B-REDI

Behavioral Health Readiness Evaluation and Decision-Making Instrument

Resource Guide

Note

The policies in this guide are current as of 13 March 2023. As updated policies are released, we encourage you to incorporate them into your guide. Some links for sites that may contain updated policies are in Tab 17: References Cited in Training & Additional Resources

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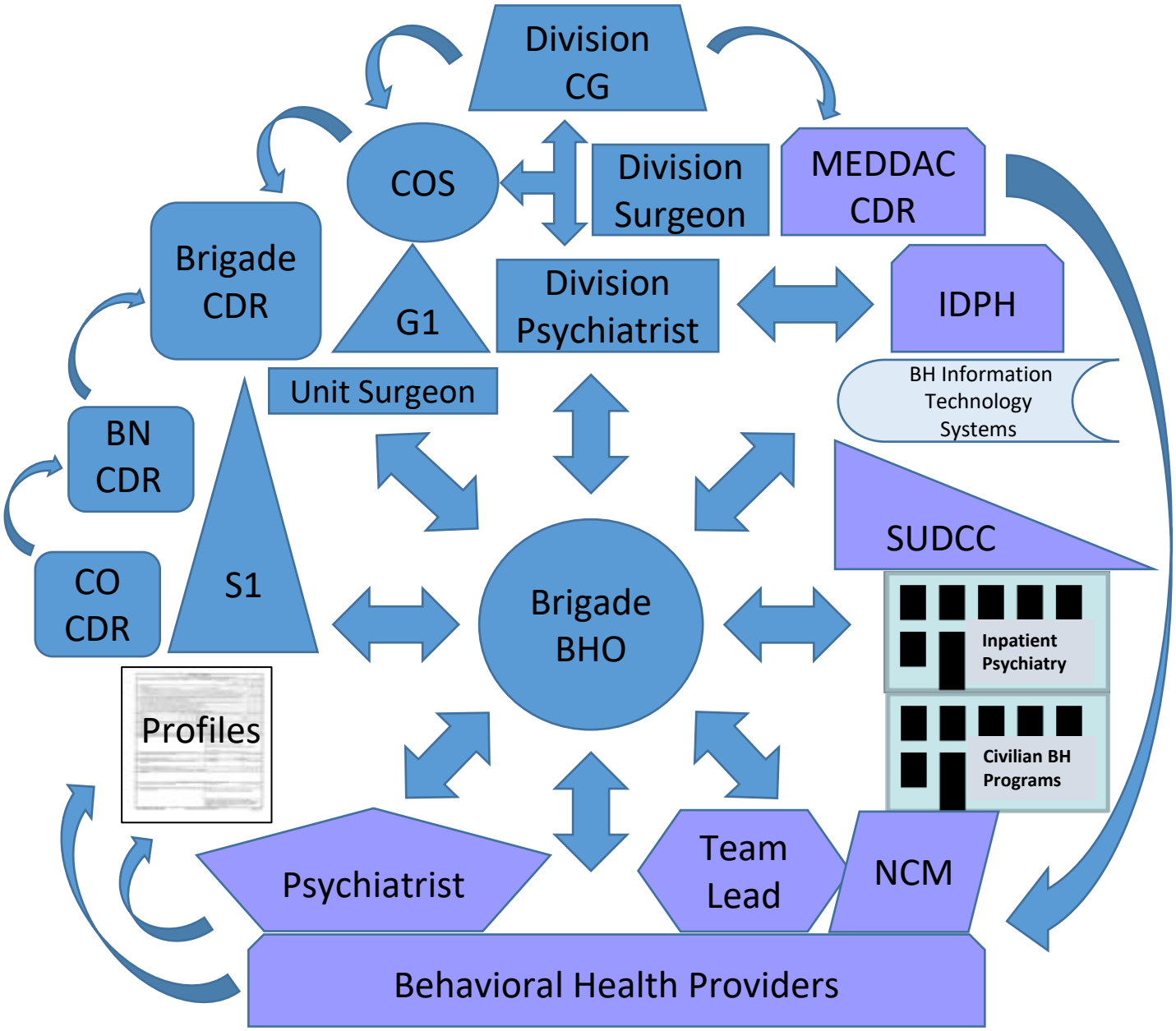
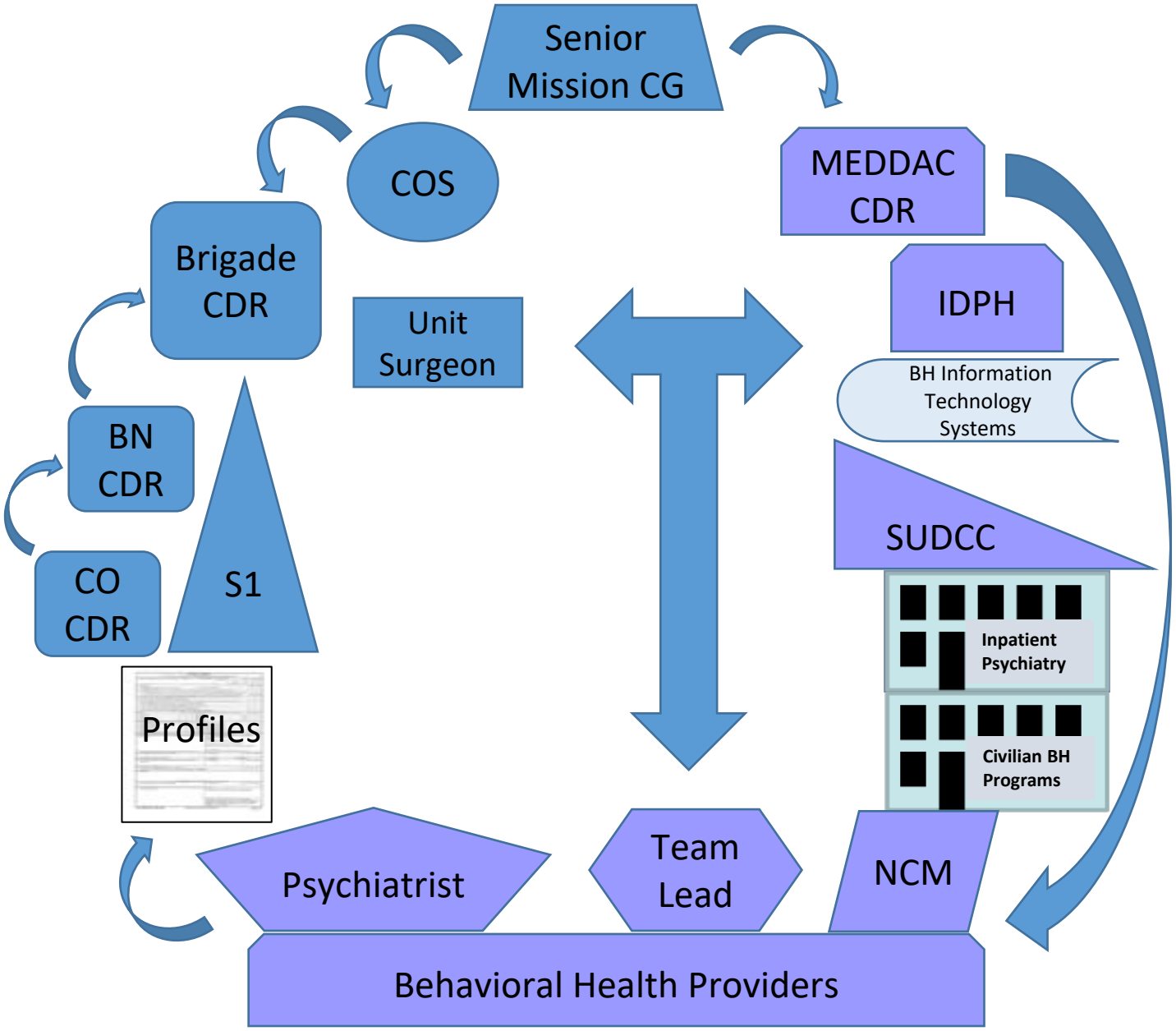


Acronyms:

Battalion (BN)
Behavioral Health (BH)
Behavioral Health Officer (BHO)
Chief of Staff (COS)
Commander (CDR)
Commanding General (CG)
Company (CO)
G1 (Division Personnel)
Installation Director Psychological Health (IDPH)
Medical Department Activity (MEDDAC)
Nurse Case Manager (NCM)
S1 (Admin Personnel - BN & Brigade Level)
Substance Use Disorder Clinical Care (SUDCC)



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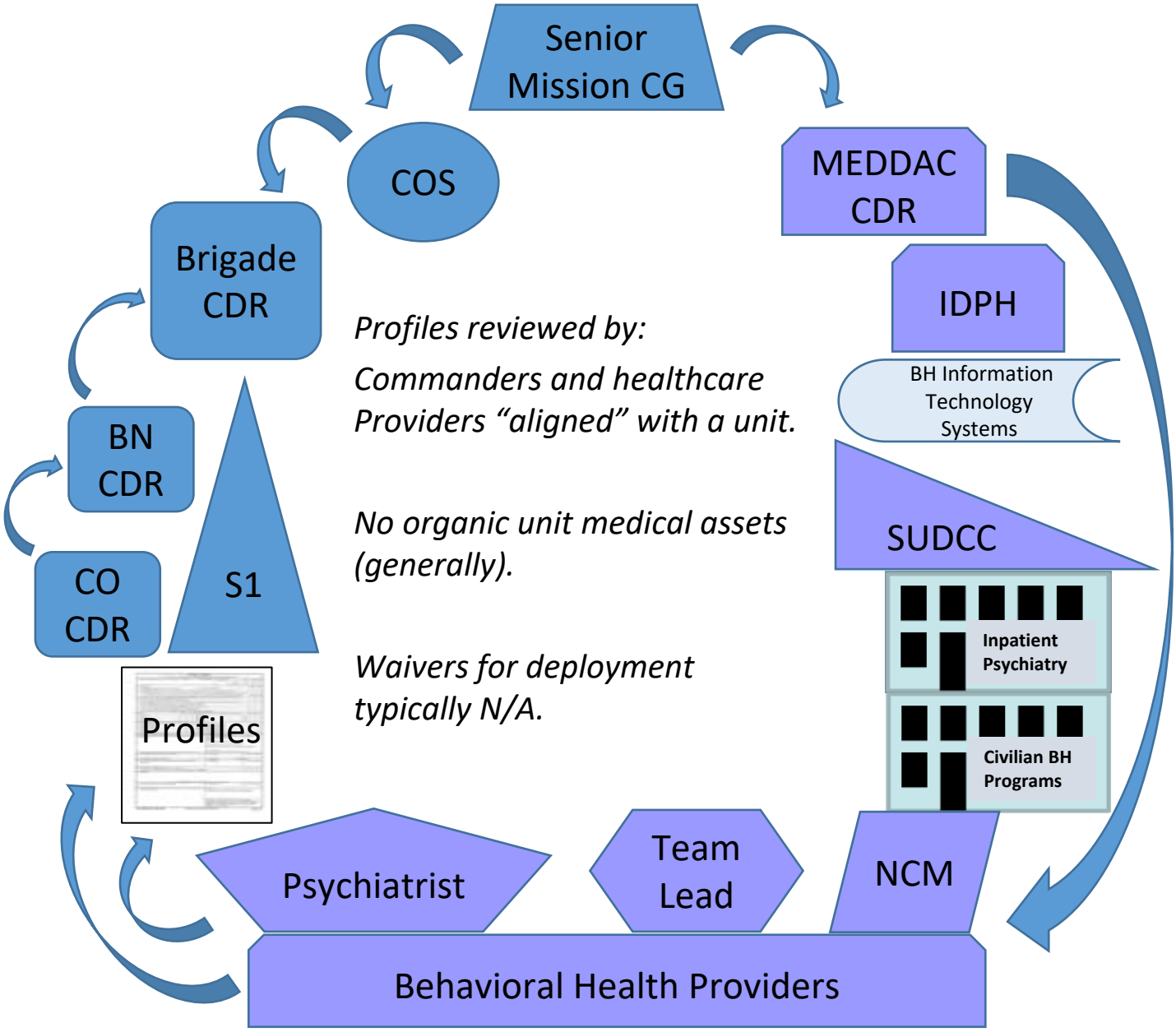

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DEPARTMENT OF THE ARMY
HEADQUARTERS, UNITED STATES ARMY MEDICAL COMMAND
2748 WORTH ROAD
JBSA FORT SAM HOUSTON, TEXAS, 78234-6000

OTSG/MEDCOM Policy Memo 21-019

MCZX

Expires 16 March 2023

16 MAR 2021

MEMORANDUM FOR COMMANDERS, MEDCOM REGIONAL HEALTH COMMANDS (RHCs)

SUBJECT: Behavioral Health eProfiling Standardization Policy

1. References:

a. ALARACT 206/211, HQDA EXORD 223-11, Army Implementation of Electronic Profile (e-profile), dated 27 May 11.

b. Memorandum, Assistant Secretary of Defense for Health Affairs, 7 Oct 13, subject: Clinical Practice Guideline for Deployment-Limiting Mental Disorders and Psychotropic Medications.

c. Department of Defense Instruction 6490.07, Deployment Limiting Medical Conditions for Service Members and DoD Civilian Employees, 5 Feb 10.

d. Department of Defense Instruction 6490.04, Mental Health Evaluations of Members of the Military Services, 4 Mar 13.

e. Department of Defense Instruction 6490.08, Command Notification Requirements to Dispel Stigma in Providing Mental Health Care to Service Members, 17 Aug 11.

f. AR 40-501, Standards of Medical Fitness, 27 Jun 19.

g. AR 40-502, Medical Readiness, 27 Jun 19.

h. DA PAM 40-502, Medical Readiness Procedures, 27 Jun 19.

i. AR 40-66, Medical Record Administration and Healthcare Documentation, Rapid Action Revision, 04 Jan 10.

j. OTSG/MEDCOM Policy Memo 19-010, 8 Feb 19, subject: Department of the Army (DA) Form 3822, Mental Status Evaluation.

*This policy memo supersedes OTSG/MEDCOM Policy Memos 17-079, subject: Behavioral Health eProfiling Standardization. Policy, 28 Dec 17.

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k. OTSG/MEDCOM Policy Memo 21-011, 9 Feb 21, subject: Behavioral Health At-Risk Management Policy.

l. OTSG/MEDCOM Policy Memo 16-099, 15 Nov 16, subject: Transferring Behavioral Health and Substance Use Disorder Clinical Care for Transitioning Soldiers.

m. FRAGO 2 to OPORD 16-33 (Realignment of Army Substance Abuse Program (ASAP) clinical care to MEDCOM) – USAMEDCOM.

n. Secretary of the Army (SA) Directive 2011-09, Employment of Licensed Professional Counselors as Fully Functioning Army Substance Abuse Program Practitioners.

o. Secretary of the Army (SA) Directive 2016-04, Realignment of the Army Substance Abuse Program's Clinical Care.

p. OTSG/MEDCOM Policy Memo 16-083, 12 Oct 2016, subject: Credentials Verification and Independent Privileging Requirement for Licensed Professional Counselors (LPC) and to Clarify the Requirements for a Waiver of Certain Credentials.

2. Purpose: To provide guidance on issuing profiles for Army personnel with behavioral health (BH) conditions and associated treatments to appropriately inform Commanders of duty limitation and treatment support recommendations.

3. Proponent: The proponent for this policy is the Behavioral Health Division, Health Care Delivery, MEDCOM G-3/5/7.

4. Applicability: This policy applies to all BH providers privileged at a Military Treatment Facility (MTF).

5. Background:

a. Variability exists throughout the Army when medical providers communicate duty limitations and other critical information regarding Soldiers with BH conditions in accordance with (IAW) AR 40-66, AR 40-502, and DA PAM 40-502 (references 1.g,h,i). This variability may contribute to confusion and serve as a barrier to effective care.

b. The Department of the Army (DA) Form 3349, Physical Profile, is the Army's standard method of communicating medical recommendations to a Commander regarding a Soldier's duty limitations. The Soldier's Commander makes the final decision on a Soldier's duties IAW the physical profile and documented duty limitations. BH providers use the DA Form 3349 in eProfile to communicate with Commanders about medical conditions and associated treatments that may interfere with execution of duties. When profiles are indicated, providers articulate how Commanders can best

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support the Soldier's BH treatment plan in order to optimize treatment outcomes. Specific and timely communication by providers can significantly enhance Soldiers' care by enabling Command teams to set conditions to reduce risk and support recovery.

c. AR 40-502 (reference 1.g) states that licensed clinical psychologists, licensed clinical social workers, physician assistants, and nurse practitioners can write temporary profiles for a period not to exceed 90 days. IAW DA PAM 40-502 (reference 1.h), any extension of a temporary profile beyond 90 days must be signed by a physician. The aforementioned providers may write a permanent profile as long as the profile is signed by a physician approving authority.

6. Policy:

a. Providers will assess Soldiers' medical readiness for duty during every clinical encounter, based on both current and recent clinical encounters. At a minimum, assessment of medical readiness will include the Soldier's mental status, risk of harm to self and others, symptom severity, prognosis for return to full duty (if no profile, may be N/A), treatment needs, and risk of decompensation or further injury if the Soldier participates in occupational activities (if no BH condition or symptoms, may be N/A). Providers will document their assessment of medical readiness along with any recommended duty restrictions in the electronic health record (EHR) at every clinical encounter with updates that reflect any significant change to Soldier's readiness status.

b. For the purpose of Command Directed Mental Evaluations, providers are defined by DoDI 6490.04 (reference d) and include Psychiatrists, Psychologists, Licensed Social Workers, and Psychiatric Nurse Practitioners. Army Directive 2011-09 (reference 1.n) authorized the Army Substance Abuse Program (ASAP) to employ licensed professional counselors (LPCs) and licensed mental health counselors (LMHCs) as independent practitioners with a well-defined scope of practice. In order to ensure their ability to carry out this duty, independently privileged LPCs and LMHCs are authorized to write temporary profiles for a period not to exceed 90 days with a physician's signature required for any extension beyond 90 days.

c. Providers will inform Soldiers when they are being placed on profiles and will describe the duty restrictions recommended. Providers will provide a hard copy, as necessary, to ensure the Soldier is aware of duty limitations.

d. When a BH profile is warranted, providers will utilize electronic profiles through the eProfile application IAW Reference 1.g. Enclosure 2 provides specific, though not exclusive, profiling guidance.

(1) When multiple situations from Enclosure 2 are applicable to a specific Soldier, providers will follow the most restrictive recommendations identified.

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(2) If a provider deviates from the minimum profiling guidance in Enclosure 2 based on his/her reasoned clinical opinion, he/she will document the rationale for this deviation in the EHR.

(3) The functional limitations documented in section 5 of the DA Form 3349 eProfile will be practical, logically related to the BH condition, written in plain language, and specific to the identified Soldier. The eProfile behavioral health template includes extensive guidance and multiple duty restrictions, many of which will not apply to every Soldier. Providers should include only duty restrictions that specifically apply to the Soldier being placed on profile, facilitating treatment and allowing the Soldier to remain safe while operating in the least restrictive conditions. Enclosure 1 provides examples of acceptable and unacceptable language.

e. IAW reference 1.j, DA Form 3822 reports will be used only for communicating with Commanders on findings of mental status evaluations. DA Form 3349 in eProfile will be used for all duty limitation recommendations to Commanders. If duty limitations that last longer than 72 hours are reported as part of the DA 3822, then the DA 3349 should be completed in addition to the DA 3822.

f. Profiles should be issued under the following circumstances:

(1) When a Soldier's BH condition(s), or the associated treatment, impairs sustained, independent functioning in his/her duties and necessitates duty limitations that require Command support and/or notification, providers will issue a temporary BH profile. Temporary profiles do not have a PULHES designation. Minimum profiling guidance is found in Enclosure 2. Providers will clearly document the clinical rationale for any deviation from these guidelines in the EHR.

(2) Providers will issue a temporary BH profile when a Soldier is at substantial risk for decompensation and/or recurrence of significantly impairing symptoms in the absence of adequate behavioral healthcare support.

(3) Providers will issue a temporary BH profile when a Soldier is at risk of harm to self or others and duty restrictions (e.g., restriction from carrying and firing weapons, etc.,) will help to mitigate this risk.

(4) Providers will issue a temporary BH profile for Soldiers that require medical stabilization prior to transferring duty stations as described in reference 1.l.

(5) Providers will use a permanent S3 or S4 profile when they have determined that a Soldier will not meet medical retention standards within a year of the initial diagnosis, also called the medical retention determination point (MRDP). Permanent S3 or S4 profiles require two signatures (the profiling officer and the Approval Authority) and will prompt disability evaluation proceedings IAW AR 40-502 (reference 1.g). AR

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40-501, AR 40-502 and DA PAM 40-502 provide further guidance on medical retention standards and MRDP (references 1.f,g,h). Providers are not required to wait a full year before determining that a Soldier has reached MRDP. Permanent profiles continue to have a PULHES designation.

(6) Prescribing a medication for a BH condition does not always require a profile. Many psychotropic medications do not impair a Soldier's ability to function in the occupational setting, do not have duty-limiting side effects, or do not increase the risk of adverse outcomes. Some medications, however, may cause impairing side effects, require increased medical monitoring after initiation, or are specifically restricted from use in the deployed setting and require that providers issue appropriate profiles. Medications that always require a profile are described in Enclosure 2.

(7) BH providers do not have to administer a profile based solely upon Combatant Command (CCMD) medical waiver requirements if the Soldier has not received an identified deployment mission and there is no other clinical reason to administer a profile. For Soldiers who are preparing for deployment after receiving a deployment mission, BH providers will initiate a temporary profile for BH conditions and/or treatment that are identified as requiring a waiver, based upon the respective published CCMD guidance that is applicable to that mission IAW procedures that are described in DA PAM 40-502 (reference 1.h). When evaluating a Soldier's appropriateness for deployment, the BH provider will consider the totality of relevant factors, such as the Soldier's symptoms, functioning, treatment, stability, vulnerabilities, mission, and environment:

(a) Providers should consider the availability, accessibility, and practicality of treatment in the designated location, the potential for deterioration or recurrence of symptoms in the designated environment, the environmental conditions, and the mission requirements. While the occupational specialty in which the Soldier will function during the deployment/exercise should be considered, it must be noted that individuals may be called upon to function outside of their initially assigned occupational specialties and training.

(b) The decision to deploy individuals on medications should be balanced with effects of the medication on performance in austere environments, necessity for medication in the management of the condition, possibility of withdrawal symptoms, and other potential side effects. Logistical factors that should be considered include availability of refills, ability to procure controlled medications, access to providers familiar with managing the medication, and potential for abuse or diversion.

(c) When a clinical assessment determines a Soldier to be medically ready from a BH perspective, but the applicable CCMD guidance declares the Soldier as requiring a waiver, the provider will issue a temporary profile that includes the following comment (with situational edits): **"This Soldier has no BH symptoms or side effects from**

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treatment that limit medical readiness. However, due to deployment medical waiver requirements, he/she requires a waiver from the appropriate combatant command surgeon before he/she can deploy during the duration of this profile." The relevant CCMD Surgeon is the waiver approval authority.

FOR THE COMMANDER:

RICHARD R. BEAUCHEMIN
Chief of Staff

2 Encls
1. Appropriate profiling comments
2. Recommended profiling actions

ENCLOSURE 1 – Samples of Appropriate and Inappropriate Instructions to Commander

Profiling comments often have specific duty limitation recommendations. Providers should provide rationale for limitations whenever possible. Appropriate examples are as follows:

- "Requires eight consecutive hours for sleep in every 24 hour period"
- "No combat, no live or simulated fire training or exposure"
- "Service Member (SM) should not be exposed to stimuli suggestive of combat experiences (i.e., no simulator training, no ranges, no simulated mortars, no patrol lanes, no IED training, etc.)."
- "No weapons/ammunition"
- "No alcohol"
- "Quarters" – this should be used sparingly for BH conditions, rarely exceed one day, and almost never exceed three days.
- "SM should have access to all BH appointments. Expected treatment needed to return SM to full duty includes: 1 to 2 appointments per week for … weeks…"
- "Please contact the profiling provider at XXX-XXX- XXXX to discuss the following potential duty limiting side effects of this medication (those with an "x") or if the Soldier displays concerning changes in mood, behavior, irritability, or safety.
  [ ] This medication has few or rare side effects, there is no current recommended restriction to duty.
  [ ] The medication may cause daytime drowsiness and consideration for limiting operation of heavy machinery during morning hours. It is expected that this side effect, if present, will diminish over time.
  [ ] The Soldier is not to participate in live fire exercises or participate at the range while taking this medication or until command receives verification of suitability by the profiling provider.
  [ ] The medication has a potential for abuse if not used correctly or as prescribed. Notify the profiling officer immediately if there is a sudden deterioration in performance."

Overly restrictive profiles hinder a Commander's ability to keep a Soldier engaged in an occupational function within the unit and can exacerbate isolation and stigma. Providers will generally avoid commenting on specific duties and should not use the following phrases:

- "No 24 hour duty"
- "No rotating shifts"
- "No formations"
- "No uniforms"
- Providers will not set work/duty times, i.e., "SM can only work from 9-5" or "cannot present to work until 1000 hours"

For cases referred to Medical Evaluation Board (MEB): "SM has been referred to the MEB process. No deployments to an austere environment; PCS, TDY or ETS until final fitness for duty has been determined or unless approved by PEBLO. SM should remain stationed near an MTF where definitive psychiatric care is available."

Suggested comments if Soldier requires deployment waiver due to Combatant Command waiver requirements associated with minimal standards of fitness for deployment, but Soldier is stable and eligible for a waiver: "This Soldier has no BH symptoms or side effects from treatment that limit medical readiness. However, due to deployment medical waiver requirements, he/she requires a waiver from the appropriate combatant command surgeon before he/she can deploy during the duration of this profile." Indicate if you as profiling authority support issuance of a waiver.

ENCLOSURE 2: Minimum Profile Guidance

Condition	Minimum Profile	Source
Schizophrenia, Schizophreniform, Schizoaffective Disorders, Bipolar I Disorder	Permanent Profile immediately indicated at time of diagnosis	HA Memorandum, DoDI 6490.07, AR 40-501
Bipolar II Disorder, Bipolar Disorder Unspecified, Brief Psychotic Disorder, Other Psychotic Disorders not due to a substance or known physiological condition	90 day temporary profile; reassess at 90 days to determine if permanent profile is warranted	
Anorexia Nervosa, Bulimia Nervosa with no improvement in symptoms or BMI despite treatment	90 day temporary profile; reassess at 90 days to determine if permanent profile is warranted	AR 40-501
Substance Use Disorders	Temporary profile will be written for substance use disorders if the disorder poses a substantial risk for deterioration and/or recurrence of impairing symptoms in the deployed environment or if active treatment was interrupted, or if duty limitations are required to ensure medical stability	DoDI 6490.07
Inpatient psychiatric hospitalization	30-day temporary profile immediately prior to discharge. Renew or provide more extended profile, as clinically indicated.	OTSG/MEDCOM Policy Memo 16-096
Intensive Outpatient Program or Residential Treatment Facility	Referring BH provider will place SM on temporary profile upon acceptance to IOP or RTF. Profile duration should last at least until completion of IOP or RTF and reevaluation in outpatient setting in order to ensure continuity of care.	

ENCLOSURE 2: Minimum Profile Guidance

Use of 4 or more psychotropics on a routine daily basis (antidepressants, anticonvulsants, antipsychotics, and benzodiazepines) used for stabilization of a BH disorder	Temporary profile for 90 days, renew while on 4 or more psychotropic medications	
Barbiturates	Temporary profile for 90 days, renew while on the medication	HA Memorandum; DoDI 6490.07
Initiation of or change in psychotropic medications	If medication is causing significantly impairing side effects or if Soldier is within 90 days of deployment and medication has yet to demonstrate efficacy and symptom stabilization	MEDCOM/OTSG Policy 16-099
Soldier requiring medical stabilization prior to impending PCS/ETS	Temporary profile until sufficient period of stability is achieved	MEDCOM/OTSG Policy 16-099

USCENTCOM 091923Z APR 20 MOD FIFTEEN TO USCENTCOM INDIVIDUAL

REF/NN/DOC/HQ USAF/17JAN2019//
AMPN/AFI 31-126/DOD MILITARY WORKING DOG (MWD) PROGRAM//

REF/OO/WEBSITE/CDC/31MAR2020//
CORONAVIRUS DISEASE 2019 (COVID-19) – PEOPLE WHO ARE AT HIGHER RISK FOR SEVERE ILLNESS. HTTPS://WWW.CDC.GOV/CORONAVIRUS/2019-NCOV/NEED-EXTRA-PRECAUTIONS/PEOPLE-AT-HIGHTER-RISK.HTML

RMKS/1. (U) THIS IS MODIFICATION FIFTEEN TO USCENTCOM INDIVIDUAL PROTECTION AND INDIVIDUAL/UNIT DEPLOYMENT POLICY. IN SUMMARY, MODIFICATIONS HAVE BEEN MADE TO PARAGRAPH 15 FROM MOD FOURTEEN, REF B.

1.A. PARAGRAPH 15 REQUIRED CHANGES IN RESPONSE TO ONGOING COVID-19 PANDEMIC; THEREFORE, IT IS BEING REPUBLISHED IN ITS ENTIRETY. MOD 15 SUPERSEDES ALL PREVIOUS VERSIONS. THE MODIFICATIONS TO THE FITNESS STANDARDS FOR MEDICAL DEPLOYABILITY (PARAGRAPH 15 AND TAB A) ARE BASED ON GUIDANCE FROM THE CENTER FOR DISEASE CONTROL (REF OO). CHANGES ARE BASED ON NON-DISCRIMINATORY DATA REGARDING THE CURRENTLY KNOWN MORBIDITY AND MORTALITY RATES FOR COVID-19, TIED TO THE FORCE PROTECTION CONCERN THAT THOSE INDIVIDUALS POSE AN UNACCEPTABLE RISK TO THE FORCE AND RISK OF OVERWHELMING THE LIMITED MEDICAL RESOURCES IN A THEATER OF COMBAT. DURING THE COVID-19 PANDEMIC, COMMANDERS HAVE THE DISCRETION TO MAKE THE REQUIREMENTS MORE RESTRICTIVE IF THEY FEEL THEIR RISK TO MISSION IS TOO HIGH. THE COVID-19 MODIFICATIONS CONTAINED HEREIN WILL BE LIMITED TO THE DURATION OF THE PANDEMIC AFTER WHICH TIME MOD 16 WILL BE RELEASED

1.B. PARAGRAPH 15 OF REF A HAS BEEN REWRITTEN AS FOLLOWS:

15.A. DEFINITIONS.

15.A.1. DEPLOYMENT. FOR MEDICAL PURPOSES, THE DEFINITION OF DEPLOYMENT IS TRAVEL TO OR THROUGH THE USCENTCOM AREA OF RESPONSIBILITY (AOR), WITH EXPECTED OR ACTUAL TIME IN COUNTRY (PHYSICALLY PRESENT, EXCLUDING IN-TRANSIT OR TRAVEL TIME) FOR A PERIOD OF GREATER THAN 30 DAYS, EXCLUDING SHIPBOARD OPERATIONS, AS DEFINED IN REF C.

15.A.2. TEMPORARY DUTY (TDY). TDY MISSIONS ARE THOSE MISSIONS WITH TIME IN COUNTRY OF 30 DAYS OR LESS.

15.A.3. PERMANENT CHANGE OF STATION (PCS). PCS PERSONNEL, INCLUDING EMBASSY PERSONNEL, WILL COORDINATE WITH THEIR RESPECTIVE SERVICE COMPONENT MEDICAL PERSONNEL FOR MEDICAL GUIDANCE AND REQUIREMENTS FOR PCS TO SPECIFIC COUNTRIES IN THE USCENTCOM AOR. AUTHORIZED DEPENDENTS MUST PROCESS THROUGH THE OVERSEAS SCREENING PROCESS AND EXCEPTIONAL FAMILY MEMBER PROGRAM (EFMP), IF REQUIRED. ALL PERSONNEL MUST BE CURRENT WITH ADVISORY COMMITTEE ON IMMUNIZATION PRACTICES (ACIP) IMMUNIZATION GUIDELINES AND DOD TRAVEL GUIDELINES. HOST NATION IMMUNIZATION AND MEDICAL SCREENING REQUIREMENTS APPLY. PORTIONS OF MOD 15 WILL APPLY AS DELINEATED IN TAB B.

15.A.4 SHIPBOARD PERSONNEL. ALL SHIPBOARD PERSONNEL WHO DEPLOY INTO THE AOR MUST HAVE CURRENT SEA DUTY SCREENING AND REMAIN FULLY MEDICALLY READY FOLLOWING ANNUAL PERIODIC HEALTH ASSESSMENT (PHA). DEPLOYMENT HEALTH ASSESSMENT PER 15.H APPLIES IF DEPLOYED TO OCONUS FOR GREATER THAN 30 DAYS WITH NON-FIXED U.S. MEDICAL TREATMENT FACILITIES (MTF).

15.B. APPLICABILITY. THIS MOD APPLIES TO U. S. MILITARY PERSONNEL, TO INCLUDE ACTIVATED RESERVE AND NATIONAL GUARD PERSONNEL, DOD CIVILIANS, DOD CONTRACTORS, DOD SUB-CONTRACTORS, VOLUNTEERS, AND THIRD COUNTRY NATIONALS

(TCN) TRAVELING OR DEPLOYING TO THE CENTCOM AOR AND WORKING UNDER THE AUSPICES OF THE DOD. LOCAL NATIONALS (LN) WILL MEET THE MINIMAL MEDICAL STANDARDS ADDRESSED IN SECTION 15.C.1.F. MILITARY WORKING DOGS (MWD) AND CONTRACT WORKING DOGS (CWD) WILL MEET MINIMAL STANDARDS ADDRESSED IN SECTION 15.C.1.G.

15.C. MEDICAL DEPLOYABILITY. THE FINAL AUTHORITY FOR ENTRY INTO THE CENTCOM AOR RESTS WITH THE CENTCOM SURGEON AND MAY BE DELEGATED TO CENTCOM SERVICE COMPONENT SURGEONS. THE DEPLOYER'S MEDICAL EVALUATING ENTITY OR DEPLOYING PLATFORM OR COMMANDER ARE NOT AUTHORIZED TO WAIVE MEDICAL DEPLOYMENT STANDARDS. DEPLOYED HEALTH SERVICE SUPPORT INFRASTRUCTURE IS DESIGNED AND PRIORITIZED TO PROVIDE ACUTE AND EMERGENCY SUPPORT TO THE EXPEDITIONARY MISSION. ALL PERSONNEL (UNIFORMED SERVICE MEMBERS, GOVERNMENT CIVILIAN EMPLOYEES, VOLUNTEERS, DOD CONTRACTOR EMPLOYEES), CONTRACT WORKING DOGS (CWD) AND MWD TRAVELING TO THE CENTCOM AOR MUST MEET MEDICAL, DENTAL, AND BEHAVIORAL HEALTH FITNESS STANDARDS, AND BE REASONABLY EXPECTED TO REMAIN SO FOR THE DURATION OF THEIR DEPLOYMENT. INDIVIDUALS DEEMED UNABLE TO COMPLY WITH CENTCOM DEPLOYMENT REQUIREMENTS ARE DISQUALIFIED FOR DEPLOYMENT IAW SERVICE POLICY AND MOD 15. PERSONNEL FOUND TO BE MEDICALLY NON-DEPLOYABLE WHILE OUTSIDE OF THE CENTCOM AOR FOR ANY LENGTH OF TIME WILL NOT ENTER OR RE-ENTER THE THEATER UNTIL THE NON-DEPLOYABLE CONDITION IS COMPLETELY RESOLVED OR AN APPROVED WAIVER FROM A CENTCOM WAIVER AUTHORITY IS OBTAINED. SEE REF D, E, F, G, H. DOD CIVILIAN EMPLOYEES ARE COVERED BY THE REHABILITATION ACT OF 1973. AS SUCH, AN APPARENTLY DISQUALIFYING MEDICAL CONDITION NEVERTHELESS REQUIRES THAT AN INDIVIDUALIZED ASSESSMENT BE MADE TO DETERMINE WHETHER THE EMPLOYEE CAN PERFORM THE ESSENTIAL FUNCTIONS OF THEIR POSITION IN THE DEPLOYED ENVIRONMENT, WITH OR WITHOUT REASONABLE ACCOMMODATION, WITHOUT CAUSING UNDUE HARDSHIP. IN EVALUATING UNDUE HARDSHIP, THE NATURE OF THE ACCOMMODATION AND THE LOCATION OF THE DEPLOYMENT MUST BE CONSIDERED. FURTHER, THE EMPLOYEE'S MEDICAL CONDITION MUST NOT POSE A SUBSTANTIAL RISK OF SIGNIFICANT HARM TO THE EMPLOYEE OR OTHERS WHEN TAKING INTO ACCOUNT THE CONDITIONS OF THE RELEVANT DEPLOYED ENVIRONMENT. SEE REF I.

15.C.1. MEDICAL FITNESS, INITIAL AND ANNUAL SCREENING.

15.C.1.A. MEDICAL READINESS PROCESSING. THE MEDICAL SECTION OF THE DEPLOYMENT SCREENING SITE MAY PUBLISH GUIDANCE, IAW MOD15 AND SERVICE STANDARDS, TO ASSIST IN DETERMINING MEDICAL DEPLOYMENT FITNESS. DEPLOYING PERSONNEL MUST HAVE AN EVALUATION BY A MEDICAL PROVIDER TO DETERMINE IF THEY CAN SAFELY DEPLOY AND OBTAIN AN APPROVED WAIVER FOR ANY DISQUALIFYING MEDICAL CONDITION(S) FROM THE COMPONENT SURGEON OR CENTCOM SURGEON PRIOR TO DEPLOYING.

15.C.1.B. FITNESS INCLUDES, BUT IS NOT LIMITED TO, THE ABILITY TO ACCOMPLISH ALL REQUIRED TASKS AND DUTIES, BY SERVICE REQUIREMENTS OR DUTY POSITION, CONSIDERING THE ENVIRONMENTAL AND OPERATIONAL CONDITIONS OF THE DEPLOYED LOCATION. AT A MINIMUM, PERSONNEL MUST BE ABLE TO WEAR BALLISTIC, RESPIRATORY, SAFETY, CHEMICAL, AND BIOLOGICAL PERSONAL PROTECTIVE EQUIPMENT; USE REQUIRED PROPHYLACTIC MEDICATIONS; AND INGRESS/EGRESS IN EMERGENCY SITUATIONS WITH MINIMAL RISK TO THEMSELVES OR OTHERS. GIVEN THE DIRECT THREAT PRESENTED BY COVID-19 AND THE SIGNIFICANT RISK OF HARM, FITNESS NOW INCLUDES PEOPLE BEING UNDER THE AGE OF 65

15.C.1.C. EXAMINATION INTERVALS. AN EXAMINATION WITH ALL MEDICAL ISSUES AND REQUIREMENTS ADDRESSED WILL REMAIN VALID FOR A MAXIMUM OF 15 MONTHS FROM THE

DATE OF THE PHYSICAL, OR 12 MONTHS FOLLOWING DEPLOYMENT, WHICHEVER IS FIRST. SEE TAB A AND REF D, J, K, L FOR FURTHER GUIDANCE. GOVERNMENT CIVILIAN EMPLOYEES, VOLUNTEERS, AND DOD CONTRACTOR PERSONNEL DEPLOYED FOR MULTIPLE OR EXTENDED TOURS OF MORE THAN 12 MONTHS MUST BE RE-EVALUATED FOR FITNESS TO STAY DEPLOYED. ANNUAL IN-THEATER RESCREENING MAY BE FOCUSED ON HEALTH CHANGES, VACCINATION CURRENCY, AND MONITORING OF EXISTING CONDITIONS RATHER THAN BEING COMPREHENSIVE, BUT SHOULD CONTINUE TO MEET ALL MEDICAL GUIDANCE AS PRESCRIBED IN MOD 15. UNLESS SPECIFICALLY OBLIGATED BY CONTRACTUAL ARRANGEMENT, EXPEDITIONARY MILITARY MEDICAL ASSETS ARE NOT TO BE USED FOR RE-EVALUATION OF CONTRACTORS TO STAY DEPLOYED. IF INDIVIDUALS ARE UNABLE TO ADEQUATELY COMPLETE THEIR MEDICAL SCREENING EVALUATION IN THE AOR, THEY SHOULD BE REDEPLOYED TO ACCOMPLISH THIS YEARLY REQUIREMENT. PERIODIC HEALTH SURVEILLANCE REQUIREMENTS AND PRESCRIPTION NEEDS ASSESSMENTS SHOULD REMAIN CURRENT THROUGH THE DEPLOYMENT PERIOD.

15.C.1.D. SPECIALIZED GOVERNMENT CIVILIAN EMPLOYEES WHO MUST MEET SPECIFIC PHYSICAL STANDARDS (E.G., FIREFIGHTERS, SECURITY GUARDS, POLICE, AVIATORS, AVIATION CREW MEMBERS, AIR TRAFFIC CONTROLLERS, DIVERS, MARINE CRAFT OPERATORS, COMMERCIAL DRIVERS, ETC.) MUST MEET THOSE STANDARDS WITHOUT EXCEPTION, IN ADDITION TO BEING FOUND FIT FOR THE SPECIFIC DEPLOYMENT BY A MEDICAL AND DENTAL EVALUATION PRIOR TO DEPLOYMENT IAW MOD 15. CERTIFICATIONS MUST BE VALID AND RENEWED AS REQUIRED THROUGHOUT THE ENTIRETY OF THE DEPLOYMENT. IT IS UP TO THE INDIVIDUAL TO PLAN FOR AND RECERTIFY THEIR RESPECTIVE REQUIREMENTS.

15.C.1.E. DOD CONTRACTOR EMPLOYEES MUST MEET STANDARDS OF FITNESS FOR DEPLOYMENT AND MUST BE DOCUMENTED TO BE FIT FOR THE PERFORMANCE OF THEIR DUTIES, WITHOUT LIMITATIONS, BY MEDICAL AND DENTAL EVALUATION PRIOR TO DEPLOYMENT IAW MOD 15. CONTRACTORS MUST COMPLY WITH REF J AND SPECIFICALLY ENCLOSURE 3 FOR MEDICAL REQUIREMENTS. EVALUATIONS SHOULD BE COMPLETED PRIOR TO ARRIVAL AT THE DEPLOYMENT PLATFORM.

15.C.1.E.1. PREDEPLOYMENT AND/OR TRAVEL MEDICINE SERVICES FOR CONTRACTOR EMPLOYEES, INCLUDING COMPLIANCE WITH IMMUNIZATION, DNA, AND PANOGRAPH REQUIREMENTS, EVALUATION OF FITNESS, AND ANNUAL SCREENING ARE THE RESPONSIBILITY OF THE CONTRACTING AGENCY PER THE CONTRACTUAL REQUIREMENTS. QUESTIONS SHOULD BE SUBMITTED TO THE SUPPORTED COMMAND'S CONTRACTING AND MEDICAL AUTHORITY. SEE TAB A AND REF J FOR FURTHER GUIDANCE.

15.C.1.E.2. ALL CONTRACTING AGENCIES ARE RESPONSIBLE FOR PROVIDING THE APPROPRIATE LEVEL OF MEDICAL SCREENING FOR THEIR EMPLOYEES. SCREENING MUST BE COMPLETED BY A MEDICAL PROVIDER LICENSED IN A COUNTRY WITH OVERSIGHT AND ACCOUNTABILITY OF THE MEDICAL PROFESSION, AND A COPY OF THE COMPLETED MEDICAL SCREENING DOCUMENTATION, IN ENGLISH, MUST BE MAINTAINED BY THE CONTRACTOR. DOCUMENTATION MAY BE REQUESTED BY BASE OPERATIONS CENTER PERSONNEL PRIOR TO ISSUANCE OF ACCESS BADGES AS WELL AS BY MEDICAL PERSONNEL FOR COMPLIANCE REVIEWS. INSTALLATION COMMANDERS, IN CONCERT WITH THEIR LOCAL MEDICAL ASSETS AND CONTRACTING REPRESENTATIVES, MAY CONDUCT QUALITY ASSURANCE AUDITS TO VERIFY THE VALIDITY OF MEDICAL SCREENINGS.

15.C.1.E.3. CONTRACTOR EXPENSE. IAW REF J, CONTRACTORS WILL PROVIDE PREDEPLOYMENT MEDICAL AND DENTAL EVALUATIONS. ANNUAL IN THEATER RESCREENING, IF REQUIRED, WILL BE AT CONTRACTOR EXPENSE. REQUIRED IMMUNIZATIONS OUTLINED IN THE FOREIGN CLEARANCE GUIDE (HTTPS://WWW.FCG.PENTAGON.MIL) FOR THE COUNTRIES TO BE VISITED, AS WELL AS THOSE OUTLINED IN PARAGRAPH 15.F. OF THIS MOD, WILL BE

TESTS FOR DIROFILARIA AND TICK BORNE DISEASES, AND DETAILED ANESTHETIZED ORAL 313 EXAM TO INCLUDE ALL TEETH.

15.C.1.G.3.D. FLUORESCENT ANTIBODY VIRUS NEUTRALIZATION (FAVN) TITERS ARE REQUIRED FOR ANY WORKING DOG THAT IS TRAVELING FROM A GULF STATE (EXCLUDING BAHRAIN) THROUGH EUROPE. VCOS WILL ENSURE THE MOST RECENT FAVN IS SUFFICIENT (> 0.5 IU/ML), LINKED TO THEIR 15 DIGIT ISO MICROCHIP, AND THEIR RABIES VACCINE COVERAGE HAS NEVER LAPSED SINCE THE FAVN WAS PERFORMED.

15.C.1.G.3.E. ANY WORKING DOG DEPLOYING TO THE CENTCOM AOR WILL ARRIVE WITH, AT MINIMUM, THEIR TOUR'S WORTH OF ALL NECESSARY PRESCRIPTION MEDICATIONS, IN ADDITION TO HEARTGUARD AND FLEA AND TICK CONTROL (INCLUDING ADVANTIX AND SCALIBOR/SERESTO COLLARS). DOGS THAT MAY GO TO EGYPT REQUIRE PRAZIQUANTEL FOR THE COUNTRY'S TAPEWORM TREATMENT REQUIREMENT.

15.C.1.G.3.F. WORKING DOGS WITH A HISTORY OF HEAT INJURY ARE INELIGIBLE TO DEPLOY TO THE CENTCOM AOR.

15.C.2. UNFIT PERSONNEL. CASES OF IN-THEATER/DEPLOYED PERSONNEL IDENTIFIED AS UNFIT, IAW THIS MOD 15, DUE TO CONDITIONS THAT EXISTED PRIOR TO DEPLOYMENT WILL BE FORWARDED TO THE APPROPRIATE COMPONENT SURGEON FOR DETERMINATION REGARDING POTENTIAL MEDICAL WAIVER OR REDEPLOYMENT. FINDINGS/ACTIONS WILL BE FORWARDED TO THE CENTCOM SURGEON AT CENTCOM.MACDILL.CENTCOM-HQ.MBX.CCSG-WAIVER@MAIL.MIL.

15.C.3. MEDICAL WAIVERS.

15.C.3.A. MEDICAL WAIVER APPROVAL AUTHORITY.

15.C.3.A.1. MEDICAL WAIVER APPROVAL AUTHORITY LIES AT THE COMBATANT COMMAND SURGEON LEVEL IAW REF I, K, M, AND IS DELEGATED TO THE USCENTCOM COMPONENT SURGEONS FOR ALL DEPLOYING PERSONNEL WITHIN THEIR RESPECTIVE COMPONENT FOR ALL HEALTH CONDITIONS, EXCLUDING BEHAVIORAL HEALTH CONDITIONS, WITH THE EXCEPTION OF ISOLATED SUBSTANCE USE DISORDERS (SUD) AND ISSUES. BEHAVIORAL HEALTH WAIVERS ARE INITIALLY EVALUATED BY THE RESPECTIVE SERVICE COMPONENT, AND MAY BE REFUSED AT THAT LEVEL. SUD MAY BE DISPOSITIONED BY THE SERVICE COMPONENT, HOWEVER APPROVAL AUTHORITY FOR ALL OTHER BH CONDITIONS RESIDES WITH THE CENTCOM SURGEON. MWD/CWD WAIVERS WILL BE EVALUATED BY THE ARCENT VETERINARY CORPS OFFICER (VCO). SENDING UNIT COMMANDER OR DESIGNEE ENDORSEMENT OF UNIFORMED SERVICE MEMBER WAIVERS IS REQUIRED PRIOR TO SUBMISSION IN ORDER TO ENSURE COMMAND AWARENESS.

15.C.3.A.2. CONTRACTORS' AND SUB CONTRACTORS' RESPECTIVE SERVICE AFFILIATION IS DETERMINED BY THE 'CONTRACTOR ISSUING AGENCY' BLOCK ON THEIR 'LETTER OF AUTHORIZATION', AND WAIVERS SHOULD BE SENT TO THE APPROPRIATE SERVICE COMPONENT WAIVER AUTHORITY. SEE SECTION 15.C.3.C. THE CENTCOM SURGEON IS THE WAIVER AUTHORITY FOR DOD CIVILIANS, CONTRACTORS, AND ORGANIZATIONS, SUCH AS DEFENSE INTELLIGENCE AGENCY, AMERICAN RED CROSS, ETC., WHO ARE NOT DIRECTLY ASSOCIATED WITH A PARTICULAR CENTCOM COMPONENT.

15.C.3.A.3. AN INDIVIDUAL MAY BE MEDICALLY DISQUALIFIED BY THE LOCAL MEDICAL AUTHORITY OR CHAIN OF COMMAND. AN INDIVIDUALIZED ASSESSMENT IS STILL REQUIRED FOR DOD. SEE PARA. 15.C AND REF I. AUTHORITY TO APPROVE DEPLOYMENT OF ANY PERSON (UNIFORMED OR CIVILIAN) WITH DISQUALIFYING MEDICAL CONDITIONS LIES SOLELY WITH THE CENTCOM SURGEON AND THE CENTCOM SERVICE COMPONENT SURGEONS WHO HAVE BEEN DELEGATED THIS AUTHORITY BY THE CENTCOM SURGEON.

15.C.3.B. WAIVER PROCESS. IF A MEDICAL WAIVER IS DESIRED, LOCAL MEDICAL PERSONNEL WILL INFORM THE NON-DEPLOYABLE INDIVIDUAL AND THE UNIT COMMAND/SUPERVISOR ABOUT THE WAIVER PROCESS AS FOLLOWS.

15.C.3.B.1. AUTHORIZED AGENTS (LOCAL MEDICAL PROVIDER, COMMANDER/SUPERVISOR, REPRESENTATIVE) WILL FORWARD A COMPLETED MEDICAL WAIVER REQUEST FORM (TAB C), TO BE ADJUDICATED BY THE APPROPRIATE SURGEON IAW PARAGRAPH 15.C.3.C. ADJUDICATION WILL ACCOUNT FOR SPECIFIC MEDICAL SUPPORT CAPABILITIES IN THE LOCAL REGION OF THE AOR. WAIVER SUBMISSION BY OR THROUGH A MEDICAL AUTHORITY IS STRONGLY ENCOURAGED TO AVOID UNNECESSARY ADJUDICATION DELAYS DUE TO INCOMPLETE INFORMATION. THE CASE SUMMARY PORTION OF THE WAIVER SHOULD INCLUDE A SYNOPSIS OF THE CONCERNING CONDITION(S) AND ALL SUPPORTING DOCUMENTATION TO INCLUDE THE PROVIDER'S ASSESSMENT OF ABILITY TO DEPLOY.
15.C.3.B.2. THE SIGNED WAIVER WILL BE RETURNED TO THE REQUEST ORIGINATOR FOR INCLUSION IN THE PATIENT'S DEPLOYMENT MEDICAL RECORD AND THE ELECTRONIC MEDICA RECORD (EMR). DISAPPROVALS MUST BE DOCUMENTED AND SHOULD NOT BE GIVEN TELEPHONICALLY.
15.C.3.B.3. A CENTCOM WAIVER DOES NOT PRECLUDE THE NEED FOR SERVICE-SPECIFIC MEDICAL WAIVERS (E.G., SMALL ARMS WAIVERS) OR OCCUPATIONAL MEDICAL WAIVERS (E.G., AVIATORS, COMMERCIAL TRUCK DRIVERS, ETC.) IF REQUIRED.
15.C.3.B.4. APPEAL PROCESS. IF THE SENDING UNIT DISAGREES WITH THE COMPONENT SURGEON'S DECISION, AN APPEAL MAY BE SUBMITTED TO THE CENTCOM SURGEON. IF THE DISAGREEMENT IS WITH THE CENTCOM SURGEON'S DECISION, AN APPEAL MAY BE COORDINATED WITH THE INDIVIDUAL'S CHAIN OF COMMAND, THROUGH THE CENTCOM SURGEON, TO THE CENTCOM CHIEF OF STAFF FOR EXEMPTION TO POLICY CONSIDERATION.
15.C.3.B.5. WAIVERS ARE APPROVED FOR A MAXIMUM OF 15 MONTHS OR FOR THE TIMEFRAME SPECIFIED ON THE WAIVER (TAB C). WAIVER COVERAGE BEGINS ON THE DATE OF THE INITIAL DEPLOYMENT.
15.C.3.B.6. WAIVERS MAY BE APPROVED, AT THE WAIVER AUTHORITY'S SOLE DISCRETION, FOI PERIODS OF TIME (E.G. 90 DAYS) SHORTER THAN THE SCHEDULED DEPLOYMENT DURATION II ORDER TO REQUIRE REASSESSMENT OF A MEDICAL CONDITION. SUCH WAIVERS WILL INCLUDE RESUBMISSION INSTRUCTIONS. ALL LABS, ASSESSMENTS, ETC. REQUIRED FOR RESUBMISSION ARE THE RESPONSIBILITY OF THE EMPLOYEE TO OBTAIN AND SUBMIT.
15.C.3.B.7. ALL ADJUDICATING SURGEONS WILL MAINTAIN A WAIVER DATABASE AND RECORD ALL WAIVER REQUESTS.
15.C.3.C. CONTACTS FOR WAIVERS
15.C.3.C.1. CENTCOM SURGEON.
CENTCOM.MACDILL.CENTCOM-HQ.MBX.CCSG-WAIVER@MAIL.MIL ;
CML: 813.529.0361; DSN: 312.529.0361
15.C.3.C.2. AFCENT SURGEON. USCENTAFSG.ORGBOX@AFCENT.AF.MIL;
CML: 803.717.7101; DSN: 313.717.7101
15.C.3.C.3. ARCENT SURGEON. USARMY.SHAW.USARCENT.MBX.SURG-WAIVER@MAIL.MIL;
CML: 803.885.7946; DSN: 312.889.7946
15.C.3.C.4. MARCENT SURGEON. USMARCENT.WAIVER@USMC.MIL;
CML: 813.827.7175; DSN: 312.651.7175
15.C.3.C.5. NAVCENT SURGEON. CUSNC.MEDWAIVERS@ME.NAVY.MIL;
CML: 011.973.1785.4558; DSN: 318.439.4558
15.C.3.C.6. SOCCENT SURGEON. SOCCENT.SG@SOCOM.MIL;
CML: 813.828.7351; DSN: 312.968.7351
15.D. PHARMACY.
15.D.1. SUPPLY. PERSONNEL WHO REQUIRE MEDICATION AND WHO ARE DEPLOYING TO THE CENTCOM AOR WILL DEPLOY WITH NO LESS THAN A 180 DAY SUPPLY (OR APPROPRIATE AMOUNT FOR SHORTER DEPLOYMENTS) OF THEIR MAINTENANCE MEDICATIONS WITH

ARRANGEMENTS TO OBTAIN A SUFFICIENT SUPPLY TO COVER THE REMAINDER OF THE DEPLOYMENT USING A FOLLOW-ON REFILL PRESCRIPTION. TRICARE ELIGIBLE PERSONNEL WILL OBTAIN FOLLOW-ON REFILL PRESCRIPTIONS FROM THE TRICARE MAIL ORDER PHARMACY (TMOP) DEPLOYED PRESCRIPTION PROGRAM (DPP) OR EXPRESS SCRIPTS. INFORMATION ON THIS PROGRAM MAY BE FOUND AT HTTPS://WWW.EXPRESS-SCRIPTS.COM/TRICARE/TOOLS/DEPLOYEDRX.SHTML.

15.D.2. EXCEPTIONS. EXCEPTIONS TO THE 180 DAY PRESCRIPTION QUANTITY REQUIREMENT INCLUDE:

15.D.2.A. PERSONNEL REQUIRING MALARIA CHEMOPROPHYLACTIC MEDICATIONS (DOXYCYCLINE, ATOVAQUONE/PROGUANIL, ETC.) WILL DEPLOY WITH EITHER ENOUGH MEDICATION FOR THEIR ENTIRE DEPLOYMENT OR WITH ENOUGH TO COVER APPROXIMATELY HALF OF THE DEPLOYMENT WITH PLANS TO RECEIVE THE REMAINDER OF THEIR MEDICATION IN THEATER (EXCLUDING PRIMAQUINE FOR TERMINAL PROPHYLAXIS) BASED ON UNIT PREFERENCE. UNITS WILL DISTRIBUTE TERMINAL PROPHYLAXIS UPON REDEPLOYMENT. THE DEPLOYMENT PERIOD WILL INCLUDE AN ADDITIONAL 28 DAYS AFTER LEAVING THE MALARIA RISK AREA (FOR DOXYCYCLINE) OR 7 DAYS (FOR ATOVAQUONE/PROGUANIL) TO ACCOUNT FOR REQUIRED PRIMARY PROPHYLAXIS. TERMINAL PROPHYLAXIS WITH PRIMAQUINE FOR 14 DAYS SHOULD BEGIN ONCE THE INDIVIDUAL MEMBER HAS LEFT THE AREA OF MALARIA RISK.

15.D.2.B. PSYCHOTROPIC MEDICATION MAY BE DISPENSED FOR UP TO A 180 DAY SUPPLY WITH NO REFILL.

15.D.2.B.1. THE PROVIDER MAY PRESCRIBE A LIMITED QUANTITY (I.E., AT LEAST A 90 DAY SUPPLY) WITH NO REFILLS TO FACILITATE CLINICAL FOLLOW-UP IN THEATER.

15.D.2.B.2. PSYCHOTROPIC MEDICATIONS AUTHORIZED FOR UP TO A 180 DAYS SUPPLY INCLUDE, BUT ARE NOT LIMITED TO; ANTI-DEPRESSANTS, ANTI-ANXIETY (NON CONTROLLED SUBSTANCES), NON-CLASS 2 (CII) STIMULANTS, AND ANTI-SEIZURE MEDICATIONS USED FOR MOOD DISORDERS. THIS TERM ALSO ENCOMPASSES THE GENERIC EQUIVALENTS OF THE ABOVE MEDICATION CATEGORIES WHEN USED FOR NON-PSYCHOTROPIC INDICATIONS.

