for the specific deployment location.

a. Minimum pre-deployment health activities, required for all deployments, include:

(1) Health Risk Management (see Appendix 1). Incorporate deployment health resourcing and activities into contingency and crisis action plans, as well as medical plans, consistent with references (c), (al), and (am).

(2) Health Resourcing. During the planning process, the CCMD and supporting commanders will ensure the capability to conduct the deployment health activities indicated by the health risk assessment, PLHA and, when available, OEHSAs.

(3) Medical Planning. CCMDs and deployed commanders incorporate OEH risk management and health surveillance requirements into Annex Q (Medical) of plans.

(4) Intelligence Planning. Health hazards should also be integrated into Annex B (Intelligence) of plans as appropriate.

(5) Communication of CCMD Deployment Health Requirements. The CCMD communicates theater and location-specific deployment health requirements to supporting DoD Components and supporting commanders prior to deployment.

(6) PLHA. PLHAs identify and, when feasible, quantify OEH threats for planning purposes, informing the scope of deployment health activities and health risk management. Conduct the PLHA prior to each deployment, consistent with Reference (an), as described in Appendix 2 of this publication.

(7) Identify and Prepare Deploying Individuals. Each DoD Component that deploys personnel ensures their deploying personnel are identified and medically ready, in accordance with References (c), (o), (s), (t), (aa), (ao) and this DHA-PI. Ensure contractors identify and provide contractor personnel who are medically, dentally, and psychologically fit, and if applicable, professionally tested and certified for deployment in accordance with References (t) and (u) and applicable contracts.

(a) Verify Service members' IMR status in the Service's electronic tracking system for IMR requirements according to Reference (aa).

(b) Ensure members of the Armed Forces have access to comprehensive counseling on the full range of methods for contraception, pregnancy prevention and menstrual suppression, pursuant to Reference (ap), including the interaction between anticipated deployment conditions and methods of contraception.

(c) Address deployment-specific immunizations, prophylaxis, Force Health Protection Prescription Products (FHPPPs) and other medical countermeasures. These measures are based on the deployment health risk assessment and occupation of the deployer, consistent with References (k), (n), (v), (aq), and applicable CCMD or Service policies. For DoD FHP investigational product use, see Reference (ar).

1. When prophylaxis, other medical countermeasures, or protective measures are required and issued, recipients must be trained on their use.

2. Health care provider questions about immunization administration, training, practice, and adverse events can be answered by DHA Immunization Healthcare Division at: <https://health.mil/vaccines> or 1-877-GET-VACC (1-877-438-8222) or DSN 761-4245.

3. Health care providers will record medication or immunization adverse events in the individual's health record.

4. Provide Service members with medications and other prescription products (other than FHPPP) for the duration of the deployment (minimum 90-day supply for deployments >30 days outside the United States) unless otherwise directed by the CCMD, Service guidance, or Reference (ap).

5. Deploying DoD civilian employees will obtain prescription products other than FHPPP from their own health care provider.

6. Prescription products for deploying contract personnel are the responsibility of the contractor, except that the government will provide theater-specific immunizations and medications not available to the general public in accordance with Subparts 207.503, 252.225-7040 of Reference (u). However, deployment health threats and countermeasures briefings will be provided to communicate health risks and countermeasures in the designated operational area.

7. Malaria Prevention. Follow CCMD guidance, References (k) and (as), and see Appendix 3 for additional information.

8. All indicated FHPPPs, (e.g., medications, immunizations), will be provided or issued under prescription by qualified personnel who have been instructed on the exclusion criteria (e.g., contraindications or those who are not required to take the medication for medical reasons) and other medical guidance applicable to the products.

9. Prescribers will consider the categories of Service members and other individuals who are required and/or eligible to receive a FHPPP and consider exclusion criteria

for identifying individuals who, for medical reasons (contraindications), are not required and/or eligible to receive a FHPPP.

10. FHPPP prescriptions will describe: Appropriate dosing information, including start and stop dates; any applicable storage, shipment, and maintenance requirements; and any other appropriate requirements or guidance pertaining to proper use and precautions.

11. FHPPP-specific medical screening and appropriate training and education will be performed and documented.

12. The provision or administration of FHPPP will be documented in health records of the individuals receiving the FHPPP.

(e) Pre-Deployment Tuberculosis Screening. Consider targeted tuberculosis screening for any deployment, based on the potential of an individual's high-risk exposure to tuberculosis and consistent with applicable CCMD or Service policy. In accordance with Reference (at), individuals at high risk for tuberculosis exposure (in the past or during deployment) are candidates for tuberculin testing, unless there is written documentation of a previous significant reaction to the tuberculin skin test or Food and Drug Administration (FDA)-approved tuberculosis blood test. Active tuberculosis is a deployment-limiting medical condition (Reference (l)).

(f) Health care providers will record adverse events in health records and report serious adverse events associated with FHPPP and DoD FHP investigational products as follows:

1. FDA MedWatch is used to report serious adverse events (<https://www.fda.gov/Safety/MedWatch/default.htm>).

2. The Vaccine Adverse Event Reporting System is used to report adverse events after a vaccination (<https://health.mil/Military-Health-Topics/Health-Readiness/Immunization-Healthcare/Vaccine-Safety-Adverse-Events/Reporting-Vaccine-Health-Problems/VAERS-Information> and <https://vaers.hhs.gov/index.html>).

(8) Personal Protective Equipment (PPE) and Monitoring Devices. PPE may include but is not limited to, hearing protection, ballistic eye protection, body armor, foot protection, respiratory protection, gloves, or other protective devices to prevent injury. Monitoring devices include dosimeters appropriate for occupational and/or environmental health hazards (e.g., radiation dosimeter).

(a) Ensure provision of PPE, other protective measures, and monitoring devices appropriate for occupational and/or environmental health hazards, with instructions on their use during deployment.

(b) Issue PPE and/or monitoring devices as required by occupational specialty and as indicated by threat to deploying personnel in accordance with References (v) and (af).

(c) When applicable, conduct fit-testing, medical qualifications and spirometry (pulmonary function testing), in accordance with References (c), (au), (av), and DoD Component-specific publications.

(d) Include training on occupational and environmental hazards associated with the deployed environment including hazardous noise per Reference (av), and Service-specific publications.

(9) Biomonitoring. The need for biomonitoring and/or embedded fragment analysis will be based on the deployment health threats, possible exposures, and approved, available bioassays as described at Appendix 4 and References (e) through (i). Routine occupational health biomonitoring, associated with certain occupational medical examinations and surveillance, is conducted in accordance with References (v) and (au).

(10) Occupational Surveillance Examinations. Ensure baseline and periodic occupational medical examinations are conducted based on occupation and possible exposures to health hazards in accordance with References (v), (au), and (av).

(11) Health Threat and Countermeasures Briefing. Health threat and countermeasures briefings are conducted whenever health hazards are identified and/or protective measures (e.g., medical countermeasures, FHPPP, PPE) are required. Medical personnel, with assistance of preventive medicine (PVNTMED) or OEH personnel, use the PLHA and other relevant information to develop comprehensive pre-deployment health threat briefings and health risk communication messages and materials.

(12) Food Protection. Identify and procure DoD-approved sources of food and water and implement food protection in accordance with Reference (y).

(a) Procure and use food sources listed in Reference (aw) or ensure the requirement for an FWRA is included in all contracts according to references (ax) and (ay), and/or use U.S. field rations and combat rations.

1. Procurement agencies will include the requirements to use sanitarily approved sources or the completion of a FWRA in all contracts.

2. When a FWRA is rated with a high or extremely high residual risk, the procurement official must receive a copy of the DD Form 2977, Deliberate Risk Assessment Worksheet, signed by the mission or higher-level Commander, prior to contract award.

(b) Request a veterinary food protection audit, which is used to approve a food or bottled water plant for listing in Reference (aw), when a potential new food source is identified.

(c) The FWRA is a requirement in the absence of food from DoD approved sources, field rations or combat rations. The CCDR or operational commander will request a FWRA, in accordance with References (y) and (ax) through (az), to identify risks inherent to food from non-approved sources and inform the commander's risk management. The FWRA does not

replace the veterinary food protection audit process for long-term procurement of food or bottled water from approved sources; however, FWRAs may be authorized for temporary food service facilities or eateries (e.g., initial entry, early phase of deployment) and are valid for the duration of the deployment or exercise but not to exceed 6 months, until approved sources are identified and procured.

(13) Privacy and Information Protection. OEH surveillance and medical surveillance information will be protected as required by References (ak), and (ba) through (bc).

b. The following additional pre-deployment health activities are required for deployments of greater than 30 days outside the United States. For deployments of 30 days or less outside the United States and operations of any duration within the United States, additional health activities are based on health risk and the decisions of the CCDR, Service component commander, or commander exercising operational control.

(1) Identify and address deployment-limiting medical conditions, including mental disorders and psychotropic medications, and process any waiver requests, in accordance with References (s) and (ao) and guidance of the applicable CCMD or other DoD Component.

(2) Pre-Deployment Health Assessment. DoD components ensure their personnel complete the DD Form 2795 within 120 days before the estimated deployment date (see Appendix 5).

(3) Neurocognitive Assessment. A neurocognitive assessment will be completed within 12 months prior to deployment, in accordance with Reference (be).

(4) Pre-Deployment Serum Specimen. Pre-deployment serum specimens must be collected within 1 year of deployment. However, the most recent serum sample in the DoD Serum Repository, including a post-deployment serum sample or Human Immunodeficiency Virus (HIV) sample, may serve as a pre-deployment serum sample if it was collected within 365 days of the upcoming deployment date. Serum samples will be forwarded to the DoD Serum Repository (Reference (q)) according to DoD Component policies. Individuals must be informed if their pre-deployment serum sample will be tested for HIV.

(5) HIV Testing. Pre-deployment HIV tests must be performed within 24 months of deployment in accordance with Reference (aa) for Service members, and in accordance with country entry requirements and CCMD policy for all deployers. HIV serum samples that are not more than 12 months old and are stored in the DoD Serum Repository satisfy the pre-deployment specimen requirement. The gaining CCMD will be consulted in all cases of HIV seropositivity pre-deployment, in accordance with Reference (s).

(6) Conduct and document pulmonary function testing on deploying Service members and DoD civilians who have known pre-existing pulmonary conditions and disease, but are medically ready to deploy and cleared pursuant to References (c), (s), (aa), and (ab). Documentation of a previous pulmonary function test satisfies this pre-deployment requirement.

(7) Deoxyribonucleic Acid Sample. Ensure a deoxyribonucleic acid sample is collected and on file in the Armed Forces Medical Examiner System – Armed Forces Repository of Specimen Samples for the Identification of Remains (AFMES-AFRSSIR) in accordance with References (t), (aa), and (bf).

(8) Deployment Health Record. The DD Form 2766, Adult Preventive and Chronic Care Flowsheet, for each deploying individual must reflect:

(a) Allergies;

(b) Blood type/rhesus factor (Reference (bg));

(c) Prescribed medical products, including FHPPPs and corrective lens prescription;

(d) Immunizations and Tuberculosis Screening. All immunizations and tuberculosis screenings, recorded in the Service's electronic immunization tracking database and the patient deployment health record (this may be accomplished using a computer-generated record), in accordance with Reference (aq), including: type of immunization, date administered, dose, lot number, and vaccine administrator identifying information such as their initials;

(e) Pre-Deployment Health Assessment. Completed DD Form 2795 in accordance with Reference (s);

(f) Medical Summary. A medical summary sheet identifying past and current medical conditions and screening tests (e.g., deployment-limiting medical conditions in accordance with Reference (s)), erythrocyte glucose-6-phosphate dehydrogenase (G6PD) deficiency screening in accordance with Reference (bh));

(9) Health Risk Communication. Health risk communication plans are developed and implemented to provide commanders and personnel with appropriate health risk communications (written and oral), for health threats and countermeasures before, during, and after deployment (see Appendix 1);

(10) Health Surveillance and Deployment Health Surveillance Plan

(a) The CCMD and supporting Service(s) identify the process and the resources needed for the regular collection, analysis, archiving, interpretation, and distribution of health-related data used to monitor the health of a deployed population, and to intervene in a timely manner to prevent, treat, or control the occurrence of disease or injury;

(b) Health surveillance and deployment health surveillance plans encompass medical surveillance, OEH surveillance, disease and injury occurrences and rates, biomonitoring (when applicable), reportable medical events and tracking reports of animal bites or other potential exposure to rabies (Reference (c)).

(c) When OEH hazards include CBRN threats, supporting Service PVNTMED and public health personnel must coordinate with CBRN defense personnel to include CBRN surveillance as well as OEHS in the deployment health surveillance plan. A deployment OEHS sampling plan is established for each site to be assessed, typically by supporting Service PVNTMED and public health personnel (see Appendix 2).

3. DURING DEPLOYMENT. During deployment health activities (see Table 2), are based on DoD policies, DoD Component policies, and the decision of the commander exercising operational control, informed by the health risk assessments for the area of operations and for the specific deployment location. The deployment phase begins when the first Service members and/or DoD civilians arrive into the deployment area.

a. Minimum deployment health activities required during all deployments include:

(1) Deployment Health Support. The lead Service for a deployment location or operational location ensures the provision of health support during deployment pursuant to References (c), (al), (bi) and (bj). The lead Service conducts QA and comprehensive retrospective analyses of deployment health data and information collected.

(2) Disease and Injury Prevention. Line and medical leaders at all levels facilitate unit and individual understanding of disease and injury prevention and the use of required, applicable, deployment health risk mitigation approaches, such as the following:

- (a) Field sanitation and hygiene practices;
- (b) Food protection;
- (c) Medical countermeasures and FHPPP use;
- (d) Arthropod repellent use (Reference (bk));
- (e) Hazardous plants and animals;
- (f) PPE care and use; and
- (g) Seeking prompt medical care for illness or injury, including animal bites.

(3) Health Surveillance. Conduct health surveillance that encompasses OEHS and medical surveillance. Use findings to inform health risk assessments and health risk management, including health risk communication plans, and future health surveillance activities.

(4) OEH Surveillance and Recordkeeping (see Appendices 2, 6, and 7).



(a) Results of environmental and OEH monitoring and sampling, including raw OEH data (such as air, water, soil, toxic industrial chemicals and materials), associated with industrial hygiene surveys and Incident Reports;

(b) OEHS data and information, exposure-related data and information, CBRN monitoring information, and Incident Reports;

(c) Quantitative and qualitative OEHS data and information includes, but is not limited to: laboratory data, field test data, surveys, Incident Reports, delineation of exposure pathways, OEHSA and POEMS.

(5) Deployment OEH or CBRN Exposure Incidents. Commanders must ensure consultation with subject matter experts occurs to facilitate a timely assessment, mitigation, and response in terms of OEH or CBRN monitoring, medical surveillance and medical follow-up.

(a) Medical or PVNTMED and public health personnel consult with line assets and complete Incident Reports (see Appendix 7).

(b) Include individual exposure data in the individual's health record (e.g., personal dosimetry), but summaries of OEH monitoring or environmental conditions (e.g., POEMS) are not specific to any individual, so are not appropriate for inclusion in health records.

(6) Biomonitoring. Conduct deployment biomonitoring when indicated for instances of depleted uranium (DU) exposure and for embedded metal fragments, as described in Appendix 4. (Routine occupational medical surveillance exam biomonitoring is conducted in accordance with References (v) and (au)).

(7) Food Protection. Food protection activities, in accordance with References (y), and (aw) through (az), contribute to health risk assessment and risk management and are included in the deployment health surveillance plan. Examples include food service facility inspections or evaluations of U.S. dining operations or mobile containerized kitchens, food protection audits and FWRA. When augmentee personnel are requested to provide food protection support to mitigate foodborne risks during deployment operations or exercises, funding is the responsibility of the CCMD or operational commander.

(8) Pest Management. Pest management operations are planned and conducted according to the integrated pest management program described in Reference (bl), and current Armed Forces Pest Management Board (AFPMB) publications, including References (bm) and (bn). The Army Public Health Center (APHC) provides the support to permanently archive the Military Services' deployment pesticide application records on DD Form 1532, Pest Management Report, or computer-generated equivalent (DD Form 1532-1, available from <https://www.acq.osd.mil/eie/afpmb/>) using DOEHRS-IH and, for any classified information, the MESL (SIPR). Individual application of arthropod repellents to skin and clothing (Reference (bk)) is not recorded.

(a) The lead Service for each deployment location reviews and approves Integrated

Pest Management Plans and Pest Management Maintenance Records, and ensures they are archived appropriately.

(b) After QA review, the lead Service submits pesticide application data to the APHC using the on-line AFPMB guidance. This process will archive the Military Services' deployment pesticide application records using DOEHRS-IH (or, when indicated by the original classification authority, the MESL (SIPR)).

(9) Feral Animal Risk Mitigation and Rabies Control. Feral animal risk mitigation is planned and conducted in accordance with Reference (bn), and in coordination with pest management operations (Reference (bl), rabies control (Reference (bo)) and rabies prevention activities. Animal bites and other potential rabies exposures are reportable to the deployed medical facility during all deployments.

(10) Individual Deployment Location Tracking. Individual location information, reflecting daily locations of each deployed Service member and DoD civilian, will be submitted and archived during all deployments, including shipboard operations that are not anticipated to involve operations ashore (see Appendix 8).

(11) Contraception Counseling. Ensure members of the Armed Forces have access to comprehensive counseling from health care providers on the full range of methods of contraception for pregnancy prevention and menstrual suppression pursuant to Reference (ap), including the interaction between anticipated deployment conditions and various methods of contraception.

(12) Sexual Assault Prevention and Response. Ensure sexual assault complaints are addressed in accordance with Reference (bp).

(13) Psychological Health. Implement combat and operational stress control programs in accordance with Reference (bq). Information about each Military Service's approach to combat and operational stress control is available through the Psychological Health Center of Excellence (<https://www.pdhealth.mil/>).

(14) Health Recordkeeping. Document medical encounters and treatment provided at all levels of care in the DoD health record in accordance with Reference (aj). If neither the DoD health record nor deployment health record is available, use the SF Form 600, Chronological Record of Medical Care or equivalent electronic format, incorporating the document into the DoD health record when it becomes available.

(a) Document all inpatient and original outpatient medical encounter documentation, including records of medical encounters provided to deployed personnel by allies and coalition partners.

(b) Record medical encounters related to OEH and CBRN exposures, in the individual health records, on a SF 600 or equivalent electronic format.

(c) Assessment and treatment of animal bites and other potential rabies exposures is documented in the DoD Health Record using DD Form 2341, Report of Animal Bite – Potential Rabies Exposure (see Appendix 9). Allied operations may require additional documentation of rabies prevention.

(15) Ensure clinical care provided by health care providers to military working animals is conducted according to Reference (br) and documented for inclusion in the DoD veterinary health record, Veterinary Services Systems Management (VSSM).

b. The following additional deployment health activities are required during deployments of greater than 30 days outside the United States. For deployments of 30 days or less outside the United States and operations of any duration within the United States, additional health activities are based on health risk and the decisions of the CCDR, Service component commander, or commander exercising operational control.

(1) Health Risk Assessment Validation. Based on the PLHA and (when available) OEHS, the CCMD and Service component commanders will ensure the capability to conduct the deployment health activities addressed in this DHA-PI and the deployment health surveillance plan. Health risk assessments should be reviewed and updated throughout the deployment using OEHS findings and other health surveillance data collected in theater.

(a) Newly identified or newly eliminated health hazards should be communicated, as indicated, to relevant organizations, including the Defense Intelligence Agency through the National Center for Medical Intelligence (NCMI), Joint Task Forces (JTFs), CCDRs, Services, and their public health centers.

(b) Ensure newly identified in-theater health hazards are assessed and incorporated into the commander's risk management and risk communication.

(2) Health Risk Communication. Health risk communication plans provide commanders and deployed personnel with timely, appropriate health risk communications (written and oral), for the deployment health threats and countermeasures and the need for medical screening or another medical follow-up. During deployment and post-deployment, provide updated health threats and countermeasures briefings and health risk communications as indicated by deployment health surveillance findings (see Appendix 1).