15.D.2.C. ALL DRUG ENFORCEMENT AGENCY (DEA) CONTROLLED SUBSTANCES (SCHEDULE I-V) ARE LIMITED TO A 90 DAY SUPPLY WITH NO REFILLS. AN APPROVED WAIVER MUST BE OBTAINED FROM THE CENTCOM WAIVER AUTHORITY PRIOR TO DEPLOYMENT, AND IS REQUIRED FOR ALL RENEWALS. CLINICAL FOLLOW-UP IN THEATER SHOULD BE SOUGHT AT THE EARLIEST OPPORTUNITY TO OBTAIN MEDICATION RENEWALS.

15.D.3. PRESCRIPTION MEDICATION ANALYSIS AND REPORTING TOOL (PMART). SOLDIER READINESS PROCESSING (SRP) AND OTHER DEPLOYMENT PLATFORM PROVIDER/PHARMACY AND UNIT MEDICAL OFFICER PERSONNEL WILL MAXIMIZE THE USE OF THE PRESCRIPTION MEDICATION ANALYSIS AND REPORTING TOOL (PMART) TO SCREEN DEPLOYING PERSONNEL FOR HIGH-RISK MEDICATIONS, AS WELL AS TO IDENTIFY MEDICATIONS WHICH ARE TEMPERATURE-SENSITIVE, OVER THE COUNTER (FOR SITUATIONAL AWARENESS REGARDING MEDICATION INTERACTION), OR NOT AVAILABLE ON THE CENTCOM FORMULARY AND/OR THROUGH THE TMOP/DPP. CONTACT THE DHA PHARMACY ANALYTICS SUPPORT SECTION AT 1.866.275.4732 OR DHA.JBSA.PHARMACY-OPS.MBX.PASS-DMT@MAIL.MIL FOR INFORMATION ON HOW TO OBTAIN A PMART REPORT. INFORMATION REGARDING PMART AS WELL AS THE CENTCOM FORMULARY CAN BE FOUND AT THE HEALTH.MIL WEBSITE AT: WWW.HEALTH.MIL/PMART.

15.D.4. TRICARE MAIL ORDER PHARMACY (TMOP). PERSONNEL REQUIRING ONGOING PHARMACOTHERAPY WILL MAXIMIZE USE OF THE TMOP/DPP SYSTEM (TO INCLUDE MEDICATIONS LISTED IN 15.D.2.B AND 15.D.2.C) WHEN POSSIBLE. THOSE ELIGIBLE FOR TMOP WILL COMPLETE ON-LINE ENROLLMENT AND REGISTRATION PRIOR TO DEPLOYMENT IF POSSIBLE. INSTRUCTIONS CAN BE FOUND AT HTTPS://WWW.EXPRESS-

SERVICE DATABASE AND ELECTRONIC MEDICAL RECORD. CONTRACTORS, PCS AND SHIPBOARD PERSONNEL ARE NOT REQUIRED TO UNDERGO ANAM TESTING.

15.H.4. POST-DEPLOYMENT HEALTH ASSESSMENT (DD FORM 2796).

15.H.4.A. ALL PERSONNEL WHO WERE REQUIRED TO COMPLETE A PRE-DEPLOYMENT HEALTH ASSESSMENT WILL COMPLETE A POST-DEPLOYMENT HEALTH ASSESSMENT ON A DD FORM 2796. THE POST-DEPLOYMENT HEALTH ASSESSMENT MUST BE COMPLETED NO EARLIER THAN 30 DAYS BEFORE EXPECTED REDEPLOYMENT DATE AND NO LATER THAN 30 DAYS AFTER REDEPLOYMENT.

15.H.4.A.1. INDIVIDUALS WHO WERE NOT REQUIRED TO COMPLETE A PRE-DEPLOYMENT HEALTH ASSESSMENT, BUT WHO COMPLETED ONE TO COVER MULTIPLE TRIPS TO THEATER EACH OF 30 DAYS OR LESS DURATION, SHOULD COMPLETE A POST-DEPLOYMENT HEALTH ASSESSMENT AT LEAST ONCE A YEAR TO DOCUMENT ANY POTENTIAL EXPOSURES OF CONCERN RESULTING FROM ANY SUCH TRAVEL AND THE POTENTIAL NEED FOR MEDICAL FOLLOW-UP.

15.H.4.A.2. INDIVIDUALS WHO WERE NOT REQUIRED TO COMPLETE A PRE-DEPLOYMENT HEALTH ASSESSMENT MAY BE REQUIRED (BY THE COMBATANT COMMANDER, SERVICE COMPONENT COMMANDER, OR COMMANDER EXERCISING OPERATIONAL CONTROL) TO COMPLETE A POST-DEPLOYMENT HEALTH ASSESSMENT IF ANY HEALTH THREATS EVOLVED OR OCCUPATIONAL AND/OR CBRN EXPOSURES OCCURRED DURING THE DEPLOYMENT THAT WARRANT MEDICAL ASSESSMENT OR FOLLOW-UP. (SEE REF C).

15.H.4.B. ALL REDEPLOYING PERSONNEL WILL UNDERGO A PERSON-TO-PERSON HEALTH ASSESSMENT WITH AN INDEPENDENT PRACTITIONER. THE ORIGINAL COMPLETED COPY OF THE DD FORM 2796 MUST BE PLACED IN THE INDIVIDUAL'S MEDICAL RECORD AND TRANSMIT AN ELECTRONIC COPY TO THE DMSS AT THE AFHSC. CONTRACT PERSONNEL ARE NOT REQUIRED TO ELECTRONICALLY SUBMIT THE DD FORM 2796; A PAPER VERSION WILL SUFFICE.

15.H.5. MENTAL HEALTH ASSESSMENT. ALL SERVICE MEMBERS WILL UNDERGO A PERSON-TO-PERSON MENTAL HEALTH ASSESSMENT IAW REF Y OR CURRENT DEPARTMENT OF DEFENSE POLICY.

15.H.5.A. ASSESSMENTS WITH BE COMPLETED BY A LICENSED MENTAL HEALTH PROFESSIONAL OR TRAINED AND CERTIFIED HEALTH CARE PERSONNEL, SPECIFICALLY A PHYSICIAN, PHYSICIAN ASSISTANT, NURSE PRACTITIONER, ADVANCED PRACTICE NURSE, INDEPENDENT DUTY CORPSMAN, SPECIAL FORCES MEDICAL SERGEANT, INDEPENDENT DUTY MEDICAL TECHNICIAN, OR INDEPENDENT HEALTH SERVICES TECHNICIAN.

15.H.5.A.1. ASSESSMENTS WILL BE ADMINISTERED WITHIN 120 DAYS PRIOR TO DEPLOYMENT, AND AFTER REDEPLOYMENT WITHIN 3 TIMEFRAMES (3-6, 7-18, AND 18-30 MONTHS). ASSESSMENTS SHOULD BE AT LEAST 90 DAYS APART.

15.H.5.A.2. CURRENTLY ADMINISTERED PERIODIC AND OTHER PERSON-TO-PERSON HEALTH ASSESSMENTS, SUCH AS THE POST-DEPLOYMENT HEALTH REASSESSMENT, WILL MEET THE TIME REQUIREMENTS IF THEY CONTAIN ALL BEHAVIORAL HEALTH AND SOCIAL QUESTIONS IAW REF Y.

15.H.5.B. MENTAL HEALTH ASSESSMENT GUIDANCE DOES NOT DIRECTLY APPLY TO DOD CONTRACTORS UNLESS SPECIFIED IN THE CONTRACT OR THERE IS A CONCERN FOR A MENTAL HEALTH ISSUE. ALL RELATED MENTAL HEALTH EVALUATIONS WILL BE AT THE CONTRACTOR'S EXPENSE.

15.H.6. POST-DEPLOYMENT HEALTH RE-ASSESSMENT (DD FORM 2900). ALL PERSONNEL WHO WERE REQUIRED TO COMPLETE A PRE- AND POST-DEPLOYMENT HEALTH ASSESSMENT WILL COMPLETE A POST-DEPLOYMENT HEALTH REASSESSMENT (DD FORM 2900) 90 TO 180 DAYS AFTER RETURN TO HOME STATION. SEE WWW.PDHEALTH.MIL FOR ADDITIONAL INFORMATION

MOD15-TAB A: AMPLIFICATION OF THE MINIMAL STANDARDS OF FITNESS FOR DEPLOYMENT TO THE CENTCOM AOR; TO ACCOMPANY MOD FIFTEEN TO USCENTCOM INDIVIDUAL PROTECTION AND INDIVIDUAL/UNIT DEPLOYMENT POLICY

1. General. This TAB A accompanies MOD FIFTEEN, Section 15.C. and provides amplification of the minimal standards of fitness for deployment to the CENTCOM area of responsibility (AOR). Individuals possessing a disqualifying medical condition must obtain an exception to policy in the form of a medical waiver prior to being medically cleared for deployment. The list of deployment-limiting conditions is not comprehensive; there are many other conditions that may result in denial of medical clearance for deployment based upon the totality of individual medical conditions and the medical capabilities present at that individual's deployed location. "Medical conditions" as used here also include those health conditions usually referred to as dental and behavioral health.

A. Uniformed Service Members must meet Service standards of fitness according to Service regulations and policies, in addition to the guidance in the parent MOD 15. See MOD FIFTEEN REF E, F, G, H, I, JJ.

B. DoD civilian personnel with disqualifying medical conditions could still possibly deploy based upon an individualized medical assessment and approved medical waiver from the appropriate CENTCOM waiver authority. All personnel must be able to perform the duties of their position.

C. DoD Contract personnel will be evaluated for fitness according to MOD FIFTEEN and DoDI 3020.41 (REF J).

D. The final authority of who may deploy to the CENTCOM AOR rests with the CENTCOM Surgeon and/or the Service Component Surgeons' waiver authority, not the individual's medical evaluating entity, deploying platform, or Commander.

E. Regardless of underlying diagnosis, waivers for disqualifying medical conditions will be considered only if all the following general conditions are met:

1. Age less than 65 years for duration of deployment.
2. The condition is not of such a nature or duration that an unexpected worsening or physical trauma is likely to have a grave medical outcome or negative impact on mission execution.
3. The condition is stable and reasonably anticipated not to worsen during the deployment in light of the physical, physiological, psychological, and nutritional effects of assigned duties and location.
4. The condition does not require frequent clinical visits (more than quarterly), ancillary tests, or significant physical limitations, and does not constitute an increased risk of illness, injury, or infection.
5. There is no anticipated need for routine evacuation out of theater for continuing diagnostics or evaluations.
6. Any required, ongoing health care or medications anticipated to be needed for the duration of the deployment are available to the applicant in theater within the Military

Health System or equivalent. Medication must have no special handling, storage, or other requirements (e.g., refrigeration, cold chain, or electrical power requirements). Medication must be well tolerated within harsh environmental conditions (e.g. heat or cold stress, sunlight) and should not cause significant side effects in the setting of moderate dehydration.

7. Individuals must be able to perform all essential functions of their position in the deployed environment, with or without reasonable accommodation, without causing undue hardship. In evaluating undue hardship, the nature of the accommodation and workplace environment must be considered. Further, the member's medical condition must not pose a significant risk of substantial harm to the member or others taking into account the condition of the relevant deployed environment, with particular consideration of areas of armed conflict in the AOR. See REF I.

8. The medical condition does not prevent the wear of personal protective equipment, including protective mask, ballistic helmet, body armor, and chemical/biological protective garments.

9. The medical condition does not prohibit required theater immunizations or medications.

10. The medical condition is not anticipated to significantly impair duty performance during the duration of the deployment.

11. The diagnosis, management, and/or treatment of medical conditions does not place an unreasonable burden on deployed medical assets, operational assets, or complicate the evaluation of other reasonably-anticipated illnesses or injuries.

2. Evaluating providers must consider that in addition to the individual's assigned duties, severe environmental conditions, extremes of temperature, high physiologic demands (water, mineral, salt, and heat management), poor air quality (especially particulates), limited dietary options, sleep deprivation/disruption, and emotional stress may all impact the individual's health. If maintaining an individual's health requires avoidance of these extremes or conditions, they should not deploy.

3. Evaluation of functional capacity to determine fitness in conditions of physiologic demand is encouraged for conditions which may impair normal functionality. The evaluating provider should pay special attention to any conditions which may present a hazard to the individual or others and/or preclude performing functional requirements in the deployed setting. Also, the type, amount, suitability, and availability of medications in the theater environment must be considered as potential limitations. Pre-deployment processing centers may vary in medical examination/screening procedures; individuals should contact their respective mobilization site for availability of a processing checklist.

4. The guidance in this document should not be construed as authorizing use of defense health program or military health system resources for health evaluations unless otherwise authorized. Generally, Defense Health Agency and Military Health System resources are not authorized for the purpose of pre-deployment or travel medicine evaluations for contractor employees IAW REF J. Local command, legal, contracting and resource management authorities should be consulted for questions on this matter.

5. Shipboard operations which are not anticipated to involve operations ashore are exempt from the deployment-limiting medical conditions listed below and will generally follow Service specific guidance. However, sovereign laws of some nations within the CENTCOM AOR may prohibit entry of individuals with certain medical conditions. Contingency plans for emergency evacuation of individuals with

1. Inflammatory bowel disease, including, but not limited to: Crohn's disease; ulcerative colitis; ulcerative proctitis; regional enteritis; granulomatous enteritis.

2. Chronic hepatitis with impairment of liver function.

3. The presence of any ostomy (gastrointestinal or urinary).

G. Surgery:

1. Any medical condition that requires surgery or for which surgery has been performed, to include cosmetic, bariatric, and reconstructive procedures, and the patient requires ongoing treatment, rehabilitation or additional surgery/revision.
2. Individuals who have had surgery requiring follow up during the deployment period or who have not been cleared/released by their surgeon (excludes minor procedures).
3. Individuals who have had surgery (open or laparoscopic) within 6 weeks of deployment.
4. Special dietary and hygienic requirements resulting from surgery cannot be reliably accommodated and may be independently disqualifying.

H. Behavioral Health Conditions: Diagnostic criteria and treatment plans should adhere to Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) and current professional standards of care. Waiver submission should include information on applicant condition, including history and baseline symptoms of known disorders, severity of symptoms with and without treatment, and likelihood to recur or deteriorate in theater if exposed to operational activity. See reference KK. Waiver required for all conditions listed below (list is not inclusive).

1. Psychotic and bipolar-spectrum disorders are strictly disqualifying.
2. Any DSM 5-diagnosed behavioral health disorder, to include personality disorders, with residual symptoms, or medication side effects, which impair social and/or occupational performance.
3. Any behavioral health condition that poses a substantial risk for deterioration and/or recurrence of impairing symptoms in the deployed environment.
4. Any behavioral health condition that requires periodic (beyond quarterly) counselling or therapy.
5. Chronic insomnia that requires regular or long-term use of sedative hypnotics / amnestics, benzodiazepines, and/or antipsychotics. PRN, or as needed, use of medication for this diagnosis must clarify frequency of actual use.
6. Anxiety disorders requiring use of benzodiazepines for management, or featuring symptoms of panic or phobia.
7. Post-Traumatic Stress Disorder, when causing impairment or not completely treated, or when therapy includes use of benzodiazepines without additional anxiety diagnosis. Waiver submission should note **if condition is** combat-related, and, if so, comment on impact that return to the operational environment could have on applicant well-being and performance.
8. Gender dysphoria, when distressing enough to require treatment. Transgender without history of, or current requirement for, transition, and not associated with

significant gender dysphoria is not disqualifying and does not require waiver. Underlying behavioral health, endocrine, and/or surgical issues (as applicable) should be stable and resolved, and all Service requirements must be met, to include the involvement of, and clearance by, Service Central Coordination Cell if transition is required. See Ref LL. Transitioning personnel's treatment course should be complete, preferably with DEERS marker change, and an adequate Real Life Experience (RLE) period should have occurred to ensure stability. Due to complex needs, those requiring or actively undergoing gender transition are generally disqualified until the process, including all necessary follow-up and stabilization, is completed.

9. Bulimia and anorexia nervosa.

10. Attention Deficit Disorder (ADD)/Attention Deficit Hyperactivity Disorder (ADHD). Evaluation and diagnosis should be appropriate per DSM 5 criteria, particularly if Class II stimulants are used for treatment. Specific clinical features or objective testing results should be included in waiver application for stimulant use. Dosages for medications should likewise be appropriate per DoHHS-CMS standards (REF MM), and justified by clinical presentation. Uncomplicated ADD/ADHD stable (treated with 0-1 non-controlled substance medication) for greater than 3 months without social or occupational impact do not require a waiver. Substantiated cases not meeting those criteria but with appropriate dosing may be adjudicated at the Service Component level, provided additional BH conditions or diagnoses requiring waiver are not present.

11. Behavioral health related hospitalization or self-mutilation within the last 12 months.

12. Suicidal Ideation or Suicide Attempt with the last 12 months.

13. Substance use causing social or occupational disruption or impairment, including enrollment in a substance abuse program (inpatient or outpatient, service specific substance abuse program) within the last 12 months, measured from time of discharge / completion of the program.

- **a.** A post-treatment period of demonstrated stability is required, the length of which will depend on individual patient factors.
- **b**. Substance use disorders (SUD), not in remission and/or actively enrolled in Service Specific substance abuse programs are not eligible for waiver.
- **c**. SUD requiring regular use of reversal agents or antagonists (Naloxone, Suboxone, Methadone) cannot be supported. Single-dose issuances of Naloxone are not intrinsically disqualifying, but require clarification of underlying SUD issues.
- **d**. Alcohol use disorder requiring pharmacotherapy for maintenance (Disulfiram, Naltrexone, Acamprosate) cannot be supported.
- **e**. Alcohol use disorders requiring random testing or other monitoring are disqualifying.

14. Use of antipsychotics or anticonvulsants for stabilization of DSM IV or DSM-5 diagnoses.

15. Use of 3 or more psychotropics (e.g. antidepressants, anticonvulsants, antipsychotics, benzodiazepines) for stabilization or any psychotropics which require a psychiatrist or other specialist to manage.

16. Behavioral health disorders without demonstrated clinical stability of at least 3 months, as defined by (1) no significant recent deterioration in clinical condition, (2) no significant impairment in work or interpersonal functioning, (3) no significant risk of sudden incapacitation should condition relapse or recur, (4) no morbid, suicidal, or homicidal ideation, intent or plan, and (5) likely to impact immediate family. Recent

changes in treatment regimen, including discontinuation, should be explained and support clinical stability as above.

17. Behavioral health disorders newly diagnosed during deployment do not immediately require a waiver or redeployment. Disorders deemed treatable, stable, and having no impairment of performance or safety by a credentialed mental health provider do not require a waiver to remain in theater.

a. Exceptions include diagnoses featuring bipolar, psychotic, or suicidal features. These individuals should be redeployed at soonest opportunity via medical evacuation with appropriate escorts and per TRANSCOM guidelines.

b. Diagnoses requiring the prescription of CSA-scheduled controlled substances will require an approved waiver to obtain routine refills of medication.

l. Medications – Recently discontinued medications are considered to have had valid clinical indications, and should include verification of control of underlying conditions and reason for cessation. Medications included as "PRN", or as needed, must include a description of typical use. Although not exhaustive, use of any of the following medications (specific medication or class of medication) is disqualifying for deployment, unless a waiver is granted:

1. Any medication which, if lost, misplaced, stolen, or destroyed, would result in significant worsening or grave outcome for the affected individual before the medication could be reasonably replaced.

2. Any medication requiring periodic laboratory monitoring, titrated dosing, or special handling/storage requirements, or which has documented side effects, when used alone or in combination with other required therapy, which are significantly impairing, or which impose an undue risk to the individual or operational objectives.

3. Blood modifiers:

a. Therapeutic Anticoagulants: warfarin (Coumadin), rivaroxaban (Xarelto), apixaban (Eliquis).

b. Platelet Aggregation Inhibitors or Reducing Agents: clopidogrel (Plavix), anagrelide (Agrylin), Dabigatran (Pradaxa), Aggrenox, Ticlid (Ticlopidine), Prasugrel (Effient), Pentoxifylline (Trental), Cilostazol (Pletal), Ticagrelor (Brilinta). Note: Aspirin use in theater is to be limited to individuals who have been advised to continue use by their healthcare provider for medical reasons; such use must be documented in the medical record.

c. Hematopoietics: filgrastim (Neupogen), sargramostim (Leukine), erythropoietin (Epogen, Procrit).

d. Antihemophilics: Factor VIII, Factor IX, Factor Xa.

4. Antineoplastics (oncologic or non-oncologic use): e.g., antimetabolites (methotrexate, hydroxyurea, mercaptopurine, etc.), alkylators (cyclophosphamide, melphalan, chlorambucil, etc.), antiestrogens (tamoxifen, etc.), aromatase inhibitors (anastrozole, examestane, etc.), medroxyprogesterone (except use for contraception), interferons, etoposide, bicalutamide, bexarotene, oral tretinoin (Vesanoid).

5. Immunosuppressants: e.g., chronic systemic steroids.

6. Biologic Response Modifiers (immunomodulators): e.g., abatacept (Orencia), adalimumab (Humira), anakinra (Kineret), etanercept (Enbrel), infliximab (Remicade), leflunomide (Arava), azathioprine (Imuran), etc.

7. Antiretrovirals used for Pre-Exposure Prophylaxis (PrEP): e.g. tenofovir disoproxil fumarate/emtricitabine (Truvada)

8. Any CSA Schedule I-V controlled substance, including but not limited to the following:
   - **a.** Benzodiazepines: lorazepam (Ativan), alprazolam (Xanax), diazepam (Valium), flurazepam (Dalmane), clonazepam (Klonopin), etc.
   - **b.** Stimulants: methylphenidate (Ritalin, Concerta), amphetamine/dextroamphetamine (Adderall), dextroamphetamine (Dexedrine), dexmethylphenidate (Focalin XR), lisdexamfetamine (Vyvanse), modafinil (Provigil), armodafinil (Nuvigil), etc.
   - **c.** Sedative Hypnotics/Amnestics: zolpidem (Ambien, Ambien CR), eszopiclone (Lunesta), zaleplon (Sonata), estazolam (Prosom), triazolam (Halcion), temazepam (Restoril), etc. Note: single pill-count issuances for operational transition do not require a waiver.
   - **d.** Narcotics/narcotic combinations: oxycodone (Oxycontin, Percocet, Roxicet), hydrocodone (Lortab, Norco, Vicodin), hydromorphone (Dilaudid), meperidine (Demerol), tramadol (Ultram), etc.
   - **e.** Cannabinoids: marijuana, tetrahydrocannabinol (THC), dronabinol (Marinol), cannabinol (CBD oil), etc. Note that possession or use may be a criminal offense in the CENTCOM AOR.
   - **f.** Anorexiants: phendimetrazine (Adipost), phentermine (Zantryl, Adipex-P), etc.
   - **g.** Androgens and Anabolic Steroids: testosterone (Axiron, AndroGel, Fortesta, Testim), oxymetholone (Anadrol-50), methyltestosterone (Methitest), etc. Preparations used in accordance with standards outlined in 7.A.8 above do not require separate waiver.
9. Antipsychotics, including atypical antipsychotics: haloperidol (Haldol), fluphenazine (Prolixin), quetiapine (Seroquel), aripiprazole (Abilify), lurasidone (Latuda), ziprasidone (Geodon), olanzapine (Zyprexa), etc.
10. Antimanic (bipolar) agents: e.g., lithium.
11. Anticonvulsants, used for seizure control or behavioral health diagnoses.
    - **a.** Anticonvulsants (except those listed below) which are used for *non-behavioral health* diagnoses, such as migraine, chronic pain, neuropathic pain, and post-herpetic neuralgia, are not intrinsically deployment-limiting as long as treated conditions meet the criteria set forth in this document and accompanying MOD FIFTEEN. No waiver required. Exceptions include:
    - **b.** Valproic acid (Depakote, Depakote ER, Depacon, divalproex, etc.).
    - **c.** Carbamazepine (Tegretol, Tegretol XR, etc.).
    - **d.** Lamotrigine (Lamictal)
12. Dopamine agonists: Ropinirole (Requip), pramipexole (Mirapex), etc.
13. Botulinum toxin (Botox): Current or recent use to control severe pain.
14. Insulin and exenatide (Byetta).
15. Injectable medications of any type, excluding epinephrine (Epipen), medroxyprogesterone acetate (Depo-Provera), and testosterone cypionate (for Low T/hypogonadism), though underlying allergy may require separate waiver.

8. **CONTACTS FOR WAIVERS (See also MOD 15, Para. 15.C.3.C.)**

A. CENTCOM. CENTCOM.MACDILL.CENTCOM-HQ.MBX.CCSG-WAIVER@MAIL.MIL; CML: 813.529.0361/0348; DSN: 312.529.0361/0348

B. AFCENT. SG.SHAW@AFCENT.AF.MIL; CML: 803.717.7101; DSN: 313.717.7101

C. ARCENT. USARMY.SHAW.USARCENT.MBX.SURG-WAIVER@MAIL.MIL; CML: 803.885.7946; DSN: 312.889.7946

D. MARCENT. USMARCENT.WAIVER@USMC.MIL; CML: 813.827.7175; DSN: 312.651.7175

UNCLASSIFIED

UNITED STATES AFRICA COMMAND INSTRUCTION

J004

ACI 4200.09A
13 September 2019

FORCE HEALTH PROTECTION REQUIREMENTS AND MEDICAL GUIDANCE FOR ENTRY INTO THE U.S. AFRICA COMMAND THEATER

References: See Enclosure I.

1. Purpose. This instruction establishes Force Health Protection (FHP) requirements, provides medical guidance, and delineates responsibilities for all travel to the U.S. Africa Command (USAFRICOM) area of responsibility (AOR). It describes applicability, medical standards of fitness, medical waiver policy, medication and equipment requirements, immunizations, laboratory testing, deployment-related health assessment requirements, medical record requirements, and pre-travel medical training requirements.

2. Superseded. United States Africa Command Instruction 4200.09, 27 January 2017.

3. Applicability. This instruction applies to Headquarters USAFRICOM and joint activities assigned to or reporting through Headquarters USAFRICOM including Offices of Security Cooperation, Security Assistance Offices, Special Operations Command Africa (SOCAFRICA), Joint/Combined Task Forces and Service Components assigned to USAFRICOM. This instruction applies to military personnel on official or leisure travel, and Department of Defense (DoD) civilians, DoD contractors, DoD sub-contractors, and volunteers on official travel to the USAFRICOM AOR or who are currently in the USAFRICOM AOR under the auspices of the DoD. Medical requirements for Local Nationals (LN) or Third Country Nationals (TCN) and DoD contractor personnel are included to the extent provided in the applicable contracts (Reference a).

4. Policy. The National Center for Medical Intelligence designates the USAFRICOM AOR as very high risk for infectious diseases, which will adversely impact mission effectiveness unless appropriate FHP measures are implemented. Additionally, the majority of countries in Africa have underdeveloped healthcare infrastructure, making medical care generally limited.

a. Pre-Travel Training Requirements: Individuals or units traveling to the USAFRICOM AOR must understand the health threats they will encounter,

including those presented by infectious diseases (specifically those with person-to-person, point source, or arthropod-borne transmission), flora and fauna, climatic extremes, environmental contamination and pollution, physical hazards such as motor vehicle accidents, and other forms of injury. Specific medical and training requirements are found in Enclosure H.

b. Exceptions to this policy will be submitted to the USAFRICOM Command Surgeon using the waiver process identified in Enclosure D.

5. Responsibilities.

a. The USAFRICOM Command Surgeon will implement a health program, which effectively anticipates, recognizes, evaluates, controls, and mitigates health threats encountered during activities in Africa (Reference a).

b. Component and subordinate activity commanders, in coordination with their Surgeons' offices, shall:

(1) Enforce FHP measures during the entire travel or deployment timeframe.

(2) Ensure subordinate units and activities establish processes to ensure personnel traveling to the USAFRICOM AOR are medically screened and provided health threat briefs, vaccinations, prophylactic medications, and other countermeasures, as appropriate.

c. All travelers carry the responsibility of understanding the threat and risks of disease and injury and will:

(1) Complete AC Form 42, USAFRICOM Travel Medical Screening Checklist (Enclosure C).

(2) Comply with FHP requirements throughout their travel.

(3) Complete required training.

6. Summary of Changes. This ACI has been revised extensively and must be read in its entirety. This version defines "deployment" as periods of more than 30 days; modifies pre-travel screening requirements for physical examination, laboratory, and dental; and modifies specific medical standards for diabetes, cardiac risk stratification, lipid screening, and others. It also adjusts yellow fever vaccination requirement to lifetime; updates malaria chemoprophylaxis guidance to emphasize use of atovaquone-proguanil; updates the Travel Medical Screening Checklist and Medical Waiver Request form; prescribes direct routing of medical waiver requests from requestor to waiver adjudicator; and adjusts training requirements for medical personnel.

7. Releasability. UNCLASSIFIED UNLIMITED. This directive is approved for public release; distribution is unlimited. Users may obtain copies on the USAFRICOM network portal.

8. Effective Date. This instruction is effective upon signature.

Todd B. McCaffrey
Major General, U.S. Army
Chief of Staff, U.S. Africa Command

Enclosures:
A. Acronyms, Abbreviations, and Terms
B. Medical Clearance
C. Medical Screening Checklist
D. Medical Waiver Process and Authorities
E. Waiver Adjudication Authority Re-Delegation
F. Medical Waiver Request
G. Theater Force Health Protection
H. Pre-Travel Training Requirements
I. References

ACI 4200.09A
13 September 2019

ENCLOSURE B

MEDICAL CLEARANCE

1. All personnel (uniformed service members, government civilian employees, volunteers, DoD contractor employees) entering the theater must be medically, dentally, and psychologically fit, and possess a current Periodic Health Assessment (PHA) or physical (See paragraph 1.e. (3) of this enclosure) (Reference b). Individuals unable to comply with entry requirements will not enter or re-enter the USAFRICOM AOR, (e.g., any person who becomes medically disqualified while in leave status will not re-enter the theater) until the disqualifying condition is cleared or a waiver is approved by the appropriate USAFRICOM waiver authority. Any person who is medically evacuated from the AOR for any condition requires a medical waiver for theater re-entry.

a. Healthcare providers evaluating personnel for travel must bear in mind that in addition to the individual's duties, the environmental conditions that may affect health include extremes of temperature, physiologic demand (water, mineral, salt, and heat management), and poor air quality (especially particulates). In addition, the operating conditions may impose extremes of diet (to include fat, salt, and caloric levels) and sleep deprivation. These conditions often result in emotional stress and sleep disturbances. If managing an individual's health condition requires avoidance of these extremes or conditions, the individual should not travel.

b. Evaluation of functional capacity in conditions of physiologic demand is encouraged to determine fitness. This assessment should include such things as a complete cardiac evaluation to include stress imaging when there is coronary artery disease or significant risk thereof, or an official functional capacity exam as determined by the initial evaluating provider. The evaluating provider should pay special attention to hematologic, cardiovascular, pulmonary, orthopedic, neurological, endocrine, dermatological, psychological, visual, and auditory conditions which may present a hazard to the individual or others and/or preclude performing functional requirements in the USAFRICOM AOR. Also, the type and amount of medications prescribed and their suitability and availability in the environment must also be considered as potential limitations. AC Form 42, USAFRICOM Travel Medical Screening Checklist, is to be used for medical clearance requirements (Enclosure C).

c. Fitness includes the ability to accomplish the tasks and duties unique to a particular operation/activity and the ability to tolerate the environmental and operational conditions of the duty location. Minimum standards of fitness include but are not limited to the ability to wear ballistic, respiratory, chemical and biological personal protective equipment (PPE), as required; the use of required prophylactic medications; and the ability to ingress/egress in emergency situations with minimal risk to themselves or others (Reference c).

Any condition that markedly impairs an individual's daily function is grounds for disapproval of travel.

d. The following criteria should be utilized to evaluate each medical condition prior to travel (Reference c):

(1) The condition is stable and reasonably anticipated not to worsen during travel in the light of physical, physiological, psychological and nutritional effects of the duties and location.

(2) The condition is not of such a nature or duration that an unexpected worsening or physical trauma is likely to have a grave medical outcome or negative impact on mission execution.

(3) Ongoing healthcare or medication needed for the duration of travel is available in theater and accessible via the individual's health plan.

(4) Medications required for the condition have no special handling, storage or other requirements (e.g., refrigeration, cold chain, or electrical power requirements).

(5) Medications are well tolerated without significant side effects.

(6) There is no requirement for evacuation out of country or theater for continued diagnostics or other evaluations.

e. Medical Fitness, Initial, and Annual Screening.

(1) DoD civilian employees are covered by the Rehabilitation Act of 1973. It must be determined, before travel and based upon an individualized assessment, that the employee can perform the essential functions of the position in the USAFRICOM AOR, with or without a reasonable accommodation, without causing undue hardship. In evaluating undue hardship, the nature of the accommodation and the extremely limited availability of care in the USAFRICOM AOR must be considered. Further, the employee's medical condition must not pose a substantial risk of significant harm to the employee or others when taking into account the conditions of the USAFRICOM AOR (Reference c).

(2) Specialized government employees who must meet specific physical standards (e.g., firefighters, security guards and police, aviators, aviation crew members and air traffic controllers, divers, marine craft operators, and commercial drivers) must meet those standards without exception, in addition to being found fit for the specific deployment by a medical and dental evaluation prior to travel. Certifications must remain valid throughout the duration of travel. If certifications expire while assigned within the

(22) Psychiatric Conditions: Medical waiver submission is required for all mental health DSM-5 diagnoses or medication use within the past seven years. Remote history of mental health diagnosis (e.g., adjustment disorder) over seven years ago and with no treatment or medication use within the past seven years does not require medical waiver.

(a) Any current diagnosis or history of a diagnosis of a psychotic or bipolar disorder, or other disorder with associated psychotic symptoms, is considered disqualifying for deployment and will not be considered for a medical waiver (Reference r).

(b) Individuals diagnosed with mental disorders must demonstrate a pattern of stability without significant symptoms or impairment for at least 90 days prior to travel in order to be considered for a medical waiver (Reference r). Psychiatric disorders with fewer than 90 days of demonstrated stability from the last change in treatment regimen (medication, either new or discontinued, or dose change) will not be considered for medical waiver.

(c) DSM-5 diagnosed psychiatric disorders with residual symptoms, or medication side effects which impair social and/or occupational performance will not be considered for medical waiver.

(d) Use of Lithium, antipsychotics, or anticonvulsants for stabilization of DSM-5 diagnosis will not be considered for medical waiver.

(e) Mental health conditions that pose a substantial risk for deterioration and/or recurrence of impairing symptoms in the deployed environment will not be considered for medical waiver.

(f) Chronic insomnia that requires the daily use of sedative hypnotics/amnestics, benzodiazepines, and antipsychotics for greater than three months will not be considered for medical waiver.

(g) Psychiatric hospitalization within the last 12 months requires a medical waiver submission package with a specialty evaluation prior to travel.

(h) Suicide ideation or attempt within the last 12 months will not be considered for medical waiver.

(i) Psychiatric disorders newly diagnosed during deployment do not immediately require a medical waiver or redeployment. Disorders that are deemed treatable, stable, and having no impairment of performance or safety by a credentialed mental health provider do not require a medical waiver to remain in theater.

(j) Substance abuse. Personnel who have a history of substance abuse disorders, or have been enrolled in a substance abuse program (inpatient or outpatient, to include self-referral), within the last 12 months require a medical waiver.

1 Substance abuse disorders (not in remission), actively enrolled in Service-specific substance abuse programs will not be considered for medical waiver.

2 After successful completion of a substance abuse program personnel are eligible for a waiver after 90 days of demonstrated medical stability.

3 Participation in Voluntary Alcohol-Related Behavioral Health Care that does not result in enrollment in a substance abuse program does not require medical waiver.

g. Pharmacy.

(1) Supply. Personnel who require medication(s) and who are traveling to the USAFRICOM AOR will travel with no less than a 180 day supply (or appropriate amount for shorter deployments or travel) of their maintenance medications with arrangements to obtain a sufficient supply to cover the remainder of the deployment using a follow-on refill prescription. Tricare-eligible personnel will have a follow-on refill prescription entered into the Tricare Mail Order Pharmacy system per the Deployment Prescription Program.

(2) Exceptions. Exceptions to the 180 day prescription quantity requirement include:

(a) Personnel requiring malaria chemoprophylactic medications (e.g. Atovaquone/Proguanil, Doxycycline, etc.) will travel with enough medication for their entire travel period in the USAFRICOM AOR. The travel period will include an additional seven days after leaving the malaria risk area for Atovaquone/Proguanil or 28 days for Doxycycline to account for required primary prophylaxis.

(b) Psychotropic medication may be dispensed for up to a 180 day supply with no refills.

(c) Tricare Pharmacy Home Delivery. Eligible DoD beneficiaries requiring ongoing pharmacotherapy will maximize use of the local medical facility Pharmacy for refills. If the required medication is not available in the USAFRICOM AOR, personnel will use the Tricare Pharmacy home delivery

system when possible for delivery to their temporary duty/deployed location. Those eligible for Tricare Pharmacy home delivery will complete online enrollment and registration prior to deployment to the maximum extent possible. Instructions and registration can be found at http://tricare.mil/dpp.

ACI 4200.09A
13 September 2019

ENCLOSURE D

MEDICAL WAIVER PROCESS AND AUTHORITIES

1. Medical Waiver Authorities.

a. As delegated by the USAFRICOM Commander, the USAFRICOM Command Surgeon has the final approval authority for medical waivers for travelers to the USAFRICOM AOR. Commanders of the traveling member, unlike the military profile system, are not authorized to override the travel determination of the medical waiver authority.

b. The USAFRICOM Command Surgeon retains medical waiver authority for:

(1) Any personnel assigned to USAFRICOM Headquarters, regardless of parent agency.

(2) Any personnel who will enter the USAFRICOM AOR on DoD PCS orders.

(3) Any DoD support agency personnel unaffiliated with a specific Service, (e.g., Defense Intelligence Agency, Defense Threat Reduction Agency, Office of the Secretary of Defense, etc.).

(4) Any non-DoD personnel (e.g., U.S. Coast Guard, Interagency, etc.) on specific DoD mission under DoD responsibility.

(5) Contractor personnel. Waivers are extremely unlikely for contractor personnel and an explanation should be given as to why other persons who meet the medical standards could not be identified to fulfill the deployed duties (Reference d). The contractor may request a waiver for an individual member through the contracting officer or designee (Reference d). Waiver authority is retained by the USAFRICOM Command Surgeon and not delegated.

(6) Medical waiver requests must be transmitted by encrypted email or other secure file transfer that is authorized for protected health information. Authorized agents (local medical provider, commander, representative, or member) for the personnel outlined above shall submit medical waiver requests directly to the USAFRICOM Command Surgeon at: africom.stuttgart.acsg.mbx.j004-force-health-protection@mail.mil; DSN 314-421-2263; Comm +49(0)711-729-2263.

c. Delegation to component/Joint Task Force Surgeons. Waiver authority is delegated to the USAFRICOM component/Joint Task Force Surgeons by the USAFRICOM Command Surgeon for all traveling personnel

within their respective component/Joint Task Force for all health conditions unless otherwise specified in this instruction. Authorized agents will forward medical waiver requests for any personnel not listed in paragraph 1.b directly to the adjudicating waiver authority. Medical waiver requests must be transmitted by encrypted email or other secure file transfer that is authorized for protected health information.

(1) Special Operations Command Africa (SOCAFRICA): The SOCAFRICA Command Surgeon has medical waiver authority for any Special Operations Forces and all personnel (uniformed or civilian) deploying in support of SOCAFRICA, regardless of location. Contact africom.stuttgart.socafrica-sg.MBX.Surgeon@mail.mil; DSN 314-421-3474 or Comm +49(0)711-729-3474.

(2) Combined Joint Task Force-Horn of Africa (CJTF-HOA): Excluding personnel covered in paragraph 1.b and 1.c (1), the CJTF-HOA Command Surgeon has medical waiver authority for any personnel (uniformed or civilian) entering CJTF-HOA on DoD orders, regardless of Service. The CJTF-HOA AOR includes: Burundi, Djibouti, Eritrea, Ethiopia, Kenya, Rwanda, Seychelles, Somalia, South Sudan, Sudan, Tanzania, and Uganda. Contact africom.lemonnier.hoa-surgeon.mbx.surgeon-cell@mail.mil; DSN 311-824-4282; Comm +253-21-358-993.

(3) Excluding personnel covered in paragraph 1.b and 1.c.(1), and 1.c.(2) Service Component Surgeons have medical waiver authority for their respective Service personnel (uniformed or civilian). However, component surgeons also have medical waiver authority for personnel traveling in support of their respective component activities (regardless of service affiliation). Service waiver authorities and contact information are as follows:

(a) Air Forces Africa: usafesgo.sgo@us.af.mil; DSN 314-480-4698; Comm +49(0)6371-47-4698.

(b) U.S. Army Africa: usarmy.usag-italy.usaraf.mbx.medical@mail.mil; DSN 314-637-8371; Comm +39(0)444-61-8371.

(c) Naval Forces Africa: cne-c6f_hss1@eu.navy.mil; DSN 314-626-6298; Comm +39(0)81-568-6298.

(d) Marine Forces Africa: hss.mfe@usmc.mil; DSN 314-431-3565.

(4) Sub-delegation. Waiver authority sub-delegated to a component/ Joint Task Force Surgeon representative is subject to approval by the USAFRICOM Command Surgeon. A letter of designation should be forwarded to the USAFRICOM Command Surgeon via email at

USAFRICOM.stuttgart.acsg.mbx.j004-force-health-protection@mail.mil (See Enclosure E for a template).

d. A USAFRICOM waiver request does not preclude the need for a Service-specific psychotropic medication small arms waiver (e.g., U.S. Navy Small Arms Waiver).

e. A USAFRICOM medical waiver cannot override host or transit nation infectious disease or immunization restrictions.

2. Medical Waiver Submission Process.

a. The parent (home station) command must support the travel of a person with an apparently disqualifying condition. The medical waiver must be endorsed by the traveler's chain of command. This endorsement indicates the individual's Command has identified them as mission critical and accepts the risk of deploying medically unfit personnel to a theater with limited medical capabilities.

b. The USAFRICOM medical waiver form (See Enclosure F) is located at http://www.africom.mil/staff-resources/theater-medical-clearance.

c. The case summary portion of the medical waiver request form must include a synopsis of the concerning condition(s) and all supporting documentation to include the provider's assessment of ability to travel. The healthcare provider evaluating personnel for travel must endorse the waiver form indicating the medical assessment was performed IAW criteria detailed in Enclosure B of this document.

d. Authorized agents will forward the medical waiver request form to the adjudicating waiver authority based on paragraph 1. above. Medical waiver requests must be transmitted by encrypted email or other secure file transfer that is authorized for protected health information.

e. It is recommended that authorized agents allow for ample processing time (at least 30 days) for medical waiver adjudication. Except in the case of DoD civilian employees who are covered by the Rehabilitation Act of 1973, an individual may be denied deployment by the local unit medical authority or chain of command. For civilian employees, an individualized assessment must be conducted to determine if they can perform the essential functions of a DoD civilian expeditionary workforce position with or without reasonable accommodations. (References a and e).

3. Adjudicating Surgeon Actions.

a. The adjudicating Surgeon will grant, deny or request further information, if needed, within five working days of receiving the waiver.

(1) The adjudicating surgeon may consider consulting the receiving medical authority with any questions regarding the deployability of the service member, civilian or contractor. Adjudication may account for specific medical support capabilities in the local region of the AOR.

(2) Additional USAFRICOM medical evaluation guidance and considerations for medical waiver submission:

(a) The condition does not require frequent clinical visits (more than quarterly) or ancillary tests (more than twice/year), does not necessitate significant limitations of physical activity, or does not constitute increased risk of illness, injury, or infection.

(b) It must be determined, based upon an individualized assessment, that the member can perform the essential functions of the position in the deployed environment, with or without a reasonable accommodation, without causing undue hardship. In evaluating undue hardship, the nature of the accommodation and the location of the deployment must be considered. Further, the member's medical condition must not pose a significant risk of substantial harm to the member or others taking into account the condition of the relevant deployed environment, with particular consideration of areas of armed conflict in the theater.

(c) The medical condition does not prevent the wear of personal protective equipment, including protective mask, ballistic helmet and/or body armor, if required.

(d) The medical condition does not prohibit required theater immunizations or medications (such as antimalarials, other chemoprophylactic antibiotics or Yellow Fever vaccination).

(e) Any unresolved acute illness or injury must not impair the individual's duty performance during the duration of the deployment.

(f) Once approved, medical waivers are only for the specified location(s), for the timeframe specified on the waiver (generally, this should be a maximum of 12 months). Waiver coverage begins on the date of the initial travel, and remains valid for the time period specified on the waiver.

b. The adjudicating surgeon will return the adjudicated/signed medical waiver form to the request originator for dissemination and inclusion in the patient's deployment medical record and/or the electronic medical record, as applicable. Documented adjudications are required and should not be given telephonically.

c. In cases of in-theater/deployed personnel identified as unfit IAW this document due to conditions that existed prior to deployment, a waiver will

be forwarded to the appropriate medical waiver authority (i.e., the Surgeon who would have received the waiver request had one been submitted) for investigation and potential redeployment determination. Findings/actions will be forwarded after completion to the USAFRICOM Command Surgeon's office at: africom.stuttgart.acsg.mbx.j004-force-health-protection@mail.mil.

d. All adjudicating surgeons shall maintain a waiver database and record/archive of all medical waiver requests and status. On a weekly basis on Fridays, adjudicating surgeons shall send a copy of the database to the USAFRICOM Command Surgeon's office at: africom.stuttgart.acsg.mbx.j004-force-health-protection@mail.mil.

UNITED STATES EUROPEAN COMMAND INSTRUCTION

ECJ4-MR
DISTRIBUTION: Contact OPR

ECI 4202.01
3 July 2019

Health Service Support
United States European Command (USEUCOM) Theater Medical Entry Requirements

References: See Enclosure (G)

1. Purpose. This ECI delegates responsibility to Service Component Commanders to determine unit medical readiness and fitness requirements for military and civilian personnel participating in USEUCOM missions and operations. This ECI provides a recommended template from which Component Commands can formulate their own theater medical screening requirements.

2. Cancellation. None.

3. Applicability. As determined by Service Component Commanders.

4. Policy. The USEUCOM Commander delegates responsibility to Service Component Commanders to determine unit medical readiness and fitness requirements for military and civilian personnel participating in USEUCOM missions and operations. The information in this instruction, ECI 4202.01, Enclosures (A) through (G), can be used to formulate Service-specific policy.

5. Discussion.

a. In accordance with (IAW) references (a) through (ii), and specifically DoD Instruction (DoDI) 6490.07, "Deployment-Limiting Medical Conditions for Service Members and DOD Civilian Employees," the Combatant Commander establishes a minimum standard for theater medical entry requirements. This instruction provides an approved and standardized template from which components can form mission tailored medical screening criteria for troops deploying into the USEUCOM theater. Enclosures (A) through (G) contain recommended Force Health Protection (FHP) standards, medical screening guidance, and waiver request procedures for deployments within the European Theater. The information is meant to synthesize and supplement DoD and Service-specific guidance in deployment health, FHP, medical policy and health

guidance for military and civilian personnel deployed across the range of military operations.

b. Suggested deployment definition. IAW reference (d), DoDI 6490.07, "Deployment-Limiting Medical Conditions for Service Members and DOD Civilian Employees", 'deployment' is defined as the relocation of forces and material to areas designated as operational areas. Within the USEUCOM Theater, deployment includes named operations, contingencies, and other official missions (i.e. Operation Atlantic Resolve).

c. The USEUCOM theater medical entry template is synchronized across the geographic combatant commands to ensure standardization where applicable. It is widely staffed through the Surgeons of the Components, rotational units, deployment processing sites, and thoroughly vetted by clinical and operational experts in key DoD agencies. It incorporates extensive feedback following two years of fielding.

d. The attached standards for theater entry account for the advanced standards of care available in Europe.

e. The information is proven to reduce burden on commanders, units, medical staff, and incoming personnel by identifying conditions before deployment to avoid turmoil during the mission.

f. The recommended template provides a needed reference for inexperienced providers, or providers in the civilian sector, who have never deployed.

g. Recommended clearance requirements.

(1) Medical Clearance.

(a) Information regarding the medical and mental health clearance requirements and standards (Deployment Limiting Conditions (DLCs), Pharmacy, Medical Equipment, Contact Lens, Alert Tags, Immunizations, Labs, and Health Assessments) can be found in Enclosures (A) through (D) of this document.

(b) Administrative requirements regarding pre-, during-, and post-depoyment health activities are summarized in Reference (a), DoDI 6490.03, "Deployment Health".

(2) Waiver Request Process. According to DoDI 6490.07, a waiver process is required within the Combatant Command. Information regarding the recommended medical waiver process and authorities can be found in Enclosures (E) of this document.

(3) Theater Force Health Protection (FHP). FHP measures can be found in Enclosure (F) of this document. Medical threat briefs will be formulated using items in

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Enclosure (C), in paragraphs 2–3 of Enclosure (F), and health risk assessments tailored to the regions of interest.

6. Recommendation. Service Components should utilize the theater entry medical standards outlined in Enclosures (A) through (G) to craft their Component-specific guidance.

7. Releasability. This publication is approved for public release; distribution is unlimited. Users may obtain copies on the USEUCOM network portal at the following website https://www.milsuite.mil/book/docs/DOC-127168.

8. Effective Date. This instruction is effective 3 July 2019.

PATRICK A. PIERCEY
Rear Admiral, U.S. Navy
Chief of Staff

Enclosures:

A. Medical Clearance – General
B. Medical Clearance – Deployment Limiting Conditions
C. Medical Clearance – Pharmacy, Medical Equipment, Contact Lens, Alert Tags, Immunizations, Labs
D. Medical Clearance – Health Assessments and Documentation
E. Medical Waiver Process and Authorities
F. Theater Force Health Protection
G. References
Glossary

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Enclosure A
Medical Clearance – General

1. Standards for Deployability to USEUCOM

a. Fitness for Duty. Individuals must meet Service specific standards of medical fitness.

b. Transparency to Command. An individual's medical condition must not create undue burden on the Command.

c. Stability of Treatment. An individual's medical condition must remain stable if treatment options become unavailable (i.e. loss of medication, malfunction of therapeutic equipment, delays in shipping, unavailability of therapist, etc.).

d. Proven Stability. Individuals must be mentally and physically stable without relapse for a minimum of 12 months following the last change of therapy or last episode of the disability (exceptions are listed within the Deployment Limiting Conditions in Enclosure (B)).

e. Successful Trial of Duty. Individuals that have completed a rehabilitative program should successfully demonstrate required fitness through a trial of duty which mimics expected conditions of deployment (i.e. environmental challenges, lifting and carrying challenges, alertness, and judgement challenges, etc.).

f. Extended Stay. An individual's condition will remain stable if an extension of deployment duty occurs.

g. Hazardous Materials. A means to secure or properly dispose of hazardous materials (i.e. needles) is available.

h. Prescription Medications.

(1) Personnel who require medication(s) will travel with up to a 180 day supply of their maintenance medications (see paragraph 1.h.(2) below for controlled medication requirements).

(2) Controlled Medications. All FDA controlled substances (Schedule CII-CV) are limited to maximum of a 90-day supply in-theater, with only 30 days' supply allowed on the person. All controlled substances need to be secured (i.e. to prevent diversion). Controlled substances must be monitored using a validated quality assurance program.

(3) Prior to deploying, individuals need to arrange to obtain a sufficient supply to cover the remainder of the deployment. Where applicable, Tricare eligible personnel should have prescription refills entered into the Tricare Mail Order Pharmacy (TMOP).

Individuals need to be aware certain countries (i.e. Germany) prohibit the mailing of prescription medications.

(4) See Enclosure (C), paragraph 1, for a detailed description of pharmacy requirements for entry into the USEUCOM AOR.

i. Border Clearance. Medical conditions must meet border clearance criteria of the countries in which the individual will be deployed.

j. Ability to Function During Flare-Up. Medical condition must not reach severity which completely incapacitates the individual.

k. Alert and Oriented. The individual must be alert and able to perform sensitive tasks with appropriate judgement when required (i.e. medications causing drowsiness must clear the body quickly).

l. Functional in Austerity. Individuals must be of sufficient fitness to successfully function and conduct the mission in the extremes of environmental conditions while wearing appropriate protective gear.

m. Clean Blood Supply. Individuals must be free of known blood-transmissible diseases. The expectation is to maximize the ability to serve as blood donors as part of a walking blood bank capability to assist in blood transfusions.

n. Low Risk to Command. The medical condition must not place coworkers at safety risk or at risk for mission failure.

o. Severity of medical condition. Conditions must be of sufficient simplicity to be managed by a general medical officer in facilities with limited equipment.

2. Medical Waiver Requirements. The following lists general medical waiver requirements for individuals with potential deployment limiting medical conditions:

a. Medical waiver is required.

(1) Deployment Limiting Conditions. Enclosure (B) contains a list of deployment limiting medical conditions that require a medical waiver.

(2) Specialist Required. A medical waiver is required for any individual who requires a follow-up evaluation with a specialist during the period of deployment; this includes follow-ups with behavioral health practitioners.

b. Medical waiver will not be granted.

(1) Special Storage or Handling Requirements. A medical waiver will not be granted for medications that require special handling, storage or other requirements

(e.g., refrigeration, cold chain, electrical power requirements, hazardous material (HAZMAT) disposal requirements, etc.) unless the individual is deploying to an installation in the AOR with the capability to support the special handling, storage, or other requirements. See Enclosure (C), paragraph 1 for more detailed information regarding medication requirements.

(2) Required Medical Equipment. A medical waiver will not be granted for medical equipment unless the device is dual-voltage (i.e. can support 220V connections) and can be supported at the deployed location. See Enclosure (C), paragraph 2 for more detailed information regarding specifications for medical equipment.

3. Medical Fitness, Initial, and Annual Screening.

a. Exam Intervals. An examination which addresses all medical issues and requirements will remain valid for a maximum of 12 months from the date of the physical examination IAW Reference (c). Extensions may be considered by the local provider when facilities are outside reasonable access range to accommodate.

(1) Medical Treatment During Deployment. Individuals treated within the theater and cleared by the treating physician may be returned to the unit without requesting a waiver. Component Surgeons may set an additional requirement to re-process as a waiver request [Note: Individuals treated for a medical condition outside of the AOR and desiring to return to the AOR to complete an existing deployment must be cleared anew by the appropriate waiver authority].

b. Cardiovascular Screening. Service members will follow service specific guidance for cardiovascular screening requirements.

c. Dental. All personnel entering the theater require a dental examination within 12 months preceding the start of travel. Dental status must be either a Class I or II. Individuals evaluated by a non-DoD civilian dentist should use a DD Form 2813, or equivalent, as proof of dental examination.

d. Psychoactive Medications. The use of psychoactive medications pose additional risk in the deployment environment, such as risk for heat injury, serotonin syndrome, lapses in judgment and alertness, etc. These medications are commonly used to treat depression, insomnia, drowsiness, concentration and alertness problems, mood disorders, anxiety, chronic pain, migraine headaches, seizures, etc. The following concerns will be scrutinized closely when considering waivers for psychoactive medications.

(1) Behavioral effects. Psychoactive medications affect alertness, sleep cycle, and judgment; all effects can be magnified when multiple medications are combined.

(2) Suicide risk. Psychoactive medications pose additional risk for suicide based on the physiologic effects of the medications, and in their normal use by patients at higher risk for suicide.

(3) Polypharmacy concerns. Medications prescribed to counter-act the side effects of other medications are problematic, due to compounding of side effects (i.e. treating awakeness and alertness, while also addressing insomnia) and contribution to polypharmacy.

(4) Prescribing practices to expedite grief recovery. Practices of prescribing medications early in the normal grieving process, prohibit sufficient non-medicated grief recovery time (minimum 6 months) to enable the strengthening of internal coping skills and maturation, especially in young (<25 years old) soldiers; these early prescribing practices can be problematic.

(5) Demonstrated stability. Must demonstrate clinical stability once a therapeutic dosage is established, over a minimum of 12 months, and tested by an adequate trial-of-duty under the expected stressful conditions of the deployment. Exceptions are provided in Enclosure (B).

(6) Serotonin syndrome concerns. Combinations of medications which activate the serotonergic system can increase the risk of serotonin syndrome, which can mimic heat injury. Both conditions (heat injury and serotonin syndrome) are difficult to recognize and diagnose, and require very different approaches to treatment.

(7) Antihistaminic properties. Psychoactive medications with antihistaminic properties not only cause drowsiness and alertness issues, but also increase the risk of heat injury.

e. DoD and Specialized U.S. Government Civilian Employees.

(1) General Standards. DoD Civilian employees are covered by the Rehabilitation Act of 1973. As such, an apparently disqualifying medical condition requires an individualized assessment to determine whether the employee can perform the essential duty functions in the deployed environment, without causing undue hardship. In evaluating undue hardship, the nature of the accommodation and the limited availability of care in certain USEUCOM AOR regions must be considered. Further, the employee's medical condition must not pose a substantial risk of significant harm to the employee or others when taking into account the conditions of the relevant deployed environment IAW Reference (d).

(2) Specific Standard. Specialized government civilian employees who must meet specific physical and mental standards (e.g., firefighters, security guards and police, aviators, aviation crew members and air traffic controllers, divers, marine craft operators, commercial drivers, etc.) must meet those standards without exception, in addition to being found fit for the specific deployment by a medical and dental

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Psychiatry/Behavioral Health Conditions (Anxiety, Major Depressive Disorders, ADD/ADHD, Eating Disorders)

All of the following mental or behavioral health (BH) related diagnoses require that the waiver be signed by a BH specialist or a letter from a BH specialist for a waiver to be considered. All substance abuse disorders and significant BH conditions (e.g. History of suicidal ideation/attempt, severe depression/anxiety, and ongoing family/relationship problems) require a Commander's Endorsement letter from the first O-5/O-6 in the individual's chain of command for a waiver to be considered (see Enclosure (E), Appendix B for example letters). USEUCOM considers 12 months as the standard recovery time from BH conditions, with exceptions considered at 6 months onward (unless stated otherwise). See the contents of Tables B14 and B15 for disease specific information.

Sequence #	Condition	Description (Waiver Required for Any of the Following, Unless Stated Otherwise)
N1	Anxiety	1. Required regular, ongoing mental health treatment within the last six months, in order to gain stability. 2. Ongoing symptoms of any type which affects ability to perform duties/occupation effectively. 3. Lack of disease stability for < 6 months 4. Any concern about the behavioral stability (social and occupational) and the potential for deterioration or recurrence of symptoms during deployment if treatment is interrupted 5. Significant psychiatric co-morbidity 6. Any requirement for antipsychotics, benzodiazepines, or lithium
N2	Major Depressive Disorders	1. Hospitalization for psychiatric reason within last 12 months (see N10 for further guidance) 2. Any ongoing depressive symptoms (cognitive/sleep/mood/suicidal) affecting performance of duties/occupation 3. Lack of disease stability for < 6 months 4. Any requirement for antipsychotics or lithium 5. Any evidence of bipolar disorder or psychotic features 6. Reasonable concern about the behavioral stability and the potential for significant deterioration or recurrence of symptoms during deployment if treatment is interrupted 7. Ongoing requirement for psychological or mental health counseling to maintain stability and functioning 8. Any suicidal ideation/attempt in the preceding 12 months (see N9) 9. Any ongoing depressive symptoms (cognitive/sleep/mood/suicidal) affecting performance of duties/occupation will not be considered for a medical waiver.
N3.1	ADHD/ADD - prerequisites for 'no waiver required'	Waiver is **not required** if **ALL** of the following are met: 1. On stable treatment regimen with CII stimulant medications (defined as greater than 6 months on a stable dose without comorbidities) and the diagnosis has been validated by a physician or doctoral level mental health provider (Service Components may require a psychiatrist). 2. The individual does not possess duty limitations or restrictions 3. The individual is able to deploy with sufficient medications to complete deployment, or arrangements have been made for delivery of medications 4. All controlled medications, to include CII stimulants, can be maintained in a locked container, properly secured
N3.2	ADHD/ADD - Items needed to accompany waiver request (if all items in N3.1 are not met, which would necessitate a waiver).	**ALL** of the following are **required** to be included in the waiver packet submission: 1. A letter of fitness from the first O-5 in the chain of Command validating that the individual can indeed perform duties/occupation in an austere environment with a long-term irregular sleep schedule while on stimulant medication. 2. Individuals will deploy with sufficient medications to complete deployment or arrange for delivery of medications (see Enclosure A, paragraph 1.h., for further guidance on prescription medication requirements) 3. Statement from provider verifying the lack of adverse effects from stimulant medication (to include insomnia and/or hypertension) **NOTE1:** The USEUCOM medical supply system is not equipped to ship and/or store large amounts of controlled substances. **NOTE2:** All controlled medications to include CII stimulants must be maintained in a locked container, properly secured **NOTE3:** Germany prohibits the delivery of medications via mail to include the military postal service (MPS) (this includes personnel in countries that receive U.S. Mail that passes through Germany).
N4	Eating Disorders (i.e. Anorexia Nervosa, Bulimia Nervosa, or other specified/unspecified feeding or eating disorder)	1. Required regular, ongoing mental health treatment within the last six months in order to maintain stability 2. Ongoing symptoms of any type which affects ability to perform duties/occupation 3. Disease stability for < 6 months 4. Any concern about the behavioral stability (social and occupational) and the potential for deterioration or recurrence of symptoms during deployment 5. Medical evaluation indicates physical health concerns related to disorder (abnormal labs, cardiac concerns, etc)

Table B-14. Psychiatric/Behavioral Health Related DLCs – Part 1

Naval Forces in Europe (NAVEUR), USAREUR, Marine Forces in Europe (MARFOREUR)) have medical waiver authority for respective Service-specific personnel (uniformed, civilian, contract employee) entering the USEUCOM AOR on DoD orders. Additionally, component surgeons will have medical waiver authority for personnel traveling to and through the USEUCOM AOR in support of their respective component activities (regardless of service affiliation).

(5) Sub-delegation. Waiver authority sub-delegated to a Component Surgeon representative is subject to approval by the USEUCOM Command Surgeon. A letter of designation should be forwarded to the USEUCOM Command Surgeon via email at eucom.stuttgart.ecj4.list.force-health-protection@mail.mil (See Appendix A to Enclosure (E) for a template).

(6) A USEUCOM waiver request does not preclude the need for a Service-specific psychotropic medication small arms waiver (e.g., US Navy Small Arms Waiver).

(7) A USEUCOM medical waiver cannot override host or transit nation infectious disease or immunization restrictions. Active duty must comply with status of forces agreements (SOFA); civilian travelers should contact the nation's embassy for up-to-date information as well as complying with the provisions of this document.

2. Medical Waiver Process.

a. If the local Command supports the deployment, a medical waiver request must be submitted to, and approved by the appropriate USEUCOM medical waiver authority before that person is cleared for entry into the theater. Except in the case of DoD civilian employees who are covered by the Rehabilitation Act of 1973, an individual may be denied deployment by the local unit medical authority or Chain of Command. For civilian employees, an individualized assessment must be conducted to determine if they can perform the essential functions of a DoD civilian expeditionary workforce position with or without reasonable accommodations. (See references (a) and (e)).

b. Authorized agents (local medical provider, Commander/supervisor, representative or individual member) will forward the medical waiver request form to the office of the Surgeon that will be adjudicating the waiver. It is recommended that authorized agents allow for ample processing time (at least 30 days) for medical waiver adjudication.

c. The USEUCOM medical waiver form is located at https://www.milsuite.mil/book/docs/DOC-127168, or contact the USEUCOM FHP branch via the organizational e-mail at eucom.stuttgart.ecj4.list.force-health-protection@mail.mil.

(1) Ensure all supporting documentation is included with the medical waiver request form to allow the adjudicating Surgeon to properly assess the ability of the individual to travel. The adjudicating Surgeon may consider consulting the receiving

medical authority with any questions regarding the deployable status of the service member, civilian or contract employee. Adjudication may account for specific medical support capabilities in the local region of the AOR.

(2) Additional USEUCOM medical evaluation guidance and considerations for medical waiver submission. Medical waivers for uniformed service members, DoD civilian personnel and DoD contract employees will be considered only if all the following circumstances are met:

(a) The condition does not require frequent clinical visits (more than quarterly) or ancillary tests (more than twice/year), does not necessitate significant limitations of physical activity, or does not constitute increased risk of illness, injury, or infection.

(b) It must be determined, based upon an individualized assessment, that the member can perform the essential functions of the position in the deployed environment, with or without a reasonable accommodation, without causing undue hardship. In evaluating undue hardship, the nature of the accommodation and the location of the deployment must be considered. Further, the member's medical condition must not pose a significant risk of substantial harm to the member or others taking into account the condition of the relevant deployed environment, with particular consideration of areas of armed conflict in the theater.

(c) The medical condition does not prevent the wear of personal protective equipment, including protective mask, ballistic helmet and/or body armor, if required.

(d) The medical condition does not prohibit required theater immunizations or medications.

(e) Any unresolved acute illness or injury must not impair the individual's duty performance during the duration of the deployment.

(3) Submit completed medical waiver requests to the office of the Surgeon that will be adjudicating the waiver. All medical waivers must be encrypted or password protected as they contain protected health information and are subject to both the health insurance portability and accountability act (1996) and the health information technology for economic and clinical health acts (2009); violators are subject to penalties as determined by the U.S. Department of Health and Human Services Office of Civil Rights.

(4) The adjudicating Surgeon will return the adjudicated/signed medical waiver form to the request originator for dissemination and inclusion in the patient's deployment medical record and/or the electronic medical record, as applicable. Documented disapprovals for valid conditions are required and should not be given telephonically.

(5) All adjudicating Surgeons will maintain a waiver database and record/archive of all medical waiver requests and status. Additionally, adjudicating Surgeons will send copies of the adjudicated waivers to the USEUCOM Command Surgeon's office at: eucom.stuttgart.ecj4.list.force-health-protection@mail.mil.

(6) Once approved, waivers are valid only for that location, for the timeframe specified on the medical waiver. Waiver coverage begins on the date of the initial deployment or travel, and remains valid IAW service specific guidelines (all waivers require renewal after 36 months).

(7) All adjudicated medical waiver requests will be archived at the USEUCOM FHP branch.

(8) In cases of in-theater/deployed personnel identified as unfit IAW this document due to conditions that existed prior to deployment, a waiver will be forwarded to the appropriate medical waiver authority (i.e., the Surgeon who would have received the waiver request had one been submitted) for investigation and potential redeployment determination. Findings/actions will be forwarded after completion to the USEUCOM Surgeon at email: eucom.stuttgart.ecj4.list.force-health-protection@mail.mil.

BY ORDER OF THE COMMANDER NORTH AMERICAN AEROSPACE DEFENSE COMMAND (NORAD) AND UNITED STATES NORTHERN COMMAND (USNORTHCOM)

NORAD AND USNORTHCOM INSTRUCTION 44-163

5 DECEMBER 2014

Medical

INDIVIDUAL MEDICAL READINESS

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

ACCESSIBILITY: NORAD and USNORTHCOM publications and forms are available on the HQ NORAD and USNORTHCOM portal library for downloading. https://portal.noradnorthcom.mil/library/Pubs/SitePages/Home.aspx

RELEASABILITY: There are no releasability restrictions on this publication.

OPR: N-NC/SG

Certified by: N-NC/SG (Col John J. DeGoes)

Supersedes NNCI44-163, 19 April 2012

Pages: 16

This instruction implements Department of Defense Instruction (DODI) 6025.19, *Individual Medical Readiness (IMR*, and DODI 6490.03, *Deployment Health*. It establishes guidance for individual medical readiness (IMR) status of deployable military, civilian, and contractor personnel designated to NORAD and USNORTHCOM (N-NC), and component and subordinate commands and in the Chemical, Biological, Radiological, Nuclear (CBRN) Response Enterprise (National Guard and Reserve Component). This publication applies to National Guard on Title 10 status when activated with NORAD and/or USNORTHCOM and Reserve forces when assigned to NORAD and USNORTHCOM. Canadian forces assigned to NORAD shall comply with Defense Administrative Orders and Directives 5023-1, Canadian Forces Health Services Group Instruction 4000-1, *Periodic Health Assessment*. Send recommendations to change, add, or delete information in this instruction to the Office of Primary Responsibility (OPR) using the AF Form 847, *Recommendation for Change of Publication;* route AF Form 847 from the field through the appropriate functional's area chain of command. This publication may be supplemented. Supplemental instructions must be approved by N-NC Surgeon (SG). Maintain and dispose of records created as a result of prescribed processes in accordance with the Chairman Joint Chiefs of Staff Manual (CJCSM) 5760.01A, *Joint Staff and Combatant Command Records Management Manual: Volume I (Procedures) and Volume II (Disposition Schedule)*. The glossary of references and supporting information are found at **Attachment 1.**

SUMMARY OF CHANGES

Incorporated changes are as follows: minor changes to clarify the medical waiver process. The definition for deployment has been updated. A task to commanders was added to include IMR

2.5. NORAD and USNORTHCOM Surgeon will:

2.5.1. Provide N-NC/J1, command DMs, and contracting officers with baseline medical and/or Force Health Protection (FHP) requirements for personnel in deployment positions.

2.5.2. Coordinate IMR requirements with USACE for tasks that may involve CBRN exposures.

2.6. NORAD and USNORTHCOM, and component and subordinate command surgeons will:

2.6.1. Verify no person is deploying with a medical condition listed in DODI 6490.07 *Deployment-Limiting Medical Conditions for Service Members and DOD Civilian Employees* unless a medical waiver has been granted IAW **paragraph 2.6.2.** of this instruction.

2.6.2. Medical waivers to conditions listed in DODI 6490.07 or this instruction may be granted on a case-by-case basis in accordance with the procedure outlined in **Attachment 2, Attachment 3,** and **Attachment 4.** USNORTHCOM Surgeon is the final approval authority for medical waivers as outlined below.

2.6.2.1. Waiver authority is delegated to the USNORTHCOM component surgeons for all personnel within their respective component.

2.6.2.2. USNORTHCOM Surgeon is the waiver authority for all personnel belonging to organizations, such as the Defense Intelligence Agency, who are not directly affiliated with a particular USNORTHCOM component command.

2.6.2.3. All adjudicating surgeons will maintain a waiver database and record all waiver requests (**Attachment 5**).

2.6.2.4. USNORTHCOM Surgeon is the final appellate authority for all component surgeons' waiver decisions. USNORTHCOM Chief of Staff is the final appellate authority for USNORTHCOM Surgeon's decision. All appeals will be made and coordinated through the individual's chain of command.

2.6.3. Combatant, component, and subordinate command surgeon offices will provide guidance to civilian healthcare providers to properly assess DOD civilian or contractors if required.

[1]See the "Clinical Practice Guidance for Deployment-Limiting Mental Disorders and Psychotropic Medications" (Tab #7) for a more in-depth supplement to DODI 6490.07.

Optometry	If vision correction is required to perform their duties, member must have two pair of glasses, one pair of protective mask inserts, and a copy of their prescription.
Dental	Verify member is dental class I or II as documented by the Service IMR system. Civilian employees must meet equivalent of class I or II dental. Contractors will furnish documentation in accordance with the contract.
Medical Fitness	Uniformed personnel and DOD civilian employees must comply with DODI 6490.07. Uniformed personnel must also comply with Service-specific requirements. Annually, civilian personnel (in addition to pre-employment requirements) must have a healthcare provider complete NORAD and USNORTHCOM Summary of Medical Fitness, NNC Form 11, and submit the form to the DM. Contractor will furnish documentation in accordance with the contract. Canadian Forces Personnel shall complete NNC Form 12, Annual Readiness Verification.
DOD Deployment Related Health Assessment (DRHA) Program	DRHA #1 (DD Form 2795) Pre-deployment DRHA is required for specific deployments based on situational requirements and published orders/guidance. Post-deployment health assessments are required if a DD Form 2795 was initiated pre-deployment or if specified for a specific deployment based on situational requirements and published orders/guidance as follows: DRHA #2 (DD Form 2796) Within 30 days of departing theater; DRHA #3 (DD Form 2900) between 90-180 days after returning from deployment; DRHA #4 between 181 days and 18 months after returning from deployment; DRHA #5 between 18-30 months after returning from deployment.
Medication	Deploy with prescription medications, at a minimum, for the anticipated length of deployment plus 30 days.

[1]See the "Clinical Practice Guidance for Deployment-Limiting Mental Disorders and Psychotropic Medications" (Tab #7) for an in-depth supplement to DODI 6490.07.

Attachment 2

USNORTHCOM SURGEON'S OFFICE WAIVER PROCESS

A2.1. USNORTHCOM must be prepared to support international partners and U.S. civil authorities in the event of natural and man-made disasters as well as acts of terrorism. Medical readiness is a key measure for mission success. Conditions that are non-limiting in a normal stateside environment can become a critical handicap in a disaster or austere environment where medical care and ancillary services may be affected rendering them limited or non-existent. It is our desire to maximize the number of personnel able to deploy but we must consider each individual's health and safety during deployment.

A2.2. The USNORTHCOM Surgeon's office has established IMR requirements in order to optimize the health of responding forces. These requirements are based on current medical intelligence reports for the USNORTHCOM area of operations and limitations deployed units face.

A2.3. While an individual may be denied the ability to deploy by policy, authority to approve deployment of medically limited individuals lies solely with the USNORTHCOM Surgeon or those designated individuals as delegated by the USNORTHCOM Surgeon. The USNORTHCOM Chief of Staff is the final appellate authority for USNORTHCOM Surgeon's decision.

A2.4. Deploying component command personnel failing to meet USNORTHCOM IMR requirements must submit a waiver through their chain of command to their respective command surgeon's office. USNORTHCOM Surgeon is the appellate authority for component command surgeon waiver decisions and is the waiver authority for all personnel not assigned to a component command. USNORTHCOM Chief of Staff is the appellate authority for USNORTHCOM Surgeon waiver decisions. All direct USNORTHCOM Surgeon waivers (non-component personnel) and component appellate requests must follow the process below:

A2.4.1. Complete the USNORTHCOM Medical Waiver Request (**Attachment 3** and **Attachment 4**).

A2.4.2. Obtain necessary supplemental information for waiver request.

A2.4.3. Submit waiver packages to the USNORTHCOM Surgeon's office via most feasible method (fax, email, hand-delivery, mail).

A2.4.4. Waiver packages will be reviewed and any needed supplemental information will be requested before final disposition by the USNORTHCOM Surgeon.

A2.4.5. Final approval or denial will be provided to the requesting unit's surgeon's office via e-mail.

A2.4.6. Signed waiver requests must be included in the patient's medical record and annotated in any electronic medical records.

Attachment 3

USNORTHCOM MEDICAL WAIVER REQUEST

A3.1. The medical waiver request is assembled electronically and will require documentation to be scanned for transmission in electronic format. The waiver request will be used by the USNORTHCOM Surgeon or designated appointee to note the disposition of the waiver request and will be returned to the individual submitting the request. Please include as much information as possible as this will decrease follow-up questions and speed decision making. Include only medical information that is pertinent to the waiver request and on a need-to-know basis that is Health Insurance Portability and Accountability Act (HIPAA) compliant.

A3.2. USNORTHCOM Medical Waiver Request.

A3.2.1. Medical Case Summary (to be completed by healthcare provider).

A3.2.1.1. History of condition

A3.2.1.2. Date of onset/diagnosis

A3.2.1.3. Previous treatments

A3.2.1.4. Current treatments

A3.2.1.5. Limitations or symptoms imposed by condition and/or treatment

A3.2.1.6. Prognosis

A3.2.1.7. Required follow-up (nature and frequency)

A3.2.2. Enclosures (as necessary to support request).

A3.2.2.1. Specialty consultations needed to establish diagnosis, treatment plan, and prognosis

A3.2.2.2. Lab reports, pathology reports, tissue examinations to demonstrate a pattern of stability

A3.2.2.3. Reports of relevant studies: x-rays, pictures, films, or procedures (ECG, echocardiogram, catheterization, endoscopic procedures, etcetera)

A3.2.2.4. Summaries and past medical documents (hospital summaries, profiles, etcetera)

A3.2.2.5. Reports of proceedings (tumor boards, medical evaluation boards, etcetera)

A3.2.3. Commander/Director Documentation.

A3.2.3.1. Statement of request to deploy an individual with a non-deployable status:

A3.2.3.1.1. Individual's criticality to the mission

A3.2.3.1.2. Changes in individual's duty assignment (if any)

A3.2.3.1.3. Individual's job description and anticipated duties, hours, work environment, etcetera

A3.2.3.1.4. Other comments supportive of deployment

A3.2.4. Privacy Act and HIPAA Notice.

A3.2.4.1. All waiver requests and responses shall include appropriate language notifying the recipient of proper use, and disposition of, information contained in these communications. An example is provided as follows:

"**For Official Use Only:** This document may contain information exempt from mandatory disclosure under the Freedom of Information Act (FOIA) of 1986 {Public Law 99-570, 5 USC 552(B)}. This information is also protected by the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act (HIPAA) of 1996 {Public Law 104-191} and any implementing regulations. It must be safeguarded from any potential unauthorized disclosure. If you are not the intended recipient, please contact the sender by reply e-mail and permanently delete/destroy all copies of the original message. Unauthorized possession and/or disclosure of protected health information may result in personal liability for civil and federal criminal penalties."

A3.2.5. Send the completed package with the cover sheet (**Attachment** 4) to the USNORTHCOM surgeon's office via most feasible method (fax, email, hand-delivery, mail) with Privacy Act and HIPPA protections (i.e., if emailed needs to encrypted and marked For Official Use Only).

-----Original Message-----
From: HQ USPACOM J3 <amhsadmin@hq.pacom.smil.mil>
Sent: Friday, October 29, 2021 2:12 PM
To: USINDOPACOM JOC NCO <joc-nco1.pacom@pacom.smil.mil>
Subject: (U) USINDOPACOM FY 2022 FORCE HEALTH PROTECTION GUIDANCE FOR USINDOPACOM AOR

NARR/REF A IS JOINT STAFF MEMO ON PROCEDURES FOR DEPLOYMENT HEALTH SURVEILLANCE (MSM-0017-12) OF 07 DEC 2012 AT HTTPS(DOUBLESLASH)JSPORTAL.SP.PENTAGON.MIL/SITES/MATRIX/DEL/JEL%20%20UNLIMITED/MCM%200017-12.PDF. REF B IS DODI 6490.03 "DEPLOYMENT HEALTH" OF 19 JUN 2019. REF C IS DHA PROCEDURAL INSTRUCTION 6490.03 "DEPLOYMENT HEALTH PROCEDURES" OF 17 DEC 2019. REF D IS ASD(HA) MEMO "CLINICAL PRACTICE GUIDANCE FOR DEPLOYMENT-LIMITING DISORDERS AND PSYCHOTROPIC MEDICATIONS" OF 7 OCT 2013. REF E IS DODI 6490.07 "DEPLOYMENT-LIMITING MEDICAL CONDITIONS FOR SERVICE MEMBERS AND DOD CIVILIAN EMPLOYEES" OF 05 FEB 2010. REF F IS DODI 3020.41 "OPERATIONAL CONTRACT SUPPORT" OF 20 DEC 11 INCORPORATING CHANGE 2, 31 AUG 2018. REF G IS AR 40-562/BUMEDINST 6230.15B/AFI 48-110_ IP/CG COMDTINST M6230.4G "IMMUNIZATION AND CHEMOPROPHYLAXIS FOR THE PREVENTION OF INFECTIOUS DISEASES" OF 07 OCT 2013. REF H IS SECDEF MEMO, "MANDATORY CORONAVIRUS DISEASE 2019 VACCINATION OF DEPARTMENT OF DEFENSE SERVICE MEMBERS" OF 24 AUG 2021. REF I IS EXECUTIVE ORDER ON REQUIRING CORONAVIRUS DISEASE 2019 VACCINATION FOR FEDERAL EMPLOYEES OF 9 SEP 2021. REF J IS EXECUTIVE ORDER ON ENSURING ADEQUATE SAFETY PROTOCOLS FOR FEDERAL CONTRACTORS OF 9 SEP 2021. REF K IS HQ USFK REG 40-9 "FORCE HEALTH PROTECTION (FHP) REQUIREMENTS FOR THE KOREAN THEATER" OF 08 FEB 2018, AT HTTPS(DOUBLESLASH) WWW.USFK.MIL/PORTALS/105/DOCUMENTS/PUBLICATIONS/REGULATIONS/USFK-REG-40-9-FHP-REQUIREMENTS-KN.PDF. REF L DHA-PI 6025.34 "GUIDANCE FOR THE DOD INFLUENZA VACCINATION PROGRAM (IVP) OF 21 AUG 2020. REF M IS NATIONAL CENTER FOR MEDICAL INTELLIGENCE WEBSITES AT HTTPS(DOUBLESLASH)WWW.NCMI.DODIIS.MIL OR (SIPR) AT HTTP(DOUBLESLASH)WWW.NCMI.DIA.SMIL.MIL. REF N IS CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC) TRAVELERS HEALTH WEBSITE AT HTTP(DOUBLESLASH)WWW.CDC.GOV/TRAVEL/. REF O IS SHORELAND TRAVAX WEBSITE AT HTTPS(DOUBLESLASH) MHS.HEALTH.MIL/TRAVAX/TRAVAX.CSHTML. REF P IS ADVISORY COMMITTEE ON IMMUNIZATION PRACTICES VACCINE RECOMMENDATIONS AND GUIDELINES WEBSITE AT HTTPS(DOUBLESLASH) WWW.CDC.GOV/VACCINES/HCP/ACIP-RECS/VACC-SPECIFIC/PNEUMO.HTML. REF Q IS "III MEF FORCE HEALTH PROTECTION REQUIREMENTS 2020" OF 19 NOV 2020. REF R IS COMPACFLT PEARL HARBOR HI "GUIDANCE ON THE JAPANESE ENCEPHALITIS VACCINE FOR U.S. NAVY PERSONNEL AND TRICARE BENEFICIARIES IN THE PACIFIC FLEET AREA OF RESPONSIBILITY" OF 14 NOV 2016. REF S IS HQ USAF (SG) MEMO "GUIDANCE ON THE USE OF JAPANESE ENCEPHALITIS VACCINE" OF 09 JAN 2015. REF T IS DODI 6490.13 "COMPREHENSIVE POLICY ON TRAUMATIC BRAIN INJURY-RELATED NEUROCOGNITIVE ASSESSMENTS BY THE MILITARY SERVICES" OF 11 SEP 2015 INCORPORATING CHANGE 1, EFFECTIVE 31 MAR 2017. REF U IS "GUIDE TO CLINICAL PREVENTIVE SERVICES" FROM THE AGENCY FOR HEALTHCARE RESEARCH AND QUALITY AT HTTPS(DOUBLESLASH) WWW.USPREVENTIVESERVICESTASKFORCE.ORG/USPSTF/. REF V IS HA POLICY 13-002 "GUIDANCE ON MEDICATIONS FOR PROPHYLAXIS OF MALARIA" OF 15 APR 2013. REF W IS ARMED FORCES PEST MANAGEMENT BOARD TECHNICAL GUIDE 36 OF NOV 2015. REF X IS HA POLICY 09-006 "POLICY FOR DECREASING USE OF ASPIRIN (ACETYLSALICYLIC ACID) IN COMBAT ZONES" OF 12 MAR 2009. REF Y IS DODD 6200.04 "FORCE HEALTH PROTECTION" OF 09 OCT 2004 CERTIFIED CURRENT AS OF 23 APR 2007. REF Z IS ASD/HA MEMO "ZIKA VIRUS INFORMATION FOR DEPARTMENT OF DEFENSE MEDICAL PERSONNEL" OF 5 FEB 2016. REF AA IS ARMED FORCES PEST MANAGEMENT BOARD TECHNICAL GUIDE 48 OF NOV 2013. REF AB IS ASD (HA) MEMO "HUMAN RABIES PREVENTION DURING AND AFTER DEPLOYMENT" OF 14 NOV 2011. REF AC IS DODI 6485.1 "HUMAN IMMUNODEFICIENCY VIRUS-1 (HIV-1) IN MILITARY SERVICE MEMBERS" OF 7 JUN 2013 INCORPORATING CHANGE 1, EFFECTIVE 28 APR 20. REF

AB IS DODI 6490.05 "MAINTENANCE OF PSYCHOLOGICAL HEALTH IN MILITARY OPERATIONS" OF 22 NOV 2011 INCORPORATING CHANGE 2, EFFECTIVE 31 MAR 2020. REF AC IS DOD VETERINARY SERVICE ACTIVITY (DODVSA) POLICY MEMORANDUM B-004, "IMPLEMENTATION OF MILITARY STANDARD 3041, REQUIREMENTS FOR FOOD AND WATER RISK ASSESSMENTS OF 12 SEP 2014, AND MILITARY HANDBOOK 3041, DOD HANDBOOK GUIDELINES FOR CONDUCTING FOOD AND WATER RISK ASSESSMENTS" OF 15 MAY 2013. REF AD IS DIRECTIVE-TYPE MEMO 17-004, "DEPARTMENT OF DEFENSE EXPEDITIONARY CIVILIAN WORKFORCE" OF 25 JAN 2017 INCORPORATING CHANGE 4, EFFECTIVE 19 APR 2021. REF AE IS USPACOM 1107.2 "FORCE HEALTH PROTECTION (FHP) PROGRAM FOR DEPLOYMENTS" OF 18 MAR 2013. REF AG IS "ARMED FORCES REPORTABLE MEDICAL EVENTS GUIDELINES AND CASE DEFINITIONS" AT HTTPS(DOUBLESLASH)HEALTH.MIL/MILITARY-HEALTH-TOPICS/COMBAT-SUPPORT/ARMED-FORCES-HEALTH-SURVEILLANCE-BRANCH/REPORTS-AND-PUBLICATIONS. REF AF IS DODI 6490.11 "DOD POLICY GUIDANCE FOR MANAGEMENT OF MILD TRAUMATIC BRAIN INJURY/CONCUSSION IN THE DEPLOYED SETTING" OF 18 SEP 2012 INCORPORATING CHANGE 2, 26 NOV 2019. REF AG IS DODD 6490.02E "COMPREHENSIVE HEALTH SURVEILLANCE" OF 08 FEB 2012 INCORPORATING CHANGE 2 EFFECTIVE 28 AUG 2017. REF AH IS "JOINT TRAVEL REGULATIONS UNIFORMED SERVICE MEMBERS AND DOD CIVILIAN EMPLOYEES" AT HTTPS(DOUBLESLASH) WWW.DEFENSETRAVEL.DOD.MIL/SITE/TRAVELREG.CFM. REF AI IS USINDOPACOM FY 2021 FORCE HEALTH PROTECTION GUIDANCE FOR USINDOPACOM MESSAGE OF 23 OCT 2020.//

RMKS// (U) THIS MESSAGE PROVIDES UPDATED USINDOPACOM MEDICAL GUIDANCE IN SUPPORT OF CONTINGENCY OPERATIONS, AS DEFINED BY REFS (A), (B), AND (C) WITHIN THE USINDOPACOM AREA OF RESPONSIBILITY (AOR) IN ACCORDANCE WITH (IAW) REFS (A) THROUGH (AK) AND CANCELS REF (AL). //GENTEXT//

1. (U) BACKGROUND.

1.A. (U) THIS INCLUDES OPERATIONAL MOVEMENT OF UNITS, INDIVIDUAL AUGMENTEES, EXERCISE SUPPORT PERSONNEL, OR THOSE OTHERWISE DEPLOYED OR TDY/TAD TO THE INDOPACOM AOR FOR 30 DAYS OR LONGER. HEALTH PROTECTION GUIDANCE FOR MEMBERS TRAVELING FOR OTHER SHORT-TERM MISSIONS SHALL CONFER WITH THEIR SERVICE COMPONENT SURGEON, FORCE HEALTH PROTECTION (FHP) OFFICER AND/OR TRAVEL CLINIC TO ENSURE ADEQUATE IMMUNIZATIONS, MEDICATIONS, REQUIRED MEDICAL WAIVERS, AND PERSONAL PROTECTIVE MEASURES ARE PRESCRIBED AND/OR ISSUED AND UTILIZED. SINCE THESE MISSIONS ARE NOT CONSIDERED DEPLOYMENTS (PER REFS A, B, AND C), CERTAIN REQUIREMENTS (E.G., HUMAN IMMUNODEFICIENCY VIRUS (HIV) TESTING, DURABLE MEDICAL EQUIPMENT, AUTOMATED NEUROPSYCHOLOGICAL ASSESSMENT METRICS (ANAM)) MAY NOT APPLY. TO ENSURE MEMBERS' SAFETY AND SUCCESSFUL EXECUTION OF THESE MISSIONS, PERSONNEL ENTERING THE USINDOPACOM AOR SHALL UTILIZE DEPLOYMENT STANDARD SCREENING PROCEDURES. SERVICE MEMBERS AND THEIR ASSOCIATED FAMILY MEMBERS BEING ASSIGNED TO USINDOPACOM AOR SHOULD GO THROUGH THE NECESSARY PROTOCOLS TO INCLUDE THEIR PERMANENT CHANGE OF STATION SCREENING OFFICE IAW RESPECTIVE SERVICE SPECIFIC GUIDANCE TO ENSURE SUITABILITY AND AVAILABILITY OF HEALTH CARE SERVICES.

1.B. (U) THIS MESSAGE APPLIES TO DEPLOYED, ACTIVE (AC), ACTIVATED RESERVE (RC) AND GUARD (NG) COMPONENT MILITARY, DEPARTMENT OF DEFENSE (DOD) CIVILIAN PERSONNEL, AND CONTRACT PERSONNEL (IAW THEIR STATEMENT OF WORK).

1.C. (U) THIS GUIDANCE DOES NOT SUPERSEDE MORE STRINGENT POLICY FROM COMMANDS, SUBCOMPONENTS, SERVICE COMPONENTS, OR APPROPRIATE GENERAL MEDICAL OFFICER CLINICAL JUDGMENT.

2. (U) DEPLOYMENT HEALTH SUITABILITY REQUIREMENTS AND WAIVERS.
2.A. (U) PERSONNEL MUST BE SCREENED AND MEET MEDICAL READINESS STANDARDS, IAW (REF D AND REF E) PRIOR TO DEPLOYMENT. ALL PERSONNEL DEPLOYING TO THEATER MUST BE MEDICALLY, DENTALLY, AND PSYCHOLOGICALLY FIT. FITNESS SPECIFICALLY INCLUDES THE ABILITY TO ACCOMPLISH TASKS AND DUTIES UNIQUE TO A PARTICULAR OPERATION AND TOLERATE ENVIRONMENTAL AND OPERATIONAL CONDITIONS OF THE DEPLOYED LOCATION.
2.B. (U) PERIODIC HEALTH ASSESSMENTS AND SPECIAL DUTY EXAMS MUST BE CURRENT PRIOR TO DEPLOYMENT. DEPLOYERS MUST ALSO COMPLY WITH HEALTH AND MENTAL HEALTH ASSESSMENTS PER PARAGRAPH 10.
2.C. (U) UNRESOLVED HEALTH PROBLEMS MANDATING SIGNIFICANT DUTY OR MOBILITY LIMITATIONS DISQUALIFY A MEMBER FOR DEPLOYMENT. OTHER MEDICAL DISQUALIFICATION AND ASSOCIATED GUIDANCE IS IDENTIFIED IN (REF E).
2.D. (U) AC, RC (TO INCLUDE ANY ACTIVE ORDERS TO THE USINDOPACOM AOR), AND DOD CIVILIAN PERSONNEL WITH THE FOLLOWING CONDITIONS MAY NOT DEPLOY UNLESS AN APPROVED DEPLOYMENT WAIVER HAS BEEN OBTAINED (SEE PARAGRAPH 2.F. FOR WAIVER SUBMISSIONS).
2.D.1. (U) CONDITIONS THAT PREVENT THE WEARING OF REQUIRED PERSONAL PROTECTIVE EQUIPMENT TO INCLUDE MANUFACTURER PERMETHRIN PRE-TREATED UNIFORMS.
2.D.2. (U) CONDITIONS THAT PROHIBIT REQUIRED IMMUNIZATIONS OR MEDICATIONS.
2.D.3. (U) CHRONIC CONDITIONS THAT REQUIRE FREQUENT CLINICAL VISITS (MORE THAN SEMIANNUALLY) OR ANCILLARY TESTS (MORE THAN TWICE/YEAR); THAT REQUIRE EVALUATION/ TREATMENT BY MEDICAL SPECIALISTS NOT READILY AVAILABLE IN THEATER; THAT FAIL TO RESPOND TO ADEQUATE CONSERVATIVE TREATMENT; THAT REQUIRE SIGNIFICANT LIMITATION TO PHYSICAL ACTIVITY; OR THAT CONSTITUTE INCREASED RISK OF ILLNESS, INJURY, OR INFECTION.
2.D.4 (U) ANY UNRESOLVED ACUTE ILLNESS OR INJURY THAT WOULD IMPAIR DUTY PERFORMANCE DURING THE DURATION OF THE DEPLOYMENT.
2.D.5. (U) ANY MEDICAL CONDITION THAT REQUIRES DURABLE MEDICAL EQUIPMENT (E.G., CPAP, TENS, CATHETERS, ETC.), REPEATED/SCHEDULED MEDICAL MANAGEMENT, LOGISTICAL SUPPORT, AND/OR INFECTION CONTROL PROTOCOLS FOR PERSONAL MEDICAL EQUIPMENT THAT ARE NOT AVAILABLE AT DEPLOYMENT LOCATION. SHIPBOARD PERSONNEL NOT IN SUPPORT OF LAND BASED OPERATIONS MAY BE EXEMPT FROM THIS REQUIREMENT PER U.S. NAVY/PACFLT POLICY.
2.D.6. (U) OPERATIONAL DENTAL READINESS BELOW CLASS 2. THESE CONDITIONS ARE GENERALLY NOT WAIVERABLE. JUSTIFICATION FOR ANY APPROVED WAIVER SHALL BE RECORDED IN WAIVER LOG (SEE PARAGRAPH 2.F.).

2.E. (U) (REF D) PROVIDES POLICY GUIDANCE FOR DEPLOYING SERVICE MEMBERS WITH PSYCHIATRIC DISORDERS AND/OR WHO ARE PRESCRIBED PSYCHOTROPIC (PSYCHIATRIC) MEDICATIONS. A MEMBER WITH A DISORDER IN REMISSION OR WHOSE RESIDUAL SYMPTOMS DO NOT IMPAIR DUTY PERFORMANCE MAY BE CONSIDERED FOR DEPLOYMENT, BUT SERVICE MEMBER MUST HAVE BEEN CLINICALLY STABLE FOR AT LEAST THREE MONTHS PRIOR TO PRE-DEPLOYMENT ASSESSMENT. NO WAIVERS WILL BE GRANTED FOR PSYCHOTIC AND BIPOLAR DISORDERS. SERVICE MEMBERS CANNOT DEPLOY ON ANTI-PSYCHOTICS, LITHIUM OR ANTI-SEIZURE MEDICATIONS. HOWEVER, OFF-LABEL USE OF THESE MEDICATIONS FOR PAIN MANAGEMENT, SLEEP DISORDERS, PTSD, ETC., WILL BE CONSIDERED BY INDIVIDUAL WAIVER REQUEST. A WAIVER REQUEST MUST BE SUBMITTED (SEE PARAGRAPH 2.F.) FOR PERSONNEL WHO ARE ON PSYCHOTROPIC MEDICATIONS, INCLUDING ANTIDEPRESSANTS, AND HAVE BEEN STABLE FOR AT LEAST THREE MONTHS WHILE ON MEDICATION. A WAIVER REQUEST WILL ALSO BE SUBMITTED FOR THOSE WITH ANY HISTORY OF INPATIENT PSYCHIATRIC HOSPITALIZATION OR USE OF PSYCHOTROPIC MEDICATIONS FOR NON-PSYCHIATRIC CONDITIONS. SERVICE MEMBERS WHO DEPLOY MUST HAVE A MINIMUM OF 90-DAY SUPPLY OF THEIR MEDICATIONS TO ALLOW FOR CONTINUED STABILITY UNTIL THEY CAN BE FOLLOWED BY A PROVIDER IN THEATER. SERVICE MEMBERS ON PSYCHOTROPIC MEDICATIONS MUST OBTAIN A SMALL ARMS WAIVER IAW SERVICE COMPONENT POLICY.

2.F. (U) WAIVER REQUESTS ARE SUBMITTED TO THE RESPECTIVE COMPONENT SURGEON, WHO MAY DELEGATE APPROVAL AUTHORITY. FOR FURTHER INFORMATION, CONTACT: USARPAC (DSN 315-437-5895/5901), PACAF (DSN 315-448-3422/3423), PACFLT (DSN 315-474-6339/9111), MARFORPAC (DSN 315-477-8668/8666), SOCPAC (DSN 315-477-7930/7929), OR DEFENSE POW/MIA ACCOUNTING AGENCY (DSN 808-204-3091). IAW REF (D), COMPONENT SURGEONS WILL TRACK AND ARCHIVE ALL APPROVED OR DENIED WAIVERS TO INCLUDE THE MEDICAL CONDITION(S) REQUIRING THE WAIVER.

2.G. (U) CONTRACTORS MUST MEET MEDICAL AND DENTAL FITNESS REQUIREMENTS PRIOR TO DEPLOYMENT AS REQUIRED PER (REF F), ENCLOSURE 3. MEDICAL AND DENTAL WAIVERS FOR CONTRACTORS SHALL FOLLOW PROCESS DESCRIBED IN PARAGRAPH 2.F.

10. (U) DEPLOYMENT HEALTH AND MENTAL HEALTH ASSESSMENTS.
10.A. (U) IAW (REFS B, C, Y, AND AH), A PRE-DEPLOYMENT HEALTH ASSESSMENT- DD FORM 2795, POST-DEPLOYMENT HEALTH ASSESSMENT (PDHA) - DD FORM 2796, POST-DEPLOYMENT HEALTH REASSESSMENT (PDHRA) - DD FORM 2900, AND MENTAL HEALTH ASSESSMENTS - DD FORM 2978 WILL BE COMPLETED BY PERSONNEL WHO DEPLOY FOR OVER 30 DAYS TO OCONUS AREAS WITHOUT A FIXED U.S. MILITARY TREATMENT FACILITY. SHIPBOARD PERSONNEL NOT GOING ASHORE TO SUPPORT LAND BASED OPERATIONS MAY BE EXEMPT FROM THESE REQUIREMENTS. RESPONSIBLE PREVENTIVE MEDICINE/PUBLIC HEALTH PERSONNEL, USINDOPACOM SURGEON, COMPONENT SURGEONS, OR JOINT TASK FORCE SURGEON MAY REQUIRE ASSESSMENTS FOR ANY DEPLOYMENT (REGARDLESS OF LOCATION OR LENGTH) BASED ON ANTICIPATED OR ACTUAL HEALTH THREATS. SERVICE MEMBERS WILL INITIATE THESE ASSESSMENTS VIA SERVICE APPROVED METHODS. HEALTH PROVIDERS WILL COMPLETE THE ASSESSMENTS IAW SERVICE MEDICAL PROCEDURES. A COPY OF THE COMPLETED ASSESSMENT FORMS MUST BE INTEGRATED IN THE SERVICE MEMBERS' HEALTH RECORD AND AN ANNOTATION OF COMPLETION NOTED IN THE APPROPRIATE BLOCK OF DD FORM 2766.
10.B. (U) TIME FRAMES FOR ADMINISTERING THE DEPLOYMENT HEALTH ASSESSMENT (DHA) FORMS OR DEPLOYMENT-RELATED HEALTH ASSESSMENTS (DRHA) WILL BE IAW (REF B AND C).
10.B.1 (U) THE PRE-DEPLOYMENT HEALTH ASSESSMENT (DD FORM 2795 OR DHRA-1) MAY BE COMPLETED WITHIN 120 DAYS PRIOR TO THE ESTIMATED DEPLOYMENT DATE.
10.B.2 (U) THE POST-DEPLOYMENT ASSESSMENT (DD FORM 2796 OR DHRA-2) SHOULD BE COMPLETED AS CLOSE TO THE REDEPLOYMENT DATE AS POSSIBLE, BUT MUST BE WITHIN 30 DAYS BEFORE OR 30 DAYS AFTER REDEPLOYMENT.
10.B.3. (U) THE POST-DEPLOYMENT HEALTH REASSESSMENT (DD FORM 2900 OR DHRA-3) MUST BE COMPLETED 90 TO 180 DAYS AFTER REDEPLOYMENT.
10.B.4. (U) DEPLOYMENT MENTAL HEALTH ASSESSMENTS (DMHA), BESIDES BEING PART OF THE DEPLOYMENT HEALTH ASSESSMENTS, WILL ALSO BE COMPLETED ONCE DURING EACH 180-DAY PERIOD OF MEMBER'S DEPLOYMENT, BETWEEN 181 DAYS AND 18 MONTHS AFTER REDEPLOYMENT (DD FORM 2978, DD FORM 3024 OR DRHA-4), AND BETWEEN 18 MONTHS AND 30 MONTHS AFTER REDEPLOYMENT (DD FORM 2978, DD FORM 3024 OR DRHA-5).
10.C. (U) ADDITIONAL GUIDANCE CAN BE FOUND AT HTTPS(DOUBLESLASH)WWW.PDHEALTH.MIL/TREATMENT-GUIDANCE/DEPLOYMENT-HEALTH-ASSESSMENTS.

Headquarters
United States Forces Korea
Unit #15237
APO AP 96271-5237

United States Forces Korea
Regulation 40-9

20 Oct 2021

Medical Services

FORCE HEALTH PROTECTION (FHP) REQUIREMENTS FOR THE KOREAN PENINSULA

*This regulation supersedes USFK Regulation 40-9, dated 8 February 2018

FOR THE COMMANDER:

BRAD M. SULLIVAN
Major General, USAF
Chief of Staff

OFFICIAL:

ROCKSON M. ROSARIO
Chief, Publications and
Records Management

Summary. This regulation establishes policies and procedures, covers minimum force health protection (FHP) requirements, and assigns FHP peninsula responsibilities.

Summary of Changes. This is a major revision, full review required.

Applicability. This guidance applies to Department of Defense (DoD) personnel (uniformed, civilian, contractors, and volunteers) traveling or deploying to the Korean peninsula and working under the auspices of the DoD for more than 30 days.

Supplementation. Issue of further supplements to this regulation is prohibited unless prior approval is obtained from Headquarters (HQ) United States Forces Korea (USFK) Surgeon (FKSG), Unit #15237, APO AP 96271-5237.

Forms. USFK forms are available at https://8tharmy.korea.army.mil/g1/forms-archives.asp.

Records Management. Records created must be identified, maintained, and disposed of according to AR 25-400-2 and USFK Regulation 923.1. Record titles and descriptions are available on the Army Records Information Management System (ARIMS) website at https://www.arims.army.mil and USFK Regulation 923.1, Appendix H~K.

Chapter 1
Introduction

1-1. Purpose
To establish a force health protection (FHP) program in accordance with (IAW) appendix A, Ref A and set requirements to effectively anticipate, recognize, evaluate, control and mitigate health threats to personnel operating on the Korean peninsula.

1-2. References
Required and related publications are listed in appendix A.

1-3. Explanation of Abbreviations and Terms
Abbreviations and terms used in this regulation are explained in the glossary.

1-4. Overview
This regulation establishes policies and procedures, covers minimum FHP requirements, and assigns FHP peninsula responsibilities. Korea is dynamic environment that may resemble peacetime during armistice but has the potential for rapid transition to hostilities. This FHP Regulation covers the spectrum of armistice to wartime operations.

1-5. Force Health Protection
FHP encompasses measures taken by commanders, supervisors, service members, and the Military Health System (MHS) to promote, protect, improve, conserve, and restore the mental and physical well-being of service members across the range of military activities and operations. These measures enable the fielding of a healthy and fit force, prevention of injuries and illness, and protection of the force from health hazards, and provision of medical and rehabilitative care to those who become sick or injured.

1-6. Responsibilities

a. Commanders. Responsible for implementing effective FHP programs and utilizing preventive medicine personnel in pre-deployment planning and briefings. Commanders and supervisors must ensure personnel obtain Korean peninsula-specific vaccinations before arrival.

b. Unit Medical Personnel. Responsible for identifying health threats and appropriate countermeasures.

c. Individuals/Units. Required to adhere to requirements specific to the Korean peninsula.

d. USFK Surgeon (FKSG). Overall staff responsibility for ensuring FHP requirements are synchronized in Operation Plans (OPLANs) and among the Service Components' health service support plans.

e. For detailed information concerning specific operations/exercises, refer to FKSG FHP Officer, Annex Q's, and higher echelon command directives.

Chapter 2
Medical Deployability and Waivers

2-1. Medical Readiness, Deployability, and Fitness for Korea
Department of Defense (DoD) personnel must be screened and meet medical readiness standards

Chapter 2
Medical Deployability and Waivers

2-1. Medical Readiness, Deployability, and Fitness for Korea

Department of Defense (DoD) personnel must be screened and meet medical readiness standards IAW Ref I, U, V, W, and X (service members), Ref I, J, L, and X (DoD civilians), and Ref C (contractors). Fitness includes the ability to accomplish all required tasks and duties, while considering the environmental and operational conditions of their assigned location. Periodic Health Assessments and specialized duty exams must be current before deployment or assignment to the Korean peninsula.

2-2. Medical Conditions Requiring a Waiver

Unresolved health problems that cause significant duty or mobility limitations are disqualifying for deployment or assignment to Korean peninsula. The following conditions require an approved waiver prior to deployment or assignment (see Ref J and R for additional requirements):

a. Conditions that prevent the wear of required Personal Protective Equipment (PPE).

b. Conditions that prohibit vaccinations or use of Medical Chemical Defense Materiel (MCDMs).

c. Chronic conditions that require frequent (more than twice/year) clinical visits or ancillary tests; that require evaluation/treatment by medical specialists not readily available on peninsula; that fail to respond to adequate conservative treatment; that require implanted medical device requiring ongoing maintenance or medical supervision; that require significant limitation to physical activity; or that constitute increased risk of illness, injury, or infection.

d. Any unresolved acute illness or injury that would impair duty performance during the duration of the assignment. If surgery has been performed, the post-surgical recovery period must be completed with clearance for full-duty to include service-specific Physical Fitness Test (PFT).

e. Any medical condition that requires durable medical equipment (e.g. Continuous Positive Airway Pressure (CPAP) machine, Transcutaneous Electrical Nerve Stimulation (TENS) machine, nebulizers, wheelchairs, catheters, dialysis machines, insulin pumps, implanted defibrillators, spinal cord stimulators, cerebral implants, etc), repeated/scheduled medical management, logistical support, and/or infection control protocols for personal medical equipment that are not available at the deployment location. Shipboard personnel not in support of land based operations may be exempt from this requirement per U.S. Navy/Pacific Fleet policy.

f. Deploying personnel with moderate to severe Obstructive Sleep Apnea (diagnostic Apnea-Hypopnea Index (AHI) and Respiratory Disturbance Index (RDI) ≥ 15/hr) and symptomatic OSA.

g. Any medical condition that could result in sudden incapacitation including history of stroke within the last 24 months, seizure disorders, and diabetes mellitus type I or II treated with insulin.

h. Service members with a history of alcohol or substance abuse treatment failure, require use of medications for treatment of a substance abuse disorder, or who have attended a substance abuse program within 12 months of deployment.

i. Any physical or mental condition restricting the ability to carry or fire an assigned weapon.

j. Any medical condition requiring anti-coagulation therapy.

k. Operational dental readiness Class 3 or 4.

l. Use of any narcotic and benzodiazepine medications on a regular basis.

m. Behavioral health condition with any of the following features (see Ref R):

(1) Admission to any inpatient, residential, or intensive outpatient behavioral health facility within the 12 months before arrival to the peninsula. Any history of multiple (2 or more) psychiatric hospitalizations is disqualifying, and no waiver submission would be indicated.

(2) Psychiatric disorders under prescription treatment for fewer than 3 months with demonstrated stability from the last change in treatment regimen (i.e., medication, either new or discontinued, or dose change), IAW Ref R.

(3) Clinical psychiatric disorders with residual symptoms that impair or are likely to impair duty performance.

(4) Mental health conditions that pose a substantial risk for deterioration and/or recurrence of impairing symptoms in the Korean peninsula.

(5) No waivers will be granted for psychotic or bipolar disorders.

2-3. Waiver Request Process and Approval

Medical waiver requests are submitted to the respective Service Components IAW Ref M. Sending unit commanders are not authorized to override a medical deployability determination.

a. Authorized agents (local medical provider, commander/supervisor, representative, or individual member) will forward a completed medical waiver request form (See Appendix G) to be adjudicated by the appropriate surgeon listed below in section 2-4. The case summary portion of the waiver should include a synopsis of the concerning condition(s) and supporting documentation to include the provider's assessment of ability to deploy. Medical waivers should be sent to the approval authority NLT 45 days before deployment and can take up to 30 days for processing.

b. Component surgeons must track and archive all approved or denied waivers.

c. Appeal Process. If the sending unit disagrees with the component surgeon's decision, an appeal may be submitted to the USFK Command Surgeon. If the disagreement is with the USFK Command surgeon's decision, an appeal may be submitted through the chain of command to the USFK Chief of Staff (CoS).

d. Personnel found to not meet USFK fitness standards after arrival in Korea will require either waiver approval or redeployment. This situation may arise either due to a pre-existing condition that was not detected or adjudicated prior to arrival or a newly diagnosed condition.

2-4. Contacts for Waivers

a. **USFK Surgeon**. indopacom.yongsan.usfk.list.j47-hssd@mail.mil. DSN: 315-755-8450.

b. **7AF Surgeon**. 7af.sgworkflow@us.af.mil. DSN: 315-784-8080.

c. **8A Surgeon**. usarmy.humphreys.8-army.mbx.8-army-surgeon-deployment-waiver@mail.mil. DSN: 315-755-2716.

d. **MARFORK**. DSN: 315-737-1424. 315-477-8667.

e. **CNFK**. DSN: 315-763-8314.

f. **SOCKOR Surgeon**. SOCKOR_CMD_Surgeon_Cell@socom.mil. DSN: 315-757-3536.

Chapter 3
Prescriptions, Medical Countermeasures, and Equipment

3-1. Prescription Medication

a. Supply. Deploying personnel will deploy with a minimum 180-day supply of prescribed medications with arrangements to obtain resupply using a follow-on refill prescription. Tricare eligible personnel will obtain refill prescriptions from the Tricare Mail Order Pharmacy (TMOP) Deployed Prescription Program.

b. Exceptions. Exceptions to the 180-day prescription quantity requirement include:

(1) Personnel assigned to the Korean peninsula in a non-deployment status for a stable condition that does not make the patient non-deployable will be prescribed at least a 90-day supply before arrival on the Korean peninsula.

(2) Psychotropic medication may be dispensed for up to a 180-day supply with no refill. Psychotropic medications include anti-depressants, anti-anxiety (non-controlled substances), non-class 2 (CII) stimulants, and anti-seizure medications used for mood disorders.

(3) Food and Drug Administration (FDA) controlled substances (schedule I-V) are limited to a 90-day supply with no refills. An approved waiver must be obtained from the proper waiver authority before deployment, and must remain valid for renewals. Clinical follow-up in theater should be sought at the earliest opportunity to obtain medication renewals.

c. Prescription Medication Analysis and Reporting Tool (PMART). Screening personnel will maximize the use of the PMART to identify those medications which are high-risk, temperature-sensitive, have interactions with over the counter medicine, or not available in South Korea and/or through the TMOP/DPP. Contact the Defense Health Agency (DHA) Pharmacy Analytics Support section at 1-866-275-4732 or usarmy.jbsa.medcom-ameddcs.mbx.pharmacoeconomic-center@mail.mil for information on how to obtain a PMART report. (www.health.mil/PMART)

5-2. Health Assessments

a. Service members in a deployment status over 30 days or Contingency Deployment status to the Korean peninsula are required to complete Pre-deployment Health Assessments (DD Form 2795), Post Deployment Health Assessments (PDHA/DD Form 2796), Post Deployment Health Re-Assessments (PDHRA/DD Form 2900) or neurocognitive assessments such as the Automated Neuropsychological Assessment Metrics (ANAM), in accordance with Ref A.

b. Service members on PCS, TCS, TAD or TDY orders during non-deployment conditions are not required to complete DD Form 2795, PDHA or PDHRA unless required by home station medical authorities.

c. Service members on PCS, TSC, TAD, TDY, or deployed to South Korea for more than 90 days will transfer TRICARE enrollment to TRICARE-Pacific upon arrival.

d. Periodic health assessments must be current IAW service policy at time of deployment and special duty exams must be current for the duration of travel or deployment period (see Ref D and I).

5-3. Mental Health Assessment

a. Service members deployed in connection with a contingency operation will undergo a person-to-person mental health assessment with a licensed mental health professional or trained and certified health care personnel IAW Ref I. Assessments will be accomplished within 120 days before deployment, and after redeployment, or as required by service policy. Assessments will be administered at least 90 days apart.

b. Service members may be assessed on an as needed basis or at the request of the commander for a command directed evaluation while deployed, or in a PCS or TAD/TDY status.

c. Mental health assessment guidance does not directly apply to DoD contractors unless specified in the contract or there is a concern for a mental health issue. Related mental health evaluations will be at the contractor's expense.

DEPARTMENT OF DEFENSE
UNITED STATES SOUTHERN COMMAND
9301 NW 33rd STREET
DORAL, FL 33172-1202

20 February 2019 SC Regulation 40-501

MEDICAL SUITABILITY SCREENING

TABLE OF CONTENTS

1. References.

a. DODI 1400.32, DOD Civilian Workforce Contingency and Emergency Planning Guidelines and Procedures, April 24, 1995.

b. DODI 3020.32, Continuation of DOD Contractor Services During Crisis, November 6, 1990

c. DODI 3020.41, Operational Contract Support, December 20, 2011

d. DOD Instruction 6025.19, "Individual Medical Readiness (IMR)," June 9, 2014

e. DOD Directive 6200.04, "Force Health Protection (FHP)," October 9, 2004

f. DODI 6485.01, Human Immunodeficiency Virus(HIV) in Military Service Members, October 26, 2006

g. DODI 6490.03, Deployment Health, August 11, 2006

h. DODI 6490.07, Deployment-Limiting Medical Conditions for Service Members and DoD Civilian Employees, February 5, 2010.

i. DoD Instruction 6490.13, "Comprehensive Policy on Traumatic Brain Injury-Related Neurocognitive Assessments by the Military Services," September 11, 2015, as amended

j. Assistant Secretary of Defense for Health Affairs Memorandum, "Clinical Practice Guidance for Deployment-Limiting Mental Disorders and Psychotropic Medications," October 7, 2013

*Supersedes SC Regulation 40-501, dated 22 April 2013

k. DTM: Directive-type Memorandum 17-004, "Department of Defense Civilian Expeditionary Workforce," January 25, 2017

l. USSOUTHCOM Policy Memorandum 1-12, Synchronized Predeployment and Operational Tracker (SPOT) in the USSOUTHCOM AOR, February 15, 2012

m. SOUTHCOM Force Health Protection Guidance, September 23, 2018, as amended

n. MOD Thirteen to US CENTCOM Individual Protection and Individual Unit Deployment Policy, March 23, 2017

2. Purpose. This regulation prescribes policy, responsibilities, and procedures for medical suitability screening when entering the United States Southern Command (USSOUTHCOM) Area of Responsibility (AOR).

3. Applicability. This regulation is provided to all Department of Defense (DOD) personnel and contractors on behalf of DoD, entering the USSOUTHCOM AOR or employed within the USSOUTHCOM AOR. United States Government (USG) Interagency partners under DoD command and control will be obligated to follow DoD guidelines unless the agency prescribes equally adequate standards for medical suitability screening for their own personnel. This regulation applies to subordinate commands (i.e., Air Force South, Army South, Marine Force South, Navy South, and Special Operations Command South) and joint task forces (i.e., JTF-Bravo, JTF-Guantanamo, and Joint Interagency Task Force South); hereafter referred to as components. This regulation applies to subordinate directorates, special staff offices, and security cooperation organizations, hereafter referred to as elements. Components and elements may require more or less stringent screening requirements to meet specific Service needs or to address interagency and non-governmental organizations (NGOs) coordination that are in direct support of DoD missions. Any Component with differing requirements will provide USSOUTHCOM Command Surgeon a copy of the Component policy for approval. Family members on accompanied tours will be regulated by the Service Members' (SM) parent service policies for screening.

4. Summary:

a. It is USSOUTHCOM's policy that all uniformed service members permanently assigned to the AOR (PCS personnel), command-sponsored dependents of uniformed service members assigned to the AOR, uniformed servicemembers scheduled to perform temporary duty in the AOR for a period greater than 30 days (TDY personnel), DoD personnel deploying to a contingency operation within the AOR, and contractors entering the USSOUTHCOM AOR will be medically screened prior to entering the theater and meet minimum medical suitability standards to ensure force health protection (FHP) and accomplishment of the mission.

b. Persons in paragraph 4a. above, not meeting the minimum medical standards may be granted a waiver based on the professional opinion of a medical provider that considers: (1) how the medical condition might impact an individual's ability to perform occupational responsibilities; (2) how the medical condition might be affected by

variables such as environment, altered sleep cycle, operational stress, etc.; and (3) available health service depending on the location and nature of operations before submitting a medical waiver.

c. It is policy of USOUTHCOM that all DoD civilian employees permanently assigned to the AOR receive a notice of medical services available in the country for which he or she will be assigned. The notice will be provided to the civilian employee upon offer of employment, and he or she will affirmatively acknowledge receipt of the information. The civilian employee will also provide a statement of understanding tha he or she may be fiduciarily responsible for any Government expenditures that result from medical care received by the employee or family members at Government expense, to include MEDEVAC.

d. This policy is a collaborative effort with USCENTCOM and Secretary of Defens Health Affairs to streamline deployment criteria common to all AORs. USSOUTHCOM Medical Limiting Conditions Guidelines are reflective of USCENTCOM Mod13- Tab A with the USSOUTHCOM noted exceptions outlined in this policy.