(3) Health Surveillance. Review information from OEH surveillance activities (including OEH and CBRN sampling and monitoring, incident reports, and the findings from food protection activities) and medical surveillance data (see Appendix 9), to detect health threats or exposures and trends of concern.

(a) OEHS. PLHA, OEHS, POEMS, Incident Reports and other OEHS findings will be completed and archived to compile longitudinal OEH information for deployment locations (See Appendices 2, 6, and 7). PVNTMED staff should identify similar exposure groups, with documentation of the types, concentrations, amounts, application methods, dates

and times, locations, and identify the personnel potentially exposed to the hazardous substances in accordance with References (v), (au), and (bs).

(b) Medical Surveillance. Disease and Injury (D&I) and Reportable Medical Events (RME).

1. Ensure sharing of D&I data among safety, occupational health, and health care providers to identify and mitigate unsafe or unhealthy conditions.

2. At unit level, review D&I rates daily to detect potential adverse health trends or exposures, assess countermeasure effectiveness, and recommend enhanced preventive measures (see Appendix 9).

3. RMEs. Report suspected and confirmed Armed Forces RMEs to DMSS via the designated electronic data collection and transmission devices, as described in Appendix 9. RMEs include items listed in the Armed Forces RME List, (References (bt) and (bu)), plus any additional items designated by the CCMD or JTF Surgeon.

4. POST-DEPLOYMENT. Post-deployment health activities (Table 3), are based on DoD policy, DoD component policies, and the decision of the commander exercising operational control, informed by the health risk assessments for the area of operations and for the specific deployment location.

a. Minimum post-deployment health activities required after all deployments include:

(1) Post-Deployment Health Threats and Countermeasures Briefings and Risk Communications. Medical personnel, with assistance of PVNTMED or OEH personnel, provide a health risk communication briefing to DoD personnel during in-theater medical out-processing or upon return to home station. Post-deployment health briefings inform personnel of deployment occupational, environmental, or CBRN health risks and exposures that they may have experienced; address individual concerns and provide information about required medical screening or chemoprophylaxis (e.g., anti-malarial medication); facilitate timely medical surveillance (e.g., biomonitoring), and medical follow-up; and help personnel reintegrate and adjust back to routine activities following a deployment.

(2) Health Care Ethics. For health care providers returning from deployment, a health care ethics debrief, and support are required in accordance with Reference (bv).

(3) AAR and Lessons Learned. Submit all AAR and lessons learned reports within 30 days after deployment. Units responsible for deployment health surveillance-related AAR and lessons learned are typically PVNTMED, bioenvironmental engineering, veterinary, and/or environmental health units but may include line (non-medical) units.

(a) Health surveillance-related AAR and lessons learned will be developed and recorded in the Joint Lessons Learned Information System, at: <https://www.jllis.mil/apps/>, consistent with Reference (bw), and any applicable component-directed processes and systems.

(b) FWRA AARs will be recorded in the Veterinary Service Information Management System (VSIMS).

(4) Medical Surveillance. Commanders and supervisors of returning deployers coordinate with supported CCMDs and supporting military medical treatment facilities (MTFs), in accordance with Reference (c), to ensure medical surveillance and medical follow-up is conducted to detect and address emerging (acute, chronic or latent) health conditions.

(a) Submit medical surveillance data and reports, including disease outbreak reports, collected during any deployment to the appropriate systems of record within 30 days of collection or completion (e.g., DRSi and/or DMSS).

(b) Conduct QA and comprehensive retrospective analyses of deployment medical surveillance data and information in the DoD Health Record and/or deployment health record, DRSi and DMSS.

(c) Implement (or continue) biomonitoring procedures as indicated by military-unique or combat-related exposures during deployment or as indicated by occupation (see Appendix 4).

(5) Health Recordkeeping. Incorporate the following into each individual's permanent DoD Health Record, consistent with Reference (aj), within 30 days of personnel returning to a demobilization site or home station:

(a) Deployment health record, documentation of theater inpatient and outpatient health care encounters and copies of applicable health assessments.

(b) Individual exposure records. Include biomonitoring data or other individual records of environmental, occupational or CBRN exposure incident in the individual's health record (e.g., personal dosimetry, DU biomonitoring), but summaries of OEH monitoring or environmental conditions are not specific to any individual, so are not appropriate for inclusion in health records.

(c) Return paper (hard copy) medical, dental, or mental health records to the home station medical record custodian, pursuant to Reference (aj).

(6) Medical Evaluations and Referrals. Each individual with health concerns or indicated medical referrals shall meet with a health care provider for evaluation of deployment-related health issues. This evaluation should be conducted by the individual's primary care manager or other authorized provider using DoD/VA clinical practice guidelines (<http://www.healthquality.va.gov/>). Deployment-related health concerns and referrals will be documented in the DoD EHR using applicable International Classification of Diseases (ICD)

codes, with appropriate secondary ICD-10 code(s) to help further define the primary code used in cases of exposure, suspected exposure or contact with a health hazard, and injuries. During medical evaluations, medical referrals and other resources to help resolve any post-deployment health issues will be discussed and applied, as appropriate for the individual. Additional guidance specific to members of the RC and DoD civilian employees are as follows:

(a) RC Members

1. Health status will be documented in the DoD health record prior to release from active duty.

2. RC members who require medical or dental evaluation or treatment upon returning from a deployment may, with the member's consent, be retained on active duty in accordance with Reference (bx), until line of duty (LOD) conditions are resolved or found fit for duty, separated or retired through the Disability Evaluation System.

3. Formal LOD determinations must be completed for all deployment-related medical concerns or conditions identified in RC members prior to release from active duty. If a RC member elects release from active duty before resolution of an established LOD condition(s) or completion of the Disability Evaluation System, a LOD determination will be completed to document the entitlement to medical and dental treatment, in accordance with Reference (bx), before release from active duty.

4. Specified RC members are required to complete a Separation Health and Physical Exam in accordance with Reference (by), prior to the release from active duty.

5. RC members will be informed how to arrange the appointments required to complete referrals.

6. RC members will receive and retain copies of any documentation of deployment health care encounters and health assessments filed in their permanent health record.

(b) DoD Civilians

1. DoD civilians who experienced an injury, disability or illness that was contracted in the performance of duty in a war-risk hazard assignment will be referred by their supervisory chain or human resources office to the Post-Combat Case Coordinator and/or Injury Compensation Program Specialist.

2. Follow-up of DoD civilian employees for deployment-related exposures, injury, disability or illness will be coordinated with their supervisory chain or human resources office and consistent with the Federal Employees' Compensation Act provisions of sections 8101 through 8173 of Reference (bz), the requirement to assign a post-combat case coordinator as defined in section 7906 of Reference (bz), availability to receive medical care in a military

MTF as authorized by Section 108.4 of Reference (ca), and other deployment provisions in accordance with References (o) and (r).

(7) Post-Deployment Tuberculosis Screening. Consider targeted tuberculosis screening for any deployment based on the potential of an individual's high-risk exposure to tuberculosis or per CCMD or other applicable Component policy. In accordance with Reference (at), recent deployers at high risk for tuberculosis exposure during deployment are candidates for post-deployment tuberculin testing, unless there is written documentation of a previous significant reaction to the tuberculin skin test or FDA-approved tuberculosis blood test.

(8) OEH and Food Protection Activities

(a) Record remaining OEHS data or reports and food protection information to maintain accessibility to follow-on elements using DOEHRS-IH, MESL (SIPR) or VSIMS, as appropriate.

(b) Conduct QA and comprehensive retrospective analyses of deployment health surveillance data and information in accordance with Service guidance and Reference (c). Analyze OEH information in DOEHRS-IH, MESL (SIPR), and VSIMS for potential medical follow-up and to inform lessons learned and future operational reports.

(c) Record OEHS-related AAR and lessons learned.

(d) Record the following baseline OEH assessments with accompanying data and information:

1. PLHA, initial OEHSA and, if required by the CCMD or Service, OEH intelligence preparation of the battlefield assessments (see Appendices 2 and 6).

2. Any OEHS monitoring and surveillance records not previously recorded (see Appendices 2, 6, and 7).

(e) Record Veterinary Service food and bottled water food protection audit reports, not recorded previously, in the VSIMS application.

(f) Record FWRA checklist-reports and AARs in the FWRA Application in VSIMS.

(g) Record completed Incident Reports (OEH or CBRN incidents), including personnel rosters, in DOEHRS-IH, as described at Appendices 6 and 7.

(h) Record any remaining OEH monitoring and food protection data or reports, including sampling results (e.g., air, water, soil, and noise), vector surveillance, general sanitation, toxic industrial chemicals or materials that were not submitted previously to DOEHRS-IH or VSIMS, as appropriate, within 30 days of collection or completion.

(i) Annotation of classified OEH monitoring information, if any, is recorded in the MESL (SIPR) as described at Appendix 6.

b. The following additional post-deployment health activities are required for deployments of greater than 30 days outside the United States. For deployments of 30 days or less outside the United States and military operations of any duration within the United States, additional health activities are based on health risk and the decisions of the CCDR, Service component commander, or commander exercising operational control.

(1) Post-Deployment Health Assessments and Mental Health Assessments. These assessments must be completed, as described in Appendix 5, at specified timeframes.

(a) Post-Deployment Health Assessment. Supporting DoD Components ensure that the DD Form 2796 is completed within 30 days before or after return from deployment.

(b) Post-Deployment Health Re-Assessment. Supporting DoD Components will ensure that the DD Form 2900 is completed within 90 and 180 days after return from deployment.

(c) Deployment Mental Health Assessments. The DD Form 2978 is required for Service members 181 days to 18 months and 18 to 30 months after return from deployment. Completing the Annual PHA during these timeframes fulfills the requirement. These additional post-deployment mental health assessments are not required for DoD civilians.

(d) When individuals deploy again prior to completing the cycle of deployment-related health assessments, the assessment schedule will be re-set as described in Appendix 5.

(2) Military-Unique Exposures. Based on information provided in Incident Reports, post-deployment health assessments, clinical encounters following deployment, or communications from the deployed location leadership, individuals who may have experienced unique military exposures must be evaluated and recorded in the individual's health record. Referrals will be made as appropriate, and in consultation with a Service public health center when necessary. Service members and DoD civilian employees identified as exposed should have identifying information stored in the incident reporting module of DOEHS-IH. For DU exposure biomonitoring procedures, see Appendix 4.

(3) Post-Deployment Serum Specimens. A serum sample will be obtained from each Service member and DoD civilian no earlier than 30 days prior to departure from theater and no later than 30 days after arrival at the demobilization site, home station, or in-patient MTF (preferably during the face-to-face health assessment) and forwarded to the DoD Serum Repository (Reference (q)), using the existing trans-shipment centers. Serum samples for personnel separating from active duty, including RC members who are demobilizing, should be obtained during demobilization. Individuals must be informed if the post-deployment serum sample will be tested for HIV.



(4) Post-Deployment Pulmonary Function Testing. Conduct and document post-deployment pulmonary function testing on Service members and DoD civilians who met the criteria for a pre-deployment pulmonary function test, pursuant to References (c), (s), (aa), and (ab). This follow-up pulmonary function test should be completed within one year of return from deployment, but prior to the next deployment, and may serve as the pre-deployment pulmonary function test if the individual deploys again.

(5) OEHS. OEHS data and information, including but not limited to the OEHSA and (if required) POEMS, recorded in DOEHRS-IH (see Appendices 2, 6, and 7). Classified content, if any, is recorded in the MESL (SIPR) (see Appendix 6).

APPENDIX 1

DEPLOYMENT OCCUPATIONAL AND ENVIRONMENTAL HEALTH RISK  
MANAGEMENT AND HEALTH RISK COMMUNICATION

1. OEH RISK MANAGEMENT

a. Deployment OEH risk management is a process that commanders use to make informed decisions to minimize long and short-term health risks, increase operational effectiveness, improve the probability of mission success and document risk decisions. OEH hazards can seriously impact the mission and erode public confidence in the military's ability to protect its personnel.

b. The goals of deployment OEH risk management are to:

(1) Minimize exposure to the OEH threat by deployed Service members and DoD civilians.

(2) Manage unavoidable OEH hazards by establishing controls that balance short term tactical or operational goals with long- or short-term health concerns and documenting those decisions.

(3) Document unavoidable exposures to OEH hazards. These exposures may or may not be medically relevant at the time they occur.

c. Risk assessment is part of the risk management process. Risk assessment is the integration of the estimated severity of a given hazard with the probability of that hazard occurring to determine the potential impact of that hazard on the health of personnel. That impact can result in immediate consequences for the mission (as with a weaponized toxic industrial chemical) or in very long-term consequences in terms of health of personnel or their families post-deployment. The system of record used to document the identified hazards is described in Appendix 6.

d. Risk communication is also part of the risk management process. Commanders use appropriate monitoring and surveillance systems to identify these hazards, assess the potential risks, determine appropriate risk control measures, and communicate these risks to their forces.

2. OEH RISK MANAGEMENT PROCESS

a. Health risk management is a five-step cyclical process, similar to the risk management process in Reference (af). The first two steps of the process (identify the hazards and assess the hazards), comprise health risk assessment. The health risk assessment informs the last three steps in the risk management process: developing and implementing controls, risk mitigation, and supervision and evaluation of the risk mitigation (Reference (af)).

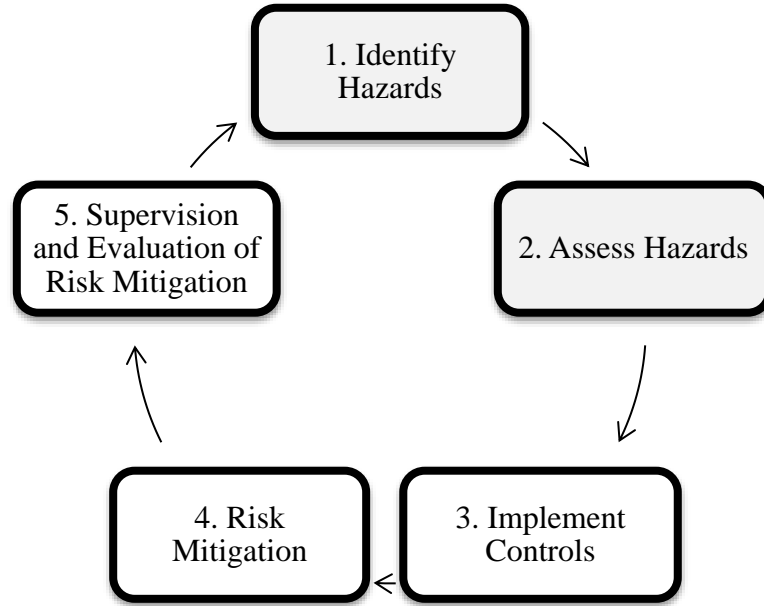


Figure: 5-Step Risk Management Process (Derived from Reference (af))

b. The process of identifying and controlling hazards across the spectrum of joint military missions, functions, operations, and activities can be summarized in the hazard probability chart (below) to facilitate comparison of different risks and support balanced decision-making.

Hazard Probability Chart

		HAZARD PROBABILITY				
		Frequent	Likely	Occasional	Seldom	Unlikely
HAZARD SEVERITY	Catastrophic	Extremely High	Extremely High	High	High	Moderate
	Critical	Extremely High	High	High	Moderate	Low
	Marginal	High	Moderate	Moderate	Low	Low
	Negligible	Moderate	Low	Low	Low	Low

		HAZARD PROBABILITY				
		Frequent	Likely	Occasional	Seldom	Unlikely
HAZARD SEVERITY	Catastrophic	Extremely High	Extremely High	High	High	Moderate
	Critical	Extremely High	High	High	Moderate	Low
	Marginal	High	Moderate	Moderate	Low	Low
	Negligible	Moderate	Low	Low	Low	Low

c. Once a hazard is identified, both its probability of occurrence and potential severity are used to project the specific estimate of risk. This process should be used to estimate risks of both the acute (short-term/tactical) and chronic (long-term/strategic life-cycle) effects to military personnel that could occur from OEH exposures during deployments. The extent and the severity of effects are presented in terms of significance to military operations, as well as anticipated medical response needs.

d. The risk level definitions are significantly different based on the risk decision being evaluated. Consider:

- (1) What is the degree of risk to Service members and does it impact the mission now?
- (2) Will this exposure result in long term health consequences in the future?

e. In order to address these concerns, risk level guidelines are shown below. In some cases, the risk may need to be adjusted by qualified personnel. However, the original risk, the reasons for that determination and the reason it was adjusted will all be included in the exposure pathway in DOEHRS-IH. Below are suggested risk level definitions for both short and long-term health effects resulting from OEH exposures.

Occupational and Environmental Health  
Exposure Risk Level Chart

<b>Risk Level</b>	Tactical Risk Definitions and Possible Medical Responses Associated with Real-Time or “Acute” Health Effects	Strategic (Life-Cycle) Risk Definitions and Possible Medical Responses Associated with Post-Deployment “Chronic” Health Effects
Extremely High	Loss of ability to accomplish the mission if hazards occur during mission. <i>Notable in-theater medical countermeasures and resources anticipated. For example, protection, treatment, and exposure documentation. Documentation of health care encounters in the individual health record and exposure-related information and data in DOEHRS-IH as an Incident Report.</i>	Significant future medical surveillance activities and health care provider resources anticipated. <i>Documentation of health care encounters in the individual health record and exposure-related information and data in DOEHRS-IH as an Incident Report, plus/minus designated DOD archive or registry, including the identification and documentation of the exposed individuals to enable active tracking. Develop and conduct specific active and/or passive medical surveillance follow-up for life cycle of observed and expected health outcomes in the identified group.</i>
High	Significant degradation of mission capabilities in terms of the required mission standard, inability to accomplish all parts of the mission, or inability to complete the mission to standard if hazards occur during the mission. <i>Some in-theater medical countermeasures and resources anticipated. For example, protection, treatment, and exposure documentation.</i>	Notable future medical surveillance activities and related resources anticipated. <i>Documentation of health care encounters in the individual health record and exposure-related information and data in DOEHRS-IH as an Incident Report, including the identification and documentation of the exposed personnel to enable passive medical surveillance-related activities.</i>

Risk Level	Tactical Risk Definitions and Possible Medical Responses Associated with Real-Time or “Acute” Health Effects	Strategic (Life-Cycle) Risk Definitions and Possible Medical Responses Associated with Post-Deployment “Chronic” Health Effects
Medium	<p>Expected degraded mission capabilities in terms of the required mission standard and will result in reduced mission capability if hazards occur during the mission.</p> <p><i>Limited in-theater medical countermeasures and resources anticipated. For example, protection, treatment, and exposure documentation.</i></p>	<p>Limited future medical surveillance activities and related resources anticipated.</p> <p><i>Documentation of health care encounters in the individual health record and exposure-related information and data in DOEHS-IH as an Incident Report. When possible, document rosters of exposed groups or individuals of health surveillance interest.</i></p>
Low	<p>Expected losses have little or no impact on accomplishing the mission.</p> <p><i>Little to no in-theater medical resources anticipated for protection and treatment. However, a summary of any negative or low-level sampling results should be documented and archived particularly if some personnel express concerns.</i></p>	<p>No specific medical action required.</p> <p><i>Documentation of health care encounters, if any, in the individual health record and record exposure-related information and data in DOEHS-IH as an Incident Report.</i></p>

f. More specific health risk assessment guidance, such as Reference (ax), plus Service or Command-specific publications, may be consulted for methods of risk quantification, especially in the case of unique hazard types. Such guidance should be used with site-specific exposure information, sampling and field data to develop risk estimates for those specific types of hazards.

### 3. HEALTH RISK COMMUNICATION

a. DoD medical personnel can better support command decision-making by integrating proven health risk communication tools and processes into their work environment. Being aware of how risks are perceived and developing two-way dialogue is critical to successful risk communication. Adopting a risk communication approach at all levels of an organization will help increase the chance that communication takes place, while minimizing the risks of unwanted outcomes.

b. Although risk communication can, and will, be challenging, adopting proven tools and strategies will help lead to successful interactions and more effective communication of actual health risk. Successful communication of health risk information requires very specialized skills gained by practice and refined over time. Health risk communication support is available from the Services’ public health centers. These communication experts provide training, document development and review, and consultative guidance on how to approach specific situations.