5. Records Management. Records generated by the implementation of this regulatio will be maintained in accordance with (IAW) CJCSM 5760.01, Joint Staff Records Schedule and DODI 6040.45, "DoD Health Record Life Cycle Management", Novemb 16, 2015, as amended.

6. Point of contact for this regulation the office of the Command Surgeon (SCSG) at COMM: 305-437-1327, or DSN 567-1327.

The proponent agency of this regulation is the US Southern Command. Users are invited to send comments and suggested improvements to: HQ USSOUTHCOM ATT SCSG, 9301 NW 33rd St., Doral, FL, 33172-1202.

FOR THE COMMANDER

PATRICIA M. ANSLOW
Major General, USA
Chief of Staff

DISTRIBUTION
D

APPENDIX B
PROCEDURES

1. General. DoD guidance and USSOUTHCOM amplification of minimal standards will be used to screen all persons that require screening pursuant to this regulation prior to entering the SOUTHCOM AOR(See Attachment B). Component or Service specific guidance may have more stringent requirements in order to meet specific service needs. Any Component with differing requirements will provide USSOUTHCOM Command Surgeon a copy of the Component policy for approval. Pre-employment and annual medical screenings of contractors will not be performed in military treatment facilities or by U.S. military personnel unless authorized by the contracting officer and respective MTF. Minimal standards are outlined below. In general, individuals with the following conditions shall not deploy :

a. Conditions affecting Force Health Protection. Conditions that prohibit immunizations or the use of Force Health Protection prescription products (FHPPs) required for the specific deployment. Depending on the applicable threat assessment, required FHPPPs may include atropine, epinephrine, certain antimicrobials and anti-malarials.

b. Unresolved health conditions requiring frequent clinical visits and/or affecting the individual's ability to perform their duties in a satisfactory manner. Any unresolved acute or chronic illness or injury that would impair duty performance in a deployed environment during the duration of the deployment. This includes conditions that require routine evacuation out of theater continuing diagnostics or acute exacerbations of a physical or mental health condition that could significantly affect duty performance.

c. Condition that could cause sudden incapacitation. Recurrent loss of consciousness for any reason or any medical condition that could result in sudden incapacitation to include history of stroke or MI within the last 24 months, heat stroke, uncontrolled vertiginous disorders, recurrent syncope, seizure disorders and diabetes mellitus I or II treated with insulin. These conditions are NON WAIVERABLE.

d. Infectious disease. Active tuberculosis or known blood-borne diseases that may be transmitted to others in a deployed environment. Any request for waiver must have complete lab work including viral load and specialist recommendation. The SOUTHCOM Command Surgeon shall be consulted in all instances of HIV and HBV/HCV seropositivity before medical clearance is granted for deployment.

e. Mental Health Disorders. Chronic or medical conditions that require ongoing treatment with antipsychotics, lithium or anticonvulsants are NON WAIVERABLE. Any history of psychiatric/mental health/behavioral health hospitalization, including substance abuse, illicit drug use, and alcohol dependency/ abuse must be thoroughly assessed with behavioral health consultation. Any behavioral health condition requiring medication must demonstrate a minimum of three months stability on medication without any change of medication in those three months to be considered for a waiver.

Psychiatric disorders newly diagnosed during deployments require evacuation out of theater and must be replaced through the normal personnel process.

2. USSOUTHCOM Amplification of minimal standards. Medical examiners will use attachment B as the governing document for deployment screening. The following exceptions will be considered on a case by case basis with a waiver approval by the respective Surgeon and will be reviewed by the SOUTHCOM SG Office:

a. Conditions outlined in Paragraph 1 above. Component Surgeon Approval.

b. Injectable Medications. Component Surgeon Approval

c. Opioids for chronic use. Component Surgeon Approval

d. Immunosuppressants. Component Surgeon Approval

e. Conditions that require surgery. Component Surgeon Approval

f. Conditions requiring Durable Medical Equipment. Component Surgeon Approval.

3. Local National (LN)/Third Country Nationals(TCN). All local national and third country national employees whose job requires close or frequent contact with non-LN/TCN personnel (i.e, dining facility workers, interpreters etc.) must be screened for tuberculosis (TB). LN and TCN employees involved in food service, including water and ice production must be screened annually for signs and symptoms of infectious diseases. Contractors must ensure LN/TCN employees receive typhoid and hepatitis A vaccinations and ensure documentation in the employees' medical record. Vision readiness standards, hearing standards must be IAW service policy/guidance for all LNs/TCNs. LNs/TCNs must have a current dental exam in his/her medical record.

4. Waivers.

a. If a medical waiver is indicated, prepare and submit a medical waiver request (Attachment A) with appropriate supporting documentation to the specific USSOUTHCOM Component Surgeon based on component guidance. Ensure to encrypt your email.

b. If the individual does not meet medical suitability requirements to enter the theater, the screening health care provider (MD, PA, and NP) should consider the individual's job duties, medical condition, and duration of assignment in the theater, available health service support and other variables depending on the location and nature of operations before submitting a medical waiver.

c. Medical examiners must consider climate, altitude, billeting options, duty assignment and duration, and health support services available in theater when deciding whether an individual with a specific medical condition is deployable.

d. Contractors are responsible for requesting medical waivers for employment consideration from the contracting officer. Contracting officers will forward the waiver request to the responsible MTF for review and approval. Responsible MTF will provide a copy of approved waiver of contracting officer, contract company, employee medical record and the Command Surgeon IAW this regulation.

e. For visits of less than 30 days, the responsible unit or MTF medical personnel will determine medical suitability screening based on the anticipated medical risks and the individual's medical condition. No medical waiver is required.

f. An adequate healthcare support system must be validated by the component Surgeon prior to approving waivers for any condition requiring ongoing health care or use of medications. Medications must be available or accessible to the individual through existing pharmacy resources, within the military health system or through mail-order supply and have no special handling, storage or other requirements.

g. If a person is found deployed with a listed condition and without a waiver for that condition, a waiver request must be initiated by the JTF or Component Surgeon if they believe a waiver is warranted. If the waiver is denied, the individual will be redeployed ASAP and the personnel process will be used to replace the individual as needed.

h. The list of conditions is not intended to be all-inclusive. A list of all possible diagnosis which could result in potential non deployability, would be too extensive. It is the intent of this Medical Suitability Standard to provide a framework for healthcare providers to make informed decisions and to outline the process for addressing medical conditions which could adversely affect the individual or the mission while OCONUS in theater.

AMPLIFICATION OF THE MINIMAL STANDARDS OF FITNESS FOR DEPLOYMENT TO THE SOUTHCOM AOR

1. General. This attachment accompanies USSOUTHCOM Regulation 40-501and provides amplification of the minimal standards of fitness for deployment to the SOUTHCOM area of responsibility (AOR). Individuals possessing a disqualifying medical condition must obtain an exception to policy in the form of a medical waiver prior to being medically cleared for deployment. The list of deployment-limiting conditions is not comprehensive; there are many other conditions that may result in denial of medical clearance for deployment based upon the totality of individual medical conditions and the medical capabilities present at that individual's deployed location. "Medical conditions" as used here also include those health conditions usually referred to as dental, psychological, and/or emotional.

A. Uniformed Service Members must meet Service standards of fitness according to Service regulations and policies, in addition to the guidance below.

B. DoD civilian personnel with disqualifying medical conditions could still possibly deploy based upon an individualized medical assessment and approved medical waiver from the appropriate SOUTHCOM waiver authority (which shall be consistent with subparagraph 4.g.(3)(c) of DoDD 1404.10 and The Rehabilitation Act of 1973, as amended).

C. DoD Contract personnel will be evaluated for fitness according to DoDI 3020.41.

D. Regardless of underlying diagnosis, waivers for disqualifying medical conditions will be considered only if all the following general conditions are met:

1. The condition is not of such a nature or duration that an unexpected worsening or physical trauma is likely to have a grave medical outcome or negative impact on mission execution.

2. The condition is stable and reasonably anticipated not to worsen during the deployment in light of the physical, physiological, psychological, and nutritional effects of assigned duties and location.

3. The condition does not require frequent clinical visits (more than quarterly), ancillary tests, or significant physical limitations, and does not constitute an increased risk of illness, injury, or infection.

4. There is no anticipated need for routine evacuation out of theater for continuing diagnostics or evaluations.

5. Any required, ongoing health care or medications anticipated to be needed for the duration of the deployment are available to the applicant in theater within the Military Health System or equivalent. Medication must have no special handling, storage, or other requirements (e.g., refrigeration, cold chain, or electrical power requirements). Medication must be well tolerated within harsh environmental conditions (e.g. heat or cold stress, sunlight) and should not cause significant side effects in the setting of moderate dehydration.

6. Individuals must be able to perform all essential functions of the position in the deployed environment, with or without reasonable accommodation, without causing undue hardship. In evaluating undue hardship, the nature of the accommodation and the location of the deployment must be considered. Further, the member's medical condition must not pose a significant risk of substantial harm to the member or others taking into account the condition of the relevant deployed environment, with particular consideration of areas of armed conflict in the AOR.

7. The medical condition does not prevent the wear of personal protective equipment, including protective mask, ballistic helmet, body armor, and chemical/biological protective garments.

8. The medical condition does not prohibit required theater immunizations or medications.

9. The medical condition is not anticipated to significantly impair one's duty performance during the duration of the deployment.

2. Evaluating providers must consider that in addition to the individual's assigned duties, severe environmental conditions, extremes of temperature, high physiologic demands (water, mineral, salt, and heat management), poor air quality (especially particulates), limited dietary options, sleep deprivation/disruption, and emotional stress may all impact the individual's health. If maintaining an individual's health requires avoidance of these extremes or conditions, they should not deploy.

3. Evaluation of functional capacity to determine fitness in conditions of physiologic demand is encouraged for conditions which may impair normal functionality. This includes such things as a complete cardiac evaluation, to include stress imaging, when there is coronary artery disease or an official functional capacity exam (FCE) for orthopedic issues. The evaluating provider should pay special attention to any conditions which may present a hazard to the individual or others and/or preclude performing functional requirements in the deployed setting. Also, the type, amount, suitability, and availability of medications in the theater environment must be considered as potential limitations. Pre-deployment processing centers may vary in medical examination/screening procedures; individuals should contact their respective mobilization site for availability of a processing checklist.

4. The guidance in this document should not be construed as authorizing use of defense health program or military health system resources for health evaluations unless otherwise authorized. Generally, Defense Health Agency and Military Health System resources are not authorized for the purpose of pre-deployment or travel medicine evaluations for contractor employees. Local command, legal, contracting and resource management authorities should be consulted for questions on this matter.

5. Shipboard operations which are not anticipated to involve operations ashore are exempt from the deployment-limiting medical conditions listed below and will generally follow Service specific guidance. However, sovereign laws of some nations within the SOUTHCOM AOR may prohibit entry of individuals with certain medical conditions. Contingency plans for emergency evacuation of individuals with diagnoses that could result in or complicate medical care in theater following evacuation should be coordinated with and approved by the SOUTHCOM Surgeon prior to entering the AOR.

6. The general guidance from SOUTHCOM Reg 40-501applies to:

A. All personnel (uniformed service members, government civilian employees, volunteers, and DoD contractor employees) deploying to theater must be medically, dentally and psychologically

fit for deployment and possess a current Periodic Health Assessment (PHA) or physical. Fitness specifically includes the ability to accomplish tasks and duties unique to a particular operation and the ability to tolerate environmental and operational conditions of the deployed location.

B. The existence of a chronic medical condition may not necessarily require a waiver to deploy. Personnel with existing conditions, **other than those outlined in this document**, may deploy if either:

1. An approved medical waiver is documented in the medical record.

OR

2. The conditions in Para. 1.D.1-1.D.9 are met. To determine stability and assess need for further care, for most conditions 90 days is considered a reasonable timeframe, subject to the examining provider's judgment. The exception to this is noted in paragraph 7.G. Psychiatric Conditions.

7. Documented medical conditions precluding medical clearance. A list of all possible diagnoses and their severity that may cause an individual to be non-deployable would be too expansive. *The medical evaluator must carefully consider whether the climate, altitude, nature of available food and housing, availability of medical, behavioral health, dental, surgical, and laboratory services, or whether other environmental and operational factors may be hazardous to the deploying person's health.* The following list of conditions should not be considered exhaustive. Other conditions may render an individual medically non-deployable (see paragraph 6). Medical clearance to deploy with any of the following documented medical conditions may be granted, except where otherwise noted. If an individual is found deployed with a pre-existing non-deployable condition and without a waiver for that condition, a waiver request to remain deployed should be submitted to the respective Component Surgeon. If the waiver request is denied, the individual will be redeployed out of the SOUTHCOM AOR. **Individuals with the following conditions will not deploy without an approved waiver:**

A. Specific Medical Conditions / Restrictions:

1. Asthma or other respiratory conditions that have a Forced Expiratory Volume-1 < 50% of predicted despite appropriate therapy, that have required hospitalization in the past 12 months, or that requires daily systemic (not inhaled) steroids. Respiratory conditions that have been well controlled for 6 months and are evaluated to pose no risk of deterioration in the deployed environment may be considered for waiver.

2. Seizure disorder, either within the last year or currently on anticonvulsant medication for prior seizure disorder/activity. Persons on a stable anticonvulsant regimen, who have been seizure-free for one year, may be considered for waiver.

3. Diabetes mellitus, type 1 or 2, on pharmacotherapy or with $HgA_1C > 7.0$.

a. Type 1 diabetes or insulin-requiring type 2 diabetes.

b. Type 2 diabetes, on oral agents only, with no change in medication within the last 90 days and HgA1C ≤ 7.0 does not require a waiver if a calculated 10-year coronary heart disease risk percentage (see paragraph 7.B.7) is less than 15%. If the calculated 10-year risk is 15% or greater, further evaluation is required prior to waiver submission. See B.8. for more detailed instructions.

c. Newly diagnosed diabetics will require 90 days of stability, either on oral medications or with lifestyle changes, before a waiver will be considered. They

G. Psychiatric Conditions: Diagnostic criteria and treatment plans should adhere to Diagnostic and Statistical Manual of Mental Disorders, Fourth or Fifth edition (DSM-IV/5) and current professional standards of care. Waiver submission should include information on applicant condition, including history and baseline symptoms of known disorders, severity of symptoms with and without treatment, and likelihood to recur or deteriorate in theater if exposed to operational activity. Waiver required for all conditions listed below (list is not inclusive).

1. Psychotic and bipolar-spectrum disorders are strictly disqualifying.
2. Any DSM IV/5-diagnosed psychiatric disorder with residual symptoms, or medication side effects, which impair social and/or occupational performance.
3. Any behavioral health condition that poses a substantial risk for deterioration and/or recurrence of impairing symptoms in the deployed environment.
4. Any behavioral health condition which requires periodic (beyond quarterly) counselling or therapy.
5. Chronic insomnia that requires regular or long-term use of sedative hypnotics / amnestics, benzodiazepines, and/or antipsychotics.
6. Anxiety disorders requiring use of benzodiazepines for management, or featuring symptoms of panic or phobia.
7. Post-Traumatic Stress Disorder, when not completely treated or when therapy includes use of benzodiazepines without additional anxiety diagnosis. Waiver submission should note if condition is combat-related, and, if so, comment on impact that return to theater could have on applicant well-being and performance.
8. Gender dysphoria, while not intrinsically disqualifying, does require underlying psychiatric, endocrine, and/or surgical issues (as applicable) to be stable and resolved, and all Service requirements must be met. Due to complex needs, those actively undergoing gender transition are generally disqualified until the process, including all necessary follow-up and stabilization, is completed.
9. Bulimia and anorexia nervosa.
10. Attention Deficit Disorder(ADD)/Attention Deficit Hyperactivity Disorder (ADHD). Evaluation and diagnosis should be appropriate per DSM IV/5 criteria, particularly if Class II stimulants are used for treatment. Specific clinical features or objective testing results should be included in waiver application for stimulant use. Dosages for medications should likewise be appropriate and justified by clinical presentation.
11. Psychiatric hospitalization within the last 12 months.
12. Suicidal Ideation or Suicide Attempt with the last 12 months.
13. Enrollment in a substance abuse program (inpatient, service specific substance abuse program or outpatient) within the last 12 months measured from time of discharge / completion of the program.
    a. A post-treatment period of demonstrated stability is required, the length of which will depend on individual patient factors.
    b. Substance abuse disorders (not in remission), actively enrolled in Service Specific substance abuse programs are not eligible for waiver.
14. Use of antipsychotics or anticonvulsants for stabilization of DSM IV or DSM-5 diagnoses.
15. Use of 3 or more psychotropics (e.g. antidepressants, anticonvulsants, antipsychotics, benzodiazepines) for stabilization, particularly if used to offset side-effects of other BH therapy.
16. Psychiatric disorders with fewer than three months of demonstrated stability from the last change in treatment regimen, including discontinuation.

17. Psychiatric disorders newly diagnosed during deployment do not immediately require a waiver or redeployment. Disorders that are deemed treatable, stable, and having no impairment of performance or safety by a credentialed mental health provider do not require a waiver to remain in theater.

a. Exceptions include diagnoses featuring bipolar, psychotic, or suicidal features. These individuals should be redeployed at soonest opportunity via medical evacuation with appropriate escorts and per TRANSCOM guidelines.

b. Diagnoses requiring the prescription of CSA-scheduled controlled substances will require an approved waiver to obtain routine refills of medication.

H. Medications – although not exhaustive, use of any of the following medications (specific medication or class of medication) is disqualifying for deployment, unless a waiver is granted:

1. Any medication which, if lost, misplaced, stolen, or destroyed, would result in significant worsening or grave outcome for the affected individual before the medication could be reasonably replaced.

2. Any medication which requires periodic laboratory monitoring, titrated dosing, or special handling/storage requirements, or which has documented side effects, when used alone or in combination with other required therapy, which are significantly impairing or which impose an undue risk to the individual or operational objectives.

3. Blood modifiers:

a. Therapeutic Anticoagulants: warfarin (Coumadin), rivaroxaban (Xarelto).

b. Platelet Aggregation Inhibitors or Reducing Agents: clopidogrel (Plavix), anagrelide (Agrylin), Dabigatran (Pradaxa), Aggrenox, Ticlid (Ticlopidine), Prasugrel (Effient), Pentoxifylline (Trental), Cilostazol (Pletal). Note: Aspirin use in theater is to be limited to individuals who have been advised to continue use by their healthcare provider for medical reasons; such use must be documented in the medical record.

c. Hematopoietics: filgrastim (Neupogen), sargramostim (Leukine), erythropoietin (Epogen, Procrit).

d. Antihemophilics: Factor VIII, Factor IX.

4. Antineoplastics (oncologic or non-oncologic use): e.g., antimetabolites (methotrexate, hydroxyurea, mercaptopurine, etc.), alkylators (cyclophosphamide, melphalan, chlorambucil, etc.), antiestrogens (tamoxifen, etc.), aromatase inhibitors (anastrozole, examestane, etc.), medroxyprogesterone (except use for contraception), interferons, etoposide, bicalutamide, bexarotene, oral tretinoin (Vesanoid).

5. Immunosuppressants: e.g., chronic systemic steroids.

6. Biologic Response Modifiers (immunomodulators): e.g., abatacept (Orencia), adalimumab (Humira), anakinra (Kineret), etanercept (Enbrel), infliximab (Remicade), leflunomide (Arava), etc.

7. Antiretrovirals used for Pre-Exposure Prophylaxis (PrEP): e.g. tenofovir disoproxil fumarate/emtricitabine (Truvada), tenofovir alafenamide (Vemlidy)

8. Any CSA Schedule I-V controlled substance, including but not limited to the following:

a. Benzodiazepines: lorazepam (Ativan), alprazolam (Xanax), diazepam (Valium), flurazepam (Dalmane), clonazepam (Klonopin), etc.

b. Stimulants: methylphenidate (Ritalin, Concerta), amphetamine/dextroamphetamine (Adderall), dextroamphetamine (Dexedrine),

dexmethylphenidate (Focalin XR), lisdexamfetamine (Vyvanse), modafinil (Provigil), armodafinil (Nuvigil), etc.

c. Sedative Hypnotics/Amnestics: zolpidem (Ambien, Ambien CR), eszopiclone (Lunesta), zaleplon (Sonata), estazolam (Prosom), triazolam (Halcion), temazepam (Restoril), etc. Note: single pill-count issuances for operational transition do not generally require a waiver.

d. Narcotics/narcotic combinations: oxycodone (Oxycontin, Percocet, Roxicet), hydrocodone (Lortab, Norco, Vicodin), hydromorphone (Dilaudid), meperidine (Demerol), tramadol (Ultram), etc.

e. Cannabinoids: marijuana, tetrahydrocannabinol (THC), dronabinol (Marinol), etc. Note that possession or use may be a criminal offense in the SOUTHCOM AOR.

f. Anorexiants: phendimetrazine (Adipost), phentermine (Zantryl), etc.

g. Androgens and Anabolic Steroids: testosterone (Axiron, AndroGel, Fortesta, Testim), oxymetholone (Anadrol-50), methyltestosterone (Methitest), etc. Preparations used in accordance with standards outlined in 7.A.7 above do not require separate waiver. All injected preparations require waiver.

9. Antipsychotics, including atypical antipsychotics: haloperidol (Haldol), fluphenazine (Prolixin), quetiapine (Seroquel), aripiprazole (Abilify), etc.

10. Antimanic (bipolar) agents: e.g., lithium.

11. Anticonvulsants, used for seizure control or psychiatric diagnoses.

a. Anticonvulsants (except those listed below) which are used for *non-psychiatric* diagnoses, such as migraine, chronic pain, neuropathic pain, and post-herpetic neuralgia, are not intrinsically deployment-limiting as long as treated conditions meet the criteria set forth in this document and accompanying MOD THIRTEEN. No waiver required. Exceptions include:

b. Valproic acid (Depakote, Depakote ER, Depacon, divalproex, etc.).

c. Carbamazepine (Tegretol, Tegretol XR, etc.).

d. Lamotrigine (Lamictal)

12. Varenicline (Chantix).

13. Botulinum toxin (Botox): Current or recent use to control severe pain.

14. Insulin and exenatide (Byetta).

15. Injectable medications of any type, excluding epinephrine (Epipen), though underlying allergy may require separate waiver.

Subject: Force Health Protection (FHP) guidance for deployment in USSOUTHCOM AOR as of 24 APRIL 2019

1. Guidance

1.A. General

1. A. (1) This message provides guidance for deployment health in the USSOUTHCOM (SOUTHCOM) area of responsibility (AOR). It synthesizes and supplements DoD and service-specific deployment health, force health protection (FHP), and/or medical policy/guidance for military and civilian personnel mobilized and/or deployed across the range of military operations. Additional mission or exercise-specific guidance may be issued separately.

1.B. For Purposes Of This Guidance, Deployment Is Defined As:

1.B.(1) Travel to or through the SOUTHCOM AOR, with time in country (boots on ground) for a period of greater than 30 days IAW with Ref C.1.B.(2) Travel to or through the SOUTHCOM AOR, with time in country (boots on ground) for a period of 30 days or less if and when in support of service component training deployments, USSOUTHCOM joint exercise program deployments, contingency deployments, or TDY/TAD travel under austere and/or field conditions.

1.B. (3). Personnel traveling to and/or transiting in the SOUTHCOM AOR for 30 days or less, who are not specifically included in paragraph 1.b. Such as official travelers in TDY/TAD status conducting brief trips in non-austere, non-field settings should seek travel medicine advice/services from their supporting medical treatment facility (MTF) specific to their travel itinerary and tailored to their individual needs. Additionally, personnel must ensure they are medically screened and cleared for travel to SOUTHCOM AOR IAW Applicable Service Policies, the DoD Foreign Clearance Guide and Ref D.

1.C. Permanent Change Of Station (PCS).

1. C. (1) PCS personnel (e.g. security cooperation office personnel and dependents) will coordinate with their respective service component medical personnel and comply with the Individual Medical Readiness (IMR) Guidance in paragraph 2 and Immunization Requirements in paragraph 3.

1.D. Applicability.

1. D. (1) This guidance applies to military personnel, DoD civilians, DoD contractors, and dependents traveling or deploying to the SOUTHCOM AOR. Shipboard operations that are not anticipated to involve operations ashore are exempt from the requirements of this instruction except for recording individual daily deployment locations or when potential health threats indicate actions necessary beyond the scope of shipboard occupational health programs or per the decision of the commander exercising operational control.

4.G. Prescription Medications.

4. G. (1) Ensure personnel deploy with a 90-day supply of any required personal prescription medications. SM deploying to JTF-B must submit prescription to Tricare mail order Pharmacy (TMOP) and have approval for 9 months prior to deployment. Inability to obtain medication via the TMOP requires JTF-B medical commander clearance prior to deployment/assignment.

6.M. Psychological Factors

6.M.(1) Mental health information, to include deployment-related stressors, suicide risk, and traumatic stress should be provided to all personnel prior to and during deployment. All personnel should be aware of deployment-related stress and injuries, their signs/symptoms and how to seek final help for themselves or their buddies to include methods for mental health referral. Personnel should be cognizant of sleep discipline and the impact of alcohol misuse.

6.M.(2) Because of the tremendous loss of life, serious injuries, missing and separated families, and destruction of whole areas often associated with disasters, it is important that personnel involved in relief operations recognize the situation they encounter may be extremely stressful.

6.M.(3) Pre-existing behavioral health problems can be a very significant factor and must be considered in the assignment of individuals to high stress positions.

(a) Narcolepsy without cataplexy.
(b) Recurrent hypersomnia.
(c) Idiopathic hypersomnia.
(d) Hypersomnia due to a medical condition.
(e) Hypersomnia due to drugs or substances.
(3) Narcolepsy with cataplexy requires referral to the DES.

d. Circadian rhythm sleep disorders. These disorders only require a referral to the DES if the condition meets the definition of a disqualifying medical condition or physical defect as in paragraph 3–1.

e. Parasomnias. These disorders are characterized by unwanted movements occurring while the Soldier is asleep and may result in physical injury. If the parasomnia is secondary to a precipitating factor such as a medication side effect, undiagnosed/untreated obstructive sleep apnea or insufficient sleep, and does not reoccur once the medication is stopped, OSA is treated, or adequate sleep is obtained, it does NOT require a referral to DES. All other parasomnias that pose a potential danger to the Soldier require referral to the DES. Parasomnias that require the above evaluation include but are not limited to rapid eye movement sleep behavior disorder.

3–33. Learning, psychiatric, and behavioral health

Diagnostic concepts and terms used in this section are in consonance with the Diagnostic and Statistical Manual of Mental Disorders (DSM–5). The minimum behavioral health evaluation will include evaluation for primary behavioral health disorders and medical conditions by a behavioral health provider which can result in significant symptoms. The causes for referral to the DES are as follows:

a. Disorders with psychotic features. For example, delusions, hallucinations, disorganized thinking or speech, grossly disorganized or abnormal motor behavior, or negative symptoms, not secondary to intoxication, infections, toxic, or other identifiable medical causes resulting in interference with social adjustment or with duty performance.

b. Bipolar and depressive disorders.
(1) Persistence or recurrence of symptoms sufficient to require extended or recurrent hospitalization.
(2) Persistence or recurrence of symptoms that interfere with duty performance and necessitate limitation of duty or duty in a protected environment.
(3) Any history of a manic episode, not secondary to intoxication, infections, toxic, or other identifiable medical causes.

c. Anxiety, obsessive-compulsive, dissociative, somatic symptom and related disorders (excluding factitious disorder), and trauma and stressor related disorders.
(1) Persistence or recurrence of symptoms sufficient to require extended or recurrent hospitalization.
(2) Persistence or recurrence of symptoms that interfere with duty performance and necessitate limitation of duty or duty in a protected environment.

d. Neurocognitive disorders. The causes for referral to the DES include persistence of symptoms or associated personality change sufficient to interfere with the performance of duty or social adjustment.

e. Chronic adjustment disorder. Referral to a DES will occur when the Soldier exhibits persistent or recurring symptoms meeting the criteria detailed in the current edition of the Diagnostic and Statistical Manual for Mental Disorders. These symptoms must be directly caused by exposure to an enduring stressor and must last longer than 6 months. The causes for referral to DES for chronic adjustment disorder are:
(1) Persistence or recurrence of symptoms sufficient to require extended or recurrent hospitalization.
(2) Persistence or recurrence of symptoms that interfere with duty performance and necessitate limitation of duty or duty in a protected environment.

f. Feeding and eating disorders.
(1) Persistence or recurrence of symptoms sufficient to require extended or recurrent hospitalization.
(2) Persistence or recurrence of symptoms that interfere with duty performance and necessitate limitation of duty or duty in a protected environment.

3–34. Tumors and malignancies

The causes for referral to the DES are as follows:

a. Malignant neoplasms that are unresponsive to therapy. Or when therapy is such as to require prolonged, intensive medical supervision, or when the residuals of treatment themselves meet the definition of a disqualifying medical condition or physical defect as in paragraph 3–1.

b. Neoplastic conditions of the lymphoid and blood-forming tissues that are unresponsive to therapy. Or when therapy is such as to require prolonged, intensive medical supervision, or when the residuals of treatment themselves meet the definition of a disqualifying medical condition or physical defect as in paragraph 3–1.

process if the commander wishes to deploy the Soldier. The commander reviews and discusses with the evaluating provider, and can request a CCMD waiver in accordance with the published policy. When the CCMD waiver decision is returned, the originating medical authority indicates the result in e-Profile and expires the temporary profile for the CCMD waiver process. A successful CCMD waiver allows the commander to make the deployability determination for Soldiers who are in MRC 3, DL7 for up to 1 year.

d. Commanders ensure Soldiers are medically ready prior to deployment. During a deployment, the commander assesses changes in a Soldier's deployment status, whether from injuries, worsening of known medical conditions, or the diagnosis of new medical conditions.

3–5. Individual medical readiness categories

Using the eight key elements of IMR and e-Profile information, the medical readiness system of record will indicate the MRC assigned in accordance with paragraph 1–5. This application of the IMR to determine the MRC subsequently supports many personnel actions throughout the Army, from readiness to PCS requirements.

3–6. Disposition of individual medical readiness data

a. MEDPROS is the database of record for all medical readiness data elements. Profiling providers will also document all readiness assessments in the EHR or the service treatment record. The medical readiness system of record and the EHR continue to gain efficiencies of communication and connectivity.

b. All IMR data will be updated in MEDPROS for all Army personnel (all components (COMPOS)), including deploying DA Civilians, regardless of TRICARE enrollment.

c. Healthcare personnel who document IMR services in the EHR (with the exception of immunizations) will update MEDPROS within 72 hours.

3–7. Individual medical readiness goals

See AR 40–502 for the Army's goals. AR 40–502 and current guidance from the Assistant Secretary of Defense, Health Affairs establish the Army IMR goal. There are no published goals for each element of IMR. Reports that provide medically ready statistics, by element, display all personnel who are current or deficient for that element. A Soldier is placed in the order of precedence for the MRCs as follows: MRC 3, then MRC 4, then MRC 2, and finally MRC 1. Personnel may be deficient for more than one element, but will only count once against the unit IMR. For example, Soldier 1 is deficient in three elements and Soldier 2 is deficient in only one element; both deficiencies count against the unit IMR score equally and only once. Soldier 1 needs to correct three items to resolve their IMR deficits and improve unit readiness. Soldier 2 needs to correct one item to become ready and improve the unit readiness.

Chapter 4
Physical Profiles

4–1. General

a. This chapter describes processes for communicating functional abilities, medical instructions and recovery time estimates to commanders, for accurate readiness and duty assignment. The Commander's Portal increases transparency in communication between profiling providers and commanders. Commanders must use the Commander's Portal to track and report personnel deployment status metrics. Standardized, accurate, and clearly worded profiles are critical to inform commanders of both a Soldier's capabilities and functional limitations, such as those outlined in table 4–1. In accordance with AR 40–502, unit commanders may not override duty limitations or instructions on DA Form 3349. Commanders will use these instructions and the functional information about the Soldier in making duty assignments to include deployment determinations. AR 40–501 provides disease-specific profiling requirements for certain medical conditions, to include but not limited to, asthma and coronary artery disease, and establishes the retention standards for medical conditions. Anatomical defects, pathological conditions, prognosis, and the possibility of further aggravation all contribute to the Soldier's ability to perform his or her duty. Profiles must be realistic with specific functional limitations written in lay terms.

b. Determining individual assignments or duties is a commander's decision. Limitations such as "no field duty," or "no overseas duty," are not proper medical recommendations. Administratively, Soldiers in certain deployment-limiting categories will have these constraints (such as pregnant Soldiers and Soldiers pending medical and administrative boarding action). Profiling providers must provide specific information on the Soldier's functional limitations, capabilities, and a description of what the Soldier "can do" to enable assignment or duty determination by the nonmedical commander or U.S. Army Human Resources Command. The profiling provider ensures that complete and accurate administrative information is annotated on the DA Form 3349.

Table 4–1
Profiling comment examples

Profiling comments with specific duty limitations and rationale: generally appropriate	Overly restrictive comments without guidance to a commander: generally inappropriate
Requires eight consecutive hours of sleep in every 24 hour period	SM can only work from 9–5, or Soldier cannot present to work until 1000 hours
Soldier should not be exposed to stimuli suggestive of combat experiences (for example, no simulator training, no ranges, no simulated mortars, no patrol lanes, no IED training, and so forth).	No uniforms
No alcohol	No formations
No weapons or ammunition	No 24-hour duty
Soldier has been referred to the MEB process. No deployments to an austere environment per personnel policy regulations. This Soldier should not be issued an individually assigned military weapon, or attend any live fire drills or ranges. Soldier should remain stationed near an MTF where definitive specialty care is available for timely IDES processing.	

c. The commander or personnel management officer determines proper assignment and duty, based on knowledge of the Soldier's profile, assignment limitations, and the duties of the grade and MOS.

d. The commander has the final decision on the deployment of Soldiers in his or her unit. When health care providers and commanders disagree on the medical readiness status of a Soldier, the decision will be raised to the first O–6 in the Soldier's chain of command, who makes the final decision whether to deploy the Soldier in consultation with the appropriate medical officer. Deployment waivers may be required for certain areas of operation.

4–2. Application

As specified in AR 40–502, the physical profile system applies to members of any COMPO of the U.S. Army throughout their military service, from accession to separation.

4–3. Physical profile serial system

a. The basis for the physical profile serial system is the function of body systems and their relation to military duties. Profiling providers will use permanent profiles to describe and rate the function of the extremities, sensory organs, physical capacity, and mental health according to the system described in the following paragraphs. The analysis of the individual's medical function plays an important role in assignments and welfare of Soldiers. Individual duty limitations can impact other Soldiers and unit mission capability. The profiling providers must execute the functional grading, restrictions, and medical instructions with great care and accuracy. Clear and accurate medical instructions to support the recovery, stable function, and maximal safe employment of Soldiers are essential.

b. The permanent physical profile has six functional areas "P–U–L–H–E–S" with four numerical designations used to reflect different levels of functional capacity, described in the following paragraph and table 4–2. The determination of the numerical designation 1, 2, 3, or 4 evaluates the functional capacity of a particular organ or system of the body.

c. The functional areas for consideration are:

(1) *P – Physical capacity or stamina.* This is general physical capacity and normally includes conditions of the heart; respiratory system; gastrointestinal system and genitourinary system; nervous system; allergic, endocrine, metabolic, and nutritional diseases; diseases of the blood and blood-forming tissues; oral maxillofacial conditions; dental conditions; diseases of the breast, and other organic defects and diseases that do not fall under other specific factors of the system.

(2) *U – Upper extremities.* This is the function and/or diseases of hands, arms, shoulder girdle, and upper spine (cervical and thoracic); as they affect strength, range of motion (ROM), and general efficiency.

(3) *L– Lower extremities.* This is the function and/or diseases of feet, legs, pelvic girdle, lower back musculature, and lower spine (lumbar and sacral) as they affect strength, ROM, and general efficiency.

(4) *H – Hearing and ears.* This is auditory performance.

(5) *E – Eyes.* This is visual acuity and diseases and defects of the eye.

(6) *S – Psychiatric.* This is personality, emotional stability, and psychiatric diseases.

d. There are four numerical designations to describe a Soldier's functional capacity, in each of the six functional areas of the physical profile serial system, applied to the permanent profiles. Guidance for assigning numerical designators is in table 4–2. Soldiers with a numerical designator of 3 or 4 are non-deployable until they have completed the medical or administrative board process described in AR 635–40. The profile serial and physical category codes described in para 4–5 support and document progress through the medical or administrative board processes.

e. All profiles will describe the Soldier's functional limitations whether the condition is just presenting or has a thorough evaluation and has reached the Medical Retention Determination Point (MRDP). The MRDP is reached if a medical condition which has been temporarily profiled has stabilized or cannot be stabilized in a reasonable period of time for up to twelve months and impacts successful performance of duty. Successful performance of duty is defined as the ability to perform basic soldiering skills required by all military personnel (section 4 of DA Form 3349 and passing one aerobic AFPT event) and perform the duties required of his or her MOS, grade, or rank. If after reaching MRDP, and transitioning to a permanent profile, the Soldier does not meet the medical retention standards listed in AR 40–501, then the numerical designator must be a 3 or a 4. Any persistent deployment-limiting condition requires inherently significant duty limitation and indicates a numerical designator of 3 or 4. This clearly communicates the significance of the duty limitations and any known deployment-limiting conditions to the commander. The Soldier's functional limitations identified in e-Profile, the ability to meet retention standards and the numerical designator of the profile (permanent 3 or 4), determines DES initiation (see AR 635–40 for description of the DES). The numerical designators described below are also exemplified in table 4–2.

(1) An individual having a numerical designation of "1" describes a high level of medical fitness, deployable.

(2) A physical profile designator of "2" under any factors indicates some medical condition or physical defect that requires some minor functional or activity limitations, deployable. (Note, a Soldier may meet medical retention standards but require a permanent 3, thus, requiring referral to MAR2 in accordance with AR 635–40).

(3) A profile containing one or more numerical designators of "3" describes one or more medical conditions or physical defects with significant functional or activity limitations and warrant processing through a MAR2 or DES process.

(4) A profile containing one or more numerical designators of "4" describes one or more medical conditions or physical defects with severe limitations of military duty performance, requires a DES board evaluation.

Table 4–2
Physical profile functional capacity guide

Profile Serial	P Physical capacity	U Upper extremities	L Lower extremities	H Hearing–ears	E Vision–eyes	S Psychiatric
Factors to consider	Organic defects, strength, stamina, agility, energy, muscular coordination, function, and similar factors.	Strength, ROM, and general efficiency of upper arm, shoulder girdle, and upper back, including cervical and thoracic vertebrae.	Strength, ROM, and efficiency of feet, legs, lower back to include lumbar, sacral, and pelvic girdle.	Auditory performance	Best corrected visual acuity at distance and organic diseases, defects or injuries of the eyes, eyelids, and/or visual system that affect the visual field and overall visual function.	Type, Severity, and duration of current psychiatric symptoms, disorder, or prognosis. Environmental and individual factors that may affect prognosis for recovery and risk for future decompensation.
1	Good muscular development with ability to perform maximum effort for indefinite periods.	No loss of digits or limitation of motion; no demonstrable abnormality; able to grasp and hold body weight (hanging bar); able to push or pull body weight; able to perform upper body	No loss of digits or limitation of motion; no demonstrable abnormality; able to perform long marches; stand over long periods, run.	Audiometric threshold at 500, 1000, and 2000 Hz not more than 25 dB in better ear AND not more than 30 dB in worse ear; at 3000 Hz not more than 25 dB in better	Distance visual acuity of 20/20, or better, in each eye with or without spectacle lenses AND the absence of any visual functional limitation due to diseases, defects, or injuries.	No current psychiatric disorder. May have a behavioral health disorder in complete remission that requires no duty limitation.

Table 4–2
Physical profile functional capacity guide

Profile	P	U	L	H	E	S
		combative to include grappling and submission holds.		ear AND not more than 35 dB in worse ear; at 4000 Hz not more than 25 dB in better ear AND not more than 45 dB in worse ear; at 6000 Hz not more than 60 dB in better ear. The better or worse ear is determined for each frequency and may not be the same at all frequencies.		
2	Able to perform maximum effort over long periods of time but may require shaving restriction, the use of daily medication such as for hypertension or asthma but remains fully deployable without deployment restrictive administrative codes.	Minimal limitations that may have slight joint mobility limitations, muscle weakness or skeletal defects that do not prevent combatives (excluding grappling and submission holds). PRT climbing drills and prolonged effort.	Minimal limitations that may have slight joint mobility limitations, muscle weakness or skeletal defects that do not prevent Marching up to 2 miles with full IOTV and 5 miles in standard uniform, APFT timed walk, ability to bike 3 miles and swim up to 300 meters, running at own pace and distance or prolonged effort.	Audiometric thresholds in both ears not more than 40 dB at 500 Hz, 40 dB at 1000 Hz, and 60 dB at 2000 Hz AND audiometric thresholds in at least one ear not more than 25 dB at 500 Hz, 30 dB at 1000 Hz, 25 dB at 2000 Hz, 40 dB at 3000 Hz, 60 dB at 4000 Hz, and 70 dB at 6000 Hz OR meets MOHT battery H2 criteria.	Best corrected distance visual acuity OR the presence of organic diseases, defects, or injuries with mild visual functional limitations that may require non-standard spectacles (tinted lenses, prism, and so forth) or workplace accommodations.	Mild, residual symptoms of a behavioral health disorder responding to outpatient treatment. Minimal risk of decompensating without continuous behavioral health support. Stable on medications without impairing side effects.
3	Unable to perform full effort for more than 15 minutes without rest.	Defects or impairments that require significant restriction of use but able to lift, push, or pull up to 40 lbs.	Defects or impairments that require no running, inability to stand over 30 minutes but able to perform the APFT bike or swim.	Exceeds H2 audiometric threshold criteria AND meets MOHT battery H3 criteria.	Best corrected distance visual acuity of 20/40 in the better-seeing eye that requires the use of optical devices other than spectacle lenses	Active behavioral health disorder that limits mission capability and/or social/ occupational functioning. Recent need for inpatient or intensive outpatient

Table 4–2
Physical profile functional capacity guide

Profile	P	U	L	H	E	S
					OR the presence of organic diseases, defects, or injuries that result in moderate visual functional limitations	treatment. Impairing side effects or significant lab monitoring requirements from medications for behavioral health disorders.
4	Functional level below P3.	Functional level below U3.	Functional level below L3.	Functional level below H3 as determined by exceeding H2 audiometric threshold criteria AND meets MOHT battery H4 criteria.	Functional level below E3.	Chronic psychiatric symptoms that drastically limit the performance of military duties.

4–4. Temporary vs. permanent profiles

There are many electronic requirements for recording profiles. As designated in AR 40–502, profiling provider must complete all profiles for medical conditions lasting greater than 3 days, both temporary and permanent, in e-Profile. The DA Form 689 (Individual Sick Slip) may be used only once for a medical condition limited to acute, minor, self-limited illnesses requiring only 1 to a maximum of 7 days of recovery. DA Form 689 may also be used to write out medical instructions for Service members from other Services, to communicate back to other commanders. Any residual duty limitations and all conditions with functional limitations clinically expected to extend beyond 7 days must be recorded on a temporary profile in accordance with AR 40–502. Profiling for the full expected duration of the condition is essential to the integrity and transparency of the readiness system. This ensures adequate communication with the commander and appropriate duty expectation for the Soldier. Temporary profiles are not associated with a PULHES or the physical function capacity; rather they are assessed by duration only. To prevent unnecessary restrictions for predictable conditions, progressive medical instructions may be written, or the profile can be modified during re-evaluation and progress in care. Additionally, to ensure maximal Soldier participation and readiness, health care providers should support duty assignments and expectations with positive profiling that clearly indicates what necessary Soldier functions a Soldier can perform. No profile will be printed without having been created in the e-Profile electronic application. Leaders accept only valid profiles created and completed within e-Profile.

a. e-Profile is an application in MODS with connectivity to the EHR. Interface capabilities will change over time, and the process will become more seamless with further integration between the EHR and the medical readiness system. Access to e-Profile is role-based. Authorized users can always access the e-Profile application at: www.mods.army.mil and then linking to e-Profile. Commanders and their designees view e-Profile information in the Commander's Portal and are no longer authorized to access e-Profile directly.

b. The DA Form 3349 consolidates all of the Soldier's permanent and temporary duty limiting conditions on a single form.

(1) Section 1 is the Soldier information.

(2) Section 2 is the permanent conditions with physical profile serial and any applicable profile codes. The profiling provider and approval authority electronically sign in the designated blocks at the end of each reason for profile.

(3) Section 3 is the active temporary conditions for a profile. Temporary conditions are described by the severity, mechanism of injury, duty status, and expiration date. The days on profile updates automatically in the system even after the document are signed. When reviewing a printed profile, the "days on profile" is static, and it becomes important to consider the date the profile was printed. Each reason for profile has the electronic signature of the profiling provider on the same line. Profiling providers will describe when a Soldier will be eligible for a record APFT for both temporary and permanent conditions. This clinical decision and clearance for activity, which may be up to twice the length of the profile and may

not exceed 90 days, will determine when a Soldier is authorized to take a record APFT. There is no mandatory recovery period. For example, if a medication requires a profile by policy with no limitations on their ability to do an APFT, the Soldier would be available for a record APFT throughout the profile, and no recovery period should be authorized. This section also captures the number of days a Soldier has been on a profile within a 12- and 24-month period.

(4) Sections 4–7 describe the medical instructions, limitations, and PT guidance. All aspects that are permanent are in bold type in the form.

(a) Section 4 is the functional activities for all Soldiers, regardless of MOS and AOC. Any permanent limitation in these functional activities indicates severe limitations and requires the condition to have a numerical designation of 3 or 4. This will initiate Soldier referral to the appropriate medical or administrative board.

(b) Section 5 contains the medical instructions. These instructions cannot be ignored. Temporary instructions will be in plain type, and permanent instructions will be in bold type.

(c) Section 6 describes any permanent or temporary APFT limitations. To complete the APFT a Soldier must complete the 2-mile run or an alternate aerobic event. If a Soldier permanently cannot perform at least an alternate aerobic event, the profile serial will have a 3 in the appropriate PULHES designator, and the Soldier will be referred to the MEB.

(d) Section 7 describes the physical readiness training capabilities. Healthcare providers will describe authorized alternate PT events from a medical perspective, for temporary and permanent conditions. For permanent conditions, a Soldier cannot perform at least an alternate aerobic event, the profile serial will have a permanent 3 in the appropriate PULHES designator. The templates will help guide the implementation of FM 7–22 in this section.

(e) Section 8 is the commander's signature block. This will automatically populate with the commander's signature when they view the profile in the Commander's Portal application.

c. Temporary profiles. Indications for a temporary profile are conditions with limitations that will improve over time. Correction or treatment of temporary conditions is medically advisable, and should usually result in a higher level of function and employment. Profiling providers manage Soldiers receiving medical or surgical care, recovering from illness, injury, or surgery by designating a temporary condition on the Soldier's DA Form 3349. The addition of the limitations to any previously existing temporary or permanent limitations in the e-Profile system will provide the commander a single source for the Soldier's medical instructions and duty limitations.

(1) Duration: The profiling provider will write the profile for the entire length of the expected recovery up to 90 days (except as directed in paras 4–8*d* (tuberculosis) and 4–9 (pregnancy)). The profiling provider will extend and modify the profile for the temporary condition, to communicate with the command, until the Soldier reaches the point in their evaluation, recovery, or rehabilitation where they have returned to full duty or the profiling provider determines that the Soldier has achieved the MRDP. MRDP may occur before the 12-month administrative timeline if the condition is stable and no further functional progress is expected. At MRDP, the profiling provider will transition any remaining duty limitations to a permanent profile. All permanent profiles require two profiling provider signatures. The second signature will need to be a physician, or for profiles within their area of expertise, an audiologist or podiatrist are second signature authorities for profiles without deployment limitations. If the profile has deployment limitations, either a 3 or 4 in the PULHES or a deployment-limiting physical-category code, the second signature must be an approval authority. The maximum duration of temporary profiles is 12 months for the same medical condition without an exception, as described in paragraph 4–4*c*(4) below. At 12 months, the Soldier is administratively defined to have reached MRDP. Profiling providers need to ensure that extensions link to the original profile. Extensions will continue to contribute to the days on profile for that condition. Creating new temporary conditions without linking them to the previous temporary profile will disrupt the tracking system for the days on profile for that condition and can compromise the accuracy of the days on profile, or delay a Soldier's progress toward MRDP. This loss of transparency impedes a commander's ability to manage their formations and undermines the readiness of the Army. All Soldiers with a temporary profile will have an updated functional assessment with medical instructions at least every 3 months and prior to extending the profile.

(2) Temporary profiles exceeding 6 months' duration, for the same medical condition, will be referred to a physician or medical specialist if clinically indicated, for that medical condition, or as required by policy. Specific conditions in AR 40–501 require specialty evaluation to determine if the Soldier meets retention standards. These referrals ensure the optimal care and support to help the Soldier return to duty, or ensure documentation of the injury or illness that supports the medical or administrative board process. Reviewing physicians or specialty health care providers will consider one of the following actions:

(a) Continuation of a temporary profile, for the same medical condition or injury, up to a maximum of 12 months from the initial profile start date;

(b) If the condition has reached MRDP, transition to a permanent profile;

(c) Determination of whether the Soldier meets the medical fitness standards for retention in accordance with AR 40–501 and, if not, refer to the DES. Once MRDP is met for one condition which does not meet retention standards, referral into the DES must commence regardless of the status of other co-existing conditions. If MRDP is met, and the Soldier

meets the medical retention standards of AR 40–501, the permanent profile must address the requirements of the MOS or AOC and may indicate referral to an administrative board in accordance with AR 635–40.

(3) Prolonged Soldier review: There are higher authority reviews for profiles lasting over 120 days. Profiles over 120 days in duration will be reviewed by operational profile review boards, above company level, every month. Commanders above the company level will use the Commander's Portal to perform a monthly review of all temporary profiles as noted below:

(a) Battalion and squadron (O–5 or equivalent) commanders will perform a monthly review of temporary profiles lasting 120 days or more.

(b) Brigade commanders (O–6 or equivalent) will perform a monthly review of temporary profiles lasting 180 days or more.

(c) Senior general officer commanders (above BDE, installation level, or equivalent) will perform a review of temporary profiles 240 days or older.

(4) Temporary profiles for conditions with duty limitations beyond 12 months are usually converted to permanent profiles. For all Soldiers, the application of the second signature for a permanent profile that does not meet retention standards initiates the requirement for DES or appropriate processing. For Active duty Soldiers whose condition does not meet retention standards, the second signature on the permanent profile also initiates the DES timeline. For the Reserve COMPOs 2 and 3, the receipt of the MEB packet at the Medical Evaluation Board Tracking Office initiates the timeline for the DES and the RC non-duty related (RC–NDR) process. Requests for exceptions are very rare because the 12-month limit for temporary profiles to reach MRDP ensures timely access to DES and RC–NDR processes, ensures consistent application of the standards, and supports Army readiness. Exceptions to the 12-month, temporary physical profile restriction must be approved by the first general officer in the Soldier's chain of command, in consultation with the senior approval authority and the senior medical officer. Requests for exceptions to the 12-month temporary profile restriction must include:

(a) A detailed written treatment plan: who, what, when, where, and how.

(b) An explanation of why the Soldier has not been referred to the DES or administrative review board.

(c) An expected MRDP.

(5) Providers who see Soldiers (officer and enlisted) in basic training, and MOS- and AOC-specific training may utilize the initial military training (IMT) templates in e-Profile to prescribe clear and concise medical recommendations to the Basic Combat Training (BCT) and Advanced Individualized Training (AIT) commanders and their drill sergeants, regarding the injured Soldier's training.

d. DD Form 689.

(1) The DD Form 689 is a means of communication, management, and disposition of short term (1 to 7 days) acute, minor, self-limited illnesses and medical conditions that are expected to resolve quickly and do not limit the functional capabilities of the Soldier beyond 7 days.

(2) The concepts from the IMT sick slip (established by OTSG/MEDCOM Policy Memo 11–095, now expired) were instrumental in the design of the new profile form to capture what the Soldier can do to train and avoid excessive limitation while protecting the Soldier to allow healing and return to full duty. The staff that provides care for BCT and AIT Soldier population will complete their profile training and utilize the IMT templates instead of the legacy IMT sick slips.

(3) See AR 40–66 for instructions on completing the "Disposition of patient" block on the form.

(4) Functional limitations expected to be greater than 3 days will be entered into e-Profile as a temporary profile, by a profiling provider, for the commander's medical readiness accountability and tracking.

e. Permanent profiles. Soldiers whose condition(s) have reached MRDP will receive a permanent profile. All permanent profiles require two profiling provider signatures; paragraph 4–6 authorizes specific roles to be the second signature. If the profile has deployment impacts either with a 3 or 4 in the PULHES or a deployment-limiting physical-category code, the second signature must be an approval authority. Some diagnoses do not meet retention standards by definition and will be referred to DES upon diagnosis, in accordance with AR 40–501.

(1) The profiling provider must evaluate whether or not the Soldier meets the medical retention standards in accordance with AR 40–501. A comprehensive review the Soldiers medical records, to include consultation notes and other pertinent medical documentation is essential to ensure that the Soldier's medical condition and treatment meet MRDP requirements. The numerical designator will describe the severity of the functional limitation and will guide further processing. Permanent profiles are reviewed annually with each PHA and will be updated to reflect any clinical change. There is no requirement to rewrite the profiles every 5 years.

(2) The MEB physician or RC approving authority reviews all MEB referrals from e-Profile prior to signing as the approval authority and second signature:

(a) To ensure that MRDP has been achieved prior to initiating referral into the DES.

(b) To coordinate inappropriate DES referrals, via e-Profile, back through the profiling provider for appropriate disposition.

(c) To assist physician approving authorities in reconciling profiling provider's questions and concerns about MRDP timing.

(d) To help discern MAR2 versus DES referrals.

(3) Medical and administrative processes once a Soldier reaches MRDP and does not meet medical retention standards.

(a) Duty related processes through one of the three forms of DES: legacy DES, IDES, or expedited DES.

(b) Non-duty related physical evaluation board (ND–PEB) processing is for the reserve COMPOs only. Soldiers who do not meet retention standards due to a non-duty related condition may request non-duty processing to determine if they may be retained and continue to serve.

(c) Administrative processing for Reserve COMPO Soldiers with non-duty related conditions proceeds when the Soldier does not request a ND–PEB.

(4) Medical and administrative processes once a Soldier reaches MRDP and meets medical retention standards.

(a) Transition to a permanent profile describing the permanent duty limitations. The Soldier's commander may also discuss a permanent profile, with the profiling provider, request a review of an established permanent profile, and/or initiate a fitness for duty request to clarify any duty performance observations or deployment status concerns. Specific guidance regarding profiling Soldiers with pseudo folliculitis is available in TB MED 287.

(b) The MAR2 is an administrative process to evaluate the Soldier's ability to serve in their MOS. Outcomes from the MAR2 are to retain the Soldier in their MOS, reclassify them to another MOS, or refer the Soldier for DES processing in accordance with AR 635–40.

4–5. Physical category codes

The physical category codes indicate limitations in personnel and administrative matters and are used in numerous Army systems. The current physical category codes described in tables 4–3 and 4–4 describe a history of an accession waiver, assignment, and deployment limitations, or the completion of medical board or administrative processing. Previously there were medically descriptive codes, but in accordance with AR 40–502, these are rescinded, and the profiling provider will describe these limitations in plain language on the profile to inform the commander's duty assignments and deployment determinations. The profiling provider may record up to three physical category codes on the DA Form 3349, in section 2, block 12. In the unlikely event that more than three codes are necessary, the additional codes will present in section 5, preceding any other medical instructions to the commander. These codes are administrative in nature and are not authorized for use in medical records to identify limitations.

Table 4–3
Physical category codes (deployment options)

Code	Description or assignment limitation	Medical criteria (examples)
Code F	No assignment or deployment to OCONUS areas where definitive medical care for the Soldier's medical condition is not available.	Individuals who require continued medical supervision with hospitalization or frequent outpatient visits for serious illness or injury.
Code V	This code identifies a Soldier with deployment restrictions to certain areas.	Explanations of condition(s) and specific restrictions are noted in the medical record.
Code X	This Soldier is allowed to continue in the military service with a disease, injury, or medical defect that is below medical retention standards, pursuant to a waiver of an unfit finding and continued on active duty or in active reserve status under AR 635–40.	

Table 4–4
Physical category codes (post board options)

Code	Description/assignment limitation
Code S	Soldier has been determined to meet medical retention standards of chapter 3 by a Medical Evaluation Board (MEB)
Code T	Waiver granted for a disqualifying medical condition, or standard, for initial enlistment or appointment. The disqualifying medical condition, or standard, for which a waiver was granted will be documented in the Soldier's accession medical examination
Code W	This Soldier has a permanent 3 or 4 profile that has been evaluated by a MAR2 with a recommendation to retain or reclassify and return to duty.
Code Y	This Soldier has been found fit for duty through the disability evaluation system (DES) (not entitled to separation or retirement because of physical disability) after complete processing under AR 635–40.

4–6. Profiling provider and approving authority

a. Profiling providers. Commanders of Army MTFs, USARC surgeons, regional support command surgeons, and the State surgeons may designate one or more physicians, dentists, optometrists, podiatrists, audiologists, chiropractors, nurse practitioners, nurse midwives, licensed clinical psychologists, licensed clinical social workers (master's level), and physician assistants (PA) as credentialed profiling providers. The commander ensures the designated profiling providers are thoroughly familiar with the contents of AR 40–502, AR 40–501, AR 635–40, and DA Pam 40–502. Profiling providers will attain and maintain profiling credentials within their scope of practice. Designating authorities will develop and institute a peer review quality assurance process for profiling providers. Profiling providers will not write temporary or permanent profiles for themselves. All permanent profiles require two profiling provider signatures. If the profile impacts deployment status with either a 3 or 4 in the PULHES, or a deployment-limiting physical-category code, the second signature must be an approval authority. Profiling provider limitations are as follows:

(1) *Physicians.* No limitations except for temporary profiles that exceed 6 months when there is a clinical indication for specialty evaluation or care. Physicians may provide second signature authority for profiles with permanent profiles with a 2 in the PULHES that do not impact deployment status. Approval authorities are required to be the second signature for permanent profiles with a 3 or 4 in the PULHES or those that assign a deployment-limiting physical-category code.

(2) *Dentists.* Dentists are specialty health care providers with no limitations within their field. Dentists will write temporary profiles for dental and oral medical conditions. Dentists may be the first signature authority on a permanent 2, 3, or 4 profiles and the second signature on permanent MRC 2 profiles without a deployment-limiting physical-category code. If a temporary dental profile is created through a system interface, it will remain active until the Soldier's dental classification changes in the medical readiness and profiling systems of record. Permanent and temporary profiles need to inform the commander's deployability determinations. Dentists have no profiling authority outside their field.

(3) *Optometrists.* No limitation within their specialty for awarding temporary profiles up to 90 days' duration. Any temporary extension beyond 90 days must be reviewed by a physician. Optometrists have no profiling authority outside their field.

(4) *Chiropractors.* No limitation within their specialty for awarding temporary profiles up to 90 days' duration. Any temporary extension beyond 90 days must be reviewed by a physician. Chiropractors have no profiling authority outside their field.

(5) *Physical therapists, occupational therapists, licensed clinical psychologists, and licensed clinical social workers.* No limitation within their specialty for awarding temporary profiles up to 90 days' duration. Any temporary extension beyond 90 days must be reviewed by a physician. Physical therapists and occupational therapists, licensed clinical psychologists, and licensed clinical social workers may initiate a permanent profile.

(6) *Audiologists.* No limitation within their specialty for awarding temporary profiles and permanent profiles in cases of sensorineural hearing loss. Physicians and audiologists can serve as the second signature on a permanent profile with an H–2 within their specialty. Any profile that assigns deployment-limiting physical-category codes must have an approval authority as the second signature. Changing to or from a permanent numerical designator "3" or "4", adding, or removing a deployment-limiting code requires an approval authority for the second signature. Audiologists have no profiling authority outside their field.

(7) *Physician assistants, nurse midwives, and nurse practitioners.* Any extension of a temporary profile beyond 180 days must be reviewed by a physician, except when the provisions of paragraph 4–9 apply. However PAs with AOC 65DM1, certified in orthopedics, have no limitations on awarding temporary orthopedic profiles or permanent profiles.

PAs, nurse midwives, and nurse practitioners may initiate permanent profiles for submission to a physician profiling provider, or the approving authority, for second signature.

(8) *Podiatrists.* No limitation within their specialty for awarding temporary and permanent profiles. Physicians and podiatrists can serve as the second signature on a permanent 2 without a deployment-limiting physical-category code within their specialty. Changing to or from a permanent numerical designator 3 or 4, or adding or removing a deployment-limiting physical-category code requires an approval authority second signature. Podiatrists have no profiling authority outside their field.

(9) *Athletic trainers.* Athletic trainers are not profiling providers, but in command-specified settings will have limited profiling authority, under the supervision of their physician or physical therapist. Athletic trainers may award short term, temporary profiles up to 7 days' in duration. They may make a one-time extension of the profile for 7 additional days. A profiling provider will complete any profiling beyond 14 days (total). Significant illnesses or injuries that are not expected to heal in this period should be referred to the appropriate health care provider to prevent any delay in care. All profiling by athletic trainers will be constrained to designated templates for the musculoskeletal system. Athletic trainers may generate temporary profiles for upper and lower extremities for mild and moderate severity.

(10) *Military Entrance Processing Station physicians, PAs, and nurse practitioners.* MEPS physicians, Pas, and nurse practitioners will be designated as profiling providers. The profiling provider must generate the profile electronically, in e-Profile.

(11) *Other Department of Defense physicians.* A physician from another Service can be a profiling provider, upon completing required training. The profiling provider must generate the profile electronically, in e-Profile. Other methods of communicating capabilities and limitations will be received as clinical input, pending the review, and to inform a valid profile from a profiling provider.

(12) *TRICARE Prime Remote profiling providers.* The RHRP profiling officials may generate profiles in accordance with contractual guidance from the supported component and Army policy. The profiling provider must generate the profile electronically, in e-Profile and ensure clinical coordination as directed by the supported component. RHRP will provide the regional health commands with a referral list of Soldiers requiring further evaluation or care coordination for active duty Soldiers.

b. Approving authority. Army MTF commanders, USARC surgeons, and the State surgeons may designate or delegate one or more physicians as approving authorities serving within their command. They ensure that the designated approval authorities are thoroughly familiar with AR 40–502, AR 40–501, AR 635–40 and DA Pam 40–502. The approving authority must be a physician. Generally, the chief medical officer or deputy commander for medical services, as appointed by the MTF commander, serves as the senior approving authority by position. Army Reserve Regional Support Command (RSC) surgeons are approval authorities by position, but cannot designate other approval authorities. All permanent profiles require two profiling provider signatures. If the profile has a 3 or 4 in the PULHES or assigns a deployment-limiting physical-category code, the second signature must be an approval authority. If the approval authority determines that a permanent 2 profile with a deployment-limiting physical-category code should be a permanent 3 profile, they should return the profile to the original profiling provider for adjustment and to initiate MEB processing in accordance with their standard procedures.

4–7. Recording and reporting of an accession physical profile

a. Individuals accepted for initial appointment, enlistment, or induction normally will be given a numerical designator of 1 or 2. The initial numerical designator will be recorded on DD Form 2808 (Report of Medical Examination) by the MEPS medical officer, at the time of the initial appointment, enlistment, or induction medical examination. The numerical designators assigned by a MEPS physician are for MEPS administrative purposes only and do not represent a "profile" as defined in accordance with this regulation.

b. The accession documentation will identify the initial numerical designator serial (DD Form 2808 and DD Form 1966 (Record of Military Processing—Armed Forces of the United States)). The modifier "T" with a brief, nontechnical description of the defect on the serial, or in those exceptional cases where the numerical designator "3" is used on initial examination, is recorded in the "Summary of Defects" section on the DD Form 2808, in addition to the exact diagnosis. It is the practice for the MEPS to assign a numerical designator "3" pending a medical waiver review of a disqualifying condition. This initial PULHES numerical designator is for MEPS administrative purposes only. It is NOT a PULHES from a DA Form 3349 in e-Profile. If the individual receives a medical waiver, the waiver documentation completed by the waiver authority should indicate the appropriate PULHES, in accordance with table 4–1. If the applicant enters the Army with any documented functional limitations or any numerical designator other than a 1 on the DD Form 2808, a DA Form 3349 in e-Profile must be completed at initial entry training.

4–8. Profiling reviews and approvals

a. Permanent "3" or "4" profiles, or profiles with a deployment-limiting physical-category code require the signatures of a profiling provider, and a physician approving authority, unless specified by policy. Permanent profiles of "3" or "4" for the IRR require two signatures to include the Army Human Resources Command Surgeon, or his or her designee. Temporary profiles require the signature of an authorized profiling provider. Permanent profiles with a PULHES of "2" without a deployment-limiting code require the initial signature of one profiling provider and the second signature of an approved profiling provider authorized in paragraph 4–6.

b. Situations that require a mandatory review of an existing physical profile include—

(1) Return to duty of a previously hospitalized Soldier. The attending physician will ensure that the patient has the correct e-Profile, assignment limitations(s), and medical follow-up instructions, as appropriate.

(2) Placing a Soldier on convalescent leave. The attending physician or component profiling provider, ensures that the patient has a profile entered into e-Profile, functional limitations(s), and medical follow-up instructions, as appropriate.

(3) When directed by the approving authority in cases of discrepancy or controversial nature requiring temporary revision of profile.

(4) At the time of the PHA or other medical examination.

(5) Upon request of the unit commander.

(6) Upon request of a PEB.

(7) A profiling provider and approving authority signatures are necessary to either change a permanent "3" or "4" profile to a permanent "1" or "2" or remove a deployment-limiting physical-category code.

(8) A change in the Soldier's health that impacts his or her basic Soldier function and ability to perform their duty.

c. The profiling provider adds a temporary condition for a Soldier in e-Profile when, in their opinion, the functional limitations or capacity of the individual temporarily alters their ability to perform their duty. Temporary e-Profiles will not exceed 3 months (90 days) except as provided for in paragraphs 4–8*d* and 4–9. Temporary functional limitations limited to acute, minor, and self-limited illnesses written on DA Form 689 will not exceed 3 days. The utilization of e-Profile for acute conditions lasting for 3–7 days supports the tracking, medical support, and communication with commands regarding the recovery of their Soldiers.

d. Tuberculosis patients returned to a duty status that requires anti-tuberculosis chemotherapy, following hospitalization, will be given a temporary profile for 1 year. The medical instructions will include assignment limitations to a fixed installation for the required medical care, support, and supervision for 1 year.

e. The hospital commander, appropriate clinical deputy, or command surgeon may verify or revise the physical profile in controversial or equivocal cases.

f. Reserve COMPO reviews and approvals are as follows. The U.S. Army Reserve Regional Support Command surgeons, major subordinate commands staff surgeons, Active Army medical facility profiling providers, State Army National Guard (ARNG) and USAR contracted profiling providers, the U.S. Army Reserve Command (USARC) Surgeon, and the U.S. Army Human Resources Command Surgeon, or their designees (IRR only), may accomplish physical profiles for Reserve COMPO Soldiers not on active duty and for those Soldiers activated on orders for less than 30 days in the Ready Reserve (ARNG/USAR), Standby Reserve (USAR), and Retired Reserve (USAR).

(1) Army Reserve profile providers will accomplish profiles for Army Reserve Soldiers, in accordance with USARC surgeon policy and procedures. The approving authority for the Army Reserve to include troop program unit (TPU) Soldiers is the USARC command surgeon and the RSC surgeons. The USARC command surgeon may delegate profile approving authorities to the operational, functional, training, and support command surgeons, and other physicians, depending on their current duty position and the need for additional approving authorities.

(2) State ARNG/Army National Guard of the United States (ARNGUS) profile providers will accomplish profiles for ARNG/ARNGUS Soldiers not on active duty in accordance with State policy. The respective State Surgeon, or their designated physician alternate, is the approving authority for permanent "3" or "4" profiles. The National Guard Bureau (NGB) Chief Surgeon is an ARNG approving authority for all ARNG/ARNGUS Soldiers. The State surgeons establish processes for awarding profiles to Soldiers with the W, V, and/or F codes, if warranted.

g. The Army Physical Disability Agency identifies Soldiers who are found unfit by a PEB but approved or COAD or COAR status with an "X" code.

h. When Soldiers are returned to duty pursuant to a PEB finding of "fit" in accordance with AR 635–40, the Army Physical Disability Agency applies the Y physical category code. The Army Physical Disability Agency submits the case file to the MEB physician to review and update the profile—to include but not limited to—adding or removing deployment-limiting physical category codes. MEB providers either determine that residual limitations warrant a permanent 2 profile, or retain the 3. Additionally, the MEB providers apply any appropriate deployment-limiting physical-category code. For ND–PEB "fit" determinations, the Army Physical Disability Agency applies the Y physical category code and return to the originating approval authority. The originating approval authority either determines that residual limitations warrant a

permanent 2 profile, or retain the 3 status. Additionally, the originating approval authority applies any appropriate deployment-limiting physical-category code. This is to ensure the returning Soldier receives a physical profile commensurate with their functional capacity under the appropriate PULHES factor. The modified profile includes assignment limitations and specific medical instructions determined in the medical board process.

i. MEB physicians, when completing the narrative summary, ensure a full record of all functional limitations is on the DA Form 3349, in e-Profile. The MEB proceeding referring the Soldier to a PEB submits the consolidated DA Form 3349. On that form, the MEB physician may be the profiling provider (1st signature). Cooperation between the MEB physician, PEB liaison officers, and the PEB is essential to support when the PEB requests additional medical information or profile reconsideration by the MTF. The functional limitations described on the profile form may affect the decision of fitness by the PEB.

j. When a MAR2 is complete:

(1) Regular Army. U.S. Army Human Resources Command applies the W code for retained and reclassified Soldiers returning to duty. At completion of the administrative review, the Soldier's primary-care health care provider determines if the Soldier has any deployment-limiting conditions, and applies a V or F physical category code as indicated.

(2) ARNG/ARNGUS: The State surgeons establish policies and processes for awarding profiles to Soldiers with the W, V, and/or F codes, if warranted.

(3) The USARC Surgeon establishes policies and processes for awarding profiles to Soldiers with the W, V, and/or F codes if warranted.

k. Commanders review all DA Form 3349s in e-Profile on their assigned and attached Soldiers. The Commander's Portal supports the commander by presenting this information in a single consolidated location.

4–9. Profiling Soldiers who are pregnant

a. Intent. The intent of these provisions is to protect the health of the Soldier and fetus while ensuring productive use of the Soldier. The commander ensures a viable program, in consultation with the Soldier and the provider. This profile guidance has been revised and includes: mandating an occupational health interview to assess risks to the Soldier and fetus; adding additional restrictions to reduce exposure to solvents, lead, and fuels that may be associated with adverse pregnancy outcomes; and authorizing the wearing of non-permethrin treated uniforms for Soldiers who are pregnant and or postpartum. After a review of the risks and benefits of permethrin treatment and that non-permethrin treated uniforms are limited to the garrison environment, the health care team may provide medical authorization for issue of non-permethrin treated uniforms. The Soldier brings this documentation to the commander who provides the paperwork to order the requested uniforms at clothing and sales.

b. Responsibilities.

(1) *Soldier.* Soldiers trying to get pregnant should seek appropriate pre-natal care. They may also request medical authorization to obtain and wear permethrin-free uniforms. Pregnant Soldiers seek medical confirmation of pregnancy and comply with the instructions of medical personnel and the individual's unit commander.

(2) *Medical personnel.*

(a) The health care team reviews the risks and benefits of permethrin treatment and may provide medical authorization for the command to issue non-permethrin treated uniforms when a Soldier intends to get pregnant. The request to wear a non-permethrin uniform is not a condition for profile, and the medical authorization is strictly administrative. Non-permethrin treated uniforms are limited to the garrison environment.

(b) For pregnant Soldiers, a credentialed health care provider (physician, nurse midwife, nurse practitioner, or PA) confirms pregnancy and, once confirmed, initiate prenatal care of the Soldier and issue a pregnancy profile by using the pregnancy profile template in e-Profile. Nurse midwives, nurse practitioners, and PAs are authorized to issue routine or standard pregnancy e-Profiles for the duration of the pregnancy. An occupational history, using DD Form 2807–1 (Report of Medical History), is taken at the first visit to assess potential exposures related to the Soldier's specific MOS. This history is ideally taken by the occupational medicine physician, occupational health PA, or occupational health nurse. However, if not feasible, the profiling provider completes the occupational history. After reviewing the occupational history, the profiling provider (physician, nurse midwife, nurse practitioner, or PA), in conjunction with the occupational health clinic as needed, determines whether any additional occupational exposures, other than those indicated in the paragraphs below, should be avoided for the remainder of the pregnancy. Examples include, but are not limited to, hazardous chemicals, ionizing radiation, and excessive vibration. If the occupational history or industrial hygiene sampling (that is, motor pool) data indicate significant exposure to physical, chemical, or biological hazards, then the e-Profile is rewritten to restrict exposure from these workplace hazards.

(3) *Unit commander.* The commander counsels all female Soldiers as required by AR 600–8–24, or AR 635–200. The unit commander consults with medical personnel as required. This includes establishing liaison with the occupational

health clinic and requesting site visits by the occupational health and industrial hygiene personnel, if necessary, to assess any work place hazards.

c. Physical profiles. Pregnancy profiles stand for the duration of the pregnancy (use the pregnancy profile template in e-Profile). Pregnancy profiles list the diagnosis as "pregnancy, estimated delivery date"; prenatal ultrasounds or other testing are not required to validate an estimated delivery date for the profile. The unit commander reviews the profile in e-Profile. Upon completion of pregnancy, the profiling provider describes the Soldier's duty limitations in a new profile.

d. Limitations. Unless superseded by an occupational health assessment, the standard pregnancy profile, DA Form 3349, indicates the following limitations:

(1) Except under unusual circumstances, the Soldier should not be reassigned to overseas commands until pregnancy is complete. (See AR 614–30 for waiver provisions and for criteria curtailing outside the continental United States (OCONUS) tours.) She may be assigned within CONUS. Medical clearance must be obtained prior to any reassignment.

(2) The Soldier will not receive an assignment to duties where nausea, easy fatigue, or sudden lightheadedness would be hazardous to her, or others, to include all aviation duty, classes 1, 2, 3, or 4. However, there are specific provisions in the medical fitness standards for flying duty of AR 40–501 that allow the aircrew member to request, and be permitted, to remain on flight status as further described in the aeromedical policy letters. Air traffic control (ATC) personnel may continue ATC duties with approval of the flight surgeon, obstetrician, and ATC supervisor.

(3) Restrict exposures to military fuels. Pregnant Soldiers must be restricted from assignments involving frequent or routine exposures to fuel vapors or skin exposure to spilled fuel such as fuel handling, or otherwise filling military vehicles with fuels such as motor gasoline, JP8, and JP4.

(4) No weapons training in indoor firing ranges is allowed, due to airborne lead concentrations and bore gas emissions. Firing of weapons is permitted at outdoor sites. (See para (13) below, for other weapons training restrictions.) No exposure to organic solvent vapors above permissible levels. (For example, work in arms room is permitted if solvents are restricted to 1999 MIL–PRF–680, degreasing solvent.)

(5) No work in the motor pool involving painting, welding, soldering, grinding, and sanding on metal, parts washing, or other duties where the Soldier is routinely exposed to carbon monoxide, diesel exhaust, hazardous chemicals, paints, organic solvent vapors, or metal dusts and fumes (for example, motor vehicle mechanics). It does not apply to pregnant Soldiers who perform preventive maintenance checks and services (PMCS) on military vehicles using impermeable gloves and coveralls, nor does it apply to Soldiers who do work in areas adjacent to the motor pool bay (for example, administrative offices) if the work site is adequately ventilated, and industrial hygiene sampling shows carbon monoxide, benzene, organic solvent vapors, metal dusts and fumes do not pose a hazard to pregnant Soldiers. (See para (13), below, for PMCS restrictions at 20 weeks of pregnancy.)

(6) The Soldier must avoid excessive vibrations. These occur in larger ground vehicles (greater than 1 1/4 ton) when the vehicle is driven on unpaved surfaces.

(7) Upon a diagnosis of pregnancy, the Soldier is exempt from regular unit physical readiness training, APFT testing, and body composition standards for the duration of the pregnancy and 180 days past pregnancy completion. After receiving medical clearance from a health care provider to participate in PT, commanders enroll Soldiers who are pregnant or postpartum to take part in Army Pregnancy Postpartum PT (P3T), in accordance with AR 350–1 and FM 7–22. P3T is designed to maintain health and fitness levels of pregnant Soldiers, and successfully integrate postpartum Soldiers back into unit physical readiness training programs, with emphasis on achieving the APFT standards, in accordance with guidance provided in the Army PRT Program, and meeting body composition standards in accordance with guidance provided in AR 600–9. Pregnant and postpartum Soldiers must be cleared by a health care provider prior to participating in P3T.

(8) Once pregnancy is confirmed, the Soldier is exempt from wearing load carrying equipment (LCE) to include interceptor body armor (IBA) and/or any other additional equipment. Wearing individual body armor and/or any other additional equipment is not recommended and must be avoided after 14 weeks' gestation.

(9) The Soldier is exempt from all immunizations except influenza and tetanus-diphtheria and from exposure to all fetotoxic chemicals noted on the occupational history form. The Soldier is exempt from exposure to chemical warfare and riot control agents (for example, nuclear, biological, and chemical training) and from wearing mission-oriented protective posture (MOPP) gear at any time.

(10) The Soldier may work shifts.

(11) The Soldier must not climb or work on ladders or scaffolding.

(12) The Soldier is authorized to wear the Army combat uniform without permethrin.

(13) At 20 weeks of pregnancy, the Soldier is exempt from standing at parade rest or attention for longer than 15 minutes. The Soldier is exempt from participating in swimming qualifications, drown proofing, field duty, and weapons training. The Soldier must not ride in, perform PMCS on, or drive in vehicles larger than light medium tactical vehicles, due to concerns regarding balance, vibrations, and possible hazards from falls.

(14) At 28 weeks of pregnancy, the Soldier must be provided a 15-minute rest period every 2 hours. Her duty week should not exceed 40 hours and the Soldier should not work more than 8 hours in any one day. The 8-hour work day does include the time spent in P3T and the hours worked after reporting to work or work call formation, but does not include the PT hygiene time and travel time to, and from, PT.

e. Performance of duty. A woman who is experiencing a normal pregnancy may continue to perform military duty until delivery. Only those women experiencing unusual and complicated problems (for example, pregnancy-induced hypertension) will be excused from all duty, in which case they may be hospitalized or placed sick in quarters. Medical personnel assist unit commanders in determining duties.

f. Sick in quarters. A pregnant Soldier is not placed sick in quarters solely on the basis of her pregnancy, unless there are complications present that would preclude any type of duty performance.

4–10. Stinging insect allergy

a. Soldiers are required to carry their prescribed epinephrine autoinjectors and wear appropriate medical warning tags. Profiling officers should prepare P2 profiles for Soldiers who are prescribed epinephrine autoinjectors, in order to inform their supervisors on the potential for use.

b. Venom immunotherapy (VIT) that can be supported in a garrison or deployed setting with a maximum interval between maintenance VIT shots every 4 weeks during the first 12 months of VIT, every 8 weeks during the second year, and every 12 weeks for the third year and thereafter, is recommended. Allergists review the service member annually for progress to resolution or worsening. Soldiers who decline VIT, should receive a P3 profile and referred to the DES.

c. After 3 years of VIT, the allergist determines:

(1) If no additional treatment or epinephrine auto-injector is required, recommend removal of P2 profile.

(2) If additional treatment is recommended, the Soldier may restart venom shots. Soldier may remain fully functional and deployable despite requiring venom allergy shots more than 3 years as long as the appropriate shot intervals are maintained.

(3) Soldiers who do not require further venom allergy shots after 3 years, but are recommended by an allergist-immunologist to carry an epinephrine auto injector, should maintain a P2 profile without deployment restrictions.

4–11. Cancer in remission

a. When an oncologist determines a Soldier is in remission after treatment for cancer and that there are no physical residuals, they may issue a P2 profile. The Soldier is considered non-deployable while in surveillance, unless the oncologist deems Soldier deployable after discussing mission requirements with CDR. If the Soldier remains in a remission up to 5 years, then the P2 profile may expire. Chronic cancers such as chronic lymphocytic leukemia or follicular lymphoma, which have not required treatment over the 5-year interval, may also have an expiration of the P2 profile.

b. If at 5 years or sooner, the Soldier experiences relapse or progression of his or her disease that is not expected to return to a prolonged remission, the oncologist writes a P3 profile and refers to the DES.

4–12. Postpartum profiles

a. Convalescent leave (as prescribed by AR 600–8–10 and Army Directive 2016–09) after delivery, is for a period determined by the attending physician. This is normally for 42 days. If a postpartum Soldier meets the definition of a birth event and service requirements from AD 2016–09, she is authorized up to 12 weeks of non-chargeable maternity leave by policy. The service requirement is that the postpartum Soldier be either on active duty or a RC Soldier, serving on call or order to active service, for a continuous period of at least 12 months. Regardless of the Soldier's eligibility for maternity leave, if there are medical indications for convalescent leave beyond the normal 42-day period, the commanders and profiling providers may grant convalescent leave as warranted.

b. Convalescent leave after completion of pregnancy (to include miscarriage) is determined on an individual basis, by the attending physician.

c. Prior to commencing convalescent leave, postpartum Soldiers are issued a postpartum profile, starting on the day of discharge, or the completion of the pregnancy if the Soldier is not hospitalized. The post-partum profile allows PT at the Soldier's own pace. Soldiers are encouraged to use the at-home component of Army P3T while on convalescent leave. If a Soldier decides to return early from convalescent leave, the temporary profile remains in effect for the entirety.

d. Soldiers receive clearance from the profiling provider to return to full duty.

e. All postpartum (any pregnancy that lasts 20 weeks and beyond) Soldiers, in accordance with DODD 1308.1, are exempt from the APFT and for record weigh-in for 180 days following completion of pregnancy. After receiving clearance from a profiling provider to resume PRT, postpartum Soldiers take part in the postpartum component of Army P3T. Postpartum Soldiers must receive clearance from a health care provider prior to returning to regular unit PRT if it is before 180

days following pregnancy completion. After receiving clearance from a health care provider to resume PRT, they are expected to use the time in preparation for the APFT.

f. Postpartum and nursing Soldiers are authorized to wear the ACU without permethrin.

g. The above guidance is only modified if, upon evaluation of a physician, it has been determined the postpartum Soldier requires a more restrictive or longer profile because of complicated or unusual medical problems.

4–13. Concussion profiles

a. Significance. Concussion, also known as traumatic brain injury, is a significant military concern that can adversely affect Soldier health, unit readiness, and mission accomplishment. Extensive research and progress in the recognition, care, and treatment of concussion has led to current policies and clinical practice guidelines for the management of concussions in the garrison and deployed environment. These programs and tools improve recognition, access to care and ultimately, outcomes.

b. Profiling. In order to ensure optimal care and reduce variance, profile providers use the appropriate concussion profile template, as required in AR 40–502. These templates also make patient and outcome tracking easier, which supports ongoing improvements in Soldier care in garrison and deployed environments. The limitations associated with repeat brain injuries are different to optimize healing and patient outcomes, and it is essential to communicate this to commanders. The DA Form 689 is not authorized for use for Soldier's diagnosed with a concussion.

4–14. Preparation, approval, and disposition of DA Form 3349

a. Preparation of DA Form 3349.

(1) A single DA Form 3349 is used to record the profiles for both permanent and temporary conditions providing a holistic view of the Soldier's duty limitations.

(2) All DA Form 3349s must be completed in e-Profile for all profiles over 7 days' duration, and using e-Profile for acute conditions lasting for 1–7 days is encouraged, to improve Soldier accountability and unit readiness tracking.

(3) Profiling providers use the various DA Form 3349 OTSG-approved templates available in e-Profile to use clear, standardized communication in lay terms. The templates align by the reason for profile and severity. For permanent profiles, the profiling providers describe severity with the physical profile functional capacity guide. All templates are thoroughly reviewed and staffed to ensure the highest quality, with clear and accurate communication. Future template suggestions and updates may be sent to the proponent of this policy.

(4) The DA Form 3349 is prepared as follows:

(a) Section 1; items 1–8. Profiling providers can initiate a profile using the Soldier's name (last, first), DOD ID number, or the Social Security number (SSN). e-Profile pre-populates as much of the section as is available from the available databases and systems of record. The profiling provider completes any unpopulated fields. Table 4–5 displays the current organization (CURORG) list that providers populate, in item 5, on DA Form 3349–SG.

Table 4–5
Current organization list

CURORG	A	Active National Guard of the United States
CURORG	B	Air National Guard of the United States
CURORG	C	Army National Guard (inactive)
CURORG	D	United States Marine Corps Reserve
CURORG	E	United States Navy, Reserve
CURORG	F	United States Coast Guard Reserve
CURORG	G	United States Air Force Reserve
CURORG	H	United States Army Reserve Troop Program Unit
CURORG	I	USAR Control Group (Individual Mobilization Augmentation (IMA))
CURORG	J	USAR Control Group (active, Guard/Reserve)
CURORG	K	USAR Control Group (annual training)

Table 4–5
Current organization list—Continued

CURORG	L	USAR Control Group (reinforcement)
CURORG	M	USAR Control Group (officer active duty obligor (OADO))
CURORG	N	USAR Control Group (dual component)
CURORG	O	USAR Standby Reserve (active status list)
CURORG	P	USAR Standby Reserve (inactive status list)
CURORG	R	USAR Retired Reserve
CURORG	S	RA Delayed Entry Program
CURORG	T	USAR Control Group Reserve Officer Training Corps (ROTC)
CURORG	U	Service academy
CURORG	V	USAR Delayed Entry Program
CURORG	Y	archived record
CURORG	Z	unknown
CURORG	1	Active Army
CURORG	2	Active Marine Corps
CURORG	3	Active Navy
CURORG	4	Active Coast Guard
CURORG	5	Active Air Force
CURORG	6	United States Army retired list
CURORG	7	Permanent Disability retired list
CURORG	8	Temporary Disability retired list
CURORG	9	Army of the United States (AUS) retired list

(b) Section 2: items 9–14. The profiling provider completes these sections only for permanent conditions. The template describes the reason for profile in lay terms. The profiling provider completes the PULHES and any pertinent profile codes. The profiling provider who initiates the profile is associated with that specific condition. Specific profiling providers (for example, physicians, audiologists, dentists, podiatrists, and so forth) are authorized to be the second signature for permanent conditions with a numerical designator of 2, without a deployment-limiting physical-category code, within their specialty. Approval authorities may review and approve permanent profiles with a numerical designator of 3 or 4, and profiles with deployment-limiting physical-category codes. An approval authority may not be both the profiling provider and the approval authority. If an approval authority rewrites a profile, they need to send the profile to either another physician or approval authority (for permanent 2, 3, or 4 profiles) to complete the second signature as described above. The approval authority is encouraged to return the profile, or provide feedback to the profiling provider to improve the process. The digital signature and date is electronically recorded on signing. The MEB physician, State surgeon, USARC surgeon, or their designees, determine whether the Soldier does or does not meet retention standards. A Soldier who enters the DES process secondary to a permanent 3 or 4 profile, indicating that they do not meet retention standards, is initially evaluated by the local or regional MEB. If the appropriate authority determines that the Soldier meets retention standards, then the MEB rewrites the profile to reflect the appropriate limitations. The modified profile accurately reflects the Soldier's limitations with a permanent 2, or a permanent 3, when indicated by policy, and the "S" code applies. The MEB profiling

provider documents the circumstances of the process and decision in section 5 on the DA 3349 to include the board members: rank, full name; date of MEB final determination; MTF or location. Permanent 3 profiles with an S code are referred to the MAR2 for personnel review. If the Soldier, upon MEB review does not meet retention standards, DES processing continues in accordance with AR 635–40. The S code identifies Soldiers who underwent MEB processing only (NOT PEB) and were found to meet retention standards with either a permanent 2 or 3 profile. MEBs completed before the S code was introduced in 2011 should be rewritten in e-Profile with an S code, current accurate capabilities and limitations, and considered for modification as described above.

(c) Section 3: items 15–22. The profiling provider completes these sections only for temporary profiles. Temporary profiles are for temporary conditions that are expected to change and improve with treatment. To allow tracking and reflect the fluidity of these conditions, e-Profile displays the as of date on the top of section 3. These conditions are selected from the temporary profile taxonomy with the designation of mild, moderate, or severe. The profiling provider selects the mechanism of injury, duty status, and expiration date. Profiling providers ensure that extensions of expired temporary conditions remain linked to the original profile, to ensure accurate calculation of the number of days.

1. The mechanism of injury is chosen from a drop down list.
2. The duty status is chosen from a drop down list. The provider's entry is based on Soldier self-report. This is independent and exclusive of any association with the line of duty process.
3. The provider sets the expiration date. e-Profile uses this to calculate the total days on temporary profile in the last 12 months, and 24 months, displaying the as of date for block 22.
4. The digital signature and date are electronically recorded on signing.

(d) Block 23. This block documents the Soldier's availability to take a record APFT for either a permanent or temporary condition. If the condition is temporary, the provider enters the anticipated APFT availability date. It is important to note, this block is to inform the command of the Soldier's capabilities and limitations and does not require the command to administer an APFT. There is no longer a prescribed recovery period after a profile; the profiling provider includes the necessary recovery period in this block. The recovery time is factored into the date authorized to take the APFT based on the profiling provider's judgment and is not to exceed 90 days (except as directed above in paragraph 4–9*d*(7) for pregnancy).

(e) Section 4: items 24–26. This section describes the functional activities necessary to perform within retention standards, the additional physical restrictions that guide personnel assignments, and the medical or administrative board referral. An "N" for No documents a Soldier who cannot perform a functional activity in either the P or T columns for permanent or temporary limitations. The additional physical restrictions require more description in weight, time or pace for permanent and/or temporary conditions. The last block documents the indicated medical or administrative board (if any). All new permanent 3 or 4 profiles require a determination in box 26.

(f) Section 5: item 27. This section documents the medical instructions to the unit commander for mission and duty assignment. These instructions have permanent restrictions listed in bold type and temporary instructions listed in normal type. The profiling provider writes the medical instructions in plain language, clearly, and to encompass the minimal limitations anticipated supporting Soldier health, welfare, and recovery of function. The commander communicates with the profiling provider for any clarification of the instructions. The medical instructions may not be ignored.

(g) Section 6. This section describes the Army Physical Fitness Test restrictions and alternative options for the aerobic event. The profiling provider documents "Yes" or "No" under either the permanent or temporary columns. Providers refer any Soldier with a permanent condition to the DES process, if they cannot complete at least one alternate event, unless prevented by a temporary condition.

(h) Section 7. This section describes the physical readiness training capabilities for the commander. These should be positive statements to describe what the Soldier can do regarding PT. It is imperative that profiling providers avoid overlimiting Soldiers which would needlessly impair their ability to train, constraining the Soldier's mission readiness. Conversely, it is important to identify training restrictions that allow a Soldier to heal.

(i) Section 8. A profile is a communication tool between the profiling officer and the commander. This can only be effective if the profiling officer generates an accurate, clear, and consistent profile and the unit commander views the profile information to make duty and mission assignments appropriately.

b. Disposition of DA Form 3349 (temporary and permanent). The electronic profile displays in the Commander's Portal for command review. The electronic profile displays in the PHA for the health care provider to complete their annual review. An electronic copy of the profile is available in Army Knowledge Online (AKO) for the Soldier review. The DA Form 3349 is valid when signed by the profiling provider for temporary and permanent 1 and 2 conditions. Permanent 2 profiles are valid from when they are written and the first signature is applied. They remain valid and in a pending status until the appropriate second signature is applied or until the profile automatically expires. The limits of automatic expiration are set in the system of record for Active and Reserve COMPOs. Permanent 3 and 4 profiles, and profiles that assign a deployment-limiting physical-category code are valid when signed by the approval authority. The commander's signature

is electronically applied when they view the profile in the Commander's Portal and has no impact on the validity of the profile. The Soldier may request a printed copy of the DA Form 3349 completed in e-Profile.

4–15. Responsibility for personnel actions

a. Commanders and personnel officers take necessary personnel actions, including appropriate entries on personnel management records and the assignment of the individual to military duties commensurate with the individual's physical profile and recorded assignment limitations.

b. Profiles are communication tools between the profiling providers and the commanders. All company level commanders are to review the profiles for the Soldiers under their command through the Commander's Portal. Senior commanders review the medical readiness of their subordinate units and provide guidance and mentorship to ensure accurate readiness reporting.

c. If the Soldier's commander believes the Soldier cannot perform within the limits of the permanent profile, or the profile limitations do not address or prevent training that the Soldier can safely complete without aggravating the condition, the commander requests clarification and reconsideration of the profile by the profiling provider. Reconsideration starts with the same profiling provider who seeks to understand the commander's observations and concerns, then either rewrites the profile or revalidates the profile as initially written. This should be a collaborative process to provide the optimal care and employment of the Soldier. In the event that the profiling provider and commander cannot come to an agreement on a temporary or a permanent profile, the commander can request a fitness for duty evaluation with another profiling provider. The second profiling provider has access to the original profile and all applicable notes.

d. The commander reviews all new or modified profiles within 14 days for active duty, and 30 days for the RCs.

4–16. Physical profile and the Army Body Composition Program

AR 600–9, is a personnel program. The DA Form 3349 does not excuse Soldiers from the provisions of AR 600–9. The AR 600–9 contains a standard memorandum for completion by a physician if there is an underlying or associated disease process that is the cause of the overweight condition. The inability to perform all APFT events or the use of certain medications is not generally sufficient medical rationale to exempt a Soldier from AR 600–9.

Chapter 5
Medical Examinations—Administrative Procedures

5–1. General

This chapter provides—

a. General administrative policies relative to military medical examinations.

b. Administrative requirements for periodic medical examinations, PHA, Separation History and Physical Examination (SHPE), mobilization, and other medical examinations.

c. Policies relative to hospitalization of examinees for diagnostic purposes and use of documentary medical evidence, consultations, and the individual health record.

d. Policies relative to the scope and recording of medical examinations and assessments accomplished for stated purposes.

5–2. Application

The provisions contained in this chapter apply to all medical examinations and assessments accomplished at U.S. Army medical facilities or accomplished for the U.S. Army.

5–3. Physical fitness

a. Maintenance of physical and medical fitness is an individual military responsibility. Soldiers have an obligation to maintain themselves in a physical condition that enables them to perform Soldier duties efficiently. Soldiers are to seek timely medical care and advice whenever they have a medical condition or physical defect and report any effects on their readiness status. Soldiers are not to wait until their annual periodic health assessment to report medical conditions. Soldiers need to provide their military health care provider, unit commander, or medical readiness noncommissioned officer with any civilian health records. The active and RC Soldier's military health record and/or scanned EHR documents any civilian health records which may impact the Soldier's readiness status.

b. Commanders ensure the documentation of a Soldier's readiness and medical status in the personnel systems of record and that the appropriate follow-up action is taken regarding the Soldier's medical or readiness status.

c. Commanders ensure that Soldiers complete and maintain all medical readiness requirements.

THE ASSISTANT SECRETARY OF DEFENSE

1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

OCT 07 2013

MEMORANDUM FOR ASSISTANT SECRETARY OF THE ARMY (MANPOWER AND RESERVE AFFAIRS)
ASSISTANT SECRETARY OF THE NAVY (MANPOWER AND RESERVE AFFAIRS)
ASSISTANT SECRETARY OF THE AIR FORCE (MANPOWER AND RESERVE AFFAIRS)
JOINT STAFF SURGEON
VICE COMMANDANT OF THE COAST GUARD

SUBJECT: Clinical Practice Guidance for Deployment-Limiting Mental Disorders and Psychotropic Medications

References:

(a) Department of Defense Instruction (DoDI) 6490.07, "Deployment-Limiting Medical Conditions for Service Members and DoD Civilian Employees," dated February 5, 2010
(b) Assistant Secretary of Defense for Health Affairs memorandum, "Policy Guidance for Deployment Limiting Psychiatric Conditions and Medications," dated November 7, 2006 (hereby cancelled)
(c) Under Secretary of Defense for Personnel and Readiness memorandum, "Standards for Determining Unfitness Due to Medical Impairment (Deployability)," dated December 19, 2007
(d) DoDI 1332.38, "Physical Disability Evaluation," dated November 14, 1996, Incorporating Change 2, April 10, 2013
(e) DoDI 6490.08, "Command Notification Requirements to Dispel Stigma in Providing Mental Health Care to Service Members," dated August 17, 2011
(f) Part 339 of Title 5, Code of Federal Regulations
(g) DoD Directive 1404.10, "DoD Civilian Expeditionary Workforce," dated January 23, 2009
(h) Assistant Secretary of Defense for Health Affairs memorandum, "Guidance for Providers Prescribing Atypical Antipsychotic Medication," dated February 22, 2012

This memorandum provides clinical practice guidance on limitations of deployment for Service members and DoD civilian employees who have been diagnosed with mental disorders or who are prescribed psychotropic medication. It supplements DoDI 6490.07, "Deployment-Limiting Medical Conditions for Service Members and DoD Civilian Employees," dated February 5, 2010 (Reference (a)), but does not alter that Instruction's procedure for obtaining waivers for deployment-limiting medical conditions. It replaces the Assistant Secretary of Defense for Health Affairs memorandum, "Policy Guidance for Deployment

Limiting Psychiatric Conditions and Medications," dated November 7, 2006 (Reference (b)), which is hereby cancelled.

This guidance does not alter or replace accession, retention, and general fitness standards for military personnel previously established by DoD, Joint Staff, or individual Military Department policy guidance or procedural safeguards applicable to civilian employees undergoing medical screening for deployment as outlined in References (a), (c), and (d). It also does not alter or replace command notification limitations and requirements for health care providers outlined in Reference (e).

1. General Guidance

   a. Procedures ensuring that Service members and DoD civilian employees (selected for deployment) are medically ready to deploy are required for accomplishment of duty in deployed environments (Reference (a)).

   b. Service members with mental disorders or who are taking psychotropic medications that prevent them from meeting retention standards, or limit their ability to deploy if that is a requirement of the member's office, grade, rank, or rating should be referred for disability evaluation if the duration of the condition or limitation is expected to exceed 1 year from date of onset (Reference (d)).

   c. If a commander wishes to deploy Service members with mental disorders, or who are taking medications that would disqualify them for deployment as defined in paragraphs 2 and 3 of this guidance, waiver requests, as outlined in Reference (a), are required.

   d. Civilian personnel determined, based on this guidance and Reference (a), to be unable to perform in their deployed position due to a deployment-limiting medical condition will be managed according to Component procedures, and in accordance with References (a), (f), and (g), as applicable, depending on the anticipated duration of the duty limitation.

2. Deployment limitations associated with mental disorders

   a. Any current diagnosis or history of a diagnosis of a psychotic or bipolar disorder, or other disorder with associated psychotic symptoms, is considered disqualifying for deployment. These conditions are not eligible for a waiver, as detailed in paragraph 1.c.

   b. Individuals diagnosed with mental disorders (excluding those disorders referenced in paragraph 2.a.) should demonstrate a pattern of stability without significant symptoms or impairment for at least 3 months prior to deployment. These individuals are eligible for a waiver as detailed in paragraph 1.c.

   c. In addition to the requirements in paragraph 2.b., individuals diagnosed with substance use disorders should not be deployed if doing so would interrupt active treatment.

   d. In addition to the requirements in paragraph 2.b., individuals should not deploy if they have been determined to be at risk for suicide or violence toward others.

3. Deployment limitations associated with psychotropic medication.

a. Medications prescribed to treat mental disorders vary in terms of their effects on cognition, reaction time, psychomotor functioning, coordination, and other physical parameters that are relevant to functioning effectively in an operational environment. Health care providers must be aware of how these effects impair performance in the operational environment and activities of daily living. Psychotropic medications may be prescribed for a variety of conditions that are not associated with a mental health diagnosis. Guidance for prescription of atypical antipsychotic medication may be found in Reference (h).

b. Psychotropic medications may pose operational problems during deployments. Important considerations in prescribing psychotropic medications are the clinical presentation and the mitigation of functional impairment. Providers must take into account potential medication side effects on a Service member's ability to function effectively in the deployed environment.

c. The decision to deploy individuals on medications should be balanced with effects on performance in austere environments, necessity for medication in the management of the condition, withdrawal symptoms, and other potential side effects. Logistical factors that should be considered include availability of refills, ability to procure controlled medications, and potential for abuse or diversion.

d. Throughout the course of care, medical providers should regularly evaluate the use of psychotropic medication for clinical response, and limitations to deployment or continued service in a deployed environment. These evaluations should be documented in the treatment record.

e. Medications that disqualify an individual for deployment include:

(1) Antipsychotics;

(2) Lithium;

(3) Short acting benzodiazepines (unless prescribed as part of a policy-directed operational fatigue management program);

(4) Barbiturates and Anticonvulsants, with the exception of those prescribed for migraine ;

(5) Medications that have special storage considerations, such as refrigeration (does not include those medications maintained at medical facilities for inpatient or emergency use); and

(6) Medications that require laboratory monitoring or special assessment of a type or frequency that is not available or feasible in a deployed environment.

(7) In cases involving conditions described in paragraph 2.b., the demonstrated pattern of stability should account for medications prescribed within 3 months of deployment that have not yet demonstrated

efficacy or have side effects that could impair a Service member's ability to deploy.

4. Assessment and Disposition during deployments.

   a. Health care providers will carefully assess the condition, treatment regimen, and risk level of all Service members and DoD civilians diagnosed with a psychiatric disorder while deployed in theater and readily communicate recommendations to the Service member's commander or civilian personnel's supervisor in accordance with privacy guidelines and Reference (e).

   b. Service members or DoD civilian personnel with other conditions (not referenced in (4a)), and who are determined to be at significant risk for performing poorly or decompensating in the operational environment, or whose condition does not improve within an acceptable time should be evacuated from theater.

   c. Individuals diagnosed with psychotic or bipolar disorders or other disorders with psychotic symptoms during deployment should return to their home station.

   d. The following factors must be considered by the health care provider before deciding to retain individuals diagnosed with mental disorders in theater:

      (1) The severity of symptoms and/or medication side effects.

      (2) The degree of functional impairment resulting from the disorder and/or medications.

      (3) The risk of exacerbation if the individual were exposed to trauma or severe operational stress.

      (4) Estimation of the individual's ability to tolerate the rigors of the deployment.

      (5) The prognosis for recovery while the Service member or DoD civilian remains in the deployed environment.

   e. Evacuations from theater should follow established in-theater medical evacuation protocols.

Questions regarding this guidance should be directed to my point of contact, Colonel (Col) Theresa Lawson. Col Lawson may be reached at Theresa.Lawson@tma.osd.mil, or (703) 681-8335.

Jonathan Woodson, M.D.

cc:
Surgeon General of the Army
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Surgeon General of the Air Force
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Deputy Assistant Secretary of Defense for Clinical and Program Policy
Joint Staff Surgeon
Commander, Joint Task Force-National Capital Region/Medical

Department of Defense

INSTRUCTION

NUMBER 6490.07
February 5, 2010

USD(P&R)

SUBJECT: Deployment-Limiting Medical Conditions for Service Members and DoD Civilian Employees

References: See Enclosure 1

1. PURPOSE. In accordance with the authority in DoD Directive (DoDD) 5124.02 (Reference (a)) and the guidance in DoDDs 6200.04 and 1400.31 (References (b) and (c)), this Instruction establishes policy, assigns responsibilities, and provides procedures for ensuring that Service members and DoD civilian employees, including Coast Guard Service members and civilian employees at all times, including when the Coast Guard is a Service in the Department of Homeland Security by agreement with that Department, (hereafter referred to collectively as "DoD personnel") deployed and deploying on contingency deployments are medically able to accomplish their duties in deployed environments.

2. APPLICABILITY. This Instruction:

a. Applies to:

(1) 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 and the Joint Staff, the Combatant Commands, 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 Department of Defense (hereafter referred to collectively as the "DoD Components").

(2) DoD personnel deployed and deploying on contingency deployments consistent with DoD and Service-specific guidance, including Reference (c) and DoD Instruction (DoDI) 1400.32 (Reference (d)).

b. Does not apply to contingency contractor personnel, who shall comply with the guidance in DoDI 3020.41 (Reference (e)), or to shipboard operations that are not anticipated to involve operations ashore, which shall follow Service-specific guidance.

c. Shall be used as a minimum medical standard for all deploying and deployed DoD personnel, BUT does not alter or replace:

(1) With respect to military personnel, the accession, retention, and general fitness for duty standards previously established by the Department of Defense, including those described in DoDI 6130.4, DoDD 6130.3, Under Secretary of Defense for Personnel and Readiness (USD(P&R)) Memorandum, Assistant Secretary of Defense for Health Affairs (ASD(HA)) Memorandum, and DoDI 6485.01 (References (f) through (j), respectively).

(2) With respect to civilian employees covered by sections 791 and 794a of title 29, United States Code (also known and hereafter referred to as "The Rehabilitation Act of 1973, as amended" (Reference (k))), the legal obligations of a DoD Component as an employer pursuant to that Act.

(3) More stringent individual Military Department policy guidance or Service-specific readiness requirements.

3. DEFINITIONS. These terms and their definitions are for the purpose of this Instruction.

a. contingency. A situation requiring military operations in response to natural disasters, terrorists, subversives, or as otherwise directed by appropriate authority to protect US interests.

b. contingency deployment. A deployment that is limited to outside the continental United States, over 30 days in duration, and in a location with medical support from only non-fixed (temporary) military medical treatment facilities. It is a deployment in which the relocation of forces and materiel is to an operational area in which a contingency is or may be occurring.

c. deployment. The relocation of forces and materiel to desired operational areas. Deployment encompasses all activities from origin or home station through destination, specifically including intra-continental United States, inter-theater, and intra-theater movement legs, staging, and holding areas.

d. medical assessment. The total of the pre-deployment activities described in section 1 of Enclosure 2 of this Instruction and those listed in paragraph E4.A1.1 of DoDI 6490.03 (Reference (l)).

e. trained DoD health-care provider. A physician, physician assistant, nurse practitioner, advanced practice nurse, independent duty corpsman, independent duty medical technician, or special forces medical sergeant.

4. POLICY. It is DoD policy that:

a. The medical standards in this Instruction are mandatory for contingency deployments, and permissible for any other deployment, based on the commander's decision.

b. DoD personnel with existing medical conditions may deploy based upon a medical assessment as described in Enclosure 2 and subparagraph E4.A1.1.1. of Reference (l), which for civilian employees shall be consistent with subparagraph 4.g.(3)(c) of DoDD 1404.10 (Reference (m)), and the requirements of The Rehabilitation Act of 1973, as amended, when such civilian employees are covered by that Act, if all of these conditions are met:

(1) The condition is not of such a nature or duration that an unexpected worsening or physical trauma is likely to have a grave medical outcome or negative impact on mission execution.

(2) The condition is stable and reasonably anticipated by the pre-deployment medical evaluator not to worsen during the deployment in light of physical, physiological, psychological, and nutritional effects of the duties and location.

(3) Any required, ongoing health care or medications anticipated to be needed for the duration of the deployment are available in theater within the Military Health System. Medication must have no special handling, storage, or other requirements (e.g., refrigeration, cold chain, or electrical power requirements). Medication must be well tolerated within harsh environmental conditions (e.g. heat or cold stress, sunlight) and should not cause significant side effects in the setting of moderate dehydration.

(4) There is no need for routine evacuation out of theater for continuing diagnostics or other evaluations. (All such evaluations should be accomplished before deployment.)

(5) In the case of civilian employees covered by The Rehabilitation Act of 1973, as amended, it is determined, based upon an individualized assessment, that the employee can perform the essential functions of the position in the deployed environment, with or without a reasonable accommodation, without causing undue hardship. In evaluating undue hardship, the nature of the accommodation and the location of the deployment must be considered. Further, the employee's medical condition must not pose a significant risk of substantial harm to the employee or others taking into account the condition of the relevant deployed environment.

c. Individuals with the conditions in Enclosure 3, based on medical assessments in accordance with Enclosure 2 and Reference (l), shall not deploy unless a waiver can be granted according to the procedures in section 3 of Enclosure 2.

d. If a Service member is found qualified for retention with no limitations on assignments or deployments following evaluation of a medical condition by competent medical and personnel authority of his or her respective Service, and if the condition remains stable, a deployment waiver of that same condition is not required by this Instruction.

e. Deploying commanders may add additional medical requirements to the standards in this Instruction based upon the demands of a specific deployment. Commanders may apply these medical standards to other deployments based on the health risk, physical demands, and medical

capabilities of the deployment. These additional standards must be consistent with The Rehabilitation Act of 1973, as amended, when applied to civilian employees covered by that Act.

f. Protected health information collected, used, and released in the execution of this Instruction shall be protected as required by DoD 6025.18-R (Reference (n)) and DoD 8580.02-R (Reference (o)).

5. RESPONSIBILITIES. See Enclosure 4.

6. PROCEDURES. See Enclosure 2.

7. RELEASABILITY. UNLIMITED. This Instruction is approved for public release and is available on the Internet from the DoD Issuances Web Site at http://www.dtic.mil/whs/directives.

8. EFFECTIVE DATE. This Instruction is effective immediately.

Gail H. McGinn
Deputy Under Secretary of Defense (Plans)
Performing the Duties of the
Under Secretary of Defense for
Personnel and Readiness

Enclosures:
1. References
2. Procedures
3. Medical Conditions Usually Precluding Contingency Deployment
4. Responsibilities

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ENCLOSURE 1

REFERENCES

(a) DoD Directive 5124.02, "Under Secretary of Defense for Personnel and Readiness (USD(P&R))," June 23, 2008
(b) DoD Directive 6200.04, "Force Health Protection (FHP)," October 9, 2004
(c) DoD Directive 1400.31, "DoD Civilian Work Force Contingency and Emergency Planning and Execution," April 28, 1995
(d) DoD Instruction 1400.32, "DoD Civilian Work Force Contingency and Emergency Planning Guidelines and Procedures," April 24, 1995
(e) DoD Instruction 3020.41, "Contractor Personnel Authorized to Accompany the U.S. Armed Forces," October 3, 2005
(f) DoD Instruction 6130.4, "Medical Standards for Appointment, Enlistment, or Induction in the Armed Forces," January 18, 2005
(g) DoD Directive 6130.3, "Physical Standards for Appointment, Enlistment, and Induction," December 15, 2000
(h) Under Secretary of Defense for Personnel and Readiness Memorandum, "Policy Guidance for Medical Deferral," February 9, 2006
(i) Assistant Secretary of Defense for Health Affairs Memorandum, "Policy Guidance for Deployment-Limiting Psychiatric Conditions and Medications," November 7, 2006
(j) DoD Instruction 6485.01, "Human Immunodeficiency Virus," October 17, 2006
(k) Sections 791 and 794a of title 29, United States Code (also known as "The Rehabilitation Act of 1973, as amended")
(l) DoD Instruction 6490.03, "Deployment Health," August 11, 2006
(m) DoD Directive 1404.10, "DoD Civilian Expeditionary Workforce," January 23, 2009
(n) DoD 6025.18-R, "DoD Health Information Privacy Regulation," January 24, 2003
(o) DoD 8580.02-R, "DoD Health Information Security Regulation," July 12, 2007

ENCLOSURE 2

PROCEDURES

1. PERFORMANCE OF MEDICAL ASSESSMENTS. All DoD personnel serving in a contingency deployment as defined in section 3 of the front matter of this Instruction must undergo a medical assessment prior to deployment in accordance with subparagraph E4.A1.1.1. of Reference (l). The mandatory portions of the assessment are:

a. Completion of DD Forms 2795, "Pre-Deployment Health Assessment," and 2766, "Adult Preventive and Chronic Care Flowsheet" (available on the Internet at http://www.dtic.mil/whs/directives/infomgt/forms/formsprogram.htm). Except for Coast Guard personnel, completed copies of both of these forms must be submitted to the Defense Medical Surveillance System and included in DoD personnel deployment paperwork, and shall serve as the deployment medical record. For Coast Guard personnel, the DD Form 2766 shall be placed in the member's health record, but all other procedures for Coast Guard personnel shall be as described in this Instruction for DoD personnel.

b. Medical record review.

c. Current periodic health assessment (Service members only).

d. Physical exam within 1 year of deployment (DoD civilian employees only).

2. DETERMINATIONS OF DEPLOYABILITY. A trained DoD health-care provider must make a provisional determination on DD Form 2795 as to the deployability of DoD personnel. This decision should be based on all of the information obtained in the medical assessment described in section 1 of this enclosure.

a. In general, DoD personnel with any of the medical conditions in Enclosure 3, and based on a medical assessment, shall not deploy unless a waiver is granted. Consideration should be made for the nature of the disability and if it would put the individual at increased risk of injury or illness, or if the condition is likely to significantly worsen in the deployed environment.

(1) For civilian employees covered by The Rehabilitation Act of 1973, as amended, it must be determined, before deployment and based upon an individualized assessment, that the employee can perform the essential functions of the position in the deployed environment, with or without a reasonable accommodation, without causing undue hardship. In evaluating undue hardship, the nature of the accommodation and the location of the deployment must be considered. Further, the employee's medical condition must not pose a significant risk of substantial harm to the employee or others taking into account the condition of the relevant deployed environment.

(2) The requirement to provide reasonable accommodations for disabilities does not apply to deployment of military members, nor to civilian employees not covered by The Rehabilitation Act of 1973, as amended.

b. All individuals deemed not deployable at the deployment processing center shall be returned to their originating unit with a DD Form 2795 and a summary of their non-deployable medical condition to provide to the unit medical personnel. The civilian supervisor shall also be notified if the individual is deemed not deployable.

3. WAIVERS. If a commander or supervisor of DoD personnel (except for SOF personnel) wishes to deploy an individual with a medical condition that could be disqualifying (see Enclosure 3, the commander or supervisor must request a waiver. The waiver request shall be submitted to the applicable Combatant Commander through the individual's servicing military medical unit in the case of a Service member, or through the individual's personnel office in the case of a civilian employee, with medical input provided by the individual's medical provider.

a. Requests for a waiver shall include a summary of a detailed medical evaluation or consultation concerning the medical condition(s). Maximization of mission accomplishment and the protection of the health of personnel are the ultimate goals. Justification shall include statements indicating service experience, position to be placed in, any known specific hazards of the position, anticipated availability and need for care while deployed, the benefit expected to accrue from the waiver, the recommendation of the commander or supervisor, and the reasonable accommodations that can be provided for civilian employees covered by The Rehabilitation Act of 1973, as amended. For all DoD personnel, the factors listed in subparagraphs 4.b.(1) through 4.b.(4), (and subparagraph 4.b.(5) for civilian employees only) of the front matter shall be discussed.

b. For SOF personnel with any of the conditions listed in Enclosure 3, medical clearance may be granted by the CDRUSSOCOM, subject to the approval of the Combatant Commander under which the Service member is deployed or will deploy.

c. In the case of civilian employees covered by The Rehabilitation Act of 1973, as amended, a waiver must be granted if it is determined, based upon an individualized assessment, that the employee can perform the essential functions of the position in the deployed environment, with or without a reasonable accommodation, without causing undue hardship. In evaluating undue hardship, the nature of the accommodation and the location of the deployment must be considered. Further, the employee's medical condition must not pose a significant risk of substantial harm to the employee or others taking into account the condition of the relevant deployed environment.

4. ROLES AND RESPONSIBILITIES

a. Commanders and Supervisors. Commanders and supervisors shall:

(1) Ensure deploying DoD personnel are appropriately assessed by competent medical authority before deployment, in accordance with Reference (l).

(2) Request waivers for DoD personnel they wish to deploy who have the medical conditions described in Enclosure 3.

(3) Ensure that DoD personnel under their command meet the medical standards of the gaining commander when individuals and their leaders deploy in support of other DoD Components. As these standards may differ by assignment, they must be coordinated separately for each deployment.

b. Supervisors. Supervisors shall additionally:

(1) Identify medical and physical requirements for deployable positions designated for fill by DoD civilian employees.

(2) Ensure that such requirements are documented in position descriptions, vacancy announcements, and other appropriate sources.

(3) Ensure that DoD civilian employees meet such requirements; take appropriate action when employees no longer meet identified requirements.

c. DoD Personnel

(1) DoD personnel in deployable positions shall be responsible for meeting the medical and physical requirements of their deployment-specific tasks.

(2) DoD personnel who are civilian employees selected for deployment opportunities outside their chain of supervision shall be responsible for meeting and maintaining the medical standards identified for the deployment by the responsible commanding officer.

ENCLOSURE 3

MEDICAL CONDITIONS USUALLY PRECLUDING CONTINGENCY DEPLOYMENT

This list of conditions is not intended to be all-inclusive. A list of all possible diagnoses and their severity that may cause an individual to be potentially non-deployable, pending further evaluation, would be too extensive. Medical evaluators must consider climate, altitude, rations, housing, duty assignment, and medical services available in theater when deciding whether an individual with a specific medical condition is deployable. In general, individuals with the conditions in paragraphs a. through h. of this enclosure, based upon a medical assessment as described in Enclosure 2 and Reference (l), shall not deploy unless a waiver is granted.

a. Conditions Affecting Force Health Protection

(1) Physical or psychological conditions resulting in the inability to effectively wear personal protective equipment, including protective mask, ballistic helmet, body armor, and chemical and/or biological protective garments, regardless of the nature of the condition that causes the inability to wear the equipment if wearing such equipment may be reasonably anticipated or required in the deployed location.