Army Public Health Center (APHC) Health Risk Communication:  
Phone: (410) 436-7941/ 1-800-222-9698 / DSN: 312-584-7941  
usarmy.apg.medcom-aphc.list.org-phcom-hrc@mail.mil

Navy and Marine Corps Public Health Center (NMCPHC) Risk Communication:  
<http://www.med.navy.mil/sites/nmcphc/environmental-programs/Pages/risk-communication.aspx>

U.S. Air Force School of Aerospace Medicine (USAFSAM) Environment, Safety and Occupational Health Service Center:  
Phone: 1-888-232-ESOH (3764) / (937) 938-3764 / DSN: 798-3764  
[esoh.service.center@us.af.mil](mailto:esoh.service.center@us.af.mil)

Defense Health Agency Immunization Healthcare Division, for assistance with immunization-related risk communication:  
Phone: 1-877-GET-VACC (1-877-438-8222) / DSN: 761-4245  
<https://health.mil/vaccines>

## APPENDIX 2

### DEPLOYMENT OCCUPATIONAL AND ENVIRONMENTAL HEALTH SURVEILLANCE PROCESS

1. DEPLOYMENT OEHS. Deployment OEHS is a critical mission to protect deployers from exposures to hazards that can cause acute, chronic and latent adverse health effects.

a. Deployment OEHS is performed at all PVNTMED levels to some extent, and should be integrated into operation plans, operation orders, base camp operations documents (e.g., standard operating procedures) and base camp management contracts as indicated at all deployment locations.

b. The purpose of deployment OEHS is to:

- (1) Identify hazards before deployment;
- (2) Characterize hazards during deployment;
- (3) Assess how Service members are potentially exposed to the hazards;
- (4) Develop surveillance plans, with OEHS sampling plans (References (an) and (cb)), to monitor the hazards;
- (5) Execute surveillance based on the surveillance plan;
- (6) Assess the identified hazards; and
- (7) Control the hazards that contain unacceptable risks.

c. The deployment OEHS process leads from the PLHA to the development of the OEHSA, for each required location. The OEHSA informs POEMS, when required. POEMS summarize the known health hazards at a location during a particular timeframe and informs providers and deployers of the associated population-based health risks.

## 2. DEPLOYMENT OEHS PROCESS

a. PLHA

(1) The CCMD develops, or requests that a supporting Service develops the PLHA in accordance with References (an) and (cb), plus applicable risk management (or operational risk management) guidance of the CCMD and Service. The PLHA will:

- (a) Identify the local health hazards for the deployment location.

- (b) Indicate the appropriate, initial, health risk management measures.
  - (c) Inform the content of health risk communication messages and materials, including pre-deployment health threats and countermeasures briefings.
- (2) The PLHA informs the completion of the initial OEHSA. The process consists of gathering site background and intelligence information to identify potential OEH hazards.
- (3) The PLHA will summarize the OEH threats and hazards identified by reviewing relevant intelligence data, past hazard assessments, and/or other location information available pre-deployment. Consult the Services' deployment health surveillance support centers and other sources, such as the:
- (a) USAFSAM, NMCPHC, and the APHC for historical deployment OEH exposure and monitoring data, and mission and site information.
  - (b) Armed Forces Health Surveillance Division (AFHSD) for health surveillance analysis products and guidance.
  - (c) Defense Intelligence Agency, especially NCMI, for current intelligence on foreign medical capabilities, infectious disease threats, environmental health risks, CBRN weapon threats, toxic industrial chemical threats, and developments in biotechnology and biomedical subjects of military importance.
  - (d) Operations and intelligence staff of the relevant operational command (unit or higher headquarters).
  - (e) APHC for food protection information and list of DoD-approved food and bottled water procurement sources for U.S. Forces.
  - (f) Veterinary Service Division for current and historical FWRA information, information on military working animal health care and DoD veterinary health record including the DoD electronic veterinary health record (VSSM), and information about zoonotic diseases and veterinary public health concerns.
  - (g) AFPMB, for information on pest management and arthropods (insects), animals and plants that may impact the DoD mission.
  - (h) DOEHRS-IH for OEHS records of existing or historic (closed) deployment locations and the MESL (SIPR) for any classified, OEHS content (see Appendix 6).
  - (i) Other sources of information to be considered include the World Health Organization, Centers for Disease Control and Prevention (CDC), and the National Institutes of Health.
- (4) The PLHA will be shared with component planners as needed.



(5) Specific health risk countermeasures (e.g., immunizations, prophylactic medications, or PPE) will be identified based on the health hazards or potential health hazards identified in the PLHA. The identified countermeasures will be administered, prescribed, and issued before deployment. Health risk countermeasures will be updated according to subsequent health surveillance findings during deployment.

(6) The PLHA is a pre-deployment, interim, assessment of potential occupational and environmental health threat sources and their relative health risks. During deployment, the PLHA is verified or corrected by assessing health surveillance findings.

(7) The PLHA may be recorded in the Environmental Health business area of DOEHRS-IH by uploading it as an attachment to the “Location – Detail” page. To do so, the user first completes the initial setup of the location within DOEHRS-IH; if there are timing conflicts between PLHA completion and initial setup of the location, then recording of the PLHA in DOEHRS-IH is not required. Any classified PLHA content may be recorded in the MESL (SIPR) according to the procedures in Appendix 6.

#### b. OEHSA

(1) The primary purpose of the OEHSA is to evaluate a site’s current potential health hazards. This survey is the main process that supports OEH risk management activities on military installations and locations in an operational environment. OEHSAs are a key element of the health risk assessment process and assist Service PVNTMED personnel to adequately support FHP and local commanders’ risk management decisions concerning OEH threats. The OEHSA documents environmental conditions, identifies potential OEH threats, guides OEH data collection activities and further risk assessments, and summarizes acute or immediate risk mitigation actions.

(2) The OEHSA builds on information gathered from the PLHA and serves to augment and support that information for a specific location. The OEHSA is the first step of the OEHS process that includes media-based data collection (e.g., air, water) and risk assessments over time.

(3) The CCDR is responsible for the OEHSA program. OEHSAs should be performed by the PVNTMED units of the lead Service supporting each location.

(4) The OEHSA must be conducted at all deployment sites which will be occupied for more than 30 days by U.S. military personnel. The initial OEHSA will be started when a site is first occupied by the PVNTMED team conducting the OEHSA and completed within 3 months.

(5) During operations, OEHSAs are initiated as basing decisions are made and sites are identified and established; each initial OEHSA should be informed by a PLHA that is conducted before the new site is occupied by U.S. military forces.

(6) Existing OEHSA will be updated as new hazards and associated exposure pathways are identified, and at least annually. Exposure incidents and high concern exposure/hazard(s)

require an update to the OEHSA within 3 months of being identified. Each OEHSA will be reviewed and either updated or revalidated (if there are no identifiable hazard changes) annually, in accordance with CCMD guidance and Reference (an).

(7) The OEHSA consolidates the identified exposure pathways used to characterize each suspected hazard. The OEHSA will identify hazards with complete or potentially complete exposure pathways that may affect the health of deployed personnel.

(8) The OEHSA will be performed according to the most recent version of the Reference (bn), using the OEHSA template online at the APHC DOEHRS-IH resources page. It will include: administrative data about the location; site history and survey background; site description; defining exposure pathways; OEH survey results for air, water, soil, entomological surveys, industrial hygiene, ionizing and non-ionizing radiation, waste management (including a section for incinerators or open burn pits, if present), noise and other physical hazards; food protection and food service sanitation; general sanitation; on-site screening sampling; CBRN threats; and overall findings and recommendations.

(9) For deployment locations where a burn pit health assessment report is required in accordance with Reference (cc), place a copy of the report in DOEHRS-IH (Environmental Health business area) and incorporate the report's findings in the OEHSA. Use the most recent OEHSA survey and the active conceptual site model to inform the burn pit site sampling plan and OEH monitoring requirements. The monitoring requirements should include the priority, frequency, and number of samples to adequately assess open-air burn pit emissions and monitor ash for hazardous constituents, consistent with References (an), (cb), and (cc).

(10) All OEHSAs will be recorded in DOEHRS-IH (Environmental Health business area), within the time specified in CCMD or component guidance, but no later than within 3 months of the completion date. If some data elements in the OEHSA are classified, the complete OEHSA will be submitted to the MESL (SIPR), as described in Appendix 6, including:

(a) A description of the properties (e.g., physical or chemical) of each OEH hazard identified;

(b) The associated survey identification of the unclassified portion of the existing OEHSA entered in DOEHRS-IH; and

(c) The unclassified portion of the OEHSA, exported as a document using the "Other" tool within the OEHSA in DOEHRS-IH.

(11) QA will be completed and each OEHSA marked "Approved by QA" either at the time it is recorded in DOEHRS-IH or within 30 days, in accordance with Reference (an) and any applicable command guidance.

c. Exposure Assessment

(1) A population's exposure to a hazard may be defined as an expression of the aggregate personal exposures (each individual contact with a substance, material, endemic and enzootic disease, or condition over time); the number of persons exposed; and the frequency, intensity, and duration of the exposure.

(2) An OEH hazard exists when a substance, material or condition is present at a level and in a form that might be associated with either an acute and/or a chronic adverse health outcome in an exposed population. There must be a completed exposure pathway that links the hazard with a known or suspected population of interest. This pathway must be documented in DOEHRS-IH either within an OEHSA or as a unique exposure pathway.

(3) An OEH exposure assessment attempts to describe this exposure, using an exposure pathway in DOEHRS-IH, by capturing information about:

- (a) Who was exposed;
- (b) The nature of the substance, material or condition;
- (c) The location and conditions at the time;
- (d) The frequency, intensity, and duration of that exposure; and
- (e) Any other relevant information.

#### d. Exposure Pathways

(1) The OEHSA consolidates the identified exposure pathways used to characterize each suspected hazard. Hazards should have a defined population of concern and will be described and evaluated using an exposure pathway in DOEHRS-IH. Both complete and potentially complete exposure pathways should be documented to the extent possible.

(2) All exposure pathways will be ranked in DOEHRS-IH based in the context of high, medium and low relative to one another. Each exposure pathway will be routinely reassessed.

#### e. Surveillance Plan

(1) As hazards are determined by the identification of a completed or potentially completed exposure pathways, a site-specific surveillance plan will be developed for each of the exposure pathways. The purpose of the surveillance plan is to determine the appropriate method of monitoring or surveillance that must be conducted to characterize the hazard and ensure proper controls are in place to eliminate or reduce the exposure. Surveillance may consist of one or more of the following:

(a) Collecting samples (e.g., air, water, soil, thermal stress, vector, industrial hygiene), according to the OEHS sampling plan;

(b) Conducting surveys (water, food protection, food service sanitation, general sanitation, entomology, waste management, workplace, etc.); and

(c) Performing other general public health inspections.

(2) Technical guidance for surveillance plans is contained in:

(a) Reference (an)

(b) Reference (cd)

(c) Other appropriate or component-directed public health guidance documents (e.g., Reference (bs)).

(d) Service public health centers can be consulted on development of surveillance plans.

(3) The surveillance plan must describe all sampling activities and include the following information, at a minimum, for each exposure pathway identified in the OEHSA (Reference (an)):

(a) The objective of the sampling (e.g., “describe Service member exposure to lead in ambient air”);

(b) Media to be sampled (e.g., air, soil, water, food, disease vectors);

(c) Sampling approach (e.g., judgment, systematic random);

(d) Number of samples and how the number was derived;

(e) Type of samples (discrete, composite, environmental, personal, QA (e.g., duplicate, blank), background, etc.) and the underlying assumptions that justify the sample type;

(f) Sampling locations and an explanation why/how those locations were selected and what potentially each location represents (e.g., exposure point, background) and indicate locations (e.g., map, site sketch, coordinates);

(g) Duration of sampling and interval between samples (if multiple) with explanation of why duration and interval were chosen;

(h) Analytical methodologies (field analytical tools and reach-back laboratory analysis) and target analyses (Analysis results from reach-back laboratories must be loaded into DOEHRS-IH by the unit that collected the sample, unless already loaded by that laboratory or relevant Service public health center);

(i) Sampling equipment (including capabilities and limitations of equipment);

(j) Sample preservation techniques; and

(k) Equipment decontamination procedures.

f. Conduct Surveillance

(1) Surveillance will be based on the described sampling plans and surveys outlined in the surveillance plan and conducted in a manner to meet the objectives of the surveillance plan.

(2) All surveillance activities will be entered into DOEHRS-IH and associated to the applicable exposure pathway. For example, samples taken to characterize ambient air will be associated (in DOEHRS-IH) with the ambient air exposure pathway.

g. Exposure Pathway Reassessment

(1) The exposure pathway will be routinely reassessed based on surveillance, hazard controls, site condition changes and other parameters. The reassessment process will include updates to the surveillance plan and associated surveillance activities.

(2) Exposure pathways that are no longer valid will be stop dated in DOEHRS-IH.

(3) Determination of whether an exposure pathway and associated surveillance plan must be reassessed (i.e., updated) versus being no longer valid (i.e., stop-dated) should be made by field PVNTMED assets in consultation with the Service public health center.

h. POEMS

(1) POEMS reflect official, unclassified, OEHS findings (e.g., hazardous noise, thermal stress, airborne pollutants, soil and water contaminants, and infectious diseases) and population-based risks for individuals assigned or deployed to contingency locations or other deployed locations during a specified time period. They are written to provide deployers and their health care providers a summary of the known environmental hazards associated with deployment to a location. Where appropriate, POEMS may cover multiple deployment locations or contingency locations within a given geographic area, based on common health risks and availability of data. All POEMS are archived in DOEHRS-IH. POEMS will also be cleared for public release on-line.

(2) Completion of the POEMS is the responsibility of the Geographic CCDR who will ensure POEMS are completed by developing them or requesting Service support to author and accomplish POEMS in accordance with CCMD written guidance.

(3) The CCMD approves content and recommends the POEMS for public release; each POEMS will be reviewed by the OSD Office of Security Review prior to release for posting on a public-access website by APHC, in accordance with Reference (bk).

(4) POEMS are written on the template developed by the Joint Environmental Surveillance Work Group, available online at:  
<https://phc.amedd.army.mil/topics/envirohealth/hrasm/Pages/POEMS.aspx>.

(5) When practicable, initial and annual POEMS will be completed for each location where Service members and DoD civilians deploy. At a minimum, the CCDR will determine which contingency locations (References (bj)), and other deployment locations require POEMS within the CCMD and conduct risk-based prioritization for the completion of initial and annual POEMS, in accordance with Reference (c).

(6) POEMS should be started as soon as sufficient site data is available and be completed no later than 1 year after completion of the initial OEHSA.

(7) Once completed, the CCMD (or designee) staffs POEMS for approval of content and recommends them for review by the OSD Office of Security Review prior to release to the public.

(a) Any comments or concerns generated during staffing will be adjudicated by the CCMD and Service authoring the POEMS prior to submission for Security Review and public release using DD Form 1910, Clearance Request for Public Release of Department of Defense Information, in accordance with Reference (bd).

(b) The responsible CCMD reviews and approves content of POEMS based on internal stakeholders' review, with adjudication of any comments performed by the POEMS author (typically, a Service public health center).

(c) The POEMS author sends the adjudicated and edited draft POEMS to Joint Staff/Health Service Division, which staffs the POEMS for external stakeholder review, followed by adjudication of any comments by the POEMS author.

(d) Annual certifications of POEMS with minor updates, and without significant health risk changes or operational security risks, may be approved in accordance with CCMD written guidance for an abbreviated CCMD staffing review, then documented in DOEHRS-IH and sent to APHC.

(8) Annually, each POEMS will be reviewed by the CCMD (or CCMD-designee) and updated; if a POEMS requires only minor updates and there are no significant health risk changes, it may be certified as current in accordance with CCMD written guidance.

i. POEMS Tracking and Recording

(1) Cleared POEMS will be archived in both the publicly accessible website (<https://phc.amedd.army.mil/topics/envirohealth/hrasm/Pages/POEMS.aspx>), and in DOEHRS-IH.

(2) CCMDs will track the status of POEMS completion, public release, and annual revision or certification as current.

(3) POEMS status reports will be tracked routinely, and reviewed least quarterly, in the CCMDs. POEMS status reports will be routed from each CCMD to the Office of the Joint Staff Surgeon, with copies to the DHA PHD and APHC, at least annually. POEMS status reports will include each CCMD's listing of locations requiring a POEMS and the date of each location's most recently completed POEMS (date of CCMD review and approval in Block 7 of DD Form 1910, Clearance Request for Public Release of Department of Defense Information) and, for recertified POEMS, the date of last certification.

### APPENDIX 3

#### MALARIA RISK AND PREVENTION

1. MALARIA. Malaria prevention is achieved through mosquito avoidance and personal protective measures, mosquito vector control, and antimalarial chemoprophylaxis that is tailored to the malaria strain(s) in the deployment location, any drug resistance patterns, and deploying individual's personal factors.

a. Monitoring compliance with personal protective measures and chemoprophylaxis is the responsibility of unit commanders. Directly observed therapy is a method for monitoring and improving chemoprophylaxis compliance.

b. *Plasmodium falciparum* species is responsible for 85 percent of malaria cases worldwide, and is the most widespread, serious, and most commonly fatal type of malaria. The three less common and less dangerous *Plasmodium* species are: *P. ovale*, *P. malariae* and *P. vivax*.

#### 2. MALARIA RISK ASSESSMENT AND RISK MANAGEMENT

a. CCMDs issue guidance prior to deployment or travel to their area of responsibility regarding specific FHP measures, including the requirements and options for antimalarial chemoprophylaxis. The risk assessment for malaria is based on the potential attack rate per month, derived from a realistic maximum attack rate and level of disease prevalence. Malaria potential attack rates are available through the NCMI, accessible at: <https://www.ncmi.detrick.army.mil/>.

b. Personal protective measures. As indicated by the deployment-specific malaria risk assessment, designated component medical personnel or readiness personnel instruct deploying individuals in the proper use of bed nets and clothing that have been treated to provide protection against biting arthropods; arthropod repellants applied to skin; proper wear of the uniform (sleeves down, pant legs tucked into boots); and field sanitation and hygiene measures that prevent or reduce mosquito breeding conditions in work and billeting locations. Refer to the DoD Insect Repellent System, described in Reference (bk), and on-line at the APHC website (<https://phc.amedd.army.mil/topics/envirohealth/epm/Pages/DoD-Insect-Repellent-System.aspx>).

c. Recommendations for antimalarial chemoprophylaxis (Reference (k)).

(1) No antimalarial chemoprophylaxis required. In general, military operations in areas where NCMI reports potential attack rates (without the use of antimalarial) of 0.1 percent per month or less do not require chemoprophylaxis. This is especially true if there is little or no *P. falciparum* transmission or if the duration or nature of travel suggests a low likelihood of infection such as no dusk-dawn exposures anticipated, and other FHP measures are in place such as the use



of treated bed nets, treated clothing, personal arthropod repellent, etc. CCMDs may determine that chemoprophylaxis is not required for specific situations, with limited duration and extent of exposure (e.g., aircrew transiting the area lodging in an air-conditioned hotel), in higher risk areas.

(2) Antimalarial chemoprophylaxis required. In general, travel to areas where NCMI reports potential attack rates (without the use of antimalarial), greater than 0.1 percent requires chemoprophylaxis. CCMDs may require antimalarial chemoprophylaxis to areas with lower attack rates, as operationally required.

d. Pre-deployment health evaluation and malaria exposure risk assessment. Prior to deployments, deploying individuals will meet with a health care provider who will:

- (1) Assess exposure risk;
- (2) Review health records for evidence of contraindications or intolerance to antimalarial medications, or other factors that may present a higher risk to the individual for malaria exposure;
- (3) Provide preventive health education on any pertinent malarial exposure information;
- (4) Select and recommend a chemoprophylaxis regimen;
- (5) Recommend presumptive anti-relapse therapy (PART) or terminal prophylaxis, if indicated;
- (6) Document and review evidence of G6PD status (in some cases quantitative test results may be needed) in health records, or order G6PD test, if not readily available;
- (7) Identify and document evidence or history of any contraindications to antimalarial medications, or any intolerance based on previous use;
- (8) Ensure complete documentation in the EHR of the individual.

e. Recommended antimalarial chemoprophylaxis.