(2) Conditions that prohibit immunizations or the use of force health protection prescription products (FHPPPs) required for the specific deployment. Depending on the applicable threat assessment, required FHPPPs may include atropine, epinephrine, and/or pralidoxime chloride (2-PAM chloride) auto-injectors; certain antimicrobials and antimalarials; and pyridostigmine bromide.

b. Unresolved Health Conditions Requiring Care or Affecting Performance

(1) Any chronic medical condition that requires frequent clinical visits, fails to respond to adequate conservative treatment, or necessitates significant limitation of physical activity.

(2) Absence of a dental exam within the last 12 months or presence of the likelihood that dental treatment or reevaluation for oral conditions will result in dental emergencies within 12 months. Individuals being evaluated by a non-DoD civilian dentist should use DD Form 2813, "DoD Active Duty/Reserve Forces Dental Examination," as proof of dental examination (available on the Internet at http://www.dtic.mil/whs/directives/infomgt/forms/formsprogram.htm).

(3) Pregnancy.

(4) Any medical condition that requires either durable medical equipment or appliances, or periodic evaluation or treatment by medical specialists that is not readily available in theater.

(5) Any unresolved acute or chronic illness or injury that would impair duty performance in a deployed environment during the duration of the deployment.

(6) Cancer that requires continuing treatment or specialty medical evaluations during the anticipated duration of the deployment.

(7) Precancerous lesions that have not been treated and/or evaluated and that require treatment and/or evaluation during the anticipated duration of the deployment.

(8) Any medical condition that requires surgery or for which surgery has been performed that requires rehabilitation or additional surgery to remove devices.

(9) Any musculoskeletal condition that significantly impairs performance of duties in a deployed environment.

(10) An acute exacerbation of a physical or mental health condition that could significantly affect duty performance.

c. Conditions That Could Cause Sudden Incapacitation

(1) Recurrent loss of consciousness for any reason.

(2) Any medical condition that could result in sudden incapacitation including a history of stroke within the last 24 months, seizure disorders, and diabetes mellitus type I or II treated with insulin or oral hypoglycemic agents.

d. Pulmonary Disorders. Asthma that has a forced expiratory volume-1 (FEV-1) of less than or equal to 60 percent of predicted FEV-1 despite appropriate therapy and that has required hospitalization at least 2 times in the last 12 months, or that requires daily systemic (not inhalational) steroids.

e. Infectious Disease

(1) Active tuberculosis or known blood-borne diseases that may be transmitted to others in a deployed environment.

(2) A diagnosis of human immunodeficiency (HIV) antibody positive with the presence of progressive clinical illness or immunological deficiency. The cognizant Combatant Command surgeon shall be consulted in all instances of HIV seropositivity before medical clearance for deployment.

f. Sensory Disorders

(1) Hearing Loss. The requirement for use of a hearing aid does not necessarily preclude deployment. However, the individual must have sufficient unaided hearing to perform duties safely.

(2) Vision Loss. Best corrected visual acuity must meet job requirements to perform duties safely.

g. Cardiac and Vascular Disorders

(1) Hypertension not controlled with medication or that requires frequent monitoring.

(2) Symptomatic coronary artery disease.

(3) History of myocardial infarction within 1 year of deployment.

(4) History of coronary artery bypass graft, coronary artery angioplasty, carotid endarterectomy, other arterial stenting, or aneurysm repair within 1 year of deployment.

(5) Cardiac dysrhythmias or arrhythmias, either symptomatic or requiring medical or electrophysiologic control (presence of an implanted defibrillator and/or pacemaker).

(6) Heart failure.

h. Mental Health Disorders

(1) Psychotic and/or bipolar disorders. (See Reference (i) for detailed guidance on deployment-limiting psychiatric conditions or psychotropic medications.)

(2) Psychiatric disorders under treatment with fewer than 3 months of demonstrated stability.

(3) Clinical psychiatric disorders with residual symptoms that impair duty performance.

(4) Mental health conditions that pose a substantial risk for deterioration and/or recurrence of impairing symptoms in the deployed environment.

(5) Chronic medical conditions that require ongoing treatment with antipsychotics, lithium, or anticonvulsants.

ENCLOSURE 4

RESPONSIBILITIES

1. ASD(HA). The ASD(HA), under the authority, direction, and control of the USD(P&R), shall review and issue to the Secretaries of the Military Departments and the Directors of the Defense Agencies and the DoD Field Activities technical adjustments to the deployment standards in Enclosure 3 as needed, based on changing conditions or additional unanticipated difficulties encountered in the in-theater management of medical conditions.

2. SECRETARIES OF THE MILITARY DEPARTMENTS, COMMANDANT OF THE COAST GUARD, AND DIRECTORS OF THE DEFENSE AGENCIES AND THE DoD FIELD ACTIVITIES. The Secretaries of the Military Departments, the Commandant of the Coast Guard, and the Directors of the Defense Agencies and the DoD Field Activities shall:

a. Direct their respective Components to apply and uniformly implement the standards in this Instruction.

b. Ensure that:

(1) All deploying DoD personnel assigned to their respective Service, Defense Agency, or DoD Field Activity have a medical assessment in accordance with Reference (l), including a medical record review, to evaluate their medical status before contingency deployments and other deployments pursuant to paragraph 4.a. of the front matter of this Instruction.

(2) Pre-deployment processes are in place to identify individuals with deployment-limiting medical conditions.

(3) DoD personnel who occupy deployable positions maintain a high state of pre-deployment health and medical readiness.

3. CHAIRMAN OF THE JOINT CHIEFS OF STAFF. The Chairman of the Joint Chiefs of Staff shall ensure that the Combatant Commanders:

a. Establish a minimum standard when developing medical requirements for entering the theater of operations that factors in the medical conditions described in Enclosure 3 of this Instruction.

b. Implement a medical requirements waiver process that includes waiver computerization and archival storage.

4. COMBATANT COMMANDERS. For all DoD personnel deployed or deploying to a theater within their respective Combatant Commands, the Combatant Commanders shall:

a. Establish a process for reviewing recommendations from the Services regarding the granting of exceptions to medical standards (waivers) for the conditions in Enclosure 3, including a mechanism to track and archive all approved or denied waivers and the medical conditions requiring the waivers.

b. Serve as the final approval authority for exceptions to the medical standards (waivers) made pursuant to the procedures in this Instruction.

5. COMMANDER, UNITED STATES SPECIAL OPERATIONS COMMAND (CDRUSSOCOM). The CDRUSSOCOM shall perform the responsibilities in section 2 of this enclosure for SOF personnel.

Department of Defense
INSTRUCTION

NUMBER 6490.08
August 17, 2011

USD(P&R)

SUBJECT: Command Notification Requirements to Dispel Stigma in Providing Mental Health Care to Service Members

References: See Enclosure 1

1. PURPOSE. In accordance with the authority in DoD Directive 5124.02 (Reference (a)), this Instruction:

a. Establishes policy, assigns responsibilities, and prescribes procedures for healthcare providers for determining command notification requirements as applied to:

(1) Service members' involvement in mental health care pursuant to paragraph C7.11.1. of DoD 6025.18-R (Reference (b)) and parts 160 and 164 of title 45, Code of Federal Regulations (Reference (c)).

(2) Service members voluntarily seeking drug and alcohol abuse education (as distinguished from substance abuse treatment), consistent with DoD Directive 1010.4 (Reference (d)), requiring DoD personnel to receive education pertaining to drug and alcohol abuse.

b. Provides guidance for balance between patient confidentiality rights and the commander's right to know for operation and risk management decisions.

c. Incorporates and cancels Directive-Type Memorandum 09-006 (Reference (e)).

2. APPLICABILITY. This Instruction:

a. Applies to OSD, the Military Departments, the Office of the Chairman of the Joint Chiefs of Staff and the Joint Staff, the Combatant Commands, 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 (hereinafter referred to collectively as the "DoD Components").

b. Applies only to healthcare provider disclosures to command authorities under paragraph C7.11.1 of Reference (b).

3. POLICY. It is DoD policy that:

a. The DoD shall foster a culture of support in the provision of mental health care and voluntarily sought substance abuse education to military personnel in order to dispel the stigma of seeking mental health care and/or substance misuse education services.

b. Healthcare providers shall follow a presumption that they are not to notify a Service member's commander when the Service member obtains mental health care or substance abuse education services.

(1) Unless this presumption is overcome by one of the notification standards listed in Enclosure 2 of this Instruction, there shall be no command notification.

(2) In making a disclosure pursuant to the notification standards, healthcare providers shall provide the minimum amount of information to the commander concerned as required to satisfy the purpose of the disclosure.

4. RESPONSIBILITIES

a. Heads of DoD Components. The Heads of the DoD Components shall require Component compliance with the policies and procedures of this Instruction.

b. Director, TRICARE Management Activity. The Director, TRICARE Management Activity under the authority, direction, and control of the Under Secretary of Defense for Personnel and Readiness, shall establish procedures comparable to those in Enclosure 2 for applicability to non-DoD health care providers in the context of mental health services provided to Service members under the TRICARE program.

5. PROCEDURES. See Enclosure 2.

6. RELEASABILITY. UNLIMITED. This Instruction is approved for public release and is available on the Internet from the DoD Issuances Website at http://www.dtic.mil/whs/directives.

7. EFFECTIVE DATE. This Instruction is effective upon its publication to the DoD Issuances Website.

Clifford L. Stanley
Under Secretary of Defense for
Personnel and Readiness

Enclosures
1. References
2. Procedures

ENCLOSURE 1

REFERENCES

(a) DoD Directive 5124.02, "Under Secretary of Defense for Personnel and Readiness (USD(P&R))," June 23, 2008
(b) DoD 6025.18-R, "DoD Health Information Privacy Regulation," January 24, 2003
(c) Parts 160 and 164 of title 45, Code of Federal Regulations
(d) DoD Directive 1010.4, "Drug and Alcohol Abuse by DoD Personnel," September 3, 1997
(e) Directive-Type Memorandum 09-006, "Revising Command Notification Requirements to Dispel Stigma in Providing Mental Health Care to Military Personnel", July 2, 2009 (hereby cancelled)
(f) DoD Instruction 6400.06, "Domestic Abuse Involving DoD Military and Certain Affiliated Personnel," August 21, 2007
(g) DoD Instruction 5210.42, "Nuclear Weapons Personnel Reliability Program (PRP)," October 16, 2006
(h) DoD Instruction 1010.6, "Rehabilitation and Referral Services for Alcohol and Drug Abusers," March 13, 1985
(i) DoD Directive 6490.1, "Mental Health Evaluations of Members of the Armed Forces," October 1, 1997
(j) DoD Directive 5400.11, "DoD Privacy Program," May 7, 2007

ENCLOSURE 2

PROCEDURES

1. HEALTHCARE PROVIDERS

a. Command notification by healthcare providers will not be required for Service member self and medical referrals for mental health care or substance misuse education unless disclosure is authorized for one of the reasons listed in subparagraphs 1.b.(1) through1.b.(9) of this enclosure.

b. Healthcare providers shall notify the commander concerned when a Service member meets the criteria for one of the following mental health and/or substance misuse conditions or related circumstances:

(1) Harm to Self. The provider believes there is a serious risk of self-harm by the Service member either as a result of the condition itself or medical treatment of the condition.

(2) Harm to Others. The provider believes there is a serious risk of harm to others either as a result of the condition itself or medical treatment of the condition. This includes any disclosures concerning child abuse or domestic violence consistent with DoD Instruction 6400.06 (Reference (f)).

(3) Harm to Mission. The provider believes there is a serious risk of harm to a specific military operational mission. Such serious risk may include disorders that significantly impact impulsivity, insight, reliability, and judgment.

(4) Special Personnel. The Service member is in the Personnel Reliability Program as described in DoD Instruction 5210.42 (Reference (g)), or is in a position that has been pre-identified by Service regulation or the command as having mission responsibilities of such potential sensitivity or urgency that normal notification standards would significantly risk mission accomplishment.

(5) Inpatient Care. The Service member is admitted or discharged from any inpatient mental health or substance abuse treatment facility as these are considered critical points in treatment and support nationally recognized patient safety standards.

(6) Acute Medical Conditions Interfering With Duty. The Service member is experiencing an acute mental health condition or is engaged in an acute medical treatment regimen that impairs the Service member's ability to perform assigned duties.

(7) Substance Abuse Treatment Program. The Service member has entered into, or is being discharged from, a formal outpatient or inpatient treatment program consistent with DoD Instruction 1010.6 (Reference (h)) for the treatment of substance abuse or dependence.

(8) Command-Directed Mental Health Evaluation. The mental health services are obtained as a result of a command-directed mental health evaluation consistent with DoD Directive 6490.1 (Reference (i)).

(9) Other Special Circumstances. The notification is based on other special circumstances in which proper execution of the military mission outweighs the interests served by avoiding notification, as determined on a case-by-case basis by a health care provider (or other authorized official of the medical treatment facility involved) at the O-6 or equivalent level or above or a commanding officer at the O-6 level or above.

c. In making a disclosure pursuant to the circumstances described in subparagraphs 1.b.(1) through 1.b.(9) of this enclosure, healthcare providers shall provide the minimum amount of information to satisfy the purpose of the disclosure. In general, this shall consist of:

(1) The diagnosis; a description of the treatment prescribed or planned; impact on duty or mission; recommended duty restrictions; the prognosis; any applicable duty limitations; and implications for the safety of self or others.

(2) Ways the command can support or assist the Service member's treatment.

d. Healthcare providers shall maintain records of disclosure of protected health information consistent with Reference (b).

2. COMMANDER DESIGNATION. Notification to the commander concerned pursuant to this Instruction shall be to the commander personally or to another person specifically designated in writing by the commander for this purpose.

3. COMMANDERS. Commanders shall protect the privacy of information provided pursuant to this Instruction and DoD Directive 5400.11 (Reference (j)) as they should with any other health information. Information provided shall be restricted to personnel with a specific need to know; that is, access to the information must be necessary for the conduct of official duties. Such personnel shall also be accountable for protecting the information. Commanders must also reduce stigma through positive regard for those who seek mental health assistance to restore and maintain their mission readiness, just as they would view someone seeking treatment for any other medical issue.

DoD Instruction 6130.03, Volume 2

Medical Standards for Military Service: Retention

Originating Component:	Office of the Under Secretary of Defense for Personnel and Readiness
Effective: **Change 1 Effective**	September 4, 2020 June 6, 2022
Releasability:	Cleared for public release. Available on the Directives Division Website at https://www.esd.whs.mil/DD/.
Approved by:	Matthew P. Donovan, Under Secretary of Defense for Personnel and Readiness
Change 1 Approved by:	Lloyd J. Austin III, Secretary of Defense

Purpose: This instruction is composed of two volumes, each containing its own purpose. In accordance with the authority in DoD Directive 5124.02:

- This instruction establishes policy, assigns responsibilities, and prescribes procedures for medical standards for the Military Services.
- This volume establishes medical retention standards and the Retention Medical Standards Working Group (RMSWG), under the Medical and Personnel Executive Steering Committee (MEDPERS), to provide policy recommendations related to this instruction.

TABLE OF CONTENTS

SECTION 1: GENERAL ISSUANCE INFORMATION

1.1. APPLICABILITY.

a. This volume applies to 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 and the Joint Staff, the Combatant Commands, 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 volume as the "DoD Components").

b. Gender dysphoria-related standards in this volume do not apply to Service members considered exempt pursuant to DoDI 1300.28.

1.2. POLICY.

It is DoD policy that:

a. Service members meet DoD medical standards established in this volume to be retained in the Military Services.

b. Service members who are unable to successfully complete their assigned duties while deployed, stationed with only operational healthcare unit support, or while in garrison conditions, be referred to:

(1) The Disability Evaluation System (DES), on a case-by-case basis, in accordance with DoD Instruction (DoDI) 1332.18 and DoDI 1332.45; or

(2) For conditions not constituting a disability, the responsible Military Department for possible administrative action, in accordance with DoDI 1332.14 or DoDI 1332.30.

c. DoD medical standards for military retention are consistent with:

(1) The criteria for DES referral, in accordance with DoDI 1332.18 and other military requirements, as further defined in Paragraph 3.2 of this volume.

(2) Deployment requirements, as defined in DoDI 6490.07, and a broader definition of deployability, as defined in DoDI 1332.18.

(3) Retention determinations for certain non-deployable Service members in accordance with DoDI 1332.45.

(4) Military Health System (MHS) efforts to improve performance, economy, and efficiency.

d. Additional, more selective medical standards for military retention may be established by the Secretaries of the Military Departments based on the Service member's office, grade, rank, or rating, as long as such standards are objectively applied and are not inconsistent with applicable laws or DoD policies.

1.3. SUMMARY OF CHANGE 1.

In accordance with the June 6, 2022 Secretary of Defense memorandum, the changes to this issuance update DoD policy with respect to individuals who have been identified as HIV-positive. Individuals who have been identified as HIV-positive, are asymptomatic, and who have a clinically confirmed undetectable viral load will have no restrictions applied to their deployability or to their ability to commission while a Service member solely on the basis of their HIV-positive status. Nor will such individuals be discharged or separated solely on the basis of their HIV-positive status.

SECTION 2: RESPONSIBILITIES

2.1. UNDER SECRETARY OF DEFENSE FOR PERSONNEL AND READINESS (USD(P&R)).

The USD(P&R):

a. Eliminates inconsistencies and inequities based on race, sex, or duty location in DoD Component application of these standards.

b. Maintains and convenes the chartered MEDPERS, in accordance with Volume 1 of this instruction.

2.2. ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS (ASD(HA)).

Under the authority, direction, and control of the USD(P&R), the ASD(HA):

a. Reviews, approves, and issues technical modifications to the standards in Section 5 to the DoD Components.

b. Reviews implementation of medical standards for military retention throughout the MHS and provides guidance to the Director, Defense Health Agency (DHA) and the Secretaries of the Military Departments.

2.3. DEPUTY ASSISTANT SECRETARY OF DEFENSE FOR HEALTH SERVICES POLICY AND OVERSIGHT (DASD(HSP&O)).

Under the authority, direction, and control of the ASD(HA), the DASD(HSP&O):

a. Reviews the standards in Section 5, associated Service-specific regulations, and Service-specific medical standards for retention, in terms of performance, economy, and efficiency throughout the MHS, and provides appropriate policy recommendations to the ASD(HA).

b. Coordinates revisions to policies related to this volume with relevant DoD Components.

c. Selects a co-chair for the RMSWG and requires records of the RMSWG be maintained and retained, in accordance with all legal requirements.

2.4. DEPUTY ASSISTANT SECRETARY OF DEFENSE FOR MILITARY PERSONNEL POLICY (DASD(MPP)).

Under the authority, direction, and control of the ASD(M&RA), the DASD(MPP):

a. Coordinates revisions to policies related to this volume with relevant DoD Components.

b. Selects a co-chair for the RMSWG.

2.5. DIRECTOR, DHA.

Under the authority, direction, and control of the USD(P&R), through the ASD(HA), the Director, DHA:

a. Publishes DHA procedural instructions necessary to implement this volume.

b. Uses the planning, programing, budgeting, and execution process to allocate resources necessary for the evaluation of medical conditions, in accordance with this volume and Service-specific medical standards for military retention.

c. Supports MHS efforts to monitor and improve medical standards for military retention.

d. Selects a representative for the RMSWG.

2.6. SECRETARIES OF THE MILITARY DEPARTMENTS AND COMMANDANT, UNITED STATES COAST GUARD (USCG).

The Secretaries of the Military Departments and the Commandant, USCG:

a. Provide guidance necessary to implement this volume and Service-specific retention medical standards, as required, to refer Service members to the:

(1) DES, in accordance with DoDI 1332.18, DoDI 1332.45, and this volume; or

(2) For members of the USCG, the USCG Physical DES, pursuant to the Commandant Instruction M1850.2 series.

b. Select a representative for the RMSWG.

SECTION 3: PROCEDURES FOR APPLYING MEDICAL STANDARDS

3.1. APPLICABILITY OF RETENTION MEDICAL STANDARDS.

The medical standards in Section 5 apply to:

a. All current Service members, including those:

(1) Accessed with a medical waiver in accordance with Volume 1 of this instruction and DoDI 1332.18.

(2) Previously found fit by the DES, in accordance with DoDI 1332.18, when the condition progresses and has become potentially unfitting.

b. Former Service members being medically evaluated for return to military service when the applicability criteria in Paragraph 4.1 of Volume 1 of this instruction does not apply.

3.2. APPLICATION OF CRITERIA USED TO DEVELOP STANDARDS.

The standards in Section 5 will be applied on a case-by-case basis considering the following criteria:

a. The affected Service member's ability to safely complete common military tasks at a general duty level. Tasks may include, but are not limited to:

(1) Climbing and going down structures such as stairs, a ladder, ladderwells, or a cargo net.

(2) Wearing personal protective gear.

(3) Running 100 yards.

(4) Standing in formation.

(5) Carrying personal equipment.

(6) Operating a vehicle.

(7) Operating an assigned weapons system, to include safe operation of an individual firearm.

(8) Subsisting on field rations.

(9) Working in extreme environments or confined spaces.

(10) Operating for extended work periods.

(11) Communicating effectively.

b. Limitations or requirements due to medical condition(s) or objections to recommended medical interventions that:

(1) Impose unreasonable medical requirements on the Military Services to maintain or protect the Service member.

(2) Require diagnostic(s), treatment(s), or surveillance for longer than 12 months that is not anticipated to be routinely available in operational locations, unless approved by the Service member's unit commander in accordance with DoDI 1332.45.

(3) Present an obvious risk to the health or safety of the member, other Service members, or other personnel serving with or accompanying an armed force in the field.

(4) Are of such a nature or duration that progressive worsening or effects of external stressors are reasonably expected to result in a grave medical outcome or an unacceptable negative impact on mission execution.

(5) Are incompatible with the physical and psychological demands required for deployment and the Service member's office, grade, rank, or rating.

3.3. IMPLEMENTATION.

a. The Military Department(s) concerned will:

(1) Apply the standards in Section 5 on a case-by-case basis.

(2) Consider which criteria in Paragraph 3.2. apply to the Service member's office, grade, rank, or rating.

(3) Determine if the Service member should be referred to the DES.

(4) Perform these evaluations in accordance with Service-specific regulations before or during the medical evaluation board component of the DES process.

b. Service members will be referred to the DES in accordance with DoDI 1332.18. The standards listed in Section 5 do not include all of the conditions that may be referred to the DES or that are compensable in accordance with Part 4 of Title 38, Code of Federal Regulations also known as "the Department of Veterans Affairs Schedule for Rating Disabilities (VASRD)". In the event of conflicting guidance or lack of a defined standard in this volume, DoDI 1332.18 will take precedence.

c. Military Departments may authorize administrative separation processing of Service members with medical conditions and circumstances not constituting a physical disability, in accordance with DoDI 1332.14 or DoDI 1332.30, that interfere with assignment or performance

of duty, if the Service member is ineligible for referral to the DES, pursuant to DoDI 1332.18, or the USCG Physical DES, pursuant to the Commandant Instruction M1850.2 series.

d. Military Department regulations regarding presumption of fitness are considered by medical and administrative personnel when applying the standards in Section 5.

e. Medical diagnoses and duty limitations will be made in conjunction with referrals or information provided by the appropriate medical specialty, in accordance with this volume and Military Service-specific regulations.

f. Military Departments will coordinate requirements for clinical evaluations, information technology, and access to medical records with the Director, DHA.

g. If a Service member fails to consent to medically appropriate treatment for a potentially disqualifying condition, the condition is considered refractory to treatment and may result in the Service member not being eligible for retention. The Military Department concerned will take appropriate administrative action in accordance with Military Department-specific policies.

SECTION 4: ACTIVITIES OF THE RMSWG

4.1. PURPOSE OF THE RMSWG.

The RMSWG—a chartered working group under the MEDPERS—convenes at least twice a year, under the joint guidance of the DASD(HSP&O) and the DASD(MPP), to review and develop policy relevant to this volume.

4.2. OVERALL GOALS OF THE RMSWG.

The RMSWG will:

a. Review and develop proposed changes to this volume in accordance with DoDI 5025.01.

b. Draft DoD medical standards for military retention based on DoD mission requirements, available scientific evidence, and expert opinion.

c. Evaluate DoD Component implementation of the standards in Section 5 of this volume.

d. Respond to requests from the MEDPERS.

e. Periodically reassess the goals of the RMSWG.

4.3. CO-CHAIRS OF THE RMSWG.

The DASD(HSP&O) and the DASD(MPP) will each select one representative to co-chair the RMSWG. The RMSWG co-chairs will:

a. Draft the RMSWG charter for MEDPERS approval.

b. Record and retain meeting minutes and other committee records.

c. Schedule meetings as required.

4.4. MEMBERSHIP OF THE RMSWG.

The RMSWG membership will include medical and personnel representatives from:

a. Each Military Service.

b. The Joint Staff.

c. Other organizations as required in accordance with the RMSWG charter.

SECTION 5: DISQUALIFYING CONDITIONS

5.1. GENERAL.

The medical standards for military retention are classified into general systems in this section. Unless otherwise stipulated, these are the conditions that do not meet the retention standard. These conditions must persist despite appropriate treatment and impair function to preclude satisfactory performance of required military duties of the Service member's office, grade, rank, or rating.

5.2. HEAD.

Defects of the skull, face, or mandible to a degree that prevents the member from properly wearing required protective equipment (e.g., military headgear) are not compatible with retention. The condition must persist despite appropriate treatment and impair function so as to preclude satisfactory performance of required military duties of the Service member's office, grade, rank, or rating.

5.3. EYES.

a. When considering the conditions listed in this paragraph, the condition must persist despite appropriate treatment and impair function to preclude satisfactory performance of required military duties of the Service member's office, grade, rank, or rating.

b. Any chronic disease process or condition of the eye, lids, or visual system that is resistant to treatment and does not meet the vision standards in Paragraph 5.4.

c. Corneal degeneration, when contact lenses or other special corrective devices (e.g., telescopic lenses, electronic magnifiers) are required to prevent progression or to meet the standards in Paragraph 5.4.

d. Aphakia, bilateral if not a surgical candidate. This condition is not compatible with retention and the Service should initiate appropriate medical and personnel actions upon diagnosis. Paragraph 5.3.a does not apply.

e. Binocular diplopia, not correctable by surgery, that is severe, constant, and in a zone less than 20 degrees from the primary position.

f. Bilateral concentric constriction to less than 40 degrees interfering with the ability to safely perform duty.

g. Absence of an eye or enucleation. This condition is not compatible with retention and the Services should initiate appropriate medical and personnel actions upon diagnosis. Paragraph 5.3.a. does not apply.

h. Night blindness requiring assistance to travel at night or resulting in duty limitations due to an inability to perform night missions.

i. Any chronic eye diseases requiring treatment with systemic immunosuppressant medication.

5.4. VISION.

When considering the conditions listed in this paragraph, the condition must persist despite appropriate treatment and impair function to preclude satisfactory performance of required military duties of the Service member's office, grade, rank, or rating. Vision standards must be met with the unaided eye or clear glasses without specialized optical aids including, but not limited to, telescopic, magnifying, or tinted lenses (excluding sunglasses for routine wear). Color vision standards will be set by the individual DoD Components.

a. With both eyes open, best corrected for both distant and near vision of at least 20/40.

b. Any condition that specifically requires contact lenses for correction of vision.

c. Anisometropia worse than 3.5 diopters (spherical equivalent difference).

d. Any scotoma large enough to impair duty performance including, but not limited to, permanent hemianopsia.

5.5. EARS.

When considering the conditions listed in this paragraph, the condition must persist despite appropriate treatment and impair function to preclude satisfactory performance of required military duties of the Service member's office, grade, rank, or rating.

a. Persistent defect that prevents the proper wearing of required military equipment (e.g., hearing protection).

b. Ménière's disease and other disorders of balance or sensorium with frequent and severe attacks that interfere with satisfactory performance of duty.

c. Any conditions of the ear that persist despite appropriate treatment and necessitate frequent and prolonged medical care or hospitalization (e.g., cholesteatoma, chronic otitis infections, and associated secondary changes).

5.6. HEARING.

Hearing loss that prohibits safe performance of duty, with or without hearing aids or other assistive devices is not compatible with retention. The condition must persist despite appropriate treatment and impair function to preclude satisfactory performance of required military duties of the Service member's office, grade, rank, or rating.

5.7. NOSE, SINUSES, MOUTH, AND LARYNX.

When considering the conditions listed in this paragraph, the condition must persist despite appropriate treatment and impair function to preclude satisfactory performance of required military duties of the Service member's office, grade, rank, or rating.

a. Vocal cord dysfunction characterized by bilateral vocal cord paralysis or dysfunction significant enough to interfere with speech or cause respiratory compromise upon exertion.

b. Any persistent condition of the sinuses or nasal cavity that requires ongoing medical care beyond operationally available maintenance medications to maintain sinonasal function.

c. Conditions or defects of the mouth, tongue, palate, throat, pharynx, larynx, and nose that interfere with chewing, swallowing, speech, or breathing.

5.8. DENTAL.

Diseases and abnormalities of the jaw or associated tissues that prevent normal mastication, speech, or proper wear of required protective equipment are not compatible with retention. The condition must persist despite appropriate treatment and impair function to preclude satisfactory performance of required military duties of the Service member's office, grade, rank, or rating.

5.9. NECK.

Limited range of motion of the neck that impairs normal function is not compatible with retention. The condition must persist despite appropriate treatment and impair function to preclude satisfactory performance of required military duties of the Service member's office, grade, rank, or rating.

5.10. LUNGS, CHEST WALL, PLEURA, AND MEDIASTINUM.

When considering the conditions listed in this paragraph, the condition must persist despite appropriate treatment and impair function to preclude satisfactory performance of required military duties of the Service member's office, grade, rank, or rating. Conditions in this paragraph do not meet the standards if the Service member cannot meet Service-specific pulmonary functional assessment (e.g., trial of duty or established standard) or if medical clearance cannot be given for safe participation in Service-specific physical fitness testing.

a. Asthma or airway hyper responsiveness with:

(1) Persistent symptoms;

(2) Forced expiratory volume in one second (FEV1) persistently below 70 percent despite treatment with inhaled corticosteroids; or

(3) More than once required oral steroid or emergent asthma treatment in the previous 12 months.

b. Chronic obstructive pulmonary disease with:

(1) Persistent symptoms;

(2) FEV1 between 50 percent and 79 percent of predicted FEV1 that cannot pass Service-determined functional assessments;

(3) FEV1 of less than 50 percent of predicted FEV1, despite treatment with inhaled corticosteroids; or

(4) More than one required hospitalization in the previous 12 months.

c. Bronchiectasis, if severe or symptomatic.

d. Thoracic cavity malformation or dysfunction, including pectus excavatum, pectus carinatum, or diaphragmagtic defect, if it is symptomatic or interferes with the wearing of military equipment or the performance of military duty.

e. Chronic or recurrent pulmonary disease or symptoms including, but not limited to:

(1) Pulmonary fibrosis;

(2) Emphysema;

(3) Interstitial lung disease;

(4) Pulmonary sarcoidosis;

(5) Pleurisy; or

(6) Residuals of surgery that prevent satisfactory performance of duty.

f. Recurrent spontaneous pneumothorax, when the underlying defect is not correctable by surgery.

g. Tuberculosis, pulmonary or extra pulmonary, with clinically significant sequelae following treatment, if resistant to treatment or if the condition is of such severity that the individual is not expected to return to full duty despite appropriate treatment.

h. Pulmonary embolism, recurrent or a single episode, if anticoagulation medications, other than aspirin, are clinically indicated for longer than 12 months.

i. Cystic fibrosis.

j. Any condition for which chronic use of supplemental oxygen is indicated.

5.11. HEART.

a. When considering the conditions listed in this paragraph, the condition must persist despite appropriate treatment and impair function to preclude satisfactory performance of required military duties of the Service member's office, grade, rank, or rating. Conditions in this paragraph do not meet the standards if the Service member cannot meet Service-specific cardiac functional assessment (e.g., a Service-defined trial of duty period) or if medical clearance cannot be given for safe participation in Service-specific physical fitness testing due to risk of disease progression or adverse cardiac event.

b. Heart valve disease; including:

(1) Any valve replacement. This condition is not compatible with retention and the Service should initiate appropriate medical and personnel actions after post-operative recovery (or a period of Limited Duty). Paragraph 5.11.a does not apply.

(2) Moderate or worse valvular insufficiency or regurgitation if a cardiologist determines that the Service member has physical activity or duty restrictions to reduce the risk of disease progression or an adverse cardiac event.

(3) Mild or worse valvular stenosis if a cardiologist determines the Service member has physical activity or duty restrictions to reduce the risk of disease progression or adverse cardiac event.

c. Cardiomyopathy or heart failure; including:

(1) Persistent cardiomyopathy or heart failure related to a potentially reversible condition when a cardiologist determines that the underlying etiology is uncorrectable.

(2) Cardiomyopathy or heart failure, upon diagnosis, when secondary to an underlying permanent condition including, but not limited to: hypertrophic cardiomyopathy, amyloidosis, sarcoidosis, ventricular non-compaction syndrome, and arrhythmogenic right ventricular cardiomyopathy. This condition is not compatible with retention and the Service should initiate appropriate medical and personnel actions upon diagnosis. Paragraph 5.11.a does not apply.

d. Clinical indication or presence of pacemaker or implantable cardioverter-defibrillator. This condition is not compatible with retention and the Service should initiate appropriate medical and personnel actions upon diagnosis. Paragraph 5.11.a does not apply.

e. Atrial and ventricular arrhythmias, other than isolated Premature Ventricular Contractions and Premature Atrial Contractions, unless successfully ablated (if indicated) and cleared by a cardiologist for unrestricted exercise.

f. Channelopathies reliably diagnosed by a cardiologist that predisposes to sudden cardiac death and syncope including, but not limited to:

(1) Brugada pattern;

(2) Acquired or Congenital Long QT syndrome; or

(3) Catecholiminergic Polymorphic Ventricular Tachycardia. This condition is not compatible with retention and the Service should initiate appropriate medical and personnel actions upon diagnosis. Paragraph 5.11.a does not apply.

g. Pre-excitation pattern (e.g., Wolff-Parkinson-White pattern) unless it is asymptomatic and associated with low-risk accessory pathway by appropriate diagnostic testing, or successfully treated with ablation.

h. Conduction disorders associated with potentially fatal or severely symptomatic events including, but not limited to:

(1) Disorders of sinus arrest;

(2) Asystole;

(3) Mobitz type II second-degree atrioventricular block;

(4) Third-degree atrioventricular block; or

(5) Sudden cardiac death unless associated with recognizable temporary precipitating conditions (e.g., perioperative period, hypoxia, electrolyte disturbance, drug toxicity, infection, or acute illness). This condition is not compatible with retention and the Service should initiate appropriate medical and personnel actions upon diagnosis. Paragraph 5.11.a does not apply.

i. Coronary artery disease; including:

(1) Acute Coronary Syndrome (ST-elevation myocardial infarction or Non-ST elevation myocardial infarction):

(a) That required intervention including, but not limited to:

1. Percutaneous coronary intervention;

2. Coronary artery bypass grafting; or

3. Thrombolytic medication.

(b) For which anti-platelet therapy, other than aspirin, occurs for longer than 12 months.

(2) Stable coronary disease, unless there is no evidence of ischemia and the Service member can achieve 10 metabolic equivalents while on optimal medical therapy.

j. Chronic pericardial disease, reliably diagnosed by a cardiologist.

k. Complex congenital heart disease including, but not limited to: tetrology of Fallot, coarctation of the aorta, and Ebstein's anomaly, unless successfully treated by surgical or percutaneous correction.

l. Symptomatic or hemodynamically significant anatomic intracardiac shunts including, but not limited to: patent foramen ovale, atrial septal defect, and ventricular septal defect, if persistent despite surgical or percutaneous correction (as indicated).

m. Recurrent syncope or near syncope (including postural orthostatic tachycardia syndrome) that interferes with duty, if no treatable cause is identified or it persists despite conservative therapy.

n. Rheumatic heart disease, if sequelae present.

o. History of spontaneous coronary artery dissection.

p. Surgery of the heart or pericardium with persistent duty limitations.

5.12. ABDOMINAL ORGANS AND GASTROINTESTINAL SYSTEM.

When considering the conditions listed in this paragraph, the condition must persist despite appropriate treatment and impair function to preclude satisfactory performance of required military duties of the member's office, grade, rank, or rating. Conditions in this paragraph do not meet retention standards if associated with the inability to maintain normal weight or nutrition, require repeated procedures or surgery, or if the condition requires immunomodulating or immunosuppressant medications.

a. Esophageal stricture, including manifestations of eosinophilic esophagitis, that requires a restricted diet or frequent dilatation.

b. Persistent esophageal disease (e.g., dysmotility disorders, achalasia, esophagitis, esophageal spasm) that is severe, or results in dysphagia.

c. Gastritis, if severe, with recurring symptoms not relieved by medication, surgery, or endoscopic intervention.

d. Non-ulcerative or functional dyspepsia not controlled by medications.

e. Recurrent gastric or duodenal ulcer, with or without obstruction or perforation confirmed by laboratory, imaging, or endoscopy.

f. Inflammatory bowel disease including, but not limited to:

(1) Crohn's disease;

(2) Ulcerative colitis;

(3) Ulcerative proctitis;

(4) Regional enteritis;

(5) Granulomatous enteritis;

(6) Chronic or recurrent indeterminate colitis; or

(7) Microscopic colitis that requires treatment with immune modulator or biologic medications.

g. Chronic proctitis with moderate to severe symptoms of bleeding, painful defecation, tenesmus, or diarrhea.

h. Malabsorption syndromes including those related to:

(1) Celiac sprue;

(2) Pancreatic insufficiency; or

(3) Sequelae of surgery including, but not limited to:

(a) Bariatric surgery;

(b) Colectomy; or

(c) Gastrectomy.

i. Functional gastrointestinal disorders, including but not limited to irritable bowel syndrome.

j. Familial adenomatous polyposis syndrome (e.g., classic or attenuated) or hereditary non-polyposis colon cancer (i.e., Lynch syndrome).

k. Chronic hepatitis with impairment of liver function.

l. Cirrhosis of the liver, portal hypertension, esophageal varices, esophageal bleeding, or other complications of chronic liver disease, resulting from conditions including, but not limited to:

(1) Hemochromatosis.

(2) Alpha-1 anti-trypsin deficiency.

(3) Wilson's disease.

(4) Alcoholic and non-alcoholic fatty liver disease.

m. Chronic gallbladder disease or biliary dyskinesia with frequent abdominal pain or recurrent jaundice.

n. Chronic liver disease because of trauma or infection, to include amoebic abscess or liver transplant recipient(s).

o. Chronic or recurrent pancreatitis.

p. Pancreatectomy or pancreas (whole organ or islet cell) transplant recipient(s).

q. Pancreaticduodenostomy, pancreaticgastrostomy, or pancreaticojejunostomy, with chronic digestive system dysfunction.

r. Acquired fecal incontinence or obstruction characterized by intractable constipation or pain on defecation.

s. Severe symptomatic hernia, including abdominal wall or hiatal.

t. Total colectomy or any partial colectomy with residual limitations.

u. Total gastrectomy, or any partial gastroectomy or gastrojejunostomy with residual limitations.

v. Colostomy, jejunostomy, ileostomy, or gastrostomy, if permanent.

5.13. FEMALE GENITAL SYSTEM.

When considering the conditions listed in this paragraph, the condition must persist despite appropriate treatment and impair function to preclude satisfactory performance of required military duties of the Service member's office, grade, rank, or rating.

a. Genital trauma or abnormalities that result in urinary incontinence or the need for catheterization.

b. Chronic pelvic pain, with or without an identifiable diagnosis, such as dysmenorrhea, endometriosis, or ovarian cysts.

c. Premenstrual dysphoric disorder.

d. Abnormal uterine bleeding resulting in anemia.

e. Chronic breast pain, so as to prevent satisfactory wearing of military equipment.

5.14. MALE GENITAL SYSTEM.

When considering the conditions listed in this paragraph, the condition must persist despite appropriate treatment and impair function to preclude satisfactory performance of required military duties of the Service member's office, grade, rank, or rating.

a. Absence of both testicles with medically required injectable hormone therapy.

b. Epispadias or hypospadias when accompanied by persistent urinary complications.

c. Chronic pelvic pain, with or without an identifiable diagnosis, to include chronic prostatitis, epididymitis, scrotal pain, or orchitis.

d. Genital trauma or abnormalities that result in urinary incontinence or the need for catheterization.

5.15. URINARY SYSTEM.

a. When considering the conditions listed in this paragraph, the condition must persist despite appropriate treatment and impair function to preclude satisfactory performance of required military duties of the Service member's office, grade, rank, or rating.

b. Chronic or interstitial cystitis.

c. Chronic incontinence, dysfunction, or urinary retention requiring catheterization.

d. Cystoplasty, if reconstruction is unsatisfactory or if refractory symptomatic infections persist.

e. Ureterointestinal or direct cutaneous urinary diversion.

f. Urethral abnormalities, if they:

(1) Result in chronic incontinence;

(2) Result in the persistent need for catheterization; or

(3) Require a urethrostomy, if a satisfactory urethra cannot be restored.

g. Ureteral abnormalities, including ureterocystostomy, if both ureters are markedly dilated with irreversible changes, or if they result in:

(1) Recurrent obstruction;

(2) Kidney infection; or

(3) Other chronic kidney dysfunction.

h. Kidney transplant recipient(s). This condition is not compatible with retention and the Service should initiate appropriate medical and personnel actions upon diagnosis. Paragraph 5.15.a. does not apply.

i. Chronic or recurrent pyelonephritis with secondary hypertension or hypertensive end-organ damage.

j. Kidney abnormalities, including:

(1) Polycystic kidney disease;

(2) Horseshoe kidney;

(3) Hypoplasia of the kidney; or

(4) Residuals of perirenal abscess when renal function is:

(a) Impaired;

(b) Associated with secondary hypertension or hypertensive end-organ damage; or

(c) The focus of frequent infection.

k. Hydronephrosis associated with significant systemic effects, renal impairment, secondary hypertension, hypertensive end-organ damage, or frequent infections.

l. Chronic kidney disease, stage 3A or worse, according to the Kidney Disease Improving Global Outcomes Guidelines Standard, as reliably diagnosed by a nephrologist. Any level of chronic kidney disease for which chronic immunosuppressant medications (e.g., medication for steroid relapsing glomerulonephritis) are required. This condition is not compatible with retention and the Service should initiate appropriate medical and personnel actions upon diagnosis. Paragraph 5.15.a does not apply.

m. Chronic nephritis or nephrotic syndrome. Service-specific criteria for proteinuria may apply.

n. Recurrent calculi that:

(1) Result in recurring infections;

(2) Result in obstructive uropathy unresponsive to medical or surgical treatment; or

(3) Are symptomatic and occur with a frequency that prevents satisfactory performance of duty.

5.16. SPINE AND SACROILIAC JOINT CONDITIONS.

When considering the conditions listed in this paragraph, the condition must persist despite appropriate treatment and impair function to preclude satisfactory performance of required military duties of the Service member's office, grade, rank, or rating. Conditions in this paragraph do not meet retention standards if medical clearance cannot be given for safe participation in Service-specific physical fitness testing.

a. Spondyloarthritis. Chronic or recurring episodes of axial or peripheral arthritis that may include extra-articular involvement that:

(1) Causes functional impairment interfering with successful performance of duty supported by objective, subjective, and radiographic findings; or

(2) Requires medication for control that needs frequent monitoring by a physician due to debilitating or serious side effects including, but not limited to:

(a) Ankylosing spondylitis;

(b) Reactive arthritis;

(c) Psoriatic arthritis; or

(d) Arthritis associated with inflammatory bowel disease.

b. Radicular or non-radicular pain involving the cervical, thoracic, lumbosacral, or coccygeal spine, whether idiopathic or secondary to degenerative disc or joint disease.

c. Kyphosis:

(1) Resulting in greater than 50 degrees of curvature, if symptomatic, so as to limit the wearing of military equipment; or

(2) If recurrently symptomatic, regardless of the degree of curvature.

d. Scoliosis:

(1) Resulting in severe deformity—greater than 30 degrees of curvature—if symptomatic, so as to limit the wearing of military equipment; or

(2) If recurrently symptomatic, regardless of the degree of curvature.

e. Congenital or surgical fusion or disc replacement.

f. Vertebral fractures after radiographic evidence of complete healing and experiencing moderate or severe symptoms that result in repeated acute medical visits.

g. Spina bifida with demonstrable signs and moderate symptoms of root or cord involvement.

h. Spondylolysis or spondylolisthesis with moderate or severe symptoms resulting in repeated acute medical visits.

5.17. UPPER EXTREMITY CONDITIONS.

When considering the conditions listed in this paragraph, the condition must persist despite appropriate treatment and impair function to preclude satisfactory performance of required military duties of the Service member's office, grade, rank, or rating. Conditions in this

paragraph do not meet retention standards if medical clearance cannot be given for safe participation in Service-specific physical fitness testing.

a. Limitation of joint motion.

b. Amputation of any part of hand and fingers.

c. Intrinsic paralysis or weakness of upper limbs when symptoms are severe and persistent.

5.18. LOWER EXTREMITY CONDITIONS.

When considering the conditions listed in this paragraph, the condition must persist despite appropriate treatment and impair function so as to preclude satisfactory performance of required military duties of the member's office, grade, rank, or rating. Conditions in this paragraph do not meet retention standards if medical clearance cannot be given for safe participation in Service-specific physical fitness testing.

a. Limitation of joint motion.

b. Foot and ankle conditions that include:

(1) Amputation of any part of the foot or toes.

(2) Conditions of the foot or toes that prevent the satisfactory performance of required military duty or the wearing of required military footwear, such as:

(a) Deformity of the toes;

(b) Clubfoot;

(c) Rigid pes planus;

(d) Recurrent plantar fasciitis; or

(e) Symptomatic neuroma.

c. Chronic foot, leg, knee, thigh, and hip conditions, such as:

(1) Chronic anterior knee pain;

(2) Instability after knee ligament reconstruction; or

(3) Recurrent stress fracture.

d. Coxa vara to such a degree that it results in chronic pain.

5.19. GENERALIZED CONDITIONS OF THE MUSCULOSKELETAL SYSTEM.

When considering the conditions listed in this paragraph, the condition must persist despite appropriate treatment and impair function so as to preclude satisfactory performance of required military duties of the member's office, grade, rank, or rating. Conditions in this paragraph do not meet retention standards if medical clearance cannot be given for safe participation in Service-specific physical fitness testing.

a. Persistent symptoms after any dislocation, subluxation, or instability of the hip, knee, ankle, subtalar joint, foot, shoulder, hand, wrist, or elbow.

b. Osteoarthritis or infectious arthritis with severe symptoms or traumatic arthritis.

c. Malunion, non-union, or hypertrophic ossification with persistent severe deformity or loss of function.

d. Prosthetic replacement of any joints, if there is resultant loss of function or persistent pain.

e. History of neuromuscular paralysis, weakness, contracture, or atrophy that is not completely resolved.

f. Osteopenia, osteoporosis, or osteomalacia resulting in fracture with residual symptoms after therapy.

g. Recurrent episodes of chronic osteomyelitis that:

(1) Are not responsive to treatment; or

(2) Involve the bone to a degree that interferes with stability and function.

h. Osteonecrosis, to include avascular necrosis of bone.

i. Chronic tendonitis, tenosynovitis, or tendinopathy.

j. Osteitis deformans (i.e., Paget's disease) that involve single or multiple bones and result in deformities or symptoms that severely interfere with function.

k. Chronic mechanical low back pain.

5.20. VASCULAR SYSTEM.

When considering the conditions listed in this paragraph, the condition must persist despite appropriate treatment and impair function so as to preclude satisfactory performance of required military duties of the member's office, grade, rank, or rating.

a. Abnormalities of the arteries including, but not limited to, aneurysms, arteriovenous malformations, or arteritis.

b. Peripheral artery disease including claudication and renal artery stenosis.

c. Hypertensive cardiovascular disease and hypertensive vascular disease.

(1) Essential hypertension that:

(a) Is not controlled despite an adequate period of therapy in an ambulatory status;

(b) Is associated with end organ damage; or

(c) Requires a treatment regimen that is not compatible with an operational environment.

(2) Secondary hypertension, unless the underlying cause has been treated with subsequent control of blood pressure.

d. Persistent peripheral vascular disease.

e. Venous disease that, despite appropriate treatment, results in:

(1) Persistent duty limitations.

(2) Limitations in the wearing of the military uniform.

f. Deep vein thrombosis (recurrent or a single episode), if anticoagulation medications, other than aspirin, are clinically indicated for longer than 12 months.

g. Surgery of the vascular system with persistent duty limitations.

h. Thoracic Outlet Syndrome including:

(1) Thoracic Outlet Syndrome—either neurogenic, arterial, or venous:

(a) With symptoms that are not controlled, despite an adequate period of therapy and surgery;

(b) That is associated with end organ damage, or

(c) That requires anticoagulation medication other than aspirin.

(2) Venous Thoracic Outlet Syndrome that required venous reconstruction with a stent or open surgery.

(3) Arterial Thoracic Outlet Syndrome that required arterial reconstruction with a bypass or interposition graft.

i. Popliteal Entrapment Syndrome:

(1) With symptoms that are not controlled despite an adequate period of therapy and surgery, is associated with end organ damage, or requires anticoagulation medication other than aspirin.

(2) That required arterial reconstruction with a bypass or interposition graft.

5.21. SKIN AND SOFT TISSUE CONDITIONS.

When considering the conditions listed in this paragraph, the condition must persist despite appropriate treatment and impair function so as to preclude satisfactory performance of required military duties of the member's office, grade, rank, or rating. Conditions in this paragraph do not meet standard if the Service member cannot properly wear the required military uniform or equipment.

a. Skin or soft tissue conditions, such as:

(1) Severe nodulocystic acne;

(2) Hidradenitis suppurativa;

(3) Inflammatory or scarring scalp disorders;

(4) Bullous dermatoses (including, but not limited to, dermatitis herpetiformis, emphigus, and epidermolysis bullosa);

(5) Lichen planus; or

(6) Panniculitis that prevents the proper wearing required military uniform or equipment.

b. Severe atopic dermatitis that prevents the proper wearing of required military uniform or equipment.

c. Any dermatitis, including eczematous or exfoliative, that prevents the proper wearing of required military uniform or equipment.

d. Persistent or recurrent symptomatic cysts, including pilonidal cysts or furunculosis, that prevent the proper wearing of required military uniform or equipment.

e. Chronic or current lymphedema.

f. Severe hyperhidrosis.

g. Scars or keloids that:

(1) Prevent the proper wearing of required military uniform or equipment; or

(2) Interfere with the function of an extremity or body area, including by limiting range of motion or causing chronic pain.

h. Neurofibromatosis, other than cutaneous neurofibromas.

i. Psoriasis or parapsoriasis that is uncontrolled or requires:

(1) Systemic immunomodulating;

(2) Immunosuppressant medications; or

(3) Ultraviolet light therapy.

j. Scleroderma that seriously interferes with the function of an extremity or body area.

k. Chronic urticaria or angioedema that is not responsive to treatment or requires duty limitations despite appropriate treatment.

l. Intractable symptomatic plantar keratosis.

m. Intractable superficial or deep fungal infections.

n. Malignant neoplasms (refer to Paragraph 5.29 for malignancies):

(1) Including melanoma, melanoma in situ, and cutaneous lymphoma (mycosis fungoides).

(2) Not including basal cell and squamous cell carcinomas.

o. Any photosensitive dermatosis, including, but not limited to:

(1) Cutaneous lupus erythematosus;

(2) Dermatomyositis;

(3) Polymorphous light eruption; or

(4) Solar urticaria.

p. Severe or chronic erythema multiforme.

q. Chronic, non-healing ulcers of the skin.

5.22. BLOOD AND BLOOD FORMING CONDITIONS.

When considering the conditions listed in this paragraph, the condition must persist despite appropriate treatment and impair function so as to preclude satisfactory performance of required military duties of the member's office, grade, rank, or rating.

a. Anemia, hereditary or acquired, when:

(1) Response to therapy is unsatisfactory; or

(2) Therapy requires prolonged, intensive, medical supervision or intervention.

b. Hypercoagulable disease associated with vascular thrombosis when anticoagulation medication of any type (except aspirin) is clinically indicated for longer than 12 months.

c. Bleeding disorders including, but not limited to:

(1) Hemophilia or other clinically significant factor deficiencies;

(2) Thrombocytopenia with persistent platelet count less than 50,000;

(3) Clinically significant Von Willebrand disease; or

(4) Platelet function disorders.

d. Chronic leukopenia:

(1) If therapy is clinically indicated due to a malignant process; or

(2) Where therapy is indicated for longer than 12 months.

e. Primary Polycythemia Vera, Essential Thrombocytosis, or Chronic Myelogenous Leukemia, if therapy beyond aspirin is clinically indicated.

f. Chronic and clinically significant splenomegaly.

g. Chronic or recurrent symptomatic hemolytic crisis.

5.23. SYSTEMIC CONDITIONS.

a. When considering the conditions listed in this paragraph, the condition must persist despite appropriate treatment and impair function so as to preclude satisfactory performance of required military duties of the member's office, grade, rank, or rating. Conditions listed in this paragraph do not meet medical retention standards if they require medication for control with frequent monitoring by a medical provider due to potential debilitating or serious side effects.

b. Disorders involving the immune system, including immunodeficiencies with progressive clinical illness.

(1) A Service member with laboratory evidence of Human Immunodeficiency Virus infection will be referred for appropriate treatment and a medical evaluation of fitness for continued service in the same manner as a Service member with other chronic or progressive illnesses, including evaluation on a case-by-case basis. Covered personnel will not be discharged or separated solely on the basis of their HIV-positive status.

(2) Primary immunodeficiencies—including, but not limited to, hypogammaglobulinemia, common variable immune deficiency, or complement deficiency—with objective evidence of function deficiency and severe symptoms that are not controlled with treatment, or when injectable medications are clinically indicated.

c. Tuberculosis (pulmonary or extra pulmonary) with clinically significant sequelae following treatment, if:

(1) Resistant to treatment; or

(2) The condition is of such severity that the individual is not expected to return to full duty despite appropriate treatment.

d. Severe chronic complications of sexually transmitted diseases including neurosyphilis.

e. Recurrent anaphylaxis, if:

(1) Immunotherapy is not sufficient in reducing the risk;

(2) Avoidance of the trigger results in long-term duty limitations; or

(3) The individual is not expected to return to duty.

f. Chronic, severe, urticarial, or histaminergic angioedema.

g. Hereditary angioedema. This condition is not compatible with retention and the Service should initiate appropriate medical and personnel actions upon diagnosis. Paragraph 5.23.a does not apply.

h. Recurrent rhabdomyolysis, a single episode of idiopathic rhabdomyolysis, or a single episode of rhabdomyolysis that is associated with underlying metabolic or endocrine abnormalities.

i. Severe motion sickness. If due to an underlying disorder, process via the relevant standard. Otherwise, it may require processing through Service specific separation guidance.

j. Sarcoidosis, eosinophilic granuloma, or amyloidosis progressive with severe or multiple organ involvement.

k. Infections (superficial, local, or systemic) that are not responsive to appropriate treatment.

5.24. ENDOCRINE AND METABOLIC CONDITIONS.

When considering the conditions listed in this paragraph, the condition must persist despite appropriate treatment and impair function to preclude satisfactory performance of required military duties of the member's office, grade, rank, or rating.

a. Adrenal dysfunction, including Addison's disease or Cushing's disease.

b. Diabetes mellitus, unless hemoglobin A1c can be maintained at less than eight percent using only lifestyle modifications (e.g., diet and exercise) or with the following medications (alone or in combination):

(1) Metformin;

(2) Dipeptidyl peptidase 4 inhibitors; or

(3) Glucagon-like peptide-1 receptor agonists.

c. Pituitary dysfunction or mass effect from pituitary tumor.

d. Diabetes insipidus, after treatment and resolution of an underlying etiology.

e. Hyperparathyroidism, when residuals or complications are present.

f. Hypoparathyroidism, when severe, persistent, and difficult to manage.

g. Goiter, if mass effect.

h. Persistent, symptomatic, hypothyroidism or hyperthyroidism that is not responsive to therapy.

i. Persistent metabolic bone disease—including, but not limited to, osteoporosis, Paget's disease, and osteomalacia—if:

(1) Associated with pathological fractures; or

(2) The condition prevents the wearing of military equipment.

j. Osteogenesis imperfecta.

k. Hypogonadism with medically required injectable hormone replacement.

l. Hypoglycemia when caused by an insulinoma or other hypoglycemia-inducing tumor.

m. Gout with frequent acute exacerbations or severe bone, joint, or kidney damage.

n. Endocrine hyperfunctioning syndromes including, but not limited to:

(1) Multiple endocrine neoplasia;

(2) Pheochromocytoma;

(3) Salt-wasting congenital adrenal hyperplasia;

(4) Carcinoid syndrome; or

(5) Endocrine tumors of the gastrointestinal tract.

5.25. RHEUMATOLOGIC CONDITIONS.

When considering the conditions listed in this paragraph, the condition must persist despite appropriate treatment and impair function so as to preclude satisfactory performance of required military duties of the member's office, grade, rank, or rating. Conditions listed in this paragraph do not meet medical retention standards if the condition requires geographic limitations to protect the individual from infectious disease risk or due to limited monitoring capabilities, is associated with adverse effects from medication, or if medical clearance cannot be given for safe participation in Service-specific physical fitness testing.

a. Systemic lupus erythematosus.

b. Mixed connective tissue disease.

c. Progressive systemic sclerosis, including:

(1) Calcinosis;

(2) Raynaud's phenomenon;

(3) Esophageal dysmotility;

(4) Scleroderma; or

(5) Telangiectasia syndrome.

d. Rheumatoid arthritis.

e. Sjögren's syndrome.

f. Chronic autoimmune vasculitides or autoimmune diseases including, but not limited to:

(1) Polyarteritis nodosa.

(2) Behçet's disease.

(3) Takayasu's arteritis.

(4) Giant cell arteritis.

(5) Anti-neutrophil cytoplasmic antibody associated vasculitis.

(6) IgG-4 disease.

(7) Henoch-Schonlein Purpura.

g. Myopathy or polymyositis.

h. Fibromyalgia or myofascial pain syndrome.

i. Connective tissue disorders if associated with cardiac manifestations or limitations from recurrent musculoskeletal dysfunction.

5.26. NEUROLOGIC CONDITIONS.

a. When considering the conditions listed in this paragraph, the condition must persist despite appropriate treatment and impair function so as to preclude satisfactory performance of required military duties of the member's office, grade, rank, or rating.

b. Cerebrovascular conditions including, but not limited to:

(1) Subarachnoid or intracerebral hemorrhage;

(2) Vascular stenosis;

(3) Stroke;

(4) Aneurysm;

(5) Arteriovenous malformation; or

(6) Recurrent transient ischemic attack unless underlying etiology is identified and definitively treated.

c. Anomalies of the central nervous system or meninges with persistent sequelae including, but not limited to:

(1) Pain.

(2) Significant sensory or motor impairment.

(3) Severe headaches.

(4) Seizures.