(1) Chloroquine is currently the drug of choice for areas where chloroquine-sensitive malaria is present (no chloroquine-resistant malaria). Atovaquone-proguanil may be considered for short-term deployments (see below). Tafenoquine is an acceptable alternative medication if intolerance or contraindications to chloroquine, atovaquone-proguanil and doxycycline are documented.

(2) Atovaquone-proguanil or doxycycline are equally acceptable as first-line prophylactic medications in areas with chloroquine-resistant *P. falciparum* malaria (CCMD Surgeon will recommend specific prophylactic guidance). Factors to consider include:

(a) For short-term travel, atovaquone-proguanil may be considered since it requires 7 days of post-exposure prophylaxis vice the 28 days for doxycycline. Therefore, atovaquone-proguanil should be considered for use during short-term travel (e.g., 2-3 weeks) or for individuals who travel frequently, where the prolonged post-exposure prophylaxis treatment courses for doxycycline result in longer durations of treatment for minimal exposures;

(b) Tafenoquine may be considered where chloroquine resistance is documented for those individuals who have contraindications or intolerance to atovaquone-proguanil and doxycycline.

(3) Primaquine is not currently FDA-approved for primary prophylaxis, however, the CDC includes it as an acceptable alternative as an off-label use. Primaquine can only be prescribed by a licensed medical provider and is not for FHP for a deploying group. PART, or terminal prophylaxis, is an FDA-approved indication for primaquine use in individuals with normal activity of the enzyme G6PD.

(4) Mefloquine should only be used in individuals with intolerance or contraindications to all other malaria chemoprophylactic medications in areas of chloroquine resistance. Before using mefloquine for prophylaxis, the prescribing provider must document in the deploying individual's health records any health history or contraindications to its use and provide the FDA-required Medication Guide and wallet cards to the deploying individual.

f. Terminal prophylaxis and PART

(1) In the presence of *P. vivax* and/or *P. ovale*, primaquine is recommended as terminal prophylaxis. Primaquine is administered for 14 days after leaving malaria exposure area together with the remainder of the primary chemoprophylaxis regimen. Primaquine should still be given if the primary prophylaxis regimen was completed. Primaquine is not required if the individual used tafenoquine as primary prophylaxis.

(2) Alternatively, tafenoquine may be considered if the individual has a history of intolerance to primaquine. The single dose of tafenoquine should overlap with the last dose of the antimalarial used for chemoprophylaxis. If tafenoquine was used for primary chemoprophylaxis, PART is not needed.

g. Contraindications and warnings

(1) Atovaquone-proguanil, doxycycline and tafenoquine are all contraindicated during pregnancy.

(2) G6PD deficiency. Both primaquine and tafenoquine can cause hemolytic anemia. Testing for G6PD deficiency is mandatory in accordance with Reference (bh), for all personnel deploying to areas requiring prophylaxis with primaquine or tafenoquine, unless previous results are documented in the health record.

Malaria Chemoprophylaxis Regimens Chart (Derived from Reference (k))

Malaria Chemoprophylaxis Regimens			
Drug	Dose	Dosing Instructions	Comments on Use as a FHPPP
Atovaquone-proguanil	250/100mg (1 tablet daily)	Begin 1 - 2 days before entering malaria-endemic area with chloroquine resistance; continue daily until 7 days after departure from area.	A first-line drug for chemoprophylaxis of chloroquine-resistant malaria
Doxycycline	100mg daily	Begin 1 - 2 days prior to travel to malaria-endemic areas with chloroquine resistance. Take daily until 28 days after leaving malaria-endemic areas.	A first-line drug for chemoprophylaxis in areas with chloroquine-resistant malaria
Chloroquine	300mg (base) weekly	Begin 1 - 2 weeks prior to arrival in malaria-endemic area. Take weekly while in the malaria-endemic area, and for 4 weeks after leaving such areas.	The drug of choice for malaria chemoprophylaxis in area with no chloroquine resistance
Mefloquine	228mg (base) weekly	Begin 1 - 2 weeks prior to arrival in malaria-endemic area. Take weekly during travel and continue for 4 weeks after departure from malaria-endemic area	Should be reserved for individuals with intolerance or contraindications to both first-line medications.
Primaquine	30 mg daily based on CDC (The 15 mg (base) dose is FDA-approved but is not recommended)	Take daily for 14 days, concurrent with final 2 weeks of drug used for primary chemoprophylaxis	Prevention of relapse (terminal prophylaxis) of vivax malaria. Requires prior G6PD testing.
Tafenoquine (primary prevention)	200 mg daily x 3 days (loading dose); 200 mg weekly (maintenance) and 200 mg week after exposure	Begin 200 mg once daily, 3 days before entering malaria-endemic area; then continue weekly starting 7 days after third dose (last loading dose) while in malaria-endemic area. Then, 200 mg dose 7 days after the last dose of the maintenance regimen. May only be used for up to 6 months.	A second-line drug for chemoprophylaxis of chloroquine-resistant malaria. Requires prior G6PD testing
Tafenoquine (terminal prophylaxis)	300 mg one-time dose	Take one-time 300 mg dose on the first or second day of the appropriate antimalarial therapy, or 7 days after return if tafenoquine was used as primary chemoprophylaxis.	Second-line drug for prevention of relapse (terminal prophylaxis) of P. vivax or P. ovale malaria. Requires prior G6PD testing.

APPENDIX 4

DEPLOYMENT-RELATED BIOMONITORING AND ANALYSIS OF EMBEDDED METAL FRAGMENTS

1. BIOMONITORING

a. In general, biomonitoring uses a scientifically validated method, in the form of a bioassay or laboratory technique, to measure a biomarker signaling a unique internal exposure. It is used to detect individual exposures to hazardous chemical, biological, radiological or physical agent(s) that are known or likely to have occurred during a deployment based on: OEHS data, operational events or incidents indicating individuals may have been exposed, or a clinical assessment following a medical encounter with a health care provider. This biomonitoring data may be helpful in ensuring appropriate follow-up surveillance and medical treatment.

b. Specific biomonitoring procedures for DU and embedded fragments have been developed and are listed below; however, this does not preclude health care providers from ordering other tests in support of individual patient care consistent with clinical standards or practice guidelines.

c. Assessment of other exposures, such as lead or other heavy metals, encountered during deployments should be guided by Reference (au), when applicable, or other relevant environmental or occupational standards.

d. The following procedures update References (e) through (i).

2. DEPLOYMENT-RELATED BIOMONITORING APPLICABILITY

a. These procedures apply only to military-unique or combat-related exposures not generally encountered in other occupational or industrial settings (see References (v) and (au)).

b. These procedures apply only when validated methods exist. The methods used (bioassays) must have accompanying clinical guidelines and health risk communication messages.

3. DU AND EMBEDDED FRAGMENT BIOMONITORING. DU may be internalized in the body due to inhalation, ingestion, or the presence of embedded fragments or particulate wound contamination. There are two types of potential health risks associated with exposure to large amounts of DU particulates or embedded fragments: heavy metal toxicity and very low-level radioactivity. The DU bioassay process is designed to identify the small number of deployers who experience a significant exposure that may reflect a health concern. In almost all individuals tested following deployment, exposure to natural uranium from the environment dwarfs any exposure to DU. DU biomonitoring has proven to be most helpful in individuals with a history of

a fragment injury in the presence of DU armor or DU munitions. However, routinely entering damaged vehicles possibly containing DU residues or fighting fires involving DU munitions, as part of the occupation, is also considered significant, and requires DU biomonitoring.

a. Either the content of a fragment or clinical judgement may trigger the requirement for biomonitoring for DU or other substances, such as heavy metals.

b. Assessment of other exposures, such as lead or other heavy metals, encountered during deployments should be guided by Reference (au), when applicable, or other relevant environmental or occupational standards.

4. BIOMONITORING DATA. Laboratories will comply with Service, Command, or DoD requirements on the archival and interpretation of radiation exposure data by a Service dosimetry center. Laboratory biomonitoring analytical reports will be electronically reported in a secure manner to the originating MTF and the requesting health care provider.

a. DoD health records. All existing DU bioassay and embedded metal fragment analytical results will be recorded in the DoD EHR to be shared, as appropriate, with the VA, joint medical commands, and the Military Departments.

b. Laboratory results.

(1) Laboratories will electronically report results in a secure manner to the originating MTF and the requesting health care provider.

(2) Laboratory biomonitoring analytical reports will include a health risk interpretation, addressing the radiation dose and probable identity of any potentially harmful composites or alloys, and copies of health risk communication materials to be discussed with the patient.

(3) Laboratories performing analyses for deployment biomonitoring will record the data in the DoD EHR, or a laboratory database which can be linked to the DoD EHR.

(4) Laboratories performing analyses for deployment biomonitoring should comply with Service, Command, or DoD requirements on the separate archival of radiation exposure data, including their interpretations, in a dosimetry center (in addition to the DoD EHR or a laboratory database which can be linked to it).

c. DU Registry (DU Archive). The DoD DU biomonitoring registry, an archive of individual DU biomonitoring findings in DOEHRS-IH, is maintained by the APHC. Results of the analyses

of DU in urine are archived in the DOEHRS-IH registry, as well as reported to the submitting MTF laboratory, referring provider, and Service dosimetry center. The Services and their laboratories ensure that DU registry records are complete, including:

- (1) DoD patient identifying information;
- (2) Information related to the DU exposure (e.g., embedded fragment containing DU, participation in an event that placed the individual at risk of DU exposure);
- (3) Laboratory results (initial and follow-up);
- (4) Assessment of the laboratory results;
- (5) Referrals;
- (6) Narrative summaries of follow-up care;
- (7) Attachments, consisting of: Interpretation of Laboratory Results memo, Laboratory Report (of the specimen with results) memo, and (where applicable) the individual's DU Questionnaire.

6. DU BIOMONITORING PROCEDURES. Procedures for the DoD DU Biomonitoring Program include a process of medical surveillance to address possible DU exposures, with referral of personnel with confirmed exposures to the DU Medical Follow-up Program in the VA. All personnel with actual or potential exposures to DU will be identified, assigned a potential exposure Level, assessed, and (as indicated) treated and referred to the DU Medical Follow-up Program.

a. Identification of possible exposures to DU. The DoD components and Services should use proactive methods, such as documentation of participation in an event that would have placed an individual at risk of DU exposure (based on Incident Reports or information provided by the line commander), and reports by the individual or a health care provider of a possible exposure, in addition to the deployment-related health assessments, to identify individuals requiring further assessment to determine the potential exposure Level.

(1) The requirement for a future DU exposure assessment and biomonitoring should be recorded in the DoD health record when it is first recognized, during or after deployment.

(2) Health care providers record the requirement for a future DU exposure assessment and a possible 24-hour urine collection in the health record, annotating the DD Form that is appropriate at the time of the encounter. Appropriate documentation, during and/or after deployment, may include: Tactical Combat Casualty Care Card (DD Form 1380), Post-Deployment Health Assessment (DD Form 2796), Post-Deployment Health Re-Assessment (DD Form 2900), and/or DD Form 2766 (Adult Preventive and Chronic Care Flowsheet), in addition to the DoD health record.

(3) The health care providers reviewing input on deployment-related health assessments should ensure referral of individuals with possible DU exposures for a formal exposure assessment and determination of whether a significant exposure may have occurred (see Enclosure 3, paragraph 6, regarding medical follow-up and referrals).

b. Levels of possible DU exposure. Possible DU exposures can be stratified from significant to inconsequential to establish criteria for performing biomonitoring. Levels I and II exposures require DU biomonitoring. Health care providers may also order testing on those determined to have had Level III exposures, based upon concerns of the patient or the provider. Based on research in Reference (ce), possible DU exposures can be stratified from significant to inconsequential to establish criteria for performing biomonitoring:

(1) Level I includes personnel in, on, or near (within 50 meters) a DU-armored vehicle when armor is breached, by any munition, or a combat vehicle struck by suspected DU munitions, as well as first responders who enter those vehicles. DU biomonitoring is required for individuals with this category of exposure.

(2) Level II includes personnel routinely entering damaged vehicles, possibly containing DU residues, or fighting fires involving DU Munitions, as part of their occupation. DU biomonitoring is required for individuals with this category of exposure.

(3) Level III includes personnel with incidental exposure to DU, such as brief, infrequent excursions on or into battle-damaged vehicles, or driving through smoke from fires involving DU materials. This category of exposure does not require DU biomonitoring.

c. Assessment of potential exposure to DU.

(1) Individuals with level I or level II exposures require DU biomonitoring as described below, in accordance with Reference (i).

(2) Health care providers may also order testing on those determined to have had Level III exposures, based upon concerns of the patient or the provider.

(3) Because DU biomonitoring requires the collection of a 24-hour urine specimen, testing is usually deferred until return from deployment due to mission priorities and logistical constraints; however, the requirement for exposure assessment, and possible DU biomonitoring, should be documented upon first recognition of the possibility of a significant exposure.

d. DU biomonitoring specimens for analysis.

(1) Specimens to assess DU exposure should be collected as soon as practicable following possible exposure, after consultation with the analytical lab utilized by the MTF.

(2) Surgically removed fragments that are suspected of containing DU should be forwarded for analysis.

(3) The 24-hour urine specimen should be forwarded for analysis.

e. Laboratory Analysis of Urine for DU.

(1) The DoD Components should follow References (h) and (i) and specific DoD, CCMD, and Service guidance when using biomonitoring during or after deployment or combat operations to assess possible DU exposures using initial and follow up specimens.

(2) DU bioassays should be performed by a DoD laboratory with approved analytic capabilities and QA or quality control processes, according to an approved protocol and sound medical practices. Contact the testing laboratory regarding the type of specimen container to use.

(3) The 24-hour urine specimen will be analyzed for total uranium, uranium isotope ratios, and urine creatinine (References (h) and (i)).

(4) Measure DU in urine in terms of the total uranium and the uranium-235/uranium-238 isotopic ratio. DU concentrations are reported per urine volume, as well as normalized to urine creatinine concentration. If the urine creatinine is determined in a separate clinical laboratory prior to the uranium isotopic analysis, a very small aliquot (1–2 ml) should be removed from the 24-hour urine collection for the creatinine measurement, with the remainder preserved for the uranium isotopic analysis. The results of the urine creatinine must be forwarded with the remainder of the urine specimen to the lab performing the uranium isotopic analysis.

(5) Forward specimens and supporting documents to analytical laboratories. The collecting laboratory, (the local MTF clinical laboratory), should verify, in advance, the specific requirements of the specialty analytical laboratory, including forms to be completed with patient history and assessment of the DU Exposure Level, and shipping requirements.

(6) Report, archive and interpret DU bioassay results.

1. Results of the analyses of DU in urine are reported to the submitting MTF laboratory, referring provider, Service dosimetry center and are archived in the DOEHRS-IH Registry at APHC. The analytic laboratories, in coordination with their occupational medicine and health physics consultants, report out the depleted and total uranium concentrations per unit volume of urine, as well as corrected to urine creatinine concentration. These results, with the laboratory's interpretation and health risk communication materials, will be provided to the collecting lab and to the health care provider.

2. The analytical laboratory ensures that copies of the results and accompanying documents, including the health risk interpretation, are entered into the DoD EHR or a separate laboratory database, until such time as the analytical laboratory is able to establish a link to the EHR.

3. Results of the analyses of DU in urine are also archived in the DU registry.



4. For urine total DU and isotopic analysis interpretation, see References (h) and (i), in addition to Service guidance.

f. Procedures for Analysis of Embedded Metal Fragments.

(1) The decision to remove an embedded fragment should be based solely on clinical criteria. Fragments removed in operational settings are submitted for analysis subject to the priorities of in-theater, clinical combat care. Fragments removed from surviving DoD personnel at MTFs should undergo laboratory analysis to determine if a long-term toxicological hazard is posed, in the event other fragments of similar composition still remain in the body. Fragments surgically removed in an MTF and suspected of containing DU should be forwarded for analysis after consultation with the analytical lab utilized by the MTF (Reference (g)).

(2) Larger DU fragments are visible radiographically.

(3) Radiation detection meters may help identify DU-contaminated wounds or burns and assist with wound cleansing. A negative reading does not necessarily provide reassurance of the absence of DU in a wound.

(4) Inhaled DU is neither visible radiographically nor detectable using a meter. The persistent finding of the presence of DU in a urine bioassay is associated with the presence of embedded DU fragments.

(5) MTFs with surgical staff who remove embedded fragments should arrange, in accordance with Service policy, for fragment analyses to be performed at an appropriate Service laboratory meeting the requirements of Paragraph 4, Packaging and shipping procedures, with consideration taken for potential infectious or radioactive risk, should be coordinated with the receiving analytical laboratory. Laboratory costs will be reimbursed pursuant to prior agreement.

(6) Laboratories analyzing fragments will adhere to the following timing, elemental analysis, and disposition processes.

1. Timing and Sampling of Fragments for Analysis. Fragments should be analyzed within 90 days of receipt at the analytical laboratory, with reporting of results within 30 days of completion of the analysis. Laboratories may develop sampling protocols to analyze only representative fragments when multiple fragments are received simultaneously from the same patient. Sampling may be based on appearance or other morphological parameters when there is a high degree of assurance that the fragments have the same composition.

2. Minimum Requirement for Elemental Analysis. At a minimum, laboratories should screen each selected fragment for radioactivity with isotopic characterization and quantitative or semi-quantitative analysis for the following metals: tungsten, iron, tin, copper, uranium (natural and depleted), lead, cobalt, nickel, and antimony. Minimum level of detection should be no greater than one percent by mass, with the coefficient of variation less than 10 percent. Results, with the laboratory's interpretation and health risk communication materials, will be provided to the submitting lab and health care provider.

3. Disposition of Specimens. All embedded fragments removed and submitted for analysis (including those not selected for analysis) become the property of the U.S. government and will not be returned to the MTF or the individual from whom the fragment(s) was (were) removed. The laboratory will archive all fragments, or their remains, for at least the duration specified in Service policy.

## 7. MEDICAL MANAGEMENT AND REFERRAL TO THE DU FOLLOW-UP PROGRAM

a. Individuals whose urine bioassays detect the presence of DU will be evaluated according to clinical protocols developed by DoD and the Services, consistent with References (e) through (i) and (r). The primary care manager or other health care provider will consult with the laboratory (occupational medicine and health physics consultants), before referral for follow-up care, consistent with References (h) and (i).

b. For DoD civilian employees, see Enclosure 3 regarding medical evaluations and referrals.

c. Service members in the DU exposure categories specified are referred to the VA DU Follow-up Program and Toxic Embedded Fragment Program.

(1) Individuals confirmed positive for DU exposure based on bioassay results are referred to the DU Follow-up Program at the Baltimore VA Medical Center, after consultation with laboratory's occupational medicine consultant.

(2) Individuals with embedded fragments or fragment-type injuries and a urine total DU >50 ng/g creatinine and isotopic analysis indicative of the presence of 10 percent or more DU, are referred to the VA Toxic Embedded Fragment Program by the primary care manager.

(3) To arrange for VA referral, contact the administrators of the DU Follow-up and Toxic Embedded Fragment Programs at:

Depleted Uranium Follow-up and Toxic Embedded Fragment Programs  
Baltimore VA Medical Center (11DU/TEF)  
10 N. Greene Street  
Baltimore MD 21201  
410-605-7373  
1-800-815-7533

APPENDIX 5

DEPLOYMENT-RELATED HEALTH ASSESSMENTS

1. PURPOSE. Deployment-related health assessments are screenings conducted at specific intervals throughout the deployment cycle to identify health concerns and facilitate appropriate evaluation, care, and education. They include the DD Form 2795, Pre-Deployment Health Assessment, DD Form 2796, Post Deployment Health Assessment, DD Form 2900, Post Deployment Health Re-Assessment, and DD Form 2978, Deployment Mental Health Assessment. This appendix provides instructions for implementing deployment health assessments and deployment mental health assessments in accordance with Reference (c).

2. REQUIREMENTS AND TIMELINE. These assessments are required for all deployments greater than 30 days outside the United States, and for other deployments and military operations based on health risk and the decisions of the CCDR, Service component or commander exercising operational control. DD Forms 2796, 2900, and 2978 apply if the DD Form 2795 was required during the pre-deployment phase and the Service member completed the deployment. At any point in the deployment cycle, when a deployment-related health assessment becomes a requirement, all ensuing assessments are also required, per the schedule below. After the individual's discharge or release from the Armed Forces, deployment-related health assessments are not required, including deployment mental health assessments, pursuant to Section 701 of Reference (cf). When timelines coincide, assessments may be combined or conducted concurrently for ease of administration. Service members may complete deployment-related health assessments as part of the Annual Periodic Health Assessment when established requirements are met. DoD civilians complete these assessments at the MTF or location designated by their DoD Component or Agency.

a. The DD Form 2795 is completed within 120 days before the estimated deployment date. The DD 2978 required for Service members during the same timeframe is incorporated into DD Form 2795 in order to streamline administration.

b. The DD Form 2796 is completed as close to the date of return from deployment as possible, but not earlier than 30 days before the estimated return from deployment date and not later than 30 days after the return from deployment, and for RC members, before they are released from active duty. Service members who respond affirmatively to the traumatic brain injury risk assessment questions on the Post-Deployment Health Assessment will be referred for further clinical evaluation that may include the administration of a post-injury neurocognitive assessment and will be tracked as appropriate (References (be) and (cg)). Individuals with affirmative responses to the traumatic brain injury risk assessment questions on the Post-Deployment Health Assessment will be tracked and followed-up consistent with References (r) and (cg).

c. The DD Form 2900 is completed within 90 and 180 days after return from deployment. For RC members, sources for referrals are: DoD MTF, VA medical facility, and lastly,

TRICARE authorized provider (network or non-network) For RC members already receiving care for a for a referral issue, the referral shall be to the same location. The DD Form 2978 required for Service members during the same timeframe, is incorporated into DD Form 2900 to streamline administration.

d. Additional DD Forms 2978 are completed by Service members within 181 days and 18 months (181-545 days), and 19 and 30 months (546-910 days) after return from deployment. These assessments are not required for civilians. The DD Form 2978 is incorporated into DD Form 3024, Annual PHA, to streamline administration; therefore, Service members who complete the Annual PHA during the appropriate timeframe fulfill this requirement.

Deployment-Related Health Assessment Timeline Chart

Within 120 days before deployment	Within 30 days before or after return from deployment	Within 90-180 days after return from deployment	Within 181days and 18 months after return from deployment	Within 18-30 months after return from deployment
DD Form 2795	DD Form 2796	DD Form 2900	DD Form 2978*	DD Form 2978*

\*Not required for civilian deployers. Annual PHA fulfills this requirement for Service members, if completed during this timeframe.

3. SETTING THE ASSESSMENT CYCLE FOR A SUBSEQUENT DEPLOYMENT. For individuals who deploy again prior to completing the deployment-related health assessment cycle, the assessment schedule will be set to the most recent deployment for which the DD Form 2795 was required.

4. COMPLETION, SUBMISSION, AND NOTIFICATION REQUIREMENTS

a. Each health assessment is divided into a deployer and a provider section. The deployer completes the deployer portion of the form, then meets with a health care provider, who is authorized to administer these assessments, for an interview.

b. The interview must be face-to face for the DD Form 2795 and the DD Form 2796 and person-to-person (e.g., face to face, by telephone) for the DD Forms 2900 and 2978.

c. The interview must be conducted in a private setting and include a review of available health records.

d. After the interview, the provider completes the provider section, documenting any concerns and recommending referrals as necessary.

e. The health care provider will notify the Service member's commander of any concerns that meet the criteria for disclosure based on Reference (ch), including but not limited to risk of harm to self, risk of harm to others, and risk of harm to the mission.

f. The forms must be completed electronically at Service-designated websites, submitted to DMSS, and documented in the Service member's or DoD civilian's deployment health record and DoD Health Record in accordance with References (c) and (aj).

#### 5. HEALTH CARE PROVIDERS AUTHORIZED TO ADMINISTER DEPLOYMENT-RELATED HEALTH ASSESSMENTS

a. Authorized health care providers include: physician, physician assistant, nurse practitioner, advanced practice nurse, independent duty corpsman, special forces medical sergeant, independent duty health services technician, or independent duty medical technician. Independently licensed mental health providers are authorized to complete DD Form 2978.

b. Health care providers who review DD Forms 2795, 2900 and 2978 are required to have a certificate documenting completion of DoD Mental Health Assessment Health Care Personnel Training (available through Joint Knowledge Online). Independently licensed mental health providers may complete Deployment Mental Health Assessments and are not required to complete the additional training.

c. Deployment Mental Health Assessments may also be conducted by a mental health technician provided:

(1) That technician has completed the training and certification requirements described above.

(2) An independently licensed mental health provider, or a physician, nurse practitioner, or physician assistant (who has completed the training and certification requirements described above) is available to supervise and countersign each assessment before a disposition is made.

APPENDIX 6

OCCUPATIONAL AND ENVIRONMENTAL HEALTH SURVEILLANCE SYSTEMS OF RECORD

1. REQUIRED SYSTEMS OF RECORD. OEHS systems of record used before, during, and after deployment include the DOEHRS-IH for unclassified data and MESL (SIPR) for classified data.

2. DOEHRS-IH

a. Background

(1) The DOEHRS-IH is an informatics system that provides the capability to manage and report OEHS information collected in both garrison and the deployment operational environment. DOEHRS-IH is a Common Access Card (CAC) enabled unclassified web-based system with multiple business areas, including the following used for deployment health: Industrial Hygiene Environmental Health, Food Service Sanitation, Radiation, Incident Reporting, Registries and Business Objects Reporting.

(2) DOEHRS-IH business areas are designed to manage all OEHS data associated with PVNTMED activities and provide a record for future data use. Each of the business areas are summarized below.

(3) The IH Exposure Assessment Model in DOEHRS-IH manages potential occupational exposure in workplaces. The model consists of the following eight process steps:

- (a) Define Scope and Support of Resources;
- (b) Basic Characterization;
- (c) Similar Exposure Group(s);
- (d) Develop Worksite Monitoring Plan;
- (e) Characterize Exposures;
- (f) Assess Exposures and Provide Control Plan;
- (g) Reporting and Recording; and
- (h) Re-Evaluation.

(4) Environmental Health. During deployments, the environmental health business area in DOEHRS-IH manages environmental hazard characterization and management through the OEHSA, associated exposure pathways, surveillance plans, and surveillance activities. OEHSA serves as the foundation document for which potential hazards are identified and future sampling and surveillance plans are developed.

(a) Food Service Sanitation. The Food Service Sanitation function globally manages operations associated with food service inspections or evaluations, recorded on DD Form 2973, Food Operations, by food service inspection personnel.

(b) Samples. The environmental health business area includes samples for air, water, soil and thermal stress. In addition, personnel potentially exposed can be associated to locations. Personnel can also be associated to exposure pathways if the cohort is defined.

(c) POEMS. Location specific POEMS are also managed in the environmental health business area of DOEHRS-IH.

(5) Radiation. Manages data associated with potential radiation hazards. The radiation business area includes air, bioassay, soil, swipe, water sampling, various radiation surveys and an ability to document x-ray, laser and radiation emitting equipment. (Individual radiation dosimetry data is stored with each Services dosimetry data repository.)

(6) Incident Reporting. Manages data associated with exposure incidents. The incident reporting module includes Initial Field Account (IFA) and Incident Report surveys, potentially exposed populations and associated hazards (see Appendix 7 for incident reporting procedures).

(7) Registries. Manages data associated with environment health surveillance registries. The Registry module includes an ability to link all registry related data from any of the business areas in DOEHRS-IH and an ability to manage the communication with personnel contained in a registry. This business area is exclusively used by Service public health centers.

(8) Business Objects Reporting. Provides the user an ability to query and report on data in DOEHRS-IH. There are other various reporting functionalities in DOEHRS-IH that enable the user to view current and historical data either discretely or collectively, including access to laboratory results for samples collected in theater, that have been sent to rear-area support organizations, such as the Service public health center (e.g., APHC).

#### b. Use of DOEHRS-IH

(1) All unclassified OEHS data will be entered in DOEHRS-IH whenever a CAC enabled unclassified computer with internet connectivity is available. When connectivity is not possible, data will be collected on DOEHRS-IH forms. These forms are available at: [https://phc.amedd.army.mil/topics/envriohealth/hrasm/Pages/DOEHRS\\_Resources.aspx](https://phc.amedd.army.mil/topics/envriohealth/hrasm/Pages/DOEHRS_Resources.aspx). At the time connectivity is reestablished, the data collected will be entered in DOEHRS-IH.

(2) OEHS activities should be updated as the deployment proceeds based on further health risk assessments, routine and Incident Report-associated monitoring and sampling, medical surveillance, and other health surveillance activities.

(3) Unit commanders will ensure that appropriate members of the unit are trained on DOEHRS-IH and that DOEHRS-IH is used in accordance with References (c) and (s).

c. Training and Resources

(1) PVNTMED personnel responsible for OEH surveillance, including QA, will establish a DOEHRS-IH user account.

(2) Training is provided by each of the Service public health centers and is required for familiarization with navigating, data entry, and retrieving information from DOEHRS-IH. Training is offered through the following means:

(a) The DOEHRS-IH web site (<https://doehrs-ih.csd.disa.mil>) contains training material under the DOEHRS-IH documentation tile. An account is required to access this material.

(b) Individual or group training is offered through webinars or through personalized training by the Service public health centers.

(c) Additional resources provided on-line at: [https://phc.amedd.army.mil/topics/envirohealth/hrasm/Pages/DOEHRS\\_Resources.aspx](https://phc.amedd.army.mil/topics/envirohealth/hrasm/Pages/DOEHRS_Resources.aspx), include training materials and all the environmental health, radiation and Incident Report sampling and survey forms.

3. MESL (SIPR)

a. Background. The MESL (SIPR) is a classified military information management system available via the Secret Internet Protocol Router Network (SIPRNet). The MESL (SIPR) provides personnel collecting classified OEHS data and information a way to record and retrieve classified OEH information. When part of the OEHS data and information is unclassified, in DOEHRS-IH, the unclassified information will be annotated to indicate that further information is in the MESL (SIPR), by reference number and title of the classified document.

b. Document Preparation, Submittal and Retrieval.

(1) When all or part of an OEHS, Incident Report or other OEHS information is classified by an original classification authority or the applicable security classification guide, prepare and submit it to the MESL (SIPR) as follows:

(a) Use systems of the appropriate level of classification level to prepare and submit information to the MESL (SIPR).



- (b) Ensure the country and location relevant to the data, the collecting unit, and date(s) of data collection are clearly marked on all documents.
  - (c) Portion mark the content in accordance with Reference (ak), and the appropriate security classification guide. Cite and reference the applicable source documents and security classification guide or other guidance issued by the original classification authority.
  - (d) Remove (or render illegible), all personally identifiable information (e.g., Social Security Number (SSN), date of birth).
  - (e) Scan documents using an image resolution of 300 dots per inch or higher and avoid scanning in color when possible.
  - (f) Convert electronic files to a searchable portable digital file (PDF) format.
  - (g) Use descriptive file names. Avoid using the default name provided by some applications or using the same file name for multiple documents.
  - (h) Remove any encryption from electronic documents.
  - (i) Ensure each electronic file contains only one complete document. Files containing multiple documents (e.g., reports, forms), should be separated into individual files.
  - (j) Ensure that multi-page documents are compiled into one complete PDF.
  - (k) Classified OEHS and Incident Reports are recorded in the classified MESL (SIPR) in addition to any component-specific classified data collection system.
- (2) There are three methods available for submitting OEHS data to the MESL (SIPR).
- (a) Reporting directly to the website, via a MESL (SIPR) user account, is preferred.
  - (b) Classified OEHS documents can be submitted via email to: [oehs.data.army@mail.smil.mil](mailto:oehs.data.army@mail.smil.mil). Reporting via classified e-mail does not require an active MESL (SIPR) account.
  - (c) Alternatively, mail electronic media or hardcopies to APHC:

Army Public Health Center  
Attn: MCHB-IP-RDD  
5158 Blackhawk Road, Bldg. E-1675  
APG-EA, MD 21010-5403

- (3) Document Retrieval. An active MESL (SIPR) user account is required to access documents stored in the MESL (SIPR).

APPENDIX 7

INCIDENT REPORTING

1. INCIDENT REPORTS. Incident reports are triggered by OEH and CBRN incidents that result in exposures with either acute illness or the potential to cause latent illness. These incidents may also meet the definition of mishaps caused by DoD activities, to be addressed in accordance with Reference (ch).

a. Because of the variety of situations and subject matter expertise associated with such incidents, the Heads of the DoD Components plan, program, budget, and issue guidance consistent with Reference (c), and this DHA-PI.

b. The determination of whether an OEH exposure is sufficient to warrant reporting as an exposure incident is somewhat subjective, but there are certain criteria to support a determination. The most obvious scenarios are those resulting in real-time health impacts that require medical countermeasures or treatment. Incident reports should be prepared for all exposure incidents meeting at least one of the following criteria:

(1) Visual/sensory cues are present indicating potential presence of an OEH hazard (e.g., smoke/cloud, odors, strange liquid/powders, etc.);

(2) The presence of an acute OEH hazard is indicated through positive detection using real-time field equipment (e.g., direct reading instruments, Joint Chemical Agent Detector, Improved Chemical Agent Monitor, M8 Chemical Detector Paper or M256 Chemical Agent Detector kit);

(3) Evaluation of data by an appropriate medical/health professional indicates that exposure could plausibly result in some significant adverse health outcome, either short- or long-term;

(4) Incident results in a significant exposure to any deployed individual(s), including from CBRN agents and acutely toxic industrial chemicals;

(5) The presence of a health hazard is plausibly associated with actual observed (acute) clinical health outcomes that are reported and/or treated (e.g., complaints of headaches, dizziness, skin or eye irritation/burning, coughing, nausea, etc.); or

(6) Concern over a perceived or potential adverse health exposure leads to involvement of PVNTMED assets and military leadership for investigation, assessment, determination and response. Document these actions as an Incident Report even when there is a determination that no adverse exposures or impacts to human health are expected.

## 2. INCIDENT REPORT INVESTIGATION

a. Investigation of Individuals. Individuals and/or military working animals exposed to chemical, biological, radiological, or physical agents, including metals, while deployed should be identified using a combination of:

(1) Proactive identification methods to seek out individuals potentially associated with the exposure incident based on information provided by line commanders and/or IFA survey.

(2) Reactive identification methods based on reports by a patient or health-care provider of concern about a possible exposure, including concerns indicated in post-deployment health assessments or the health record.

### b. Investigation of Exposure Incidents

(1) Promptly investigate and assess exposures to OEH hazards (including CBRN agents) that may result in an acute illness or potentially cause a latent illness.

(2) Determine and create a roster of all personnel affected or possibly exposed in the incident.

(3) Document any acute and any known or anticipated latent health outcomes and any medical follow-up required, PPE or countermeasures used, effectiveness of and compliance with countermeasures, and any other exposure incident response activities.

(4) Conduct and document environmental monitoring and sampling.

(5) All patient medical encounters associated with exposures or exposure concerns must be entered into the DoD health record, using a SF 600 or equivalent electronic format.

(6) Ensure the health risks are communicated to the population at risk (PAR). Document the health risk communication messages and materials used that are relevant to the incident investigation.

## 3. DOCUMENTATION AND REPORTING OF EXPOSURE INCIDENTS

### a. Method of Documentation of OEH Exposure

(1) IFA survey-When an incident occurs, the affected unit(s) should complete an IFA survey, with input from personnel involved in the incident or witness to the incident and the assistance of on-site or reach-back PVNTMED personnel. The purpose of the IFA survey is to document information about the incident closest to the time that it occurred, so follow on actions and the Incident Report survey can be as accurate as possible.

(2) Incident report survey - Whether an IFA survey is completed or not, an Incident Report survey must be conducted for the incident.

(3) The DOEHRS-IH Incident Reporting Module is the system of record for DoD exposure documentation and provides an electronic mechanism for users to directly complete data fields to document information surrounding exposure incidents. This process ensures an archived record of the incident and assessment, and details of specific personnel, procedures, and data, and documents recommendations regarding medical surveillance or follow-up. The IFA and Incident Report surveys can be found in DOEHRS-IH or the following website (<https://mesl.apgea.army.mil/mesl/doehrsResources/initialize.do>). All IFA and Incident Report surveys will be entered in the DOEHRS-IH Incident Reporting Business Area.

(4) Designated PVNTMED personnel prepare the Incident Report, completing it at the lowest classification possible to facilitate distribution, entering the relevant data into the DOEHRS-IH Incident Reporting module or, in the absence of access to it, by utilizing a hard copy version to record the data and providing all necessary information to the appropriate Service public health center.

b. Information Documentation Requirements

(1) Specific data required to be documented include:

- (a) Location, date, and time of incident;
- (b) A summary of events or description of what transpired;
- (c) Unit rosters of all personnel involved (affected or possibly exposed), and indicate those persons medically treated and their disposition. Any RME reports or D&I reports should be included;
- (d) Acute or latent health outcomes that are known or that may be anticipated, and any medical follow-up required, as well as the overall types and severity of acute and chronic health effects and the risk levels;
- (e) Documentation of PPE or countermeasures used, effectiveness of, and compliance with, countermeasures, and any other exposure incident response activities;
- (f) Results of environmental monitoring including hazard and exposure information (duration, frequency, field measurements and laboratory results); and
- (g) Health risk communication materials provided to health care providers, patients, or PAR.

(2) Most of the required elements to be documented in the Incident Report will be obtained from supporting documents, which may be referenced as attachments. However, additional interpretation of the data may be required in the form of a summary. For example,

PVNTMED personnel completing the Incident Report should summarize the incident information and provide a qualitative risk estimate of the level of the acute health effects presented during the incident as well as an estimate of the risk for long-term health consequences, using the risk definitions in appropriate technical guidance. PVNTMED personnel should refer to Reference (bs) and CCMD or Service guidance regarding OEH risk estimation and may contact their Service public health center for advice.

(3) An Incident Report must be completed for all OEH or CBRN exposure incidents that result in an acute illness or that have the potential to cause latent illness.

(4) Initial Incident Reports will be made within seven days after an incident or outbreak. Interim and final reports will be completed and recorded in DOEHRS-IH no later than seven days after investigations and report completion.

(5) If portions of the Incident Report are classified, indicate in the unclassified Incident Report (in DOEHRS-IH) that the complete Incident Report is available within the classified MESL (SIPR) and provide the reference number and title of the classified document (see Appendix 6).

(6) Also submit exposure incident investigation records (OEH or CBRN agents) via applicable CCMD or Service-specific systems (hard copy or electronic) for further disposition and archiving.

APPENDIX 8

DAILY LOCATION TRACKING OF DEPLOYED SERVICE MEMBERS AND  
DEPARTMENT OF DEFENSE CIVILIANS

1. GENERAL LOCATION REQUIREMENTS. In general, systems to track the duty locations of Service members, DoD civilian employees, and contractors during deployment periods, including natural and manmade disasters are established and maintained consistent with References (c), (t), (u), (v), (ad), and (ah). During deployments, a process will be in place to record locations of individual Service members and DoD civilians at least once daily, in accordance with Reference (c).

a. Location records will help determine the PAR for occupational and environmental exposures, for any associated medical follow-up required, and for reporting to OSD.

b. The following detailed data and reporting procedures apply:

(1) Record daily locations in: six-digit grid coordinates, latitude/longitude coordinates, and/or geographic location codes as a “location record.”