(5) Alteration of consciousness, personality, or mental function.

d. Permanent or progressive cognitive impairment due to Alzheimer's disease or other dementias. This condition is not compatible with retention and the Service should initiate appropriate medical and personnel actions upon diagnosis. Paragraph 5.26.a does not apply.

e. Neuromuscular disorders and muscular dystrophy including, but not limited to:

(1) Facioscapulohumeral muscular dystrophy.

(2) Limb girdle dystrophy.

(3) Myotonic dystrophy.

f. Chronic or recurrent demyelinating processes (e.g., multiple sclerosis, transverse myelitis, or recurrent optic myelitis).

g. Migraine, tension, or cluster headaches, when manifested by frequent incapacitating attacks.

h. Traumatic brain injury associated with persistent sequelae including, but not limited to:

(1) Pain.

(2) Significant sensory, cognitive, or motor impairment.

(3) Severe headaches.

(4) Seizures.

(5) Alteration of consciousness, personality, or mental function.

i. Peripheral neuropathy or paralytic disorders resulting in permanent functional impairment.

j. Provoked seizures, if recurrent more than 6 months after the Service member begins treatment and the effects of medication:

(1) Prohibit satisfactory performance of duty;

(2) Require significant follow-up; or

(3) Require modifications to reduce psychological stressors or enhance safety.

k. Epilepsy. This condition is not compatible with retention and the Service should initiate appropriate medical and personnel actions upon diagnosis. Paragraph 5.26.a does not apply.

l. Myasthenia gravis, unless only involving extraocular muscles.

m. Tremor, tic disorders, or dystonia (e.g., Tourette's Syndrome) with significant functional impairment.

n. Recurrent, neurogenic, or unexplained syncope or near syncope that interferes with duty.

5.27. SLEEP DISORDERS.

When considering the conditions listed in this paragraph, the condition must persist despite appropriate treatment and impair function so as to preclude satisfactory performance of required military duties of the member's office, grade, rank, or rating.

a. Clinical sleep disorders—including circadian rhythm disorders, insomnia, narcolepsy, cataplexy, or other hypersomnia disorders—that cause sleep disruption resulting in excessive daytime somnolence or other impacts on duty such as:

(1) Mood disturbance;

(2) Irritability; or

(3) Chronic use of prescription medication to promote sleep or maintain daytime wakefulness.

b. Obstructive sleep apnea, of any severity:

(1) With continued symptoms despite treatment with positive airway pressure machines or oral positional devices; or

(2) That requires supplemental oxygen or any chronic medication to maintain wakefulness.

c. Sleep-related movement disorder that causes sleep disruption resulting in excessive daytime somnolence or other impacts on duty, such as:

(1) Mood disturbance;

(2) Irritability; or

(3) Chronic use of prescription medication to promote sleep or maintain daytime wakefulness.

5.28. BEHAVIORAL HEALTH.

The following conditions, defined using the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders, unless otherwise stated, are not compatible with retention and the Service should initiate appropriate medical and personnel actions upon diagnosis.

a. Schizophrenia, delusional disorder, schizophreniform disorder, schizoaffective disorder, and brief psychotic disorder. Substance- or medication–induced psychotic disorder and psychotic disorder(s) due to another medical condition should be considered on a case-by-case basis.

b. Bipolar I disorder.

c. Other bipolar spectrum disorders—including bipolar II disorder, cyclothymic disorder, substance- or medication–induced bipolar disorder—will be considered on a case-by-case basis if, despite appropriate treatment, they:

(1) Require persistent duty modifications to reduce psychological stressors or enhance safety; or

(2) Impair function so as to preclude satisfactory performance of required military duties of the member's office, grade, rank, or rating.

d. Other behavioral health conditions, defined using the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders—including, but not limited to, anxiety disorders, depressive disorders, or eating or feeding disorders—will be considered on a case-by-case basis if, despite appropriate treatment, they:

(1) Require persistent duty modifications to reduce psychological stressors or enhance safety; or

(2) Impair function so as to preclude satisfactory performance of required military duties of the member's office, grade, rank, or rating.

e. Per Paragraph 3.3, disqualifying behavioral health conditions should either be referred to the DES or processed for administrative separation, based on whichever is appropriate for that condition.

5.29. TUMORS AND MALIGNANCIES.

When considering the conditions listed in this paragraph, the condition must persist despite appropriate treatment and impair function to preclude satisfactory performance of required military duties of the Service member's office, grade, rank, or rating.

a. All malignancies will be evaluated for potential recurrence and need for medical surveillance that could require permanent duty limitations, in accordance with Military Department regulations.

b. Malignant neoplasms that are not responsive to therapy or have residuals of treatment that limit satisfactory performance of duty.

c. Benign tumors with mass effect or that interfere with the wearing of military equipment.

5.30. MISCELLANEOUS CONDITIONS.

Conditions listed in this paragraph do not meet medical retention standards if they require medication for control with frequent monitoring by a medical provider due to potential debilitating or serious side effects or geographic limitations to protect the individual from infectious disease risk.

a. Porphyria.

b. Cold-related disorders or injuries with sequelae.

c. Organ or tissue transplantation for which long-term immunosuppressant therapy is clinically indicated.

d. History of heatstroke or heat injury.

(1) Three or more episodes of heat exhaustion or heat injury within 24 months. A single episode of heat injury with severe complications (e.g., compartment syndrome) that affects successful performance of duty or persistent end organ effects.

(2) Heat stroke, when symptoms fail to resolve or when sequelae pose significant risks for future operations.

e. Any chronic condition that requires immunomodulating or immunosuppressant medications.

f. Any chronic pain condition that requires chronic controlled medications listed under Controlled Substance Schedules 2-4, pursuant to Title 21, United States Code.

g. Chronic complications or effects of surgery that:

(1) Present a significant risk of infection;

(2) Result in duty limitations; or

(3) Require frequent specialty care resulting in an unreasonable requirement on mission execution.

h. Any persistent condition that requires geographic limitations to the member for assignment, temporary duty, or deployment to protect the individual from infectious disease risk, due to limited monitoring capabilities or other reasons.

GLOSSARY

G.1. ACRONYMS.

ACRONYM	MEANING
ASD(HA)	Assistant Secretary of Defense for Health Affairs
DASD(HSP&O)	Deputy Assistant Secretary of Defense for Health Services Policy and Oversight
DASD(MPP)	Deputy Assistant Secretary of Defense for Military Personnel Policy
DES	Disability Evaluation System
DHA	Defense Health Agency
DoDI	DoD instruction
FEV1	forced expiratory volume in one second
MEDPERS	Medical and Personnel Executive Steering Committee
MHS	Military Health System
USD(P&R)	Under Secretary of Defense for Personnel and Readiness
USCG	United States Coast Guard
RMSWG	Retention Medical Standards Working Group

G.2. DEFINITIONS.

Unless otherwise noted, these terms and their definitions are for the purpose of this volume.

TERM	DEFINITION
covered personnel	Individuals who have been identified as HIV-positive, are asymptomatic, and who have a clinically confirmed undetectable viral load.
garrison conditions	Defined in DoDI 6465.03
heat exhaustion	A syndrome of hyperthermia (core temperature at time of event usually ≤40°C or 104°F) with physical collapse or debilitation occurring during or immediately following exertion in the heat, with no more than minor central nervous system dysfunction (e.g., headache or dizziness).

TERM	DEFINITION
heat injury	Heat exhaustion with clinical evidence of organ or muscle damage without sufficient neurological symptoms to be diagnosed as heat stroke.
heat stroke	A syndrome of hyperthermia (core temperature at time of event usually ≥40°C or 104°F), physical collapse or debilitation, and encephalopathy as evidenced by delirium, stupor, or coma, occurring during or immediately following exertion or significant heat exposure. It can be complicated by organ or tissue damage, systemic inflammatory activation, and disseminated intravascular coagulation.
medical condition	Any disease or residual of an injury that results in a lessening or weakening of the capacity of the body or its parts to perform normally, according to accepted medical principles.
medically required	A medically necessary health care treatment or supply for which there is no medically appropriate substitute that can meet operational requirements.
office, grade, rank, or rating	Defined in DoDI 1332.18.
operational healthcare unit	Defined in DoD Manual 6025.13.
persistent	Twelve months, or less if reasonably anticipated to exceed 12 months.
trial of duty	Service-defined assessment of a Service member's ability to perform the duties of their office, grade, rank, or rating, considering their physical and psychological demands and tasks, medical history, and prognosis.

REFERENCES

Code of Federal Regulations, Title 38, Part 4 (also known as "the Department of Veterans Affairs Schedule for Rating Disabilities (VASRD)")

Commandant Instruction M1 850.2 (series), "Physical Disability Evaluation System," May 19, 2006

Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition

DoD Directive 5124.02, "Under Secretary of Defense for Personnel and Readiness (USD(P&R))," June 23, 2008

DoD Instruction 1300.28, "Military Service By Transgender Persons And Persons With Gender Dysphoria", September, 4, 2020

DoD Instruction 1332.14, "Enlisted Administrative Separations," January 27, 2014, as amended

DoD Instruction 1332.18, "Disability Evaluation System (DES)," August 5, 2014, as amended

DoD Instruction 1332.30, "Commissioned Officer Administrative Separations," May 11, 2018, as amended

DoD Instruction 1332.45, "Retention Determinations For Non-Deployable Service Members," July 30, 2018

DoD Instruction 5025.01, "DoD Issuances Program," August 1, 2016, as amended

DoD Instruction 6130.03, Volume 1, "Medical Standards for Military Service: Appointment, Enlistment, or Induction" May 5, 2018, as amended

DoD Instruction 6465.03, "Anatomic Gifts and Tissue Donation," June 8, 2016

DoD Instruction 6490.07. "Deployment-Limiting Medical Conditions for Service Members and DoD Civilian Employees," February 5, 2010

DoD Manual 6025.13, "Medical Quality Assurance (MQA) and Clinical Quality Management in the Military Health System (MHS)," October 29, 2013

Kidney Disease: Improving Global Outcomes, "Clinical Practice Guideline for the Evaluation and Management of Chronic Kidney Disease (CKD)," 2012 or current version[1]

Secretary of Defense Memorandum, "Policy Regarding Human Immunodeficiency Virus-Positive Personnel within the Armed Forces," June 6, 2022

United States Code, Title 21

[1] Accessible at https://kdigo.org/guidelines/ckd-evaluation-and-management

DEPARTMENT OF THE ARMY
HEADQUARTERS, UNITED STATES ARMY MEDICAL COMMAND
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OTSG/MEDCOM Policy Memo 19-001

JAN 0 3 2019

MCZX

Expires 3 January 2021

MEMORANDUM FOR COMMANDERS, REGIONAL HEALTH COMMANDS

SUBJECT: Behavioral Health Evaluations for Administrative Separations of Active Duty Enlisted Soldiers under AR 635-200, 5-13 and 5-17

1. References:

a. Department of Defense Instruction (DODI) 1332.14, Enlisted Administrative Separations, 22 Mar 18.

b. DODI 6490.04, Mental Health Evaluations of Members of the Military Services, 4 Mar 13.

c. Department of Defense Instruction (DODI) 6495.02, Sexual Assault Prevention and Response (SAPR) Program Procedures, 28 Mar 13, Change 3, 24 May 17.

d. Army Regulation 40-501, Medical Services Standards of Medical Fitness, 14 Jun 2017.

e. Army Regulation 635-40, Disability Evaluation for Retention, Retirement, or Separation, 19 Jan 2017.

f. Army Regulation 635-200, Active Duty Enlisted Administrative Separations, 19 Dec 2016.

g. American Psychiatric Association. (2013). Diagnostic and Statistical Manual of Mental Disorders (5th ed.). Arlington, VA: American Psychiatric Publishing.

h. Department of Defense. (2017). Financial Management Regulation. Volume 7A: "Military Pay Policy – Active Duty and Reserve Pay." Under Secretary of Defense (Comptroller).

2. Proponent: The proponent for this policy is Behavioral Health Division (BHD), Health Care Delivery, MEDCOM G-3/5/7.

*This policy supersedes OTSG/MEDCOM Policy Memo 16-076, 08 Sep 16, subject: Behavioral Health Evaluations for Administrative Separations of Active Duty Enlisted Soldiers under AR 635-200, Chapters 5-13 and 5-17

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SUBJECT: Behavioral Health Evaluations for Administrative Separations of Active Duty Enlisted Soldiers under AR 635-200, 5-13 and 5-17

3. Applicability: This policy applies to all medical and behavioral health (BH) providers credentialed at Army Medical Treatment Facilities (MTF).

4. Purpose: To outline procedures for identification of candidates, mandatory BH screening, evaluation, and administrative review prior to separations of Soldiers under AR 635-200, Chapters 5-13 and 5-17 for BH conditions, not for reasons of other physical health conditions.

5. Background: In accordance with (IAW) DODI 1332.14 (Ref 1a), administrative separations for personality disorders or other authorized BH conditions require BH clinical screenings and other specific procedures prior to execution. Only qualified BH providers, as outlined in DODI 6490.04 (Ref 1b), may perform these screenings and evaluations. The following standards apply for providers authorized to perform these evaluations:

a. All screenings and BH clinical evaluations may be performed by independently credentialed BH providers who are authorized to perform Command Directed Behavioral Health Evaluations as defined by DODI 6490.04. This definition includes the following BH providers: Psychiatrists, Clinical Psychologists, Licensed Clinical Social Workers, and Psychiatric Advanced Practice Registered Nurses.

b. For cases where the evaluating provider does not meet these authorization requirements, to include BH providers in training or other non-authorized BH providers, clinical supervision of the evaluation by a fully licensed and independently-privileged provider meeting authorization requirements described above must be documented in the military Electronic Heath Record (EHR) with an endorsement and signature by the supervising provider.

c. Traumatic Brain Injury (TBI) screenings and/or diagnostic evaluations may also be performed by physicians and other healthcare professionals with experience and competence in assessment and treatment of TBI.

6. Policy:

a. All active duty and activated enlisted Soldiers being considered for separation for a BH condition under AR 635-200, Chapters 5-13 and 5-17, will receive a BH screening, medical record review and clinical interview by an authorized BH provider prior to separation. BH providers will ensure that Soldiers are screened and evaluated for the following conditions or events:

(1) Post-Traumatic Stress Disorder (PTSD)
(2) TBI
(3) Depressive Disorder
(4) Sexual assault that occurred during service

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(5) Other significant BH conditions potentially requiring a Medical Evaluation Board (MEB) or other BH conditions potentially falling below medical retention standards.

b. Only Soldiers diagnosed with a BH condition listed in Annex 1 are eligible for administrative separation IAW AR 635-200, Chapters 5-13 and 5-17. Soldiers with a BH condition not listed in Annex 1 will be referred to the Disability Evaluation System (DES) if the condition fails medical retention standards and the Medical Retention Determination Point (MRDP) has been reached. Z Codes (formerly V Codes) are not eligible BH conditions for administrative separation or DES referral. Administrative separation exceptions can be granted on a case by case basis for diagnoses not on the BH condition list in Annex 1.

c. In the case of separations due to a personality disorder diagnosis:

(1) When a Soldier has less than two years of military service, the Soldier is eligible for a Chapter 5-13 separation.

(2) When a Soldier has two or more years of military service, the Soldier is eligible for a Chapter 5-17 separation.

(3) Personality disorder diagnoses must be corroborated by a peer or higher-level BH provider. The Installation Director of Psychological Health (IDPH) review of the BH evaluation packet may suffice as this peer corroboration.

7. Procedures:

a. Annex 9 contains a checklist for preparing all Soldier administrative separation packets for Chapters 5-13 and 5-17. IDPHs are encouraged to utilize this checklist to ensure all required elements for Chapters 5-13/17 have been completed. An IDPH concurrence memo template is in Annex 9 for use when a Soldier deployed to an Imminent Danger Pay Area (IDPA). The Department of the Army (DA) Form 3822 will be used to communicate relevant findings and recommendations to the Commander. The DA 3822 is valid for six months except when an acute adjustment disorder is diagnosed. In these cases, the DA 3822 is only valid for the remaining period of time that the adjustment disorder remains acute (six months from time of diagnosis).

b. Screening Tools:

(1) Only approved screening tools found in Annexes 4-8 will be used to assess for PTSD, TBI, Depressive Disorder, and sexual assault. BH providers must administer the required measures via the Behavioral Health Data Portal (BHDP) whenever possible. Any measures not available in BHDP may be administered using alternative methods. Results will be included in the Soldier's EHR.

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(2) Screening tools used in the administrative separation process are not diagnostic. Instead, screening tools are designed to identify individuals who may require further clinical assessment. A Soldier with a positive screen is required to undergo a clinical evaluation to establish the correct diagnoses. BH providers will refer Soldiers for testing and/or evaluation within other specialty clinics, as necessary, to establish the presence or absence of a diagnosis, although most diagnostic evaluations should be able to be completed by BH providers. For example, if TBI screening is positive, but the clinical interview reveals a lack of any concussive event, a referral to a TBI specialist is not usually indicated.

(3) BH providers will document on the DA 3822 that a sexual assault screening occurred. BH providers will document the results of the screening and if the report is restricted or unrestricted in the EHR. BH providers will not document the results of the screening on the DA 3822 unless the conditions below are present:

(a) If a Soldier endorses an incident(s) of sexual assault while in the military, the BH provider must document in the EHR whether, in the provider's clinical opinion, the alleged assault(s) impact(s) the Soldier's BH condition and/or otherwise contributes to the administrative separation.

(b) When the sexual assault has been documented as an unrestricted report and the assault has a medical bearing on the administrative separation proceeding, then the BH provider may document this on the DA 3822. Soldier endorsement of a sexual assault incident contributing to the basis of the 5-17 separation does not prohibit the separation. See Annex 9 for more details on requirements when a sexual assault is present.

c. Recommendations for Administrative Separation: BH providers may recommend that a commander consider administrative separation of a Soldier only when all conditions below are present:

(1) A BH evaluation was completed within the past three months that includes the following elements documented in the EHR:

(a) Screening for PTSD, TBI, Depressive Disorder, and sexual assault in the military using approved scales in Annexes 4-8.

(b) Any previously documented diagnosis of PTSD, TBI, depressive disorder, or any other BH condition within the past 24 months that could warrant referral to the DES must be evaluated and documented as either not currently active (in remission) or currently active, but meeting AR 40-501 retention standards. IAW DoDI 1332.14, unless found fit for duty by the DES, a separation for personality disorder, or other BH condition

not constituting a physical disability, is not authorized if service-related PTSD is also diagnosed, regardless of the level of impairment on current duty status.

(c) The provider must conduct a full clinical evaluation when a Soldier reports symptoms consistent with PTSD, TBI, depressive disorder, or any other boardable BH condition. If a condition exists that causes the Soldier to fall below medical retention standards and has reached MRDP, as currently described in AR 40-501, the provider wil not recommend administrative separation. However, if the Soldier meets retention standards IAW AR 40-501, the provider will clearly state that the Soldier meets medical retention standards in the documentation of his/her evaluation.

(2) The Soldier has a BH diagnosis authorized for administrative separation, as listed in Annex 1, and the condition is of sufficient severity to interfere with effective military performance. Administrative separation exceptions can be granted on case by case basis for diagnoses not on the BH condition list in Annex 1. Clinical documentation must meet the following standards:

(a) List all specific diagnostic criteria met, as specified in DSM-5, for the BH condition used as the basis for administrative separation.

(b) Describe the impact of the reported BH condition on the Soldier's occupationa functioning with reasonable clinical attempts to address the condition.

(c) Include results of all required screening measures in the Soldier's EHR with statements of how any positive results were evaluated.

d. Specific considerations for Adjustment Disorder diagnoses.

(1) A diagnosis of Adjustment Disorder, Persistent (Chronic) Type, should be made when the stressor and/or consequences of the stressor are persistent or recurrent and symptoms are sufficient to require extended or recurrent hospitalization, interfere with duty performance necessitating limitations to duty or duty in a protected environment. The disorder should last six months or longer with the six-month period starting when a provider has determined the Soldier met all diagnostic criteria for the adjustment disorder – this start date may be prior to the date of the BH evaluation. The Soldier must meet the diagnostic criteria throughout the entire six-month period. When a Soldier is unable to function in the military setting due to this diagnosis and has reached the MRDP, the provider will refer the Soldier to the DES.

(2) If Acute Adjustment Disorder renders a Soldier unable to perform duties in the military setting, the provider may recommend administrative separation if the following conditions are met:

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(a) A Soldier meets criteria for a current Adjustment Disorder and is offered treatment.

(b) The condition continues to interfere with assignment to or performance of duty even after treatment has been offered/provided. For Soldiers who engage in treatment, a reasonable period of treatment may facilitate return to duty and is necessary in order to determine response to such treatment. When Soldiers decline treatment, EHR documentation should reflect this preference, and the provider need not wait to recommend administrative separation.

(c) Duration of illness must be less than six months at the time the Commander initiates the separation proceeding. By definition, the disturbance in an Acute Adjustment Disorder begins within three months of onset of a stressor and lasts no longer than six months after the stressor or its consequences have ceased. A Soldier with multiple separate Acute Adjustment Disorders, each in response to an identifiable stressor, is eligible for Chapter 5-17 administrative separation.

(d) The provider must clearly document in the EHR how the condition interferes with assignment to or performance of duty. This impairment should include input from the Command team to ensure a complete assessment of functional status. IAW AR 635-200, Commanders will ensure that adequate counseling and rehabilitative measures are taken before initiating separation proceedings.

e. Behavioral Health Administrative Review (BHAR). BH providers will use the BHAR web application to submit supporting documentation for administrative separations to the IDPH for review and endorsement. In cases of Soldiers with a past or current IDPA status, review and endorsement are required from both the IDPH and the Office of The Surgeon General (OTSG). The BHAR web application can be found at the following site: https://bhar.army.mil.

f. IDPH Review and Endorsement:

(1) IDPH is responsible for ensuring, in writing, all required screening results have been documented in the EHR and fully considered in the determination for administrative separation eligibility.

(2) The Soldier's entire medical record was reviewed and there are no known BH or medical conditions that currently fail medical retention standards.

(3) The clinical interview was performed and documentation addresses any areas of potential concern for a BH condition that could warrant referral to the DES.

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(4) After confirming the above requirements, the IDPH will endorse the recommendation in a memorandum (Annex 9) that will be loaded into BHAR. If BHAR is unavailable, the memo will be loaded into the Soldier's EHR.

(g) OTSG Review and Endorsement:

(1) Any Soldier being considered for administrative separation governed by this policy and who is either currently deployed, or who has ever deployed to an IDPA, requires OTSG level review after the IDPH has endorsed the action in a memorandum (Annex 9). BH providers **will not** make a final recommendation for separation to the Commander until OTSG has endorsed the action and provided a signed endorsement memorandum. For these cases, IDPHs will forward all related documentation of the BH evaluation to OTSG for review and endorsement in the BHAR web application. The documentation must cover all items in the checklist. Refer to Annex 2 for a full list of IDPAs.

(2) Recommendations requiring OTSG review **will be** processed when all checklist items from Annex 9 are completed.

(3) OTSG endorsement will be documented in a memorandum by the Army Director of Psychological Health (DASG-HSZ). OTSG will load the endorsement memorandum into BHAR. IDPHs will ensure the Soldier's Commander receives the OTSG endorsement memorandum. If BHAR is unavailable, the memorandum will be loaded into the Soldier's EHR. The memorandum is valid for 180 days.

8. Regional Directors of Psychological Health may opt to require providers to obtain an IDPH or higher level provider review for Soldiers without an IDPA status.

9. IDPHs are responsible for ensuring proper execution of this policy. IDPHs may delegate responsibilities outlined in this policy to their respective clinic service chiefs where appropriate.

10. Alternative approaches for receiving BH clearance for AR 635-200, Chapters 5-13 and 5-17 administrative separations for BH condition are not authorized.

FOR THE COMMANDER:

RICHARD R. BEAUCHEMIN
Interim Chief of Staff

Encls
1. Annex 1: Behavioral Health Diagnoses Authorized

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2. Annex 2: Designated Hostile Fire or Imminent Danger Pay Areas
3. Annex 3: Screening Tools
4. Annex 4: PTSD Checklist 5 (PCL5)
5. Annex 5: TBI Screening Tool
6. Annex 6: Patient Health Questionnaire (PHQ-2)
7. Annex 7: Patient Health Questionnaire (PHQ-9)
8. Annex 8: Sexual Assault Screening Tool
9. Annex 9: Checklist for Preparing Active Duty Administrative Separation Packets, IDPH Memo

Annex 1: DSM-5 Behavioral Health Diagnoses Authorized for Administrative Separation under AR 635-200, Chap 5-17. Exceptions can be granted on case by case for additional diagnoses

Adjustment Disorders, Acute
Adjustment Disorder with depressed mood (F43.21)
Adjustment Disorder with anxiety (F43.22)
Adjustment Disorder with mixed anxiety and depressed mood (F43.23)
Adjustment Disorder with disturbance of conduct (F43.24)
Adjustment Disorder with mixed disturbance of emotions and conduct (F43.25)
Adjustment Disorder unspecified (F43.20)

Personality Disorders
Paranoid Personality Disorder (F60.0)
Schizoid Personality Disorder (F60.1)
Schizotypal Personality Disorder (F21)
Antisocial Personality Disorder (F60.2)
Borderline Personality Disorder (F60.3)
Histrionic Personality Disorder (F60.4)
Narcissistic Personality Disorder (F60.81)
Avoidant Personality Disorder (F60.6)
Dependent Personality Disorder (F60.7)
Obsessive-Compulsive Personality Disorder (F60.5)
Other Specified Personality Disorder (F60.89)
Unspecified Personality Disorder (F60.9)

Disruptive, Impulse-Control, and Conduct Disorders
Intermittent Explosive Disorder (F63.81)
Conduct Disorder, Childhood Onset (F91.1)
Conduct Disorder, Adolescent-Onset (F91.2)
Conduct Disorder, Unspecified Onset (F91.9)
Pyromania (F63.1)
Kleptomania (F63.3)
Other Specified Disruptive, Impulse-Control, and Conduct Disorder (F91.8)
Unspecified Disruptive, Impulse-Control, and Conduct Disorder (F91.9)

Sleep Wake Disorders
Non-Rapid Eye Movement Sleep Arousal Disorder, Sleepwalking type (F51.3)

Paraphilic Disorders
Voyeuristic Disorder (F65.3)
Exhibitionistic Disorder (F65.2)
Frotteuristic Disorder (F65.81)
Sexual Masochism Disorder (F65.51)
Sexual Sadism Disorder (F65.52)
Pedophilic Disorder (F65.4)
Fetishistic Disorder (F65.0)
Transvestic Disorder (F65.1)

Annex 1: DSM-5 Behavioral Health Diagnoses Authorized for Administrative Separation under AR 635-200, Chap 5-17. Exceptions can be granted on case by case for additional diagnoses

Other Specified Paraphilic Disorder (F65.89)
Unspecified Paraphilic Disorder (F65.9)

Obsessive-Compulsive and Related Disorders
Hoarding Disorder (F42)
Trichotillomania (Hair-Pulling Disorder) (F63.2)
Excoriation (Skin-Picking) Disorder (L98.1)

Non-Substance Related Addictive Disorders
Gambling Disorder (F63.0)

Anxiety Disorders
Specific Phobia, Situational (F40.248)

Somatic Symptom and Related Disorders
Factitious Disorder (F68.10)

Elimination Disorders
Enuresis (F98.0)
Other Specified Elimination Disorder, with urinary symptoms (N39.498)
Unspecified Elimination Disorder, with urinary symptoms (R32)

Intellectual Disability
Intellectual Disability, Mild (F70)

Communication Disorders
Childhood-Onset Fluency Disorder (Stuttering) (F80.81)
Social (Pragmatic) Communication Disorder (F80.89)

Autism Spectrum Disorders
Autism Spectrum Disorder (F84.0)

Attention-Deficit/Hyperactivity Disorders
Attention-Deficit/Hyperactivity Disorder, Combined presentation (F90.2)
Attention-Deficit/Hyperactivity Disorder, Predominantly inattentive presentation (F90.0)
Attention-Deficit/Hyperactivity Disorder, Predominantly hyperactive/impulsive presentation (F90.1)
Other Specified Attention-Deficit/Hyperactivity Disorder (F90.8)
Unspecified Attention-Deficit/Hyperactivity Disorder (F90.9)

Specific Learning Disorders
Specific Learning Disorder, with impairment in reading (F81.0)
Specific Learning Disorder, with impairment in written expression (F81.81)
Specific Learning Disorder, with impairment in mathematics (F81.2)

Annex 2: DESIGNATED HOSTILE FIRE OR IMMINENT DANGER PAY AREAS

REFERENCE: DOD 7000.14-R, Volume 7A, Chapter 10, as of November 2016. Per MILITARY PAY-E-Message 18-035 **Mali, Niger,** and the **North and Far North Regions of Cameroon** are authorized as an Imminent Danger Area for Imminent Danger Pay (IDP) purposes. The effective date of this message is 7JUN17.

*Figure 10-1. Imminent Danger Pay Areas

Area	Includes	Effective Dates	
		From	Through
Afghanistan	Land area and airspace	Nov 1, 1988	
Algeria	Land area	Mar 7, 1995	
Sea areas adjacent to the Arabian Peninsula to include:	The surface area of the following sea boundaries: Red Sea, Gulf of Aden, Gulf of Oman, and Arabian Sea north of 10°00'N latitude and west of 68°00'E longitude	Sep 19, 2001	May 31, 2014
Persian Gulf	Water area and airspace	Mar 1, 1998	May 31, 2014
Azerbaijan	Land area	Jun 9, 1995	
Bahrain	Land area and airspace	Jun 13, 1997	May 31, 2014
Burundi	Land area	Nov 29, 1996	
Chad	Land area	Aug 11, 2008	
Colombia	Land area	Jun 1, 1985	
Congo, Democratic Republic of (formerly Zaire)	Land area	Jan 1, 1997	
Cote D'Ivoire	Land area	Feb 27, 2003	
Cuba	Limited to Service Members performing duties within the Joint Task Force Guantanamo Bay Detention Facilities	Dec 26, 2006	
Djibouti	Land area	Jul 31, 2002	
East Timor	Land area	Nov 1, 2001	May 31, 2014
Egypt	Land area	Jan 29, 1997	
Eritrea	Land area	Jul 31, 2002	
Ethiopia	Land area	Sep 13, 1999	
Greece	Land area within a 20-km radius from the center of Athens (38-01 N, 23-44 E)	Mar 27, 2007	
Haiti	Land area	Nov 23, 1994	May 31, 2014
Indonesia City of Jakarta Provinces of: Central Java, East Kalimantan, Central Sulawesi and Papua Region of Aceh	Land area	Oct 31, 2001 June 1, 2014 June 1, 2014 June 1, 2014	May 31, 2014

Annex 3: SCREENING TOOLS

Healthcare providers must administer the required measures as follows:

1. PTSD Checklist-5 Annex 4
2. Traumatic Brain Injury (TBI) Annex 5
3. Patient Health Questionnaire (PHQ)-2 Annex 6
4. PHQ-9 Annex 7
5. Sexual Assault Annex 8

Use Behavioral Health Data Portal (BHDP) whenever possible. Any measures not available in BHDP may be administered using alternative methods. The BHDP results and summary scores for each measure should be documented in the Electronic Health Record. BHDP automatically scores each measure but if BHDP is not available, providers must score each instrument prior to submission of packet to The Office of The Surgeon General.

To meet compliance, all questionnaires must be administered and interpreted by authorized providers. A two-phase screening process should be used for PTSD and the depression screener, PHQ. A positive result on a screening measure should trigger the administration of the more in-depth symptom measure. BHDP automatically follows this rubric, administering the more detailed symptom measure if the initial screening instrument indicates further assessment is needed.

Annex 2: DESIGNATED HOSTILE FIRE OR IMMINENT DANGER PAY AREAS

*Figure 10-1. Imminent Danger Pay Areas (Continued)

Area	Includes	Effective Dates	
		From	Through
Iran	Land area	Nov 4, 1979	
Iraq	Land area and airspace	Sep 17, 1990	
Israel	Land area	Jan 31, 2002	
Jordan	Land area	Jan 29, 1997	
Kenya	Land area	July 31, 2002	
Kosovo	Land area and airspace	June 22, 1992	
Kuwait	Land area and airspace	Aug 6, 1990	May 31, 2014
Kyrgyzstan	Land area	Sep 19, 2001	May 31, 2014
Lebanon	Land area	Oct 1, 1983	
Liberia	Land area	Aug 6, 1990	May 31, 2014
Libya	Land area and airspace	Mar 19, 2011	
Malaysia State of Sabah	Land area	Oct 31, 2001 June 1, 2014	May 31, 2014
Mali	Land area	Feb 5, 2013	Sep 30, 2013
Mediterranean Sea	Water area of the Mediterranean Sea extending from the North African Coast northward into Mediterranean Sea, bounded on the east at 26° 00' E longitude, extending north to 34° 35' N latitude, extending west to the East Coast of Tunisia	Mar 19, 2011	
Montenegro	Land area and airspace	Jun 22, 1992	May 31, 2014
Oman	Land area	Sep 19, 2001	May 31, 2014
Pakistan	Land area	Nov 29, 1996	
Philippines	Land area	Oct 31, 2001	
Qatar	Land area and airspace	Aug 7, 1997	May 31, 2014
Rwanda	Land area	Oct 6, 1997	May 31, 2014
Saudi Arabia	Land area and airspace	Aug 2, 1990	May 31, 2014
Serbia	Land area and airspace (includes the province of Vojvodina)	Jun 22, 1992	May 31, 2014
Somalia Somalia Basin	(1) Land area and airspace (2) Water area of the Somalia Basin with coordinates: 1110N-5115E, 0600N-4830E, 0500N-5030E, 1130N-5334E; and 0500N-5030E, 0100N-4700E, 0300S-4300E, 0100S-4100E, 0600N-4830E	Sep 28, 1992 Dec 26, 2006	

Annex 2: DESIGNATED HOSTILE FIRE OR IMMINENT DANGER PAY AREAS

*Figure 10-1. Imminent Danger Pay Areas (Continued)

Area	Includes	Effective Dates	
		From	Through
*South Sudan	Land area and airspace	July 9, 2011	
Sudan	Land area and airspace	Oct 4, 1993	
Syria	Land area Airspace	Jul 31, 2003 Sep 21, 2014	
Tajikistan	Land area	Mar 31, 1997	May 31, 2014
Tunisia	Land area and airspace	Mar 19, 2011	
Turkey Izmir	Land area, excluding the Turkish Straits (i.e., the Dardanelles, the Sea of Marmara, and the Bosporus Straits) and including the limited airspace south of 37-45N and east of 43-00E. Geographic area encompassing 40-mile radius from center of Izmir, Turkey	Mar 1, 1998 Mar 1, 1998	 Oct 23, 2014
Uganda	Land area	Jan 19, 2000	
United Arab Emirates (UAE)	Land area	Sep 19, 2001	May 31, 2014
Uzbekistan	Land area	Sep 19, 2001	May 31, 2014
Yemen	Land area	May 25, 1999	

NOTES:

1. The designation of a land area encompasses all internal waters, unless otherwise noted. For HFP and/or IDP purposes, the term "internal waters" is defined as waters landward of the baseline, drawn in accordance with international law.
2. The designation of a water area (such as the Persian Gulf) includes the territorial seas of those waters, but not the internal waters of the coastal lands. For example, all waters of the Persian Gulf seaward of the baseline of the coastal states, drawn in accordance with international law, would be included in the Persian Gulf designation.
3. Unless otherwise specifically indicated, airspace is NOT part of the included area. When airspace is specifically included, it will normally be that space directly vertically above the approved land or sea area.
4. This figure reflects all designated areas, which were active within the last ten years.

Annex 4: PTSD CHECKLIST 5 (PCL5)

PATIENT NAME: _____ **DATE:** _____

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

In the past month, how much were you bothered by:	*Not at all*	*A little bit*	*Moderately*	*Quite a bit*	*Extremely*
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again *(as if you were actually back there reliving it)*?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience *(for example, heart pounding, trouble breathing, sweating)*?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience *(for example, people, places, conversations, activities, objects, or situations)*?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world *(for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)*?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings *(for example, being unable to feel happiness or have loving feelings for people close to you)*?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being "superalert" or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

PCL-5 (8/14/2013) Weathers, Litz, Keane, Palmieri, Marx, & Schnurr -- National Center for PTSD

TOTAL SCORE: _____

PTSD (PCL-5) Scoring Instructions Next Page

Annex 4: PTSD CHECKLIST 5 (PCL5)

PTSD Checklist- 5 (PCL5) Scoring Instructions:

The PCL5 will be administered if the Soldier screens positive on the PC-PTSD, as previously described.

Positive: A PCL5 score equal to or greater than 30 indicates that an in depth clinical evaluation for PTSD is warranted. Providers will document the PCL5 total score in the Electronic Health Record (EHR) and detail whether the Soldier meets each of the diagnostic criteria for the disorder.

Negative: A diagnostic clinical interview for PTSD is not required based on screening if the Soldier has a PCL5 score of less than 30.

Annex 5: BHDP TBI SCREENING TOOL

PATIENT NAME: _____ **DATE:** _____

During the last 24 months did you experience any of the following events? (check all that apply):

1. ☐ Blast (Improvised Explosive Device, RPG, Land mine, Grenade, etc.)
2. ☐ Vehicular (any type of vehicle, including aircraft)
3. ☐ Fragment
4. ☐ Fall
5. ☐ Other specify (sports injury to your head):_____
6. ☐ None of the above

Did any of the following happen to you or were your told happened to you, IMMEDIATELY after any of the injury events previously referenced: (select all that apply)

1. ☐ Losing consciousness knocked out/blacked out
2. ☐ Felt dazed, confused or "saw stars"
3. ☐ Had your "bell rung"
4. ☐ Didn't remember or had trouble remembering part or all of the event
5. ☐ Had a concussion
6. ☐ Had a head injury
7. ☐ None of the above

Did any of the following problems begin or get worse after the injury event(s) you previously referenced? (select all that apply):

1. ☐ Memory problems or lapses
2. ☐ Balance problems or dizziness
3. ☐ Ringing in the ears Memory problems
4. ☐ Sensitivity to light
5. ☐ Irritability
6. ☐ Headaches
7. ☐ Sleep problems
8. ☐ Difficulty concentrating
9. ☐ Nausea/vomiting
10. ☐ Other specify:_____
11. ☐ None of the above

In the past week, have you had any of the following symptoms? (select all that apply)

1. ☐ Memory problems or lapses
2. ☐ Balance problems or Dizziness
3. ☐ Ringing in the ears Memory problems
4. ☐ Sensitivity to light
5. ☐ Irritability

Annex 5: BHDP TBI SCREENING TOOL

6. ☐ Headaches
7. ☐ Sleep problems
8. ☐ Difficulty concentrating
9. ☐ Nausea/vomiting
10. ☐ Other specify:_____
11. ☐ None of the above

TBI Screening Tool Instructions

Positive: If the patient endorses at least one item in each of the following domains on the questionnaire used, the screening is considered positive and a clinical interview for TBI symptoms is required. Positive responses are defined as:

Domain 1: An endorsement of any injury during service that might have involved the head.

Domain 2: An endorsement of an alteration of consciousness of any severity.

Domain 3: Endorsement of current symptoms that began or worsened after the event reported in Domain #1 which may be related to a TBI/concussion.

In screen positive cases where the initial clinical interview by an authorized BH provider determines that no substantive TBI-related symptoms currently exist, no actual head trauma occurred or symptom timing does not correlate in any possible manner with head injury events, then a referral to a TBI specialist provider should not occur and the current diagnostic interview is considered an adequate interview to rule-out a current TBI diagnosis. A BH provider may refer the Soldier to a TBI clinic when presence or absence of ongoing TBI is unclear.

Negative: If the patient does not have at least one positive response on each of the three domains, the screening is negative. A diagnostic evaluation is not required based on the screening results.

Annex 6: PATIENT HEALTH QUESTIONNAIRE (PHQ-2) DEPRESSION SCREENING TOOL

PATIENT NAME: _____ **DATE:** _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3

FOR OFFICE CODING 0 + ____ + ____ + ____

=Total Score: ____

PHQ-2 Scoring Instructions

The PHQ-2 will be used as the initial depression screening tool and the PHQ9 will be given as indicated by the PHQ2 score. A total score should be calculated after each administration of the PHQ2 and PHQ9.

PHQ-2 Patient Health Questionnaire

Positive: If the *PHQ2 score is equal to or greater than 3, then the screening is positive and the PHQ9 should be administered.*

Negative: *If the PHQ2 score is less than 3, then the screening is negative and the PHQ9 is not required.*

Annex 7: PATIENT HEALTH QUESTIONNAIRE (PHQ-9) DEPRESSION SCREENING TOOL

PATIENT NAME: _____ **DATE:** _____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

PHQ-9 Scoring Instructions Next Page

Annex 7: PATIENT HEALTH QUESTIONNAIRE (PHQ-9) DEPRESSION SCREENING TOOL

PHQ-9 Scoring Instructions

The PHQ-2 will be used as the initial depression screening tool and the PHQ9 will be given as indicated by the PHQ2 score. A total score should be calculated after each administration of the PHQ2 and PHQ9.

PHQ-9 Patient Health Questionnaire

The PHQ-9 will be administered if the Soldier screens positive on the PHQ-2, as previously defined.

Positive: If the score is 10 or higher, the screening is positive and a diagnostic evaluation is required to assess for the presence of a depressive disorder.

Negative Screening: If the score is less than 10, the screening is negative and further evaluation is not required based on the screening.

Total Score	Depression Severity
0-9	Depressive disorder unlikely
10-14	Minor depressive symptoms. Evaluation indicated.
15-19	Moderate depressive symptoms. Evaluation indicated.
20-27	Severe depressive symptoms. Evaluation indicated.

Annex 8: SEXUAL ASSAULT SCREENING

PATIENT NAME: _____ **DATE:** _____

1. During your time in the military, have you experienced sexual harassment in the workplace, to include: unwelcome sexual advances, requests for sexual favors, and/or deliberate or repeated offensive comments or gestures of a sexual nature; use of any form of sexual behavioral by any person in a supervisory or command position to control influence or affect your career, pay or job?
O Yes O No

2. During your time in the military, have you experienced sexual assault, to include: intentional sexual contact characterized by the use of force, threats, intimidation, or abuse of authority, or intentional sexual contact when you did not or could not consent?
O Yes O No

3. If "Yes" to Question 1 or Question 2, has this experience impacted your functional and/or behavior?
O Yes O No O Not Applicable

SEXUAL ASSAULT SCREENING INSTRUCTIONS

Screening for all forms of trauma exposure should be approached with compassion and sensitivity, but screening for a history of sexual trauma requires particular care due to the stigma associated with this type of trauma. For accurate screening, good rapport with the individual is essential, as is close attention to issues of confidentiality (e.g., not screening in the presence of other providers or Family Members). Regardless of the care taken by the interviewer, the individual's shame and self-blame may prevent or delay disclosure, particularly for males or individuals who have experienced punishment or disbelief following previous disclosures.

When screening for a history of sexual assault, it is important to avoid words like "rape" and "sexual harassment." Asking the question, "while you were in the military, were you ever raped?" assumes that the individual knows how rape is defined and perceives what happened to him/her as a rape. Additionally, these words are "loaded terms" for many people and the individual may respond negatively in order to avoid the social stigma that often accompanies a sexual assault history.

A method of screening that is likely to yield the most accurate results possible without the Soldier perceiving questions as too intrusive involves general questions that use descriptive, non-judgmental wording.

For additional information, refer to the following website:
http://www.ptsd.va.gov/professional/trauma/war/military-sexual-trauma.asp

Annex 8: SEXUAL ASSAULT SCREENING

SEXUAL ASSAULT SCREENING INSTRUCTIONS

Screen positive – Answering "Yes" to Question #3 is positive. When a screen positive exist the following actions must be taken:

(1) Evaluate for the presence of a Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) BH condition and/or consider how the event may impact a condition being considered under Chap 5-17.

(2) If the Soldier endorses an incident of sexual assault in the military, the provider must document in the EHR whether the alleged assault impacts the Soldier's BH condition and/or otherwise contributes to the administrative separation. (Note: This opinion is based solely on the clinical judgment of the provider and does not constitute a forensic legal opinion as pertains to criminal responsibility, state of mind at the time of any alleged behavior that is the basis for the administrative separation, competency, or other determinations typically required by courts).

(3) If a BH condition is found to exist as a result of a sexual assault during the military, the provider may disclose the DSM-5 BH condition to a Commander if the condition either impacts medical fitness standards or relates to the basis for the administrative separation. If the sexual assault is a restricted report, then the assault itself cannot be disclosed to the Commander.

(4) If the Soldier has already filed a restricted report of the incident of sexual assault, this information must remain restricted and cannot be further disclosed. However, if the Soldier wishes to change his or her restricted report to an unrestricted one or specifically authorizes disclosure, the BH provider should refer the Soldier to the unit Sexual Assault Response Coordinator (SARC) for this purpose.

(5) If the Soldier has not previously filed a report of his or her sexual assault, the BH provider will provide the Soldier with point of contact information for the SARC/Victim Advocate for appropriate counseling and election of a restricted or unrestricted report, if desired.

Annex 9: Checklist for Preparing *AR 635-200, 5-17* Separation Packets

☐ Complete Department of the Army (DA) Form 3822. Complete form detailing conclusions, relevant evaluation findings and recommendations for the Commander.

☐ Diagnoses. On DA Form 3822, document Soldier's current diagnoses as listed in DSM-5.

☐ IAW DODI 1332.14, January 27, 2014, Change 3 March 14, 2018 the following verbatim statements must be included on DA Form 3822 (select appropriate sentence in italics):

- "Soldier meets criteria for Ch. 5-13/17 administrative separation. Soldier currently meets medical retention standards."
- "There *is/is not* evidence of a documented change in diagnosis from a boardable to a non-boardable condition within the last 90 days."
- If change in diagnosis is evident, add the statement: "The diagnostic change was sufficiently justified in the clinical write-up."
- "The condition is of sufficient severity to interfere with the Soldier's ability to function in the military. The Soldier is not amenable to BH treatment and is unlikely to respond to Command efforts at rehabilitation."
- (For a personality disorder diagnosis): "The symptoms or behavioral problems existed prior to enlistment and do not simply represent maladjustment to the military."

☐ Specific diagnostic criteria (for diagnosis used as basis for administrative separation). Document in the EHR the specific diagnostic criteria met for BH condition used as basis for administrative separation from DSM-5.

☐ PTSD. A two-phase screening process must be used for PTSD screening. A positive result on the Primary Care Post-Traumatic Stress Disorder (PC-PTSD) Screen should trigger the administration of the PSTD Checklist 5 (PCL5).

- Document that PTSD screening has been performed on the DA 3822.

For positive screens or a history of potential PTSD symptoms, the evaluation and documentation in the EHR must include:

- The specific PTSD diagnostic criteria met from DSM-5. Specify how each PTSD criterion applies to the Soldier.
- Explain why the Soldier endorsed items on PTSD screener if PTSD not diagnosed.

Annex 9: Checklist for Preparing *AR 635-200, 5-13/17* Separation Packets

☐ Traumatic Brain Injury. The BHDP TBI screen must be used for TBI screening.

- Document that TBI screening has been performed on the DA 3822.

When the TBI screen is positive or a history of potential TBI symptoms exist, the evaluation and documentation in the EHR must include:

- Soldier's history of past TBI/concussion.
- Soldier's current symptoms and if such symptoms are related to a previous TBI/concussion.
- If applicable that no TBI referral was indicated because in the clinical interview Soldier revealed no history of a concussive event even though TBI screen was positive.

☐ Depression. Confirm screening for depression with the PHQ2/PHQ9 and ensure that any evidence of depression has been addressed.

- Document that depression screening has been performed on the DA 3822.
- Positive depression screens, or a history of potential depressive symptoms exists, the evaluation and documentation in the EHR must include:
  - Soldier's history of a depressive disorder diagnosis (date of diagnosis and disorder diagnosed)
  - The specific depressive disorder currently diagnosed, if any, and the DSM-5 diagnostic criteria of that disorder are met. Specify how each diagnostic criterion applies to the Soldier.
  - Soldier's current occupational impairment is related to current or previous depressive disorder.

☐ Sexual Assault. Confirm screening for sexual assault to ensure that any evidence of sexual assault during military service has been addressed.

- Document that sexual assault screening has been performed on the DA 3822.
- When a sexual assault during military service has been endorsed, the evaluation and documentation in the EHR must include:
  - The results of the sexual assault screening.
  - If Soldier's sexual assault appears to impact their BH condition and/or otherwise contributes to the reason for separation.

Annex 9: Checklist for Preparing *AR 635-200, 5-13/17* Separation Packets

Note 1: Only report the presence of a history of sexual assault while serving in the military on a DA 3822 if the sexual assault report is unrestricted and has a medical bearing on the administrative separation proceeding. If the sexual assault is protected as a restricted report, it must remain restricted and cannot be further disclosed to the Command.

Note 2: If a BH condition exists as a result of the sexual assault, this BH condition alone may be reported on the DA 3822 for determination of the presence of a condition warranting DES referral.

☐ Electronic Health Record. At minimum, include 1-2 notes from the Soldier's EHR that substantiate the screening evaluation was performed to include a statement stating Soldier has never deployed or Soldier was deployed to (name of country).

☐ Installation Directors of Psychological Health (IDPH) must confirm review and endorsement memo (at end of *Annex 9*) with the administrative separation recommendation for Soldiers with an IDPA status. The IDPH will also confirm all required screening has been documented in the EHR and fully considered in the recommendation for administrative separation. The IDPH will furthermore confirm that the Soldier's entire medical record was thoroughly reviewed and no active BH conditions were found that fail medical retention standards IAW AR 40-501, Chapter 3 and require disposition through medical channels.

☐ Confirm the following: All administrative separation documentation (e.g., DA Form 3822, screener results, submission memorandum, etc.) have been scanned or annotated in the EHR.

SIGNATURES, CORROBORATION, AND ENDORSEMENTS

☐ Signature of evaluating provider. The evaluating provider must sign the DA 3822 once complete. If evaluating provider does not meet authorization requirements detailed in this policy, a supervisory co-signature is required from an authorized provider.

☐ Imminent Danger Pay Area (IDPA) and Personality Disorder Corroboration. A second BH provider must corroborate administrative separations of Soldiers with an IDPA status or diagnosed with a personality disorder. This can be performed by the IDPH or designee when reviewing the BH evaluation packet.

☐ Signature of IDPH, MTF BH Chief, or equivalent official. This signature represents IDPH, MTF Chief of BH, or equivalent official's administrative review of packet and endorsement memo (at end of *Annex 9*) with recommendation for administrative separation for Soldiers with an IDPA status.

Annex 9: Checklist for Preparing *AR 635-200, 5-13/17* Separation Packets

SPECIAL INTEREST CASES

☐ Acute Adjustment Disorder. Acute Adjustment Disorder is eligible for administrative separation if the following applies:

- Soldier experiences one or more acute adjustment disorder episodes and does not respond to treatment offered and/or attempted. When Soldiers decline treatment, EHR documentation should reflect this preference, and the provider need not wait to recommend administrative separation.
- Even after the attempted treatment, the condition continues to interfere with assignment to or performance of duty.
- Duration must be less than six months, and the provider must clearly document in the EHR how the condition interferes with assignment to or performance of duty. The DA 3822 should include the *Acute* specifier.

☐ Unauthorized Diagnosis (Boardable BH Condition) - A DSM-5 diagnosis not listed in Annex 1. In cases where any BH or medical provider has documented a known boardable BH or medical condition in the past two years, the following process applies:

- The treating provider recommending administrative separation must document that each boardable BH diagnosis was considered, meets medical retention standards, and does not contribute to the Soldier's inability to function in the military.
  - Psychological testing may be used to support a clinical assessment and must be documented in the EHR. When conducting psychological and neuropsychological assessment, providers will consider the full range of available data resources (testing, collateral reports, available medical/military records, clinical interview, and clinical diagnostic impressions).
  - Special consideration will be made regarding findings of secondary gain or malingering. Any diagnosis or assertion of malingering must be clearly documented in the medical record IAW with current policy. Psychological testing results alone are insufficient to make a determination of malingering.
  - The provider must conduct a full clinical evaluation when a Soldier reports symptoms consistent with PTSD, TBI, depression or any other boardable BH condition. If a condition exists that causes the Soldier to fall below medical retention standards and has reached MRDP, as currently described in AR 40-501, the provider will not recommend administrative separation. However, if the Soldier meets retention standards IAW AR 40-501, the provider will clearly state that the Soldier meets medical retention standards in the documentation of his/her evaluation.

Annex 9: Checklist for Preparing *AR 635-200, 5-13/17* Separation Packets

Letterhead

MEMORANDUM FOR Name, Chief, Department of Behavioral Health, Fort xxxx

SUBJECT: OTSG Requirements for Administrative Separation of Soldiers for Behavioral Health (BH) conditions under Chapter 5-13 or 5-17 for Soldier Rank, Name and DOD ID #

1. Soldier is recommended for administrative separation IAW AR 635-200, Chapter 5-13/17. The diagnosis and problems presented by this Soldier are appropriate for administrative separation according to criteria set forth in AR 635-200, Chapter 5-13/17 for BH conditions not amounting to disability.

2. Soldier's Commander and treating providers agree that administrative separation is the most appropriate disposition. Command was provided safety and treatment recommendations for this Soldier.

3. Soldier was evaluated in accordance with OTSG requirements for PTSD, mTBI, and depression and was found not to meet diagnostic criteria. Soldier was screened for incidents of sexual assault occurring while on active duty and stated there had been none. If these statements are not true, provide details.

4. Soldier meets diagnostic criteria, according to the DSM-5, for the following disorder(s): List each criterion and give specific examples of how Soldier meets the criteria. Address differential diagnoses as necessary.

5. Describe impact of BH condition on occupational functioning and attempts at treatment. Soldier will likely not respond to command efforts at rehabilitation or to treatment methods currently available within a military setting. The disorder is of sufficient severity to significantly impair the Soldier's ability to function effectively in the military environment.

6. The Soldier's medical record does not contain evidence of a documented change in diagnosis from a medically boardable condition to a non-boardable condition within the past 90 days.

7. The point of contact for this memorandum is LTC John M. Doe, Provider Telephone and Email.

Provider signature block and Electronic Certificate Signature

Annex 9: Checklist for Preparing *AR 635-200, 5-13/17* Separation Packets

Letterhead

SUBJECT: OTSG Requirements for Administrative Separation of Soldiers for Behavioral Health conditions under Chapter 5-13 or 5-17 for Soldier rank, name and DoD ID #

1. The required screenings are documented in the electronic health record and were fully considered in the determination for administration separation recommendation.

2. A thorough review of the entire medical record revealed no evidence that the Soldier has a BH or medical condition that would cause him/her to fall below medical retention standards.

3. All administrative separation documents have been scanned or copied into the Soldier's electronic health record.

4. IDPH Signature is indication of administrative review and agreement of clinical and administrative contents of this memorandum.

_____

IDPH Electronic Certificate Signature

DEPARTMENT OF THE ARMY
HEADQUARTERS, UNITED STATES ARMY MEDICAL COMMAND
2748 WORTH ROAD
JBSA FORT SAM HOUSTON, TX 78234-6000

REPLY TO ATTENTION OF

MHCO-CL-P

OTSG/MEDCOM Policy Memo 16-087
18 OCT 2016

Expires 18 October 2018

MEMORANDUM FOR COMMANDERS, MEDCOM MAJOR SUBORDINATE COMMANDS

SUBJECT: Release of Protected Health Information (PHI) to Unit Command Officials

1. References:

a. DoD 6025.18-R, Health Information Privacy Regulation, 24 Jan 03, http://www.dtic.mil/whs/directives/corres/pdf/602518r.pdf.

b. Federal Register Notice, Volume 68, No. 68, Page 17357, 9 Apr 03, subject: DoD Health Information Privacy Program, http://www.gpoaccess.gov/fr/index.html.

c. AR 40-66, Medical Records and Healthcare Documentation, 17 June 08 with Rapid Action Revision, 4 Jan 10.

d. DoDI 6490.08, Subject: Command Notification Requirements to Dispel Stigma in Providing Mental Health Care to Service Members, 17 August 11.

2. Purpose: This memorandum presents Office of The Surgeon General and US Army Medical Command (MEDCOM) policy and general guidelines for disclosing and accounting for the minimum necessary Armed Forces members' PHI to be disclosed to commanders and other authorized unit officials.

3. Proponent: The proponent for this policy is the MEDCOM Health Insurance Portability and Accountability Act (HIPAA) Privacy Officer, Patient Administration Division, Patient Care Integration Directorate, G3/5/7.

4. Policy:

a. As published in reference documents, the Privacy Rule of the HIPAA provides standards for disclosure of PHI about Armed Forces members without their authorization. These standards include certain exemptions established to support the unique requirements of military operations. PHI disclosures permitted under the military exemptions must also comply with the minimum necessary and disclosure accounting standards to meet the intent of the law.

*This policy supersedes OTSG/MEDCOM Policy Memo 14-080, 24 Sep 14, subject: Release of Protected Health Information (PHI) to Unit Command Officials.

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SUBJECT: Release of Protected Health Information (PHI) to Unit Command Officials

b. Medical commanders will provide timely and accurate information to support unit commanders' decision-making on the health risks, medical fitness and readiness of their Soldiers. The unit surgeon, when available and as appropriate, will be involved in the communication process. The general procedures below are consistent with the military provisions of the HIPAA Privacy Rule for release of PHI to unit command officials.

c. The military provisions under the Privacy Rule do not apply to the Family Members of military personnel, retirees and their Families, civilian employees, or other government officials. Disclosure of PHI on non-military personnel must be made in accordance with (IAW) references 1.a. and 1.c.

5. Responsibilities:

a. The MEDCOM HIPAA Privacy Officer is responsible for this policy, providing staff supervision and updating the policy as necessary.

b. Regional Health Command Commanders will include compliance with this policy as a component of their Organizational Inspection Program (OIP).

c. Medical Treatment Facility (MTF) Commanders will designate personnel by roles who will be authorized to release information to unit surgeons and/or unit command officials. Note: HIPAA applies to unit surgeons as part of TSG's covered entity. MTF Commanders will ensure that 100% of privileged providers and patient administration personnel are trained upon their arrival at the MTF. Training materials are provided at https://www.us.army.mil/suite/page/419354. MTF Commanders will coordinate with senior installation commanders to ensure that PHI training is presented annually in installation–level formums, e.g., town hall meetings. Training materials are provided at https://www.us.army.mil/suite/files/33416135. MTF Commanders will include compliance with this policy as a component of their OIP.

d. MTF Privacy Officers and patient administrators will provide staff assistance to those who release PHI to unit command officials to ensure that the release of PHI is in compliance with applicable federal laws, DoD instructions, Army regulations and this policy.

e. Unit command officials include the chain of command, namely: corps commanders, division commanders, brigade commanders, battalion commanders, and company commanders. Unit Commanders will designate unit command officials in writing who will be responsible for requesting and receiving a Soldier's PHI, such as executive officers, command sergeants major, first sergeants, platoon leaders, and platoon sergeants. Unit command officials are not required to have HIPAA training.

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They are not part of the covered entity. Unit command officials must protect the PHI IAW the Privacy Act of 1974.