(2) Once an initial in-theater location record is established in the component-designated (or Service-specific), system of record for each newly arrived individual, subsequent changes are required only when the individual changes their previously recorded once-daily location or when the Service member departs the theater.

(3) Location records will be electronically reported to the DMDC via the component-designated system of record at least weekly. The DMDC system will have the capability to create reports on individuals and units for specified locations and dates.

c. Deployment Location Data

(1) Personnel/Location Data. Each unit deployed in a theater of operations will establish, maintain, and report a daily accountability or when changes in location occur of all personnel assigned, attached, or temporary duty or temporary additional duty to the unit, along with their once-daily location records. Location data is expressed in six-digit grid coordinate, latitude/longitude coordinates, and/or geographic location code.

(2) Data Currency. While this information need not be submitted to DMDC in real time, it will be reported to DMDC via the component or Service-specific system of record at least weekly.

(3) Data Accuracy. Components reporting individual daily location data will designate accountability and deployment health system points of contact to identify and resolve any discrepancies between data in component systems (e.g., component-designated accountability system, Medical Readiness Reporting System, Medical Operational Data System, Aeromedical

Service Information Management System), and the DMDC system for individual daily location data, in coordination with DMDC.

(4) Data Classification. This data may be unclassified or classified as directed by the designated original classification authority. If any element is classified, it must be portion-marked as described in Reference (ak), with reference to the applicable original classification authority or specific security classification guidance.

(5) The CCDR or Service component commander will retain all location records for missions that exceed DMDC’s classification capability. When these records are downgraded, they will be marked accordingly and transmitted electronically to DMDC for archiving via the Services’ system of record.

2. INDIVIDUAL LOCATION DATA ELEMENTS. Required Data Elements. Reference (c) establishes the data elements required to record and preserve Service member and DoD civilian location information during deployments, including shipboard operations and enduring locations, as shown in the chart below. Individually identifiable information and Privacy Act information are protected in accordance with References (ba) through (bc).

Required Individual Location Elements Chart

Element Name	Description
DoD Electronic Data Interchange Person Identifier (EDIPI) (If unavailable, SSN)	The DoD EDIPI stored on the CAC.
SSN—Leave blank if DoD EDIPI is included	The identifier assigned by the Social Security Administration to a person. Use only in the absence of DoD EDIPI.
Service Branch Code	A-Army; N-Navy; M-Marine Corps; F-Air Force; C-Coast Guard; DoD
Uniformed Service Organization Component Code	R - Regular; G - Guard; V - Reserve; C - DoD Civilian; E - Contractor
Member Surname Text	The text of a designation applied to a person, generally referred to as the last or family name.
Member Forename Text	The text of a designation applied to a person, generally referred to as the first name.
Member Middle Initial Text	The initial of a name designation applied to a person, commonly used between the first and last names. If not applicable, report as blank.
Member Birth Calendar Date	The date when a person was born. Format: YYYYMMDD
Assigned Unit Identification Code (UIC)	The Service-unique code that represents the unit to which the member is assigned. Army: Report a W, the UIC and one blank Navy: Report an N, the UIC and one blank Marine Corps: Report the Reporting Unit Code (RUC) and the Monitored Command Code (MCC) Air Force: Report an F, the unit portion of the Personnel Accounting System (PAS) Code and two blanks Coast Guard: Report the UIC

Element Name	Description
Attached UIC	The Service-unique code represents the unit to which member has reported to duty. Army: Report a W, the UIC and one blank Navy: Report an N, the UIC and one blank Marine Corps: Report the RUC and MCC Air Force: Report an F, the unit portion of the PAS Code and two blanks Coast Guard: Report the UIC
Deployment Start Date	The date and time (Zulu) that the member began the deployment. Format: YYYYMMDDHHMM
Deployment End Date	The date and time (Zulu) that the member ended the deployment. Format: YYYYMMDDHHMM
Operation Plan Identification Code	The code originates from the Joint Chiefs of Staff, Joint Operation Plan and Execution Segment system and is used to identify a specific operation plan.
Location Start Date	The date and time (Zulu) that the member arrived at the location being reported. Format: YYYYMMDDHHMM
Location End Date	The date and time (Zulu) that the member departed at the location being reported. Format: YYYYMMDDHHMM
Location Longitude Coordinate Code3	Report the degrees, minutes and seconds of the longitude of the member's location
Location Longitude Direction Code3	E East; W West
Location Latitude Coordinate Code3	Report the degrees, minutes and seconds of the latitude of the member's location
Location Latitude Direction Code3	N North; S South
Grid Coordinate Code4	Two-byte alphabetic map sheet designation and six-digit grid coordinate. Format: AB123456
Geolocation Code5	Geographic Location Code
Location Country Code	The two-byte alphabetic code that represents the principal geopolitical entity of the world. Report U.S. for the 50 States and District of Columbia. If afloat at sea or unknown, report ZZ.
Location State Code	The two-byte alphabetic code that represents the state or the District of Columbia for domestic deployments.
Location Calendar Date	The date the member was at the location being reported on. Format: YYYYMMDD
Operation Name Text	Joint Staff or component name of an operation
Location Name Text	Joint Staff or Component name of the location (e.g., forward operating base, contingency location, enduring location, base camp, etc.)



APPENDIX 9

DISEASE AND INJURY SURVEILLANCE, REPORTABLE MEDICAL EVENTS, AND  
REPORT OF ANIMAL BITE AND RABIES PREVENTION

1. PURPOSE. The purpose of D&I surveillance is to promote and maintain healthy and fit deployed forces through monitoring injuries and illnesses and instituting interventions as needed.

2. D&I COORDINATION. PVNTMED personnel coordinate with safety officers and safety and occupational health specialists for information sharing on trends to implement intervention strategies and reduce injury rates. PVNTMED personnel also coordinate with logistics and engineering specialists for information sharing and intervention strategies that prevent and reduce illness associated with food, water, or disease vectors.

3. D&I RATES. D&I rates, including disease and non-battle injury (DNBI) rates and battle injury rates, are identified, tracked and reported to unit medical and line leadership. D&I rates may indicate the existence or emergence of a problem that could negatively impact mission readiness and accomplishment, and a need for implementing additional PVNTMED countermeasures for the PAR.

4. D&I PROCEDURES. D&I trends, whether measured as counts or rates, are an important type of health surveillance for use at unit-level and other organizational levels. Because the most valuable D&I surveillance data is near real-time, PVNTMED and public health personnel must monitor D&I daily at the MTF level to enable early identification of potential adverse health trends and assessment of countermeasure effectiveness.

a. The purpose of D&I surveillance is to promote and maintain a healthy and fit deployed force, through monitoring of illnesses and injuries, and instituting necessary interventions. Specific objectives include:

(1) Detection of disease outbreaks and sentinel events.

(2) Promotion of other areas of public health and PVNTMED, such as injury prevention, and monitoring of environmental and occupational exposure sources.

b. D&I surveillance is not meant to capture the overall clinic/hospital caseload, justify specific resources, or track other business-oriented aspects of healthcare operations. D&I should not be used to track the incidence of chronic diseases where preventive efforts in the theater of operation are generally neither effective nor available (e.g., cardiovascular disease or cancer). Such conditions should have been identified, prevented, or treated in the garrison setting prior to deploying as part of the Annual PHA and Deployment Health Assessments in accordance with References (c), (s), (aa), (ab), and this DHA-PI.

c. The population of interest in D&I surveillance consists of Service members and other personnel eligible for DoD medical care. Routine rate calculation should be based on the average troop strength or PAR for the reporting period. D&I surveillance data on other individuals seen by U.S. military medical assets should also be captured and archived.

d. For determination of D&I rates or counts, only the initial visit should be counted, although some patients with multiple ailments diagnosed during a single visit may need to be counted in more than one category.

e. Indicators of potential emergencies include (but are not limited to), communicability, severity of disease, a fatality, or a condition that suggests a failure in the established public health system or medical countermeasures. Significant differences between expected and actual rates should heighten surveillance, lead to an investigation and, if validated, require intervention and reporting to the CCMD authority in addition to routine periodic reporting.

f. Specific procedures for D&I surveillance. The attending medical staff must capture at least the demographics, chief complaint, diagnosis(es), ICD-10 code(s), and disposition on every patient encounter. Specific surveillance procedures, preferably utilizing electronic reporting systems, should follow specific Service or command guidelines, in accordance with procedures developed by the AFHSD pursuant to Reference (q).

(1) Specific categories for use in D&I surveillance are listed at Paragraph 7.

(2) For cases of injury or exposure, suspected exposure or contact with a health hazard, include appropriate external cause codes (e.g., cause of injury) or secondary ICD-10 codes (e.g., contact with or suspected exposure to metals, external cause codes) to help to further define the primary code used.

(3) FHP personnel using electronic surveillance systems baseline legacy data when the electronic system does not support the archival of baseline data.

g. D&I surveillance objectives include:

(1) Disease outbreak detection

(2) Sentinel event detection

(3) Other relevant areas of public health and PVNTMED, such as injury prevention and exposure monitoring of environmental and occupational sources.

h. The scope of personnel involved in D&I surveillance are Service members and other authorized personnel eligible for DoD medical care. Also, recommend capturing and archiving D&I surveillance data on other individuals (e.g., third country nationals, local nationals (military and civilian), detainees, prisoners of war, and refugees), seen by U.S. military medical assets.

i. Local D&I data must be evaluated at least once daily with more frequent attention to infectious disease categories during periods of increased threat; (e.g., intelligence reports of planned attack with bio-warfare agent, known ongoing outbreak, etc.). Electronic health event data collection systems, such as the Theater Medical Information Program-Joint suite of systems, which include the Medical Situational Awareness in the Theater (MSAT) and the DoD EHR (currently the Armed Forces Health Longitudinal Technology Application-Theater for theater outpatient care and Theater Medical Information Program Composite Health Care System Caché for theater inpatient care) and the Theater Medical Data Store, are available at most levels of care in any theater of operation. Others, such as Electronic Surveillance System for the Early Notification of Community-based Epidemics may be available and directed by the command or Service.

j. These systems should be utilized as the primary public health and PVNTMED surveillance tools, eliminating the need for paper-based reporting in most situations. Advantages of these electronic systems include graphical presentations of trends, including statistical testing, over time for the various D&I categories, filters to identify RMEs based on applicable ICD codes, and role-based access to patient identifying information to facilitate local public health efforts. Additionally, upstream authorities, (e.g., Service component command, JTF Surgeon General (SG), CCMD SG, Military Service specific public health centers (APHC, NMCPHC, the USAFSAM)), and the AFHSD are available to monitor regional or command-focused aggregates, possibly identifying larger patterns and trends.

k. For sites without a DoD EHR system that feeds MSAT, the local staff will need to revert to manual procedures and/or electronic data on local computers or networks. For sites without a DoD EHR, but with SIPRNet access, the Annex Q DNBI Reporting portion of MSAT is available for input of local data and information for review by higher headquarters. During prolonged periods without SIPRNet access to MSAT, a weekly report will be submitted for entry into MSAT via secure phone, secure e-mail (preferred), or secure fax through command channels to the JTF SG and to the CCMD SG. The supported CCMD SG will release D&I reports to the Joint Staff, the DHA, and the Military Service components when significant medical threats are encountered.

l. Epidemiology for the North Atlantic Treaty Organization (EpiNATO) using the EpiNATO surveillance system. U.S. forces participating in North Atlantic Treaty Organization (NATO) operations may also be required to report surveillance findings following EpiNATO definitions and guidelines. This is an additional requirement and cannot replace D&I surveillance as the categories are different in design due to the different focus, purpose, and objectives of EpiNATO (more in keeping with providing humanitarian relief and capturing total workload, including chronic diseases). To minimize this additional administrative burden, an EpiNATO report is available in MSAT with the local health events mapped directly to EpiNATO categories based on the recorded ICD diagnostic codes.

m. D&I surveillance derives from electronic patient records, sick call logs, safety mishap reports, or other sources. The attending medical staff must capture the following information, at a minimum, on every patient encounter:

(1) Patient's name, DoD EDIPI (if none, then SSN), gender, unit, (UIC or RUC), and duty location.

(2) Type of visit - new vs. follow-up. **Note:** Providers must be trained to use the ICD code to identify follow-up visits.

(3) Primary (chief) complaint, the reason for seeking care.

(4) Pertinent travel history, including forward deployment or duties outside the deployment location perimeter.

(5) Final diagnosis(es), in order of importance related to the primary complaint. Ongoing training and feedback to the local medical staff is the most effective way to improve the accuracy of coding.

(6) Injuries, which must be classified into recreation/sports, motor vehicle accident (MVA), work/training, or other. The attending health care provider should provide applicable primary and secondary ICD-10 codes, with an external cause code (ICD-10-CM code) for any injury.

(7) Final projected disposition into one of the following categories:

- (a) Full duty;
- (b) Light (limited) duty (number of days);
- (c) Sick in quarters (number of days);
- (d) Inpatient admissions (number of days);
- (e) Transported to another facility; and

(8) D&I category.

n. For sites/units without a DoD EHR or other records of raw data compiled to create D&I reports, the D&I reports must be forwarded to the next level of care (e.g., Role 1 to Role 2, Role 2 to Role 3). Any paper-based medical encounter records must be scanned and appended to the DoD EHR.

## 5. ELECTRONIC D&I SURVEILLANCE

- a. Login to the classified MSAT website at least once daily at <https://msat.fhp.smil.mil>.

b. The default opening page, (Unit Status/Current Status), includes a link near the top of the page that will open a list of any recent RME. Investigate, validate, and document RMEs as required by CCMD or Service guidance.

c. In the Joint Medical Work Station portal within MSAT, use the “Surveillance” tab to access the various surveillance functions. These functions provide the user with daily incident counts, via tabular or graphical representations, for each of the D&I categories for their identified unit or any aggregation of units (as determined by the user-defined filter). Select Electronic Surveillance System for the Early Notification of Community-based Epidemics or z-score algorithm to evaluate the data using different statistical methods. Users can also export data for additional analysis in local applications (Microsoft Excel, EpiInfo™, etc.), as desired.

d. Many factors, including geography, climate, seasonal variation, local vectors and endemic diseases, exposure, success of protective measures, and type of military operations, can affect the expected number of cases or incident rates at a given site. For this reason, historical reference rates derived during other operations are of little value. Rather, it is vital to develop local reference values at the earliest opportunity.

e. Rates are ideal for health surveillance, but have always been problematic, especially in regional/aggregate analyses. Counts are “easier” to obtain and very useful; however, be aware of abrupt, large changes in the local denominator PAR. Appropriate statistical analyses mitigate some of the possible deficiencies for counts compared to rates. MSAT currently provides surveillance information based on counts and will remain the standard approach until such time as Deployable Theater Accountability System, Deliberate and Crisis Action Planning and Execution Segments, or an equivalent personnel system is available throughout the theater. These real-time personnel tracking systems have been validated as accurate and timely. Then MSAT will incorporate automatic PAR feeds and convert to rate-based monitoring. Another alternative, if accurate denominators are unavailable, is to calculate and monitor the proportion of each category in comparison to the total incidents each day, week, or month. For example, the percentage of influenza like illness cases out of all outpatient visits.

f. Local staff should provide additional detail, such as interventions taken and results of same, about any validated outbreak as part of the daily medical situational report as required by CCMD SG or Service component command instructions.

g. MSAT supports role-based access and individuals must apply for an account (<http://msat.fhp.smil.mil>). Supervisor validation is necessary for access to protected health information. Individuals may apply for access prior to deploying and on-line MSAT training is available from <https://train.msat.testinginfrastructure.com/portal/>. It is essential that the deployed medical unit submit a joining report via MSAT in the Joint Medical Work Station portal by going to Annex Q Reporting, Create Report, Joining. This establishes the deployed unit in MSAT and ensures that any records submitted from the DoD EHR are properly assigned to the correct UIC for analysis and display.

h. To correctly identify units in MSAT, ensure consistent naming conventions are used for joining reports and similar files. Follow the naming convention guidance provided by CCMD.

In the absence of CCMD guidance, the recommended naming convention for unit names in joining reports is: Contingency Location or Base Name\_City or Town Name\_Country\_Deployed Medical Unit Name\_UIC.

## 6. MANUAL D&I SURVEILLANCE

a. Manual reporting should rarely be necessary. In the unusual event of electronic system unavailability for a prolonged period of time, a worksheet is a useful way to focus local surveillance work, using following calculations. It can be used daily and summarized weekly. For rate calculation, obtain the average troop strength or PAR for the reporting period from the local personnel function.

b. Review available records and add up the total number of new cases (excluding follow-ups), seen during the day/week in each D&I (or DNBI) category. Fill in the appropriate block. Add up the total D&I and record the number in the space provided.

c. To calculate rates, divide the total number of patients seen in each category by the average troop strength or PAR, and multiply by 100. Remember to calculate an overall D&I total rate.

d. Example. If there were 20 dermatological cases this week in 500 troops, the rate (percent) for dermatological cases would be calculated as follows:

$$(1) DNBI_{derm}, (\%) = (20/500) \times 100$$

$$(2) DNBI (\%) = (\# Patients/\# Troops) \times 100$$

$$(3) DNBI_{derm} (\%) = (0.04) \times 100$$

$$(4) DNBI_{derm} (\%) = 4\%$$

(5) Next, add up the total number of estimated light duty days in each category, and fill in the appropriate block.

e. Compare counts or calculated rates for each category with the local reference values for that category (comment is required under the section “Problems Identified-Corrective Actions” for all categories where the results exceed the expected values or an equivalent statistical analysis). When comparing values, keep the following information in mind:

(1) Exceeding an expected count or rate by a small amount is not necessarily an indication of a significant problem. Results between two and three standard deviations should heighten surveillance. Results exceeding three standard deviations require investigation and, if validated, intervention and reporting to the JTF and/or CCMD SG.

(2) Use professional judgment in interpreting the D&I rates. Track counts/rates over time and compare them with your unit's past D&I rates for comparable situations, to include seasonal variation when such data are available.

f. Provide weekly summaries (daily during times of high threat or in the presence of an ongoing outbreak), of D&I findings to the unit and to medical personnel at higher echelons. The CCMD is the releasing authority for all reportable D&I outcomes. The AFHSD and Military Service public health centers are available to coordinate with deployed theater medical surveillance teams or the CCMD or JTF SG when adverse trends occur. Theater surveillance teams will augment organic PVNTMED units to investigate outbreaks or other adverse D&I findings as needed.

## 7. D&I CATEGORIES

a. Count only the initial visit. Do not count follow-up visits.

(1) Some patients with multiple ailments diagnosed during a single visit may need to be counted in more than one category. Example: Soldier presents with sprained ankle and diarrhea. Count in Gastrointestinal Infections and Injury, Recreational/Sports.

(2) Estimate number of patients for each disposition category (returned to duty, light duty/limited duty/profile, sick in quarters, hospitalized, or evacuated and anticipated lost work days).

b. Categories for Outbreak Detection (naturally-occurring or deliberate)

(1) Fever, Unexplained. Oral temperature of 100.5 or greater for 24 hours, or history of chills and fever without a clear diagnosis. Such fever cannot be explained by other inflammatory/infectious processes such as respiratory infections, heat, and overexertion. Includes septicemia and viremia. Exclude entry if more specific diagnostic code is present allowing categorization as respiratory, neurological or gastrointestinal illness syndrome. Targeted Conditions-tropical diseases such as malaria, dengue, yellow fever, and typhoid fever.

(2) Influenza-like Illness. Illnesses characterized by fever (oral temperature >100.5 F or 38 C) AND either cough OR sore throat. Includes pneumonia. Targeted Conditions-pandemic influenza, adenovirus, pulmonary anthrax, tularemia, pneumonic plague, or emerging febrile infections (e.g., severe acute respiratory syndrome).

(3) Rash. Acute condition that may be consistent with smallpox (macules, papules, or vesicles predominantly of face, arms, and legs of unclear etiology or rule out smallpox). Includes specific diagnoses such as chicken pox or smallpox and non-specific diagnoses such as viral exanthema. Excludes allergic or inflammatory skin conditions such as contact or seborrheic dermatitis, rosacea, rash not otherwise specified, rash due to poison ivy, sunburn, and eczema. Targeted Conditions-smallpox, chemical warfare blister agent.

(4) Localized Cutaneous Lesion. Localized edema and/or cutaneous lesion (vesicle, ulcer, or eschar) that might be consistent with cutaneous anthrax or tularemia. Includes insect bites. Excludes generalized rashes, diabetic ulcers or ulcers associated with peripheral vascular disease. Targeted Conditions—cutaneous anthrax or tularemia; diseases reflecting cutaneous parasitism, like cutaneous leishmaniasis.

(5) Hemorrhagic Illness. Acute systemic illness characterized by fever, chills, back pain or generalized myalgia and varying hemorrhagic manifestations such as bleeding gums, epistaxis, hematemesis, melena, metrorrhagia, strawberry tongue, disseminated intravascular coagulation (DIC), petechiae, or bruising; consistent with viral hemorrhagic fever. Associated acute blood abnormalities may include leukopenia, neutropenia, thrombocytopenia, decreased clotting factors, or albuminuria. Targeted Conditions—any virus that causes viral hemorrhagic fever, e.g., Yellow Fever, Dengue, Rift Valley Fever, Crimean Congo Hemorrhagic Fever, Kyasanur Forest Disease, Omsk Hemorrhagic Fever, Hantan, Junin, Machupo, Lassa, Marburg, or Ebola.

(6) Gastrointestinal Infectious. All diagnoses consistent with infection of the intestinal tract, upper or lower. Includes any type of diarrhea, gastroenteritis, “stomach flu,” “food poisoning,” nausea/vomiting, hepatitis, etc. Excludes non-infectious intestinal diagnoses such as hemorrhoids, ulcers, hernias, etc. and chronic conditions such as irritable bowel syndrome. Targeted Conditions—salmonella, shigella, campylobacter, Escherichia coli, noroviruses, cholera, typhoid, gastrointestinal anthrax, etc. **Note:** Though not infectious in nature, cases of illness due to emetic chemical warfare agents would be captured by this category.

(7) Botulism-like. Acute paralytic conditions consistent with botulism. Cranial nerve VI (lateral rectus) palsy, ptosis, dilated pupils, decreased gag reflex, media rectus palsy; acute descending motor paralysis (including muscles of respiration); or acute symptoms such as diplopia, dry mouth, dysphagia, difficulty focusing on a near point. Targeted Conditions—botulism.

(8) Neurological. Acute infection or intoxication of the central nervous system. Includes meningitis, encephalitis, or encephalopathy and acute non-specific symptoms such as meningismus and delirium. Excludes alcohol intoxication or any chronic, hereditary or degenerative conditions of the central nervous system such as obstructive hydrocephalus, Parkinson’s, Alzheimer’s. Targeted Conditions—pneumococcal or meningococcal meningitis, viral encephalitides, rabies, toxic material/chemical exposures, etc.

(9) Shock/Coma/Death. Acute onset of shock or coma from potentially infectious causes. Includes sudden death (of unknown cause or <24 hours after onset of symptom), death in emergency room. Excludes shock from trauma.

c. Categories for Other Conditions of Public Health Concern

(1) Combat and Operational Stress Reactions. The term is defined in Reference (bq), as the physical, emotional, cognitive, or behavioral reactions, adverse consequences, or psychological injuries of Service members who have been exposed to stressful or traumatic



events in combat or military operations. Combat and operational stress reactions vary in severity as a function of operational conditions, such as intensity, duration, frequency of combat exposure, rules of engagement, leadership, effective communication, unit morale, unit cohesion, and perceived importance of the mission, etc. combat and operational stress reactions do not represent mental health disorders or medically diagnosable conditions and concerns. Post-traumatic stress disorder is not equivalent to or another name for combat and operational stress reaction.

(2) Dermatological. Diseases of the skin and subcutaneous tissue, including, heat rash, fungal infection, cellulitis, impetigo, contact dermatitis, blisters not associated with trauma, ingrown toenails, unspecified dermatitis, etc. Includes sunburn. Excludes trauma, laceration, and items mapped to rash or localized cutaneous lesions.

(3) Ophthalmologic. Any acute diagnosis involving the eye, including conjunctivitis, sty, corneal abrasion, foreign body, sudden blindness or low vision, etc. Excludes routine referral for refraction (glasses).

(4) Psychiatric/Mental Disorders. Debilitating mental, behavioral or somatic symptoms that meet diagnostic criteria for or have been previously diagnosed as a psychiatric/mental disorder including post-traumatic stress disorder and adjustment disorders. Excludes symptoms due to identified physical disease or injury, or symptoms better explained as a transient combat/operational stress reaction.

(5) Respiratory, Upper. Acute upper respiratory infections, allergic/irritant conditions, and other disorders of the ear, nose, and throat. Includes “common cold”, tonsillitis, otitis, sinusitis, vertigo, hearing problems, and allergic rhinitis. Also, exacerbation of chronic conditions, (e.g., hay fever). Excludes stable chronic conditions or acute laryngitis/tracheitis Map cases in this category to influenza-like illness.

(6) Reactive Airway Disease (RAD)/Asthma, Acute Non-Febrile RAD/Asthma. RAD is coughing, wheezing or shortness of breath without a known infectious cause. Excludes non-specific diagnoses of bronchitis or pneumonia (map to fever or influenza-like illness).

(7) RMEs. All items listed in the Armed Forces RME List (References (bt) and (bu)), plus any additional items designated by CCMD or JTF SG (see Paragraph 8, below).

#### d. Injuries

(1) Heat Injuries and Cold Injuries - Climatic injuries. Includes heat stroke, heat exhaustion, heat cramps, heat-related dehydration, hypothermia, frostbite, trench foot, immersion foot, and chilblain.

(2) Injuries, Sports/Recreational/Physical Training (including Unit Physical Fitness). Any injury occurring as a direct consequence of the pursuit of personal and/or informal group

fitness, e.g., non-command sanctioned game of soccer. Excludes injuries incurred during command-sanctioned formal training programs, (e.g., formation running (map to Work/Training)).

(3) Injuries, MVAs. Any injury occurring as a direct consequence of an MVA.

(4) Injury, Work/Military Operations/Training (not Unit Physical Training). Any injury occurring as a direct consequence of military operations/duties or of an activity carried out as part of formal military training, to include organized runs and physical fitness programs.

(5) Injury, Other. Any injury not included in the previously defined injury categories. Includes rape and injuries secondary to fights (not related to hostile action) and injuries caused by hostile actions.

(6) Injury, Other Hostile Action. Any injury that is the result of hostile activity, includes direct injuries such as projectile, fragments, amputations, brain injuries due to explosive blast exposure, and indirect injuries such as spraining an ankle while diving for cover due to sniper fire. Excludes and injuries that map to categories above.

(7) All Other. Any medical condition not fitting into any category above.

(8) Definable. A category established (in addition to others in this section) for a specific deployment based on public health concerns (e.g., occupational, environmental, and/ or CBRN exposures of concern; malaria; dengue; and airborne high altitude and/or low open injuries, etc.).

## 8. RME

a. During deployment, the Services will conduct RME surveillance using DRSi or the DHA-designated system for RME surveillance. RME guidelines and case definitions are within the DRSi. RME case definitions designated by the AFHSD based on input from the three Services and the DoD Joint Preventive Medicine Policy Group, are posted on the AFHSD website at: <https://health.mil/Military-Health-Topics/Combat-Support/Armed-Forces-Health-Surveillance-Branch>. RMEs, including disease clusters and outbreaks, must be transmitted to the AFHSD in accordance with Reference (az). Suspected and confirmed cases will be reflected in the DMSS.

### b. Purpose and Process for RMEs

(1) RMEs include all items listed in the Armed Forces RME List (References (bt) and (bu)), plus any additional items designated by CCMD or JTF SG. RMEs represent a special concern to the military leadership and public health authorities because they are associated with the potential for disease outbreaks, or they may constitute sentinel events that indicate the failure of FHP measures. Many are consistent with conditions that are reportable under U.S. federal or individual state laws. RME are based on definitive diagnoses and/or working diagnoses and available laboratory results. The Services maintain specific policies for the reporting of medical events, but all conform to the minimum requirements listed in Reference (bu).

(2) Central reporting of these events ensures immediate visibility of potential threats to FHP. Medical providers at all levels are responsible for knowing the list of RMEs and reporting via Service specific systems, and assisting in epidemiological investigations, as necessary. FHP personnel responsible for monitoring RME reporting must use available health information systems to discover the occurrence of events that have not been reported by a provider. Resources include, but are not limited to, electronic records systems, sick call logs or emergency room admission records, and should be reviewed daily or according to command directives.

(3) For conditions that may require further investigation, reporting should not be delayed by lack of confirmatory or definitive laboratory testing or uncertain clinical criteria. In the deployed environment, rapid assessment and containment of disease outbreaks is essential to maintaining force strength.

(4) Reporting of other conditions and exposures as RMEs. These may be added to the RME reporting system when accommodated by the corresponding Service or CCMD reporting system.

- (a) Chemical, biological, nuclear, and radiological exposure.
- (b) Pneumonia, coded by organism, to include eosinophilic pneumonia.
- (c) Acinetobacter infections, coded as a bacterial infection specific to an anatomical site, along with antibiotic sensitivities, if available, and recent travel history.
- (d) Death or injury from failure of helmet or body armor (injury due to war operations).
- (e) Acoustic trauma (otic barotrauma).
- (f) Traumatic loss or damage to vision or eye; injury, penetrating or non-penetrating.

## 9. REPORT OF ANIMAL BITE AND RABIES PREVENTION

a. Every case of potential or confirmed rabies exposure requires prompt reporting, by the individual, for medical attention and completion of DD Form 2341, Report of Animal Bite – Potential Rabies Exposure. Initiation of rabies post-exposure prophylaxis is an RME in accordance with References (bt) and (bu).

b. Routes of rabies exposure. Routes of exposure to rabies include a bite from an animal capable of spreading rabies (most mammals), saliva or neural (brain) tissue contact with mucous membranes or broken skin (e.g., scratch), or contact with a bat (potential or actual contact). Therefore, animal bites or scratches, mucous membrane exposures, bat exposure, and other potential exposures to rabies are reported, treated and tracked using DD Form 2341 and according to CCMD instructions.

c. Reporting and documentation requirements. Reporting is the responsibility of both medical personnel and the exposed individual. Cases are tracked from initial medical evaluation through rabies risk assessment and, when indicated, the completion and reporting of post-exposure rabies prophylaxis.

(1) Deployed medical personnel ensure health record documentation of a possible rabies exposure event, using DD Form 2341 or electronic equivalent, which also serves as the animal bite report reflecting a timely assessment, treatment, and Rabies Advisory Board (RAB) review of each case.

(2) Medical personnel must record administration of rabies post-exposure prophylaxis, when indicated by risk, on the DD Form 2341, in the applicable immunization records and as an RME.

(3) The exposed individual should seek prompt medical evaluation and, at the conclusion of the deployment, note the exposure event (e.g., dog bite, awoke and found a bat in sleeping quarters, etc.), on post-deployment health assessments. The reviewing health care provider shall verify that post-exposure risk assessment and prophylaxis, when indicated, are complete.

#### d. Rabies Exposure Procedures Overview

(1) Any potential exposure to rabies must be medically evaluated promptly with appropriate wound care and potential exposures to rabies documented on DD Form 2341 and recorded in the health record. Medical evaluation and treatment will not be delayed by attempts to identify and capture the animal for observation or for euthanasia and rabies testing.

(2) RAB review must occur as soon as possible for each potential exposure case, within 24 hours of a high-risk exposure (including but not limited to bites from a symptomatic animal or bite wounds to the face/head or hands), following the first health care encounter and initiation of the DD Form 2341. Virtual meeting of the RAB (E-mail, teleconferencing, or other electronic means) is appropriate in order to ease workload and ensure timely review for risk mitigation.

(3) Each RAB will, at a minimum, be comprised of two U.S. military health care providers trained in rabies risk assessment or PVNTMED, and a U.S. military veterinarian. These Boards provide timely treatment recommendations for each case of potential exposure and also meet routinely (at least monthly in deployed settings, virtually or in-person), to evaluate exposure reporting, post-exposure prophylaxis administration, documentation, and other rabies prevention program initiatives according to References (bn), (bo) and (ci).

(4) Military Services medical personnel will track completion of DD Form 2341 in coordination with the U.S. Army Veterinary Corps Officer serving each deployment location.

(5) Upon redeployment, Military Services medical personnel will ensure post-deployment medical follow-up for those who report any potential or confirmed rabies exposures.

For those who redeploy before completing the indicated rabies post-exposure prophylaxis series, medical personnel will ensure completion. Medical personnel will also review post-deployment health assessments to verify post-exposure prophylaxis is completed, when indicated.

(6) Bites from U.S. military working dogs present a very low rabies risk to personnel as all U.S. military working dogs are immunized against rabies in accordance with Reference (bo). However, any bites must be medically evaluated and recorded on DD Form 2341, and, in consultation with U.S. veterinary personnel, the dog observed for a 10-day period after the incident.

e. Rabies Prevention. Since rabies infection is almost always fatal, prevention is critical. Prevention of both animal-induced injury and rabies infection is enabled by a command and unit culture conducive to avoidance of exposure to animals for most individuals, plus occupational training and pre-exposure rabies immunization in accordance with References (cj) and (ck), for those with animal-handling duties, backed by rapid medical attention for all animal bite cases (or other potential exposure to rabies virus). Secondary rabies prevention requires timely post-exposure prophylaxis, administered before symptoms begin.

(1) Pre-exposure prophylaxis. Rabies pre-immunization prior to deployment is required for animal handlers, particularly animal control personnel, veterinarians, and others whose designated duties (e.g., special operations personnel), place them at occupational risk of animal bites or rabies virus exposure, in accordance with References (bn), (cj), and (ck). For example, animal control activities for feral animal risk mitigation must be conducted only by designated individuals who are appropriately trained and immunized against rabies (Reference (bn)).

(2) Command policy and avoidance. Command policy on exposure avoidance, backed by prompt medical evaluation should an exposure occur, is the primary means of preventing human rabies and other conditions (zoonoses), that are transmissible between animals and humans. Exposure avoidance policy is accomplished through risk communication, integrated pest management (Reference (bl)) and feral animal risk mitigation (Reference (bn)).

(3) Post-exposure reporting, treatment, prophylaxis and follow-up.

(a) Personnel must promptly report all animal bites or other possible rabies exposure events to medical personnel, including bites from wild, stray or feral mammals, contact with saliva or neural (brain) tissue on mucous membranes or broken skin, or contact with a bat (potential or actual contact). Recognition of a possible rabies exposure and the need for prompt medical evaluation should be conveyed in deployment health threats and countermeasures briefings and other risk communication messages.

(b) Post-exposure treatment consists of appropriate wound care and rabies prophylaxis administered in accordance with the recommendations of the CDC and its Advisory Committee for Immunization Practices (ACIP) ([www.cdc.gov/rabies/resources/index.html](http://www.cdc.gov/rabies/resources/index.html)).

(c) Post-exposure prophylaxis routines and schedules differ according to the individual's history of vaccination or immunosuppression. Health care providers should conduct

risk-based post-exposure prophylaxis according to the ACIP in consultation with the RAB in accordance with References (y) and (bo), documented on DD Form 2341 and in the health record in accordance with References (aj) and (bo), and reported in accordance with References (bt) and (bu).

(d) Military Services medical personnel will enable post-deployment medical follow-up, utilizing the Service-established tracking system, for those who redeploy before completing the indicated rabies post-exposure prophylaxis series.

GLOSSARY

PART I. ABBREVIATIONS AND ACRONYMS

AAR	after action report
AD	Assistant Director
AC	active component
AFHSD	Armed Forces Health Surveillance Division
AFPMB	Armed Forces Pest Management Board
APHC	Army Public Health Center
ASD(HA)	Assistant Secretary of Defense for Health Affairs
CAC	Common Access Card
CAP	crisis action plan
CBRN	Chemical, Biological, Radiological, and Nuclear
CCDR	combatant commander
CCMD	combatant command
CDC	Centers for Disease Control and Prevention
CS	Combat Support
DHA	Defense Health Agency
DHA-PI	Defense Health Agency-Procedural Instruction
D&I	disease and injury
DMDC	Defense Manpower Data Center
DMSS	Defense Medical Surveillance System
DNBI	disease and non-battle injury
DOEHS-IH	Defense Occupational and Environmental Health Readiness System - Industrial Hygiene
DRSi	Disease Reporting System internet
DU	depleted uranium
EDIPI	Electronic Data Interchange Person Identifier
EHR	Electronic Health Record
EpiNATO	Epidemiology for the North Atlantic Treaty Organization
FDA	Food and Drug Administration
FHP	Force Health Protection
FHPPP	Force Health Protection Prescription Product
FWRA	Food and Water Risk Assessment
G6PD	glucose-6phosphate dehydrogenase
HIV	Human Immunodeficiency Virus
ICD	International Classification of Diseases

IFA	Initial Field Account
IH	industrial hygiene
IMR	individual medical readiness
JTF	Joint Task Force
LOD	line of duty
MESL (SIPR)	Military Exposure Surveillance Library - Secret Internet Protocol Router
MSAT	Medical Situational Awareness in the Theater
MTF	military medical treatment facility
MVA	motor vehicle accident
NATO	North Atlantic Treaty Organization
NCMI	National Center for Medical Intelligence
NMCPHC	Navy and Marine Corps Public Health Center
OEH	Occupational and Environmental Health
OEHS	Occupational and Environmental Health Surveillance
OEHSA	Occupational and Environmental Health Site Assessment
PAR	population at risk
PART	presumptive anti-relapse therapy
PHA	periodic health assessment
PDF	portable digital file
PHD	Public Health Directorate
PLHA	Preliminary Hazard Assessment
POEMS	periodic occupational and environmental monitoring summaries
PPE	personal protective equipment
PVNTMED	preventive medicine
RAB	Rabies Advisory Board
RAD	reactive airway disease
RC	Reserve Component
RME	reportable medical event
RUC	Reporting Unit Code
SF	Standard Form
SG	Surgeon General
SIPRNet	Secret Internet Protocol Router Network
SHPE	Separation History and Physical Exam
SSN	Social Security Number
UIC	Unit Identification Code
USAFSAM	U.S. Air Force School of Aerospace Medicine



VA Department of Veterans Affairs  
VSIMS Veterinary Service Information Management System  
VSSM Veterinary Services Systems Management

## PART II. DEFINITIONS

Unless otherwise noted, these terms and their definitions are for the purposes of this publication.

battle injury. Damage or harm sustained by personnel during or because of battle conditions.

bioassay. Defined in Reference (c).

biomonitoring. Defined in Reference (c).

CBRN agents. Specific warfare agents that pose health threats such as toxic chemicals intended for use in military operations; microorganisms that cause disease in personnel, plants, or animals or cause the deterioration of material; toxins; or agents that emit radiation, generally alpha or beta particles, often accompanied by gamma rays, from the nuclei of an unstable isotope.

contingency location. Defined in Reference (bj)

deployer. An individual included in Paragraphs b-e of the Applicability Paragraph of this publication.

deployment. Defined in Reference (ag).

deployment health activities. Defined in Reference (c).

deployment health record. DD Form 2766, Adult Preventive and Chronic Care Flowsheet, or component-directed electronic equivalent, available for an individual throughout the deployment cycle.

D&I. Defined in Reference (c).

DNBI. Defined in Reference (c).

DoD health record. Defined in Reference (aj).

DoD veterinary health record. Defined in Reference (c).

EHR. Defined in Reference (aj).

enduring location. Defined in Reference (bi).

enduring location master list. Defined in Reference (bi).

EpiNATO. The NATO-sponsored morbidity surveillance system for the monitoring, collection and evaluation of D&I data from deployers' outpatient and inpatient medical encounters in accordance with NATO standard agreements.

exposure. Human contact due to a completed exposure pathway with a hazardous or potentially hazardous chemical, physical, or biological agent. Exposure may be short-term, of intermediate duration, or long-term. Assessment of individual health risk is dependent on the exposure concentration (how much), the frequency and duration of exposure (how long), and the multiplicity of exposures with other similar exposure agents.

exposure pathway. Occurs when five elements: source of contamination, environmental media and transport mechanism, point of exposure, route of exposure, and receptor population link the contaminant source to the receptor population by inhalation, dermal contact, or ingestion. If a completed or potentially completed exposure pathway exists, the receptor population is considered at risk for exposure.

feral animal risk mitigation. Defined in Reference (c).

FHPPPs. Certain drugs, vaccines, and other medical products useful for protecting the health of deployed personnel that may be used only under a physician's prescription. Examples of such products are atropine and/or 2-Pam chloride auto-injectors, certain antimicrobials, antimalarial, and pyridostigmine bromide. The use of investigational new drugs for FHP must be prescribed according to Reference (ar).

food inspection. Defined in Reference (y).

food protection. Defined in Reference (y).

food service sanitation inspections. Defined in Reference (y).

FWRA. Defined in Reference (y).

Health Record. Defined in Reference (aj).

health risk communications. The timely process of effectively communicating the nature of health and safety hazards and risks (probability and severity), their countermeasures, health outcomes, necessary medical follow-up, and other health-related information to commanders, Service members, family members, and others in an honest and understandable manner that fosters trust.

Health Risk Communications Plan. A document that specifies the means of delivery and development of key messages on deployment health and safety threats and risks (including actual and potential exposures), associated countermeasures, and any necessary medical follow-up for deployed personnel.

home station. Defined in Reference (ag).

health surveillance. Defined in Reference (q).

health threat and countermeasures briefing. Defined in Reference (c).

medical surveillance. Defined in Reference (q).

military working animal. Defined in Reference (z).

OEH. Defined in Reference (v).

OEH activities. The regular collection, analysis, archiving, interpretation, and dissemination of OEH-related data for the purposes of monitoring the health of or potential health hazard impact on a population or an individual, and for intervening in a timely manner to prevent, treat, or control the occurrence of disease or injury, and to assess the effectiveness of controls.

OEH surveillance. Defined in Reference (q).

OEHSA. Defined in Reference (c).

operational area. Defined in Reference (ag).

PAR. The deployed population or a subset of the deployed population that is at risk of experiencing an event or being exposed to the health threat during a specified period and at a specified location.

PLHA. Defined in Reference (c).

preventive medicine. Defined in Reference (v).

POEMS. Defined in Reference (c).

redeployment. Defined in Reference (ag).

RME. Defined in Reference (c).

toxic industrial chemicals and materials. Any chemicals or materials used or produced in an industrial process (raw material, final products, or byproducts, including solid and liquid wastes and air pollutants) that pose a health hazard due to their toxic properties. Exposure may occur due to normal industrial operations of the facility, hazardous waste accumulation, accidental release, or because of conflict or terrorist actions.

United States. Defined in Reference (ag).

Table 1. Pre-Deployment Health Activities

<b>Pre-Deployment Health Activity</b>	<b>System of Record</b>	<b>All Deployments ≤ 30 Days outside the United States and operations of any duration in the United States</b>	<b>All Deployments &gt; 30 Days outside the United States</b>
Incorporate deployment health into contingency and crisis action plans as well as medical plans	Component-designated planning system	X Reference (c), 2.13	X Reference (c), 2.13
During the planning process, ensure the capability to conduct deployment health activities	Component-designated planning system	X Reference (c), 2.13	X Reference (c), 2.13
Combatant commands (CCMDs) and deployed commanders incorporate occupational and environmental health (OEH) risk management and health surveillance requirements into Annex Q (Medical) of the contingency or Crisis Action Plan	Component-designated	X Reference (c), 2.13	X Reference (c), 2.13
Integrate health hazards into Annex B (Intelligence) of plans as appropriate	Component-designated	X Reference (c), 2.13	X Reference (c), 2.13
Communicate theater and location-specific deployment health requirements to supporting DoD Components and supporting commanders	Command-designated systems	X Reference (c), 2.13	X Reference (c), 2.13
Conduct Preliminary Hazard Assessment (PLHA)	Defense Occupational and Environmental Health Readiness System Industrial Hygiene (DOEHRS-IH), with any classified portions in the Military Exposure Surveillance Library - Secret Internet Protocol Router MESL (SIPR)	X Reference (c), 2.13	X Reference (c), 2.13
Identify deployable personnel and ensure they are medically ready	Component-designated System	X Reference (c), 2.9	X Reference (c), 2.9
Ensure that contractors provide	Component-	X	X

<b>Pre-Deployment Health Activity</b>	<b>System of Record</b>	<b>All Deployments ≤ 30 Days outside the United States and operations of any duration in the United States</b>	<b>All Deployments &gt; 30 Days outside the United States</b>
individuals fit for deployment	designated system	Reference (c), 1.2 and 2.9	Reference (c), 1.2 and 2.9
Verify individual medical readiness status	Service-designated system	X Reference (c), 2.10 and Reference (aa)	X Reference (c), 2.10 and Reference (aa)
Conduct any medical assessments required	Health record	X Reference (c), 2.9 and References (o), (s) and (ao)	X Reference (c), 2.9 and References (o), (s), and (ao)
Ensure comprehensive counseling on the full range of methods of contraception	Health record for any prescription	X Reference (c), 3.3 Reference (ap)	X Reference (c), 3.3 Reference (ap)
Administer deployment-specific medical countermeasures (e.g., immunizations, prophylaxis, Force Health Protection Prescription Product (FHPPP) and other prescriptions)	Health record	X Reference (c), 2.9 and 2.13	X Reference (c), 2.9 and 2.13
Include malaria prevention, when indicated	Health record	X Reference (c), 2.9 and References (k) and (as)	X Reference (c), 2.9 and References (k) and (as)
Consider tuberculosis screening, based on the potential of a high-risk exposure to tuberculosis or per CCMD or DoD Component policy	Health record	C Reference (c), 2.9 and 3.3., and Reference (at)	C Reference (c), 2.9 and 3.3, and Reference (at)
Issue personal protective equipment, including applicable training and medical screening	Component-designated system	X Reference (c), 2.9	X Reference (c), 2.9
Consider biomonitoring, based on the deployment health threats, occupation and possible exposures, and approved available bioassays	Health record	C Reference (c), 2.10	X Reference (c), 2.10
Verify occupational medical surveillance exam status, when applicable	Health record	X Reference (c), 2.9 and Reference (v)	X Reference (c), 2.9 and Reference (v)
Conduct pre-deployment health threats and countermeasures briefing	Component-designated system and, for medical countermeasures and force health prescription products, the Health record	X Reference (c), 2.9	X Reference (c), 2.9
Identify and procure DoD-approved sources of food and water and implement food protection	Worldwide Directory of Sanitarily Approved Food	X Reference (c), 2.9, 2.10 and 2.13 Reference 6400.04E	X Reference (c), 2.9, 2.10 and 2.13 Reference 6400.04E

Pre-Deployment Health Activity	System of Record	All Deployments ≤ 30 Days outside the United States and operations of any duration in the United States	All Deployments > 30 Days outside the United States
	Establishments for Armed Forces Procurement, Veterinary Service Information Management System (VSIMS), and any component-designated system		
In the absence of approved-source foods, field rations or combat rations, the commander determines if the risk of alternate food sources is acceptable, using a food and water risk assessment (FWRA)	DOEHRS-IH (any classified content in the MESL (SIPR)) and VSIMS	X Reference (c), 2.13	X Reference (c), 2.13
Identify and address deployment limiting medical and mental health conditions and psychotropic medications	Health Record and Command-designated tracking system	C Reference (c), 2.9 and 3.3 and References (s) and (ao)	X Reference (c), 2.9 and 3.3, and References (s) and (ao)
Complete the DD Form 2795, Pre-Deployment Health Assessment, within 120 days before the estimated deployment date	Defense Medical Surveillance System (DMSS) and health record	C Reference (c), 3.3	X Reference (c), 3.3
Complete the neurocognitive assessment within 12 months prior to deployment	Health record	C Reference (ce)	X Reference (ce)
Collect serum specimen within one year prior to deployment	DMSS, DoD Serum Repository	C Reference (c), 2.9 and 3.3, and Reference (q)	X Reference (c), 2.9 and 3.3, and Reference (q)
Conduct Human Immunodeficiency Virus (HIV) when required	Health record, DMSS, DoD Serum Repository	C Reference (c), 2.9 and 2.10	X Reference (c), 2.9 and 2.10
Pulmonary function testing for individuals with known pre-existing pulmonary conditions and disease	Health record and Service-designated system	C Reference (c), 2.10	X Reference (c), 2.10
Ensure a deoxyribonucleic acid (DNA) sample is on file	Armed Forces Medical Examiner System – Armed Forces Repository of	C Reference (c), 2.9, and References (t), (aa) and (bf)	X Reference (c), 2.9, and References (t), (aa) and (bf)

<b>Pre-Deployment Health Activity</b>	<b>System of Record</b>	<b>All Deployments ≤ 30 Days outside the United States and operations of any duration in the United States</b>	<b>All Deployments &gt; 30 Days outside the United States</b>
	Specimen Samples for the Identification of Remains		
Compile the deployment health record, consisting of at least: Blood type/rhesus factor, Prescribed medications (including FHPPPs) and/or allergies, Corrective lens prescription, Immunizations record, completed Pre-Deployment Health Assessment (when required), and medical summary sheet	DD Form 2766, Adult Preventive and Chronic Care Flowsheet, or component-directed electronic equivalent	C Reference (c), 2.10 and Reference (s)	X Reference (c), 2.10 and Reference (s)
Develop health risk communication Plan (before, during, and after deployment)	Component-directed system	C* Reference (c), 2.13	X Reference (c), 2.13
Develop deployment health surveillance plan	None, unless Component or Command-designated system	C* Reference (c), 2.10 and 2.13	X Reference (c), 2.10 and 2.13
<p><b>NOTES:</b> X=Required; C=Commanders' risk-based decision (CCDRs, Service component commanders or commanders exercising operational control).</p> <p>* Conducting activities with asterisks is highly recommended, to the extent feasible, for deployments with health threats that have an extremely high or high-risk estimate (see Appendix 1 of this publication).</p>			

Table 2. During Deployment Health Activities

<b>During Deployment Health Activity</b>	<b>System of Record</b>	<b>All Deployments ≤ 30 Days outside the United States and operations of any duration in the United States</b>	<b>All Deployments &gt; 30 Days outside the United States</b>
Provide deployment health support (lead Service)	Component or Command-designated systems, DoD Electronic Health Record system, Disease Reporting System internet (DRSi) transmitted to Defense Medical Surveillance System (DMSS), Defense Occupational and Environmental Health Readiness System - Industrial Hygiene DOEHRS-IH, and, if applicable, Military Exposure Surveillance Library - Secret Internet Protocol Router (MESL (SIPR))	X Reference (c), 2.10	X Reference (c), 2.10
Facilitate disease and injury prevention by deployment health risk mitigation approaches (e.g., field sanitation and hygiene practices, etc.) at unit and individual levels)	None, unless Component or Command-designated system	X Reference (c), 2.13	X Reference (c), 2.13
Conduct health surveillance (medical surveillance, occupational and environmental health (OEH) surveillance, disease and injury surveillance, biomonitoring reports of animal bites, and reportable medical events)	DMSS, DRSi, DOEHRS-IH, MESL (SIPR), +/-Epidemiology for the North Atlantic Treaty Organization (EpiNATO) or other Component-directed system	C* Reference (c), 2.10, 2.13	X Reference (c), 2.10, 2.13
Collect and record OEH surveillance data and information (e.g., Occupational and Environmental Health Site Assessment (OEHSA), periodic occupational and environmental monitoring	DOEHRS-IH (MESL (SIPR) for any classified portions of an OEHSA or Incident Report), and for cleared POEMS, the public access website	X Reference (c), 2.10 and 2.13	X Reference (c), 2.10 and 2.13



<b>During Deployment Health Activity</b>	<b>System of Record</b>	<b>All Deployments ≤ 30 Days outside the United States and operations of any duration in the United States</b>	<b>All Deployments &gt; 30 Days outside the United States</b>
summaries (POEMS) (when required), Incident Reports)			
Conduct biomonitoring, when indicated (e.g., depleted uranium exposure)	Health record, DOEHRS-IH	C* Reference (c), 2.10 and 2.13	X Reference (c), 2.10 and 2.13
Implement food protection	Veterinary Service Information Management System (VSIMS), DOEHRS-IH, MESL (SIPR)	X Reference (c), 2.9, 2.10 and 2.13	X Reference (c), 2.9, 2.10, and 2.13
Plan, conduct, and record pest management operations	DOEHRS-IH, MESL (SIPR), DD Form 1532 or equivalent DD Form 1532-1	X Reference (bl)	X Reference (bl)
Include feral animal risk mitigation, as appropriate	None, unless Component or Command-designated system	X Reference (c), 2.13	X Reference (c), 2.13
Record individual location, at least daily, for all deployed Service members and DoD Civilians	Component or Command-designated system, with copies to Defense Manpower Data Center at least weekly	X Reference (c), 2.1, 2.9	X Reference (c), 2.1, 2.9
Implement combat and operational stress control programs	None, unless Component or Command-designated systems	X Reference (bq)	X Reference (bq)
Record medical encounters in the health record	Health record (if unavailable, DD 2766, Adult Preventive and Chronic Care Flowsheet, or electronic equivalent)	X Reference (c), 2.10	X Reference (c), 2.10
Evaluate and document animal bite reports and, when applicable, submit as a reportable medical event (RME)	Health record, DD Form 2341, Report of Animal Bite – Potential Rabies Exposure and, when applicable, DMSS via DRSi and any Command-designated system	X Reference (c), 2.10 and 2.13	X Reference (c), 2.10 and 2.13
Evaluate and record individual exposures to OEH hazards and Chemical, Biological, Radiological, and Nuclear	Health record or, if unavailable, DD 2766, Adult Preventive and Chronic Care Flowsheet, or electronic equivalent	X Reference (c), 2.10	X Reference (c), 2.10

<b>During Deployment Health Activity</b>	<b>System of Record</b>	<b>All Deployments ≤ 30 Days outside the United States and operations of any duration in the United States</b>	<b>All Deployments &gt; 30 Days outside the United States</b>
agents, including any individual exposure data			
Document clinical care provided by health care providers to military working animals	Veterinary health record (Veterinary Services Systems Management) or interim hard copy document	X Reference (c), 2.10 and 2.11, and Reference (br)	X Reference (c), 2.10 and 2.11 and Reference (br)
Validate the health risk assessment and ensure capability to conduct deployment health activities indicated by the Preliminary Hazard Assessment and OEHSA	DOEHRS-IH, MESL (SIPR)	C* Reference (c), 2.13	X Reference (c), 2.13
Communicate health risks (health risk communication plan)	None, unless Component or Command-designated systems	C* Reference (c), 2.13	X Reference (c), 2.13
Complete the OEHSA	DOEHRS-IH,	C Reference (c), 2.10, 2.13	X Reference (c), 2.10, 2.13
Conduct disease and injury surveillance, including disease and non-battle injuries	DMSS via DRSi and any Command-designated system (e.g., EpiNATO); health record	C* Reference (c), 2.10 and 2.13	X Reference (c), 2.10 and 2.13
Submit RMEs	DMSS via DRSi and any Command-designated system; health record	C* Reference (c), 2.10 and 2.13	X Reference (c), 2.10 and 2.13
<b>NOTES:</b> X=Required; C=Commanders' risk-based decision (CCDRs, Service component commanders or commanders exercising operational control).			
* Conducting activities with asterisks is highly recommended, to the extent feasible, for deployments with health threats that have an extremely high or high-risk estimate (see Appendix 1 of this publication).			

Table 3. Post-Deployment Health Activities

Post-Deployment Health Activity	System of Record	All Deployments $\leq$ 30 Days outside the United States, and Operations of any duration in the United States	All Deployments > 30 Days outside the United States
Conduct health risk communication (post-deployment health briefing)	None, unless Component or Command-designated systems	C* Reference (c), 2.13	X Reference (c), 2.13
Conduct post-deployment health care ethics debrief and support	Note, unless Component or Command-designated systems	X Reference (bv)	X Reference (bv)
Submit after action report and lessons learned	Joint Lessons Learned Information System, Defense Occupational and Environmental Health Readiness System - Industrial Hygiene (DOEHRS-IH), Military Exposure Surveillance Library - Secret Internet Protocol Router MESSL (SIPR), Veterinary Service Information Management System (VSIMS)	X Reference (c), 2.10 and 2.13	X Reference (c), 2.10 and 2.13

Ensure medical surveillance is in place and recorded to identify and address post-deployment health concerns	Health Record, DRSi, Defense Medical Surveillance System (DMSS), Defense Manpower Data Center (DMDC), DOEHRS-IH, MESL (SIPR), in addition to any Component or Command-designated system	X Reference (c), 2.10 and 2.13	X Reference (c), 2.10 and 2.13
Implement or continue biomonitoring, as indicated	Health record, depleted uranium Registry (DOEHRs-IH)	X Reference (c), 2.10	X Reference (c), 2.10
Incorporate documentation of in theater healthcare encounters into the DoD electronic health record (e.g., deployment health record, individual exposure records)	Health record	X Reference (c), 2.10	X Reference (c), 2.10
Complete medical evaluation and referrals, using medical and exposure documentation	Health record and DOEHRs-IH, MESL (SIPR)	X Reference (c), 2.10	X Reference (c), 2.10
Complete Separation History and Physical Exam, when required	Health Record	C Reference (by)	X Reference (by)
Consider tuberculosis screening, based on the potential of a high-risk exposure to tuberculosis or per combatant command or Component policy	Health record	C Reference (c), 3.3 and Reference (at)	C Reference (c), 3.3 and Reference (at)
Submit any remaining Occupational and Environmental Health (OEH) monitoring and food protection data or reports	DOEHRs-IH, MESL (SIPR), VSIMS	X Reference (c), 2.10 and 2.13	X Reference (c), 2.10 and 2.13
Conduct QA and comprehensive retrospective analyses of deployment health data and information	DMSS, DOEHRs-IH, MESL (SIPR), VSIMS	X Reference (c), 2.10 and 2.11	X Reference (c), 2.10 and 2.11
Record baseline and routine OEH surveillance and food protection data and information (e.g., Preliminary Hazard Assessment, initial Occupational and Environmental Health Site Assessment, food protection audits, incident reports) not previously recorded	DOEHRs-IH, MESL (SIPR), VSIMS	X Reference (c), 2.10 and 2.13	X Reference (c), 2.10 and 2.13

Collect and use disease and injury data	Disease Reporting System internet (Transmitted to DMSS)	C* Reference (c), 2.20 and 2.13	X Reference (c), 2.10 and 2.13
Complete DD Form 2796, Post-Deployment Health Assessment, within 30 days before or after return from deployment	DMSS and health record	C Reference (c), 3.3	X Reference (c), 3.3
Complete DD Form 2900, Post-Deployment Health Re-Assessment 90 to 180 days after return from deployment	DMSS and health record	C Reference (c), 3.3	X Reference (c), 3.3
Complete DD Form 2978, Mental Health Assessment 7-18 months and 18-30 months after return from deployment	DMSS and health record	C Reference (c), 3.3	X Reference (c), 3.3
Collect post-deployment serum specimens, when required	DMSS, DoD Serum Repository	C* Reference (c), 3.3 and Reference (q)	X Reference (c), 3.3 and Reference (q)
Pulmonary function testing for individuals with known pre-existing pulmonary conditions and disease who required a pre-deployment pulmonary function test	Health record and Service-designated system	C Reference (c), 2.10	X Reference (c), 2.10
<p><b>NOTES:</b> X=Required; C=Commanders' risk-based decision (CCDRs, Service component commanders or commanders exercising operational control).</p> <p>* Conducting activities with asterisks is highly recommended, to the extent feasible, for deployments with health threats that have an extremely high or high-risk estimate (see Appendix 1 of this publication).</p>			