6. Procedures:

a. The PHI of Soldiers may be released to authorized unit surgeons and unit command officials as related to the purposes outlined in the regulation at reference 1.a. (paragraph A, enclosure 1). The Soldier's authorization is required for PHI disclosures not applicable to the military clause or other provisions of reference 1.a., Chapter 7.

(1) Command management programs involving disclosure of PHI as governed by Army or DoD policy (paragraph B, enclosure 1) do not require a Soldier's authorization, unless otherwise indicated. The specific PHI released in connection with these programs will be IAW the governing policy.

(2) Instances when the MTF Commander will proactively inform the Commander within 24 hours of medical concerns are at paragraph C, Enclosure 1. Most importantly, these situations focus on, but are not limited to, circumstances where the Soldier's judgment or clarity of thought might be suspect by the clinician or to avert a serious and imminent threat to health or safety of a person, such as suicide, homicide or other violent action.

(3) The processes for how unit command officials are notified are described in paragraph D, enclosure 1.

(4) Written or phone requests not connected with a regulatory command management program will be honored by a release of the minimum necessary information that addresses only the Soldier's general health status, adherence with scheduled appointments, profile status, and medical readiness requirements (paragraph E, enclosure 1). In accordance with reference 1.c., advise unit commanders to use DA Form 4254 (Request for Private Medical Information) to request additional PHI. The DA Form 4254 may be transmitted by email.

b. Collaborative communication between commanders (or their designated representatives) and healthcare providers is critical to the health and well-being of our Soldiers. Healthcare providers must not limit communication to eProfile, but should speak with commanders when required. Commanders can get medical readiness information from the Commanders' Medical Readiness Portal. Commanders should also share information with healthcare providers, relating changes in Soldier behavior or other information that could impact a diagnosis or treatment. This is especially important during periods of Soldier transition (PCS, TDY, separation, etc.).

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c. The MTF staff will use the Military Health System Protected Health Information Management Tool (PHIMT) to account for PHI disclosure as required by reference 1.c.. When the PHIMT is not available, the healthcare provider will document the release of the PHI in AHLTA or the Service Treatment Record. The documentation will include the date of the disclosure, name and address of the individual receiving the information, a brief description of the PHI disclosed, and the basis for the disclosure. These procedures will be assessed during OIPs.

d. The MTF shall advise unit command officials that once the MTF releases PHI to unit command officials, it is their responsibility to protect the information IAW the Privacy Act of 1974 (AR 340-21). The information should further be disclosed to others only on a need to know basis. If a Soldier believes that their PHI was inappropriately disclosed to others by unit command officials, they may file a Privacy Act complaint with their unit Privacy Act Officer and/or pursue other avenues of corrective action.

e. Healthcare providers will discuss with Soldiers those circumstances under which their commander will receive notification to include duty restrictions, changes in deployment status, medications that may limit duty performance and anytime a Soldier is perceived to be a risk to themselves or others. A suggested handout is at enclosure 2.

f. In other special circumstances, the notification to the Commander of a Soldier's PHI is based on whether the proper execution of the military mission outweighs the interests served by avoiding notification, as determined on a case-by-case basis by a healthcare provider (or other authorized official of the MTF involved) at the O-6 or equivalent level or above, or a commander at the O-6 level or above. When such decisions are made, the MTF will notify the MEDCOM Patient Administration Division within 72 hours.

FOR THE COMMANDER:

ROBERT L. GOODMAN
Chief of Staff

Encls

Guidelines for Release of Protected Health Information (PHI) to Unit Command Officials

A. The purposes for which the minimum necessary PHI of an individual may be used or disclosed to unit command officials exercising authority over a member of the Armed Forces without the individual's authorization are the following:

1. To determine the member's fitness for duty, including but not limited to the member's compliance with standards and activities carried out under AR 50-1 (Biological Surety), AR 50-5 (Nuclear Surety), AR 50-6 (Chemical Surety), AR 600-9 (The Army Body Composition Program), AR 635-40 (Physical Evaluation for Retention, Retirement, or Separation), and similar requirements.

2. To determine the member's fitness to perform any particular mission, assignment, order or duty, including compliance with any actions required as a precondition to performance of such mission, assignment, order or duty.

3. To carry out activities under the authority of DoD Directive 6490.2, Joint Medical Surveillance.

4. To report on casualties in any military operation or activity IAW applicable military regulations or procedures.

5. To carry out any other activity necessary to the proper execution of the mission of the Armed Forces.

B. These are examples of regulatory and command management programs that do not require a Soldier's authorization for PHI disclosure. Medical information released under these programs will be IAW the governing policy:

1. To coordinate sick call, routine and emergency care, quarters, hospitalization, and care from civilian providers using DD Form 689 (Individual Sick Slip) IAW AR 40-66 (Medical Record Administration and Health Care Documentation) and AR 40-400 (Patient Administration).

2. To report results of physical examinations and profiling IAW AR 40-501 (Standards of Medical Fitness).

3. To screen and provide periodic updates for individuals in personnel reliability/special programs, such as AR 50-1 (Biological Surety), AR 50-5 (Nuclear Surety), AR 50-6 (Chemical Surety), and AR 380-67 (Personnel Security Program).

4. To review and report IAW AR 600-9 (The Army Body Composition Program).

5. To initiate Line of Duty (LOD) determinations and to assist investigating officers IAW AR 600-8-4 (Line of Duty Policy, Procedures, and Investigations).

Guidelines for Release of Protected Health Information (PHI) to Unit Command Officials

6. To conduct medical evaluation boards and administer physical evaluation board findings IAW AR 635-40 (Physical Evaluation for Retention, Retirement, or Separation) and similar requirements.

7. To review and report IAW AR 600-110 (Identification, Surveillance, and Administration of Personnel Infected with Human Immunodeficiency Virus (HIV)).

8. To carry out activities under the authority of AR 40-5 (Preventive Medicine) to safeguard the health of the military community.

9. To report on casualties in any military operation or activity IAW AR 600-8-1 (Army Casualty Operations/Assistance/Insurance) or local procedures.

10. To medically administer flying restrictions IAW AR 40-8 (Temporary Flying Restrictions Due to Exogenous Factors) and AR 40-501 (Standards of Medical Fitness). To participate in aircraft accident investigations IAW AR 40-21 (Medical Aspects of Army Aircraft Accident Investigation).

11. To respond to queries of accident investigation officers to complete accident reporting per the Army Safety Program IAW AR 385-10 (The Army Safety Program).

12. To report mental status evaluations IAW MEDCOM Regulation 40-38 (Command Directed Behavioral health Evaluations).

13. To report special interest patients IAW AR 40-400 (Patient Administration).

14. To report the Soldier's dental classification IAW AR 40-3 (Medical, Dental, and Veterinary Care) and HA Policy 02-011 (Policy on Standardization of Oral Health and Readiness Classifications).

15. To assist in serious incident reporting IAW AR 190-45 (Law Enforcement Reporting).

16. To carry out Soldier Readiness Program and mobilization processing requirements IAW AR 600-8-101 (Personnel Processing In-, Out-, Soldier Readiness, Mobilization, and Deployment Processing).

17. To provide initial and follow-up reports IAW AR 608-18 (The Army Family Advocacy Program).

18. To allow Senior Commanders to review Soldier medical information to determine eligibility for assignment/attachment to a Warrior Transition Unit (WTU). (Annex A to FRAGO 3 to EXORD 118-07, 021000Q JUN 2007).

19. To provide initial and follow-up reports IAW AR 600-85 (The Army Substance Abuse Program).

Guidelines for Release of Protected Health Information (PHI) to Unit Command Officials

20. To provide PHI to Investigating Officers IAW AR 15-6 (Procedures for Administrative Investigations and Boards of Officers).

21. Other regulations carrying out any other activity necessary to the proper execution of the mission of the Army.

C. Due to the unique nature of the military mission, there are instances when an MTF Commander will proactively inform a commander of a Soldier's minimum necessary PHI/medical/behavioral health condition. The Electronic Profiling System (e-Profile) will be used. These instances are shown below. The examples provided are not all inclusive:

1. Harm to Self and/or Harm to Others. Soldier's judgment or clarity of thought is perceived as a serious and imminent threat to health or safety of a person, such as suicide, homicide, or other violent action.

Example: A Soldier indicates that he is thinking of hurting himself or his wife.

Example: A high-risk Soldier who receives multiple behavioral health services and requires high risk multi-disciplinary treatment plans, such as a Soldier receiving care for Behavioral Health, Family Advocacy and substance abuse.

Note: Routine behavioral healthcare would not trigger command notification.

2. Medications That Could Impair Duty Performance.

Example: A Soldier is placed on lithium which can reach toxic levels if the Soldier is dehydrated. Note: a Soldier is not allowed to deploy on lithium.

Example: A Soldier is prescribed a pain medication that impairs his ability to drive a vehicle.

Example: A Soldier is prescribed a number of medications (polypharmacy) which could have an impact on the Soldier's well-being, well-being of others, and/or duty performance.

3. Harm to Mission/Condition Impairs the Soldier's Performance of Duty.
Example: A Soldier becomes delusional or has hallucinations.

Example: A Soldier develops epilepsy.

Example: The provider believes there is a serious risk of harm to a specific military operational mission. Such serious risk may include disorders that significantly impact impulsivity, insight, reliability, and judgment.

4. Special Personnel. The member is in the Personnel Reliability Program or is in a position that has been pre-identified by Service regulation or the command as having

Guidelines for Release of Protected Health Information (PHI) to Unit Command Officials

mission responsibilities of such potential sensitivity or urgency that usual notification standards would significantly risk mission accomplishment.

5. Substance Abuse Treatment Program. The member has entered into or is being discharged from, a formal outpatient or inpatient treatment program consistent with AR 600-85 for the treatment of substance abuse or dependence. Those who seek alcohol-use education, who have not had an alcohol referral incident (such as arrest for driving under the influence) do not require command notification unless they also choose to be formally evaluated and are diagnosed with a substance abuse or dependence disorder. However, those enrolled in the Confidential Alcohol Treatment and Education Program will remain exempt from command notification when receiving a formal evaluation and/or are diagnosed with a substance abuse or dependence disorder.

6. Command-Directed Behavioral Health Evaluation. The behavioral health services are obtained as a result of a command-directed behavioral health evaluation consistent with DoDI 6490.4 (Requirements for Mental Health Evaluations of Members of the Armed Forces) and MEDCOM Regulation 40-38.

7. Injury indicates a safety problem or a battlefield trend.

8. Risk of heat/cold injury.

9. Hospitalization/inpatient care.

10. Seriously ill or very seriously ill.

D. Processes available for notifying a unit command official of a Soldier's condition IAW paragraphs A, B, and C are shown below. Immediately notify unit command officials when deemed urgent; immediately in AM if non-urgent hospital admission; or in any case not later than 24 hours. Notification may occur by these methods:

1. Use the DD Form 689 (Individual Sick Slip) to provide PHI and give to Soldier to deliver to unit command officials. (Disclosure accounting is not required.)

2. Use the eProfile system for temporary and permanent profiles. Deployment medical readiness, profile and dental readiness information is provided in the Commander's Medical Readiness Portal.

3. Personal telephone call between the provider and the company or battalion commander followed up by written communication, such as eProfile. Email may be used as a method to notify command officials of the need to pick up information or contact the MTF designee for information.

4. In making a disclosure according to the circumstances described in subparagraphs C.1. through C.6. of this enclosure, healthcare providers shall provide the minimum amount of information to satisfy the purpose of the disclosure. Healthcare providers are not

required to state the medication prescribed or the underlying diagnosis. In general, healthcare providers may disclose:

a. A description of the treatment prescribed or planned; impact on duty or mission; recommended duty restrictions; any applicable duty restrictions/limitations; prognosis, and implications for the safety of self or others.

b. Ways the command can support or assist the Service member's treatment.

E. Procedures for processing unit officials' phone or written requests not connected with a regulatory command management program:

1. Authenticate authority of requester -- phone and written requests must include at least requester's name, official position, and signature (written requests).

2. Authenticate reason for request -- requests not connected to regulatory command management program as listed in paragraph B. should pertain only to the Soldier's general health status, adherence with scheduled appointments, profile status and medical readiness requirements.

3. Release minimum necessary information -- only enough for the purpose of the disclosure. Examples follow:

a. General health status -- Provide medical status as very seriously ill, seriously ill, or a special category description (see AR 40-400 for descriptions), or as "stable," "good," or "fair,",etc. (See AR 40-66 for descriptions).

b. Scheduled for Appointment/Appointment Reminders -- Specialist Smith is scheduled for an appointment on (date/time).

c. Kept sick call/appointment -- Specialist Conrad did (or did not) make that appointment.

d. Profile status -- Sergeant Dole should not do any push-ups due to his back condition. This is a temporary profile for 30 days.

e. Medical readiness requirements -- Corporal Jones needs a current typhoid shot.

4. Phone requests for information must be followed up with a written request for medical information by the requestor (AR 40-66, paragraph 2-5b.).

F. Procedures for obtaining and releasing PHI of Soldiers hospitalized in a civilian hospital. The following best practices will help to achieve consistent results:

1. Establish procedures with local civilian facilities for notification and coordination of PHI release on all admitted military personnel.

Guidelines for Release of Protected Health Information (PHI) to Unit Command Officials

2. Establish installation policy under Director of Health Services' authority for unit Commanders to request Soldier medical status updates through designated MTF point of contact (i.e., PAD, Case Managers).

Your Protected Health Information May Be Shared With Your Commander

In providing your care today, your healthcare provider may determine that your current condition has an impact on your fitness for duty or there is a regulatory requirement that your condition is reported to your Commander. Reporting could include, but not be limited to the following:

1. **Danger:**

   a. To avert a serious and imminent threat to health or safety of yourself or others, such as suicide, homicide, or other violent action.

   b. Injury indicates a safety problem or a battlefield trend.

   c. You are Seriously Ill/Very Seriously Ill.

2. **Drugs:**

   a. Medications that could impair your duty performance.

   b. Substance Abuse Treatment Program: If you have entered into, or are being discharged from, a formal outpatient or inpatient treatment program consistent with AR 600-85 for the treatment of substance abuse or dependence. Those who seek alcohol-use education, who have not had an alcohol referral incident (such as arrest for driving under the influence) do not require command notification unless they also choose to be formally evaluated and are diagnosed with a substance abuse or dependence disorder. However, those enrolled in the Confidential Alcohol Treatment and Education Program will remain exempt from command notification when receiving a formal evaluation and/or are diagnosed with a substance abuse or dependence disorder.

3. **Duty:**

   a. Condition impairing your performance of duty.

   b. Special Personnel: If you are in the Personnel Reliability Program or in a position that has been pre-identified by Service regulation or the command as having mission responsibilities of such potential sensitivity or urgency that normal notification standards would significantly risk mission accomplishment.

   c. You are hospitalized.

4. **Directed:** Command-Directed Behavioral health Evaluation. The behavioral health services are obtained as a result of a command-directed behavioral health evaluation consistent with DoDI 6490.4 (Requirements for Mental Health Evaluations of Members of the Armed Forces) and MEDCOM Regulation 40-38.

Encl 2

Your Protected Health Information May Be Shared With Your Commander

5. **Deployment Limiting:**

   a. Profile limitations.

   b. Immunizations needed.

   c. Medical Evaluation Board/Physical Evaluation Board information.

   d. Risk of heat/cold injury.

   e. **Deployment** Implications of **Drugs** and **Duty** limitations.

6. **Diet:** Army Body Composition Program documentation.

Should you have questions regarding the release of your protected health information to your Commander, talk to your healthcare provider, the Patient Administration Division, or the Health Insurance Portability and Accountability Act Privacy Officer at your medical/dental treatment facility.

DEPARTMENT OF THE ARMY
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OTSG/MEDCOM Policy Memo 21-011

MCZX

0 9 FEB 2021

Expires 9 February 2023

MEMORANDUM FOR COMMANDERS, MEDCOM REGIONAL HEALTH COMMANDS (RHC)

SUBJECT: Behavioral Health At-Risk Management Policy

1. References:

a. Department of Defense Instruction 6490.08 Command Notification Requirements to Dispel Stigma in Providing Health Care to Service Members, 17 Aug 11.

b. OTSG/MEDCOM, Policy Memo 16-087, Release of Protected Health Information (PHI) to Unit Command Officials, 18 Oct 16.

c. OTSG/MEDCOM, Policy Memo 19-010, Department of the Army (DA) Form 3822, Mental Status Evaluation, 8 Feb 19.

d. VA/DoD Clinical Practice Guideline for Assessment and Management of Patients at Risk for Suicide, Version 2.0, 2019

e. OTSG/MEDCOM, Policy Memo 17-079, Behavioral Health eProfiling Standardization Policy, 28 Dec 17.

f. ALARACT 057/2020, Privately Owned Firearms and Behavioral Health, dated 18 Jun 20.

g. Behavioral Health Data Portal Manual: Medical Operational Data System User Guide Behavioral Health Data Platform, 18 Oct 14.

h. The Joint Commission, National Patient Safety Goals (NPSG) Effective January 2021 for the Behavioral Health Care Program, NPSG.15.01.01, Reduce the Risk for Suicide, 28 Oct 20.

i. Department of Defense Instruction 6490.09 DOD Directors of Psychological Health, Change 2, 25 Apr 17.

·This policy memo supersedes OTSG/MEDCOM Policy Memo 16-096, 15 Nov 6, subject: Behavioral Health At-Risk Management Policy.

MCZX
SUBJECT: Behavioral Health At-Risk Management Policy

2. Purpose: Provide guidance regarding clinical care, case management, surveillance, and command communication for individuals at-risk for suicide or homicide seen by behavioral health (BH) providers.

3. Proponent: The proponent for this policy is the Behavioral Health Division, Health Care Delivery, MEDCOM G-3/5/7.

4. Applicability: This policy applies to all BH providers privileged at the Military Medical Treatment Facilities (MTF) and behavioral healthcare delivered within Army Medicine.

5. Definitions and Terminology:

a. Every effort should be made by BH providers to use standard terminology as outlined in the DoD/VA Clinical Practice Guideline (CPG) for Assessment and Management of Patients at Risk for Suicide.

b. The following are examples of terms that should be avoided in documentation of BH Risk issues: parasuicide, suicide gesture, suicide threat, manipulative act, nonfatal suicide, failed attempt, completed suicide, successful suicide.

c. Key terminology and definitions include:

(1) BH Risk: A provider's assessment of risk that a patient may deliberately act in a manner that may result in harm or death to the patient or another person.

(2) BH Risk Levels outlined in this policy follow the nomenclature of the acute risk levels outlined in the VA/DoD Clinical Practice Guideline (CPG) for Assessment and Management of Patients at Risk for Suicide, but extends the risk levels to include risk o harm to others, not only suicide risk. In addition, this policy does not address the concept of "chronic risk" as described in VA/DoD CPG, although the description of "chronic risk" outlined in the CPG may be a useful term clinically in assessing chronic risk factors and co-morbidities that are important for clinicians to consider in their overa risk assessment and clinical management strategies.

(3) BH Risk Screening: A systematic application of a validated self or provider-administered screening tool to help identify those in need of further clinical assessment These tools may also be used to monitor progress during treatment.

(4) BH Risk Evaluation/Assessment: A provider's overall clinical assessment of the patient's risk level, based on clinical judgment, after consideration of self-report measures, current clinical examination, collateral information, warning signs, risk factors, and protective factors. Based on the risk assessment, providers will document the level of acute risk as: low risk, intermediate risk, or high risk, based on the descriptions included in the 2019 VA/DOD CPG for Assessment and Management of Patients at Risk for Suicide (see table in Annex 1).The term "no elevated BH risk," can

be utilized to describe an individual considered to not be at increased BH risk compared to a demographically comparable general population baseline.

(5) Safety Plan or Crisis Response Plan: A Safety Plan (also called a Crisis Response Plan) is an individualized written document developed in collaboration with the patient (for example, an index card that the patient can carry) that includes at a minimum the following components: (1) identification of warning signs of crisis (may be behavioral, cognitive, affective, or physical), (2) coping or self-management skills/ strategies (e.g., distraction techniques), (3) current support persons who patient would feel comfortable contacting during a crisis and their contact information, (4) professionals who can be contacted (e.g., primary care provider, BH provider, chaplain), (5) crisis/emergency resources to include nearby emergency services, and crisis line numbers (Suicide Lifeline 1-800-273-8255 CONUS, DSN phone or commercially via 00800-1273-TALK (8255) in Europe, 0808-555-118 or DSN 118 in Korea), and (6) lethal means safety which is a way to improve the safety of the environment and restrict access to lethal means consistent with applicable federal, state, and local issuances (e.g., securing personal weapons, safe disposal of excess medications). Safety plans are not "contracts for safety" and clinicians should not request that patients sign them.

(6) Ideation: The term ideation may be used in a broad sense for any thoughts related to self-directed violence or violence toward others, which may be passive (such as thoughts of being better off dead) or active (such as engaging in suicidal behavior). Suicidal ideation refers specifically to thoughts of engaging in suicide-related behavior.

(7) Self-Directed Violence: Behavior that is self-directed and deliberately results in injury or potential for injury to oneself. This may be suicidal, non-suicidal, interrupted by self or others, or undetermined (per Annex 3).

(8) Preparatory Behavior: Acts or preparation towards engaging in self-directed or other violence. This can include anything beyond a verbalization or thought, such as assembling means of harm (e.g., buying a gun, collecting pills) or preparing for one's death (e.g., writing a suicide note, giving things away).

(9) Suicidal Intent: There is past or present evidence (implicit or explicit) that an individual wishes to die, has means to kill him/herself, and understands the probable consequences of his/her actions or potential actions.

(10) Suicide Attempt: A non-fatal, self-directed, potentially injurious behavior with an intent to die as a result of the behavior. A suicide attempt can be further classified as with or without injury and interrupted by self or other.

(11) Suicide: Death caused by self-directed injurious behavior with an intent to die as a result of the behavior.

MCZX
SUBJECT: Behavioral Health At-Risk Management Policy

6. Policy:

a. In the course of their duties, clinicians will encounter patients at risk for harm to themselves or others. Patients may present for care through routine screening processes (e.g., Periodic Health Assessment or primary care), self-referral, emergency services or administratively required behavioral health evaluations. Clinicians have the responsibility to provide assessment and treatment, effectively communicate with leaders when indicated, and mitigate risk to the best of their ability.

b. On initial BH clinical encounters, BH providers will document a comprehensive BH risk evaluation, and update this, as clinically indicated, on follow-up visits. There is insufficient evidence to recommend any specific risk stratification or documentation approach. However, comprehensive risk evaluations should include, at a minimum, the following factors:

(1) Prior suicide attempt(s).

(2) Current suicidal (or homicidal) ideation.

(3) Presence of intent (taking into consideration such factors as current plan; preparatory behaviors, reasons for living, and ability to maintain safety or abide by safety plan).

(4) Key risk/protective factors, including prior psychiatric hospitalization, current psychiatric conditions (e.g., mood disorders, substance use disorders and psychotic symptoms), relevant recent biopsychosocial stressors, and social supports—including assessing for intimate partner or family violence, when indicated.

c. The Behavioral Health Data Portal (BHDP) should be utilized according to BHDP guidelines and documented in the Electronic Medical Record (EMR). The BH provider-determined risk level will also be updated within the BHDP treatment status section based on the patient's current risk level to ensure consistency with clinical assessment. If the BHDP is not available, paper screening tools, such as the PHQ-9 or Columbia Suicide Severity Rating Scale (C-SSRS), may be used instead. On initial BH encounters, providers will screen each patient with the initial screening questions from the lifetime version of the C-SSRS. Any "yes" response will be explored clinically to assess if the symptoms are current. On follow-up visits the past-month screener version of the C-SSRS will be utilized or clinicians may elect to cover the comparable domains through their clinical interview (i.e., documentation of ideation, intent, planning, and preparatory behaviors). The risk level will not be determined solely on the basis of responses on the C-SSRS, rather through clinical judgment and consideration of various sources of collateral information. The results of screening will be documented in the EMR.

MCZX
SUBJECT: Behavioral Health At-Risk Management Policy

d. Required Actions. Providers are expected to provide adequate documentation and rationale in the EMR for actions taken (or not taken) as a result of the risk level that they determine to be present. BH risk will be assessed at every appointment and BHDP risk level will reflect clinical determination unless unavailable. Actions recommended by the latest VA/DoD CPG for the Assessment and Management of Patients at Risk for Suicide are included in Annex 1-2. This policy focuses on required actions based on the acute risk level, though chronic risk factors are also relevant to consider in the acute assessment and clinical management. Minimum actions that should be documented for acute risk include the following:

(1) No Elevated BH risk or Low BH Risk (per Annex 1):

(a) Routine BH outpatient behavioral healthcare practices and treatment planning are appropriate, with referral back to Primary Care once stable.

(b) If a no-show occurs, a call by the BH clinic is not mandatory, but may be considered as a means to attempt to encourage a patient to continue care.

(2) Intermediate BH Risk (per Annex 1):

(a) The frequency of outpatient BH visits should be determined by acuity level and clinical judgement, and the level of care, to include consideration of moving the patient to intensive outpatient treatment or in-patient treatment, should be assessed.

(b) If the patient is treated in an outpatient setting, a well-articulated safety plan or crisis response plan, meeting minimum requirements outlined above in section 5c(5), should be established. A hard copy of the safety plan will be provided to the patient. The safety plan will be reviewed routinely and updated as clinically appropriate to ensure that it remains relevant to the patient and his or her circumstances. Uploading the safety plan into the EMR is not required, but sufficient information about the safety plan should be included in the clinical documentation to allow other providers involved in the patient's care to support and reinforce the safety plan.

(c) BH providers should consider the need for command notification, restriction of access to lethal means (to include personally owned firearms; see below), and duty limitations (communicated via eProfile). Profiles should be written in accordance with (IAW) OTSG/MEDCOM eProfiling Standardization Policy. A direct phone call to the Service Member's commander may be helpful to communicate the clinical concern, recommended duty limitations, and methods by which the commander can support the Service Member. The Service Member should be informed if command contact will occur. See ALARACT 057/2020 for more information on authorized methods of recommending unit support for mitigating BH risk.

(d) Service Members in this category may be considered for At-Risk Case Tracking (ARCT) enrollment, see para 6g(2), but such tracking is not mandated.

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(e) If a patient at intermediate BH risk is a no-show for a BH appointment, the provider or BH clinic representative will attempt to contact the patient the same day to ensure no obvious risk status change and to coordinate appropriate BH clinical follow-up, and will document how this contact was made in the EMR. If the Service Member is not available, the unit commander may be notified based on the clinical judgment of the provider.

(3) High BH Risk (per Annex 1):

(a) BH providers should consider an increase in outpatient behavioral healthcare treatment frequency, re-evaluation of diagnosis, and/or re-consideration of treatment plan. Strong consideration should be given to utilization of a higher level of care, such as hospitalization, especially if the high risk is acute or imminent. The rationale for key decisions, such as outpatient treatment frequency or change in level of care should be documented in the EMR.

(b) Duty to warn procedures should be utilized IAW DODI 6490.08 and Tarassoff Law for cases where a specific violence risk is present and an identified target(s) has (have) been identified.

(c) The Service Member must be immediately enrolled in the ARCT list. In addition to being tracked on the ARCT, all high risk Service Members will be offered BH case management services by the Nurse Case Manager (NCM) or Installation Director of Psychological Health (IDPH) designated representative. Upon enrollment in the ARCT, BHDP must be updated to reflect the Service Member's current risk level and enrollment in the ARCT under the "significant event" section of BHDP. Upon the patient's removal from the ARCT, BHDP "significant event" section must also be updated to reflect the change in the Service Member's status.

(d) For Active Duty patients, BH providers will immediately contact unit commanders regarding change in BH risk status when a Service Member is newly deemed high BH risk. BH providers must create a physical profile detailing current condition, duty limitations, and recommended command actions to support the Service Member per OTSG/MEDCOM eProfiling Standardization policy. At a minimum, the Service Member will receive a physical profile for 30 days, and this profile will remain active at least until dis-enrolled from ARCT. The Service Member will be made aware of the profile, recommended duty limitations, and contact with command. See ALARACT 057/2020 for more information on authorized methods of recommending unit support for mitigating BH risk.

(e) If the patient continues to be treated in the outpatient setting, a well-articulated safety plan or crisis response plan, meeting minimum requirements outlined above in section 5c(5), should be established. A hard copy of the safety plan will be provided to the patient. The safety plan will be reviewed routinely and updated as

clinically appropriate to ensure that it remains relevant to the patient and his or her circumstances. Uploading the safety plan into the EMR is not required, but sufficient information about the safety plan should be included in the clinical documentation to allow other providers involved in the patient's care to support and reinforce the safety plan.

(f) BH providers should take steps to restrict access to lethal means, and will promote the voluntary use of gun locks and other safe storage methods for privately owned firearms.

(g) If a patient with high BH risk is a no-show for a scheduled appointment, the provider or BH clinic representative must attempt to contact the patient the same day (preferably during the scheduled appointment time) to determine the reason for the no-show, screen for current BH risk status, and arrange appropriate follow-up. If the patient is an Active Duty Service Member and the BH provider or clinic representative is unable to reach the Service Member, the provider will contact the unit commander to help arrange contact with the Service Member for creating an appropriate follow-up plan and to screen for current BH risk status.

(h) If indicated (i.e., imminent high risk), providers should take immediate action to keep the patient and others safe, to include direct observation in an environment with limited access to lethal means until the patient is on a secure unit. The provider will arrange for inpatient hospitalization and notify the unit commander of the current situation.

(i) Regardless of risk assessment, providers should consider ways to promote protective factors, such as enhancing social support, inquiring about religious/or spiritual beliefs or services as there is evidence of spirituality having protective effects from suicide. At a minimum, providers will inquire about social supports, and the spirituality of presenting patients, recent changes in belief system, and willingness to engage in chaplain support or counseling. Comprehensive plans include Garrison or Army Community Services, Army Wellness Centers, Spiritual and Chaplain services, Legal, or other relevant resources ensures comprehensive support for those at risk. Army BH providers are proficient and comfortable with non-BH resources for referral available in support of their patients.

(j) Transitions can be a stressful time within the military life cycle and are identified as a vulnerable time period for Soldiers and their Families. Regardless of the risk assessment, all Service Members engaged in BH services will also be offered the *inTransition* program in order to support movement to the next duty station. Additionally, the clinic will provide contact numbers for clinical and emergency services in the event the Soldier has concerns during the permanent change of station (PCS) transition. Providers will provide profiles for those Soldiers determined clinically unfit for Permanent Change of Station per OTSG/MEDCOM Policy, Behavioral Health eProfiling

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Standardization Policy and communicate transition concerns to Soldier's commander. Those designated as "high risk" are unfit for PCS.

(4) IAW DoDI 6490.16, commanders and health professionals are permitted to ask for and record information about a Service Member's privately owned firearms, ammunitions, and other weapons if the commander or health professionals have reasonable grounds to believe the Service Member is at risk of suicide or causing harm to others. If health professionals and commanders reasonably believe a Service Member is at such risk, they will, consistent with the law, ask the Service Member to voluntarily store his/her privately owned firearms and ammunition for temporary safekeeping. Providers will assess for access to weapons and consider recommending removal or restriction of privately owned weapons based on risk determination. Providers will promote the voluntary use of gun locks and other safe storage methods for privately owned firearms.

(5) For intermediate or high risk Service Members, providers may consider involving Family Members in the patient's care and safety planning as clinically appropriate and in accordance with the patient's preferences and signed Release of Information. Providers may also consider enrolling the patient into the Sole Provider Program or other MTF program that is designed to monitor and promote medication treatment compliance concerns, designating one sole provider and designated alternate as the only providers authorized to prescribe, countersign, or telephonically approve prescriptions for the patient. It is generally best to manage suicide risk in collaboration with the care for other health conditions that are being treated, communicating with unit physician assistant or primary care manager.

f. Authorized methods of recommending unit support for mitigating BH risk:

(1) Service Members assessed to be at acute, imminent, or emergent risk for suicide who meet criteria for hospitalization should be hospitalized without delay. Unit watch is not an authorized medical disposition. In general, Service Members should be released to outpatient care services only when they can be reasonably expected to self-manage safety issues, seek help when appropriate, and participate in outpatient treatment without increased NCO and/or officer supervision.

(2) BH providers are not authorized to recommend any type of unit watch or "buddy watch" as a means to avoid or delay a medically necessary hospitalization. Unit watch or "buddy watch" is generally defined as including some, or all, of the following: (1) 24-hour continuous observation by unit members; (2) any form of restriction outside the context of UCMJ; and/or (3) chain-of-command directed management of medications prescribed to a Service Member. During operational deployment conditions, or other isolated situations in which immediate hospitalization or evacuation is not possible, unit commanders, in close consultation with supporting BH providers, can establish a time-limited plan to provide increased NCO and/or officer supervision, in

order to ensure appropriate Service Member safety until access to necessary medical care or a medical evacuation is available.

(3) BH providers are encouraged to make recommendations to unit commanders to support Service Members for whom an acute hospitalization is not indicated. Some potential command support actions include: ask a Service Member to voluntarily secure weapons, restrict duty assignments based on current medical condition, restrict access to military weapons, conduct an inspection of barracks to remove hazardous items, encourage periodic check-ins with a Service Member, and create alternate housing arrangements for a period of time to create a safer and more supportive environment in accordance with, ALARACT 057/2020. These recommendations should be documented on a DA Form 3822, Mental Status Exam and provided to the unit commander. Specific duty restrictions which may limit medical readiness should be additionally documented via a physical profile.

(4) The IDPH will ensure training availability for unit commanders and leaders as it applies to high risk mitigation strategies and this policy. This outreach can be done through installation Commanders' and First Sergeants' Courses as well as through active outreach services. Command and Leader education should include behavioral health emergency procedures for the installation during and after duty hours, expectations for command-provider communication, Commander and Service Member Rights as it applies to BH admissions and involuntary admissions and how to establish a recurrent command-led risk mitigation program involving key leaders, legal, medical, BH, and chaplain resources at the battalion-level.

g. At-Risk Case Tracking (ARCT):

(1) All MTF BH Department clinics must have a local process for managing and reviewing at-risk cases within their outpatient behavioral healthcare venues. ARCT meetings should be scheduled on a regular basis (generally weekly), and include the appropriate personnel as determined by the clinic (depending on such factors as the clinic size, acuity level of patients on the ARCT, personnel involved in the care of these patients, and other factors). The following core personnel should be considered for this: clinic chief/sub-chief, clinic case manager, clinic providers, and 68Xs/Social Services Assistants/Behavioral Health Technicians. Family Advocacy Program (FAP) and Substance Use Disorder Clinical Care personnel should be included when they are co-managing patients on the ARCT. Inclusion of unit BH providers, Behavioral Health Care Facilitator, and/or unit surgeon/primary care manager should be considered to ensure comprehensive assessment of the patient. Command engagement by the ARCT and treating providers is important to understand the Soldier's function, informing sound clinical recommendation.

(2) Specific categories of patients are required to be tracked in the ARCT meetings unless reasons for non-inclusion are documented in the medical record. Mandatory patient inclusions include:

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(a) Patients in the High Acute BH Risk category or those with Chronic BH Risk with clinical concern.

(b) Patients recently discharged from a BH acute or residential inpatient unit in the last 30 days (Patients discharged from hospitalization, may have stabilized enough for discharge but will require continued ARCT/high risk monitoring and profile for a minimum of 30 days).

(c) Patients known to have had a suicide attempt in the past 60 days.

(d) Actively psychotic patients.

(e) Service Members medically evacuated from Theater for a BH reason in the last 30 days.

(3) Categories of patients where At-Risk Case Tracking should be considered, but is not mandatory, include:

(a) Patients discharged from intensive outpatient/partial-hospitalization without marked clinical improvement compared to entry into these programs.

(b) Patients with a newly designated Intermediate Acute Risk category or an intermediate or high chronic risk category where a BH provider has concern of risk potentially worsening.

(c) Service Members with suspected violence/child abuse or neglect.

(d) Service Members on a combination of four or more psychotropics, sleep medications, and/or narcotics that are used daily (this does not include as needed medication).

(4) When adding a patient to the ARCT, a provider will immediately notify the clinic NCM or IDPH's designated representative of a patient referral for the ARCT when the mandatory inclusion criteria are met or a provider deems such tracking important for the treatment plan.

(5) Expected actions by the clinical team in support ARCT cases:

(a) The NCM or IDPH-designated representative will review relevant medical records, coordinate with the behavioral healthcare team and unit leadership, and contribute to ARCT meetings.

(b) The NCM or IDPH designee will offer case management services to patients designated as high risk and document case management provided, as well as ensure ARCT staffing notes are documented in the patient's EMR. Thus the high risk patient

may have three documented notes entered into their EMR weekly: ARCT staffing note, case management note and therapy note.

(c) The NCM or IDPH designee will have oversight of BH appointments and coordinate care delivery for all ARCT cases.

(6) Removal from ARCT:

(a) Removal from At-Risk Case Tracking is a team decision. Reduction of clinical surveillance and BH case management is made by the care team after performing a multi-disciplinary case review during the ARCT clinic meeting and should be based on current clinical status compared with initial clinical status at the time of ARCT enrollment, and stability of symptoms.

(b) Patients may not be removed from ARCT if they continue to meet the ARCT mandatory inclusion criteria. For example, a patient discharged from an inpatient BH unit may not be removed from ARCT until at least 30 days post-discharge.

(c) Patient's removal from the ARCT should be clearly documented with clinical reasoning in the EMR and the BHDP risk level should be updated, as well.

h. Emergency Department (ED):

(1) Providers will consider suicide risk for patients evaluated in EDs as part of the overall medical assessment. Screening tools, such as the PHQ-9 and Columbia Suicide Severity Rating Scale (C-SSRS) screener may be utilized as part of the suicide risk assessment.

(2) For patients evaluated in the ED for a suicide attempt, preparatory behavior with suicidal intent, suicidal ideation, or self-directed violence, the ED team will consult with the on-call or supporting BH provider concerning appropriate level of care and, if discharged to outpatient care, ensure that a follow-up appointment is in place prior to ED discharge on the next clinic day but not to exceed 72 hours. For Active Duty Service Members, in consultation with the on-call or supporting BH provider prior to ED discharge, the ED team or the on-call/ supporting BH provider will ensure that the unit commander is aware of the Service Member's presence in the ED, the BH clinic follow-up plan, any recommended medical limitations and other recommended support efforts needed from the unit commander to ensure Service Member safety. On-call/ supporting BH providers or ED providers (in consultation with the on-call/supporting BH provider) are also required to submit physical profiles, DA Form 3349, through the e-Profile application for those Service Members requiring medical limitations.

(3) For patients admitted to inpatient medical wards, who present with safety or BH considerations, the inpatient nurse case manager or designee will ensure BH has

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input in the patient's discharge and safety planning. Commanders or designees will be notified of any safety concerns to mitigate at risk behavior(s).

i. Inpatient Behavioral Health (IBH):

(1) The IBH team will ensure that a Service Member's unit commander or command- designated representative (an NCO or officer) is aware of the inpatient admission. The IBH team will initiate communication with the unit commander or command-designated representative to participate in treatment planning meetings to ensure an appropriate treatment plan is developed that the unit commander can support before patient discharge.

(2) Inpatient BH units will ensure patients being discharged have a written safety plan as described in 5c(5) above, as well as a copy of the written discharge summary. Any allegation of family violence which precipitated inpatient treatment, requires mandatory report to FAP upon admittance. Prior to discharge, FAP is required to provide input on safety planning, victim advocacy, recommendations for a Military Protection Order or No Contact Order. The documents will be thoroughly reviewed with the patient prior to discharge. The patient will have an outpatient BH appointment not later than seven days, but preferably in 72 hours after discharge. All Service Members being discharged will have a physical profile in eProfile prior to discharge to ensure proper communication of duty limitations to the unit commander. The profile must specify considerations to maintain safety.

(3) IBH teams will coordinate with the local Multi-Disciplinary Outpatient BH (MULTI-D) or Embedded Behavioral Health clinic to ensure the Service Member is placed on the ARCT. The IBH team will update BHDP to indicate high-risk status prior to discharge.

FOR THE COMMANDER:

RICHARD R. BEAUCHEMIN
Chief of Staff

3 Encls
1. Acute Risk Table
2. Chronic Risk Table
3. Definitions/Self-Directed Violence Classification System

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Enclosure 1: 2019 VA/DoD Clinical Practice Guideline for the Assessment and Management of Patients at Risk for Suicide: Acute Risk Table
https://www.healthquality.va.gov/guidelines/MH/srb/VADoDSuicideRiskFullCPGFinal5088212019.pdf.

Sidebar 2a. Essential Features from Risk Stratification Table – Acute Risk

Level of Risk	Essential Features	Action
High Acute Risk	– Suicidal ideation with intent to die by suicide – Inability to maintain safety, independent of external support/help Common warning signs: – A plan for suicide – Recent attempt and/or ongoing preparatory behaviors – Acute major mental illness (e.g., major depressive episode, acute mania, acute psychosis, recent/current drug relapse) – Exacerbation of personality disorder (e.g., increased borderline symptomatology)	– Typically requires psychiatric hospitalization to maintain safety and aggressively target modifiable factors – These individuals may need to be directly observed until they are transferred to a secure unit and kept in an environment with limited access to lethal means (e.g., keep away from sharps, cords or tubing, toxic substances) – During hospitalization co-occurring conditions should also be addressed
Intermediate Acute Risk	– Suicidal ideation to die by suicide – Ability to maintain safety, independent of external support/help These individuals may present similarly to those at high acute risk, sharing many of the features. The only difference may be lack of intent, based upon an identified reason for living (e.g., children), and ability to abide by a safety plan and maintain their own safety. Preparatory behaviors are likely to be absent.	– Consider psychiatric hospitalization, if related factors driving risk are responsive to inpatient treatment (e.g., acute psychosis) – Outpatient management of suicidal thoughts and/or behaviors should be intensive and include: frequent contact, regular re-assessment of risk, and a well-articulated safety plan – Mental health treatment should also address co-occurring conditions
Low Acute Risk	– No current suicidal intent AND – No specific and current suicidal plan AND – No recent preparatory behaviors AND – Collective high confidence (e.g., patient, care provider, family member) in the ability of the patient to independently maintain safety Individuals may have suicidal ideation, but it will be with little or no intent or specific current plan. If a plan is present, the plan is general and/or vague, and without any associated preparatory behaviors (e.g., "I'd shoot myself if things got bad enough, but I don't have a gun"). These patients will be capable of engaging appropriate coping strategies, and willing and able to utilize a safety plan in a crisis situation.	– Can be managed in primary care – Outpatient mental health treatment may also be indicated, particularly if suicidal ideation and co-occurring conditions exist

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Enclosure 2: VA/DoD Clinical Practice Guideline for Assessment and Management of Patients at Risk for Suicide, Version 2.0, 2019: Chronic Risk Table
https://www.healthquality.va.gov/guidelines/MH/srb/VADoDSuicideRiskFullCPGFinal5088212019.pdf.

Sidebar 2b. Essential Features from Risk Stratification Table – Chronic Risk[1]

Level of Risk	Essential Features	Action
High Chronic Risk	Common warning sign: – Chronic suicidal ideation Common risk factors: – Chronic major mental illness and/or personality disorder – History of prior suicide attempt(s) – History of substance use disorders – Chronic pain – Chronic medical condition – Limited coping skills – Unstable or turbulent psychosocial status (e.g., unstable housing, erratic relationships, marginal employment) – Limited ability to identify reasons for living	These individuals are considered to be at chronic risk for becoming acutely suicidal, often in the context of unpredictable situational contingencies (e.g., job loss, loss of relationships, and relapse on drugs). These individuals typically require: – Routine mental health follow-up – A well-articulated safety plan, including lethal means safety (e.g., no access to guns, limited medication supply) – Routine suicide risk screening – Coping skills building – Management of co-occurring conditions
Intermediate Chronic Risk	– These individuals may feature similar chronicity as those at high chronic risk with respect to psychiatric, substance use, medical and pain disorders – Protective factors, coping skills, reasons for living, and relative psychosocial stability suggest enhanced ability to endure future crisis without engaging in self-directed violence	These individuals typically require: – Routine mental health care to optimize psychiatric conditions and maintain/ enhance coping skills and protective factors – A well-articulated safety plan, including lethal means safety (e.g., safe storage of lethal means, medication disposal, blister packaging) – Management of co-occurring conditions
Low Chronic Risk	– These individuals may range from persons with no or little in the way of mental health or substance use problems, to persons with significant mental illness that is associated with relatively abundant strengths/ resources – Stressors historically have typically been endured absent suicidal ideation – The following factors will generally be missing: • History of self-directed violence • Chronic suicidal ideation • Tendency towards being highly impulsive • Risky behaviors • Marginal psychosocial functioning	– Appropriate for mental health care on an as needed basis, some may be managed in primary care settings – Others may require mental health follow- up to continue successful treatments

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Enclosure 3: VA/DoD Clinical Practice Guideline for Assessment and Management of Patients at Risk for Suicide, Version 2.0, 2019: Definitions/Self-Directed Violence Classification System
https://www.healthquality.va.gov/guidelines/MH/srb/VADoDSuicideRiskFullCPGFinal5088212019.pdf.

Appendix B: Self-Directed Violence Classification System

Type	Sub-type	Definition	Modifiers	Terms
Thoughts	Non-Suicidal Self-Directed Violence Ideation	Self-reported thoughts regarding a person's desire to engage in self-inflicted potentially injurious behavior. There is no evidence of suicidal intent. For example, persons engage in Non-Suicidal Self-Directed Violence Ideation in order to attain some other end (e.g., to seek help, regulate negative mood, punish others, to receive attention).	N/A	• Non-Suicidal Self-Directed Violence Ideation
Thoughts	Suicidal Ideation	Thoughts of engaging in suicide-related behavior. For example, intrusive thoughts of suicide without the wish to die would be classified as Suicidal Ideation, Without Intent.	Suicidal Intent: • Without • Undetermined • With	• Suicidal Ideation, Without Suicidal Intent • Suicidal Ideation, With Undetermined Suicidal Intent • Suicidal Ideation, With Suicidal Intent
Behaviors	Preparatory	Acts or preparation towards engaging in Self-Directed Violence, but before potential for injury has begun. This can include anything beyond a verbalization or thought, such as assembling a method (e.g., buying a gun, collecting pills) or preparing for one's death by suicide (e.g., writing a suicide note, giving things away). For example, hoarding medication for the purpose of overdosing would be classified as Suicidal Self-Directed Violence, Preparatory.	Suicidal Intent: • Without • Undetermined • With	• Non-suicidal Self-Directed Violence, Preparatory • Undetermined Self-Directed Violence, Preparatory • Suicidal Self-Directed Violence, Preparatory
Behaviors	Non-Suicidal Self-Directed Violence	Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. There is no evidence, whether implicit or explicit, of suicidal intent. For example, persons engage in Non-Suicidal Self-Directed Violence in order to attain some other end (e.g., to seek help, regulate negative mood, punish others, to receive attention).	Injury: • Without • With • Fatal Interrupted by Self or Other	• Non-Suicidal Self-Directed Violence, Without Injury • Non-Suicidal Self-Directed Violence, Without Injury, Interrupted by Self or Other • Non-Suicidal Self-Directed Violence, With Injury • Non-Suicidal Self-Directed Violence, With Injury, Interrupted by Self or Other • Non-Suicidal Self-Directed Violence, Fatal

NEW PHYSICAL PROFILE (DA FORM 3349)

PHYSICAL PROFILE RECORD

The proponent agency for this form is the Office of the Surgeon General

SECTION 1: SOLDIER INFORMATION

1. NAME (Last, First, Middle Initial)	2. RANK	3. DoD ID NUMBER	4. COMPONENT	5. CURORG	6. UIC
Doe, John, S	COL	123-45-6789-1	COMPO 3 (Reserve)	J	W5BWA0

7. UNIT, ORG., STATION, ZIP CODE OR APO, MAJOR COMMAND	8. AOC/MOS/SQI/JOB/TITLE
94th CSF (A. Co.), N. Little Rock, AR 72118, 807th MDSC)	66H/Med Surg Nurse/Clinical Head Nurse

SECTION 2: PERMANENT PROFILE

9. REASON FOR PROFILE: (In Lay Terminology)	10. P	U	L	H	E	S	11. PROFILE CODES			12. PROFILING PROVIDER	13. APPROVING AUTHORITY	14. DATE
High blood pressure	**2**									**Smith, H MD**	**Tom, H MD**	**02022016**
Hearing Loss				**3**			**W**			**Field, S MD**	**Tom, H MD**	**12202015**
Low back pain			**2**							**Craig, H MD**	**Tom, H MD**	**05152004**
COMBINED PULHES	**2**	**1**	**2**	**3**	**1**	**1**						

SECTION 3: ACTIVE TEMPORARY PROFILE(S) AS OF:

15. REASON FOR PROFILE: (In Lay Terminology)	16. SEVERITY	17. MECHANISM OF INJURY	18. DUTY STATUS	19. EXPIRATION DATE	20. DAYS ON PROFILE	21. PROFILING PROVIDER
Ankle pain	Severe	Sports	AD	02122016	10	Smith, M MD
Shoulder pain	Moderate	Training	AD	03012016	40	Smith, M MD
Thumb pain	Mild	Off-Duty Activities	AD	03022016	30	Field, S MD

22. TOTAL DAYS ON TEMPORARY PROFILE IN THE LAST: 12 MONTHS: 10 24 MONTHS: 40 DATE: 02022016

23. IS SOLDIER AVAILABLE TO TAKE RECORD APFT? ☐ YES ☒ NO
IF "NO", ANTICIPATED APFT AVAILABILITY DATE: 03222016

SECTION 4: FUNCTIONAL ACTIVITIES

24. A SOLDIER MUST BE REFERRED TO THE DISABILITY EVALUATION SYSTEM (DES) IF THERE IS AT LEAST ONE PERMANENT (P) "3" IN THE PULHES AND LIMITATION(S) NOTED IN THE FUNCTIONAL ACTIVITIES. TEMPORARY (T) LIMITATIONS DO NOT CAUSE REFERRAL TO DES.

INDICATE THOSE ACTIVITIES THAT THE SOLDIER CANNOT PERFORM BY PLACING AN "N" IN THE APPROPRIATE COLUMN(S).	P	T
a. Physically and/or mentally able to carry and fire individual assigned weapon?		N
b. Ride in a military vehicle wearing usual protective gear without worsening condition?		
c. Wear helmet, body armor, and load bearing equipment (LBE) without worsening condition?		N
d. Wear protective mask and MOPP 4 for at least 2 continuous hours per day?		
e. Move greater than 40 lbs. (e.g. duffle bag) while wearing usual protective gear (helmet, weapon, body armor, LBE) up to 100 yards?		N
f. Live and function, without restrictions in any geographic or climatic area without worsening condition?		
25. ADDITIONAL PHYSICAL RESTRICTIONS (CHECK IF APPLICABLE)		

☒ a. LIFTING/CARRYING RESTRICTION: MAXIMUM WEIGHT RESTRICTION: Permanent: 40 lbs. Temporary 20 lbs.

☒ b. STANDING LIMITATION: Permanent: 0 min Temporary 60 min

☒ c. MARCHING WITH STANDARD FIELD GEAR: Permanent: Time: ____ min / Distance: ____ mi | Temporary: Time: 0 min / Distance: 0 mi

26. MEDICAL/ADMINISTRATIVE BOARD STATUS: MEB MAR2 Complete ND-PEB (USAR/ARNG ONLY)

SECTION 5: MEDICAL INSTRUCTIONS TO UNIT COMMANDER (PERMANENT RESTRICTIONS LISTED IN BOLD TYPE)

27.

Soldier needs to maintain a 90-day supply of his medication. This Soldier has a permanent hearing loss that requires him to maintain his hearing aids and a 6-month supply of batteries. A comprehensive evaluation has determined that the Soldier may have hearing difficulties, especially in noise.
Commanders should be aware of this limitation and ensure the Soldier's hearing capability does not interfere with assigned tasks.
Recommend fitting with tactical earplugs or tactical communication and protection system (TCAPS) for training and deployments.
Refer to the installation Army Hearing Program manager for mission-specific recommendations.
Adherence to these recommendations will minimize the likelihood that the Soldier will sustain further hearing loss.

Soldier may not stand for more than 60 minutes for the next 10 days, load-bearing limitation to 20 pounds for the next 10 days. Soldier may not lift more than 20 pounds for the next 21 days. Soldier must complete his assigned exercises three times a day.

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NAME: Doe, John, S	RANK: COL	DoD ID NUMBER: 123-45-6789-1	DATE: 02022016

CONTINUATION (From page 1, Section 5)

SECTION 6: ARMY PHYSICAL FITNESS TEST (SEE FM 7-22)

	P		T			P		T	
28. APFT EVENT	YES	NO	YES	NO	29. ALTERNATE APFT (Only if Soldier is unable to do APFT 2 mile run)	YES	NO	YES	NO
2 MILE RUN		X		X	APFT WALK	X			X
SIT-UPS		X		X	APFT SWIM	X			X
PUSH-UPS	X			X	APFT BIKE	X			X

SECTION 7: PHYSICAL READINESS TRAINING CAPABILITIES

(SEE FM 7-22; ACTIVITIES RELATED TO PERMANENT CONDITIONS ARE IN BOLD TYPE)

30.

RESTRICTED: No running, jumping, lifting or Military Movement Drills. No combatives. Conditioning Drill 1: No Power Jump or V-Up. No Heel Hook or Leg Tuck. Load bearing: No foot march or movements with body-armor/ruck. No standing in gear. Walk at own pace and distance not to exceed 15 minutes. Must be able to maintain 3mph without pain or limp, otherwise must use Endurance Training Machine. Shoulder Stability Drill, Push-Up/Sit-Up Drill, Overhead Arm Pull.

MODIFIED*: Preparation Drill, Conditioning Drill 1 (Mountain Climber, Leg Tuck and Twist, Modified Push-Up). May perform crunches. Strength Training Machines/ Free Weight Training: at own weight and tolerance. Endurance Training Machines: Elliptical. Swim at own tolerance***. Climbing Drill 1 (Straight- Arm Pull, Pull-Up, Alternating Grip Pull-Up). 4 for the Core, Hip Stability Drill, Recovery Drill.**

STANDARD: Preparation Drill: Forward Lunge. Endurance Training Machines: Bike, Upper Body Cycle. Recovery Drill:

***Soldier may modify these activities and the movements required to reach the starting position in accordance with Ch 6, FM 7-22.**

****When performing Strength Training, must ensure that the position or movement does not strain the spine. Climbing Drill: must execute caution when mounting and dismounting the bar; if spotters are not able to safely assist or if the Soldier has to jump down to the ground, this activity should be restricted and not performed.**

*****May participate in approved aquatic rehabilitation program.**

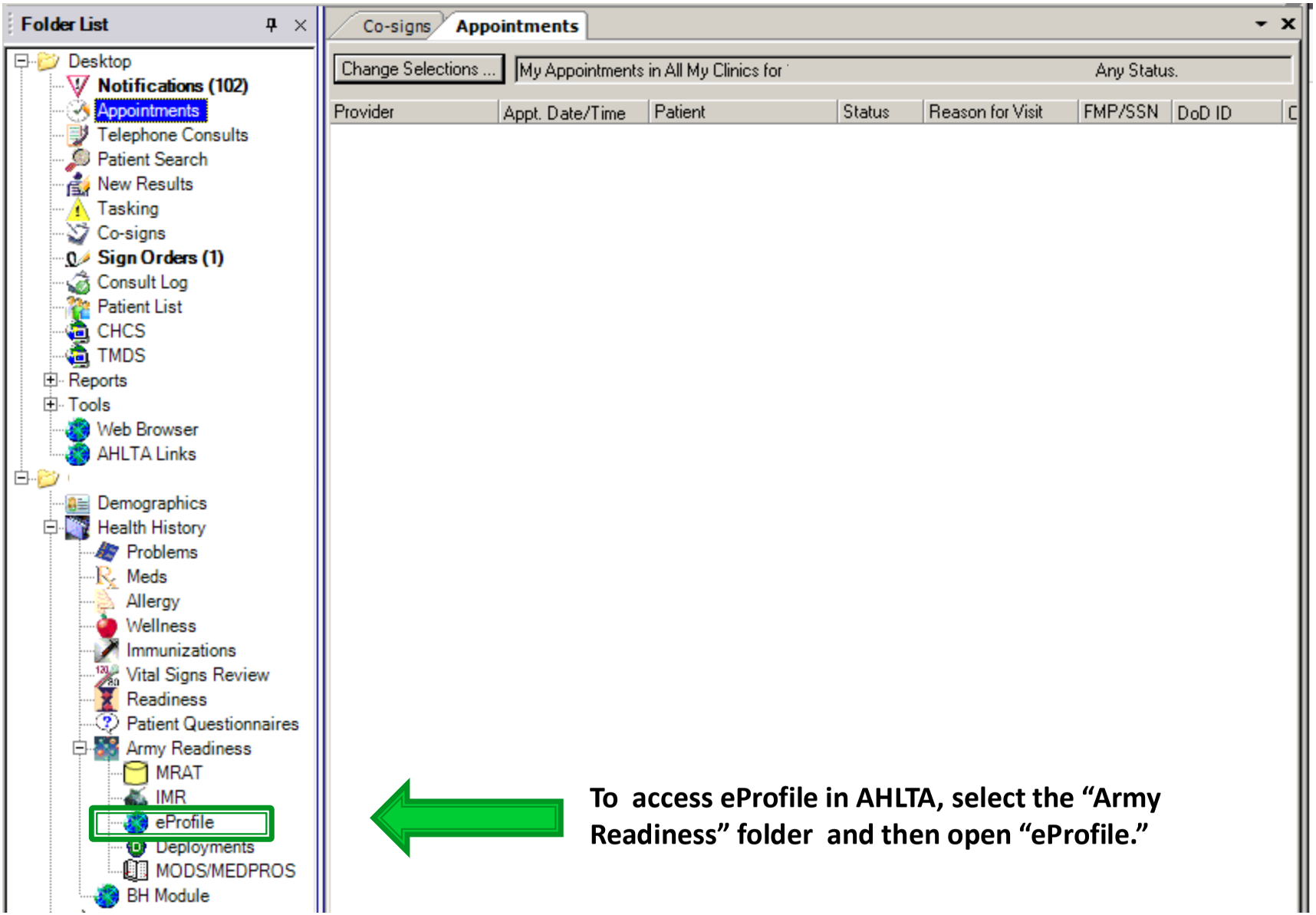
Soldier will be placed in Level 1 (gym-based) or Level 2 Reconditioning Program according to entry and exit criteria in Ch 6, FM 7-22.
Soldier should perform injury specific exercises as prescribed by the medical provider during unit Physical Readiness Training.
Additional Physical Readiness Training RESTRICTIONS:
No Guerrilla Drill
No Obstacle Course
No Conditioning Drill 2 and 3

SECTION 8: UNIT COMMANDER

31. COMMANDING OFFICER:	Digital Signature 12345678	32. DATE: 02022016

DA FORM DA 3349, _____2016 PREVIOUS EDITIONS ARE OBSOLETE PAGE 2 OF 2

Accessing eProfile in AHLTA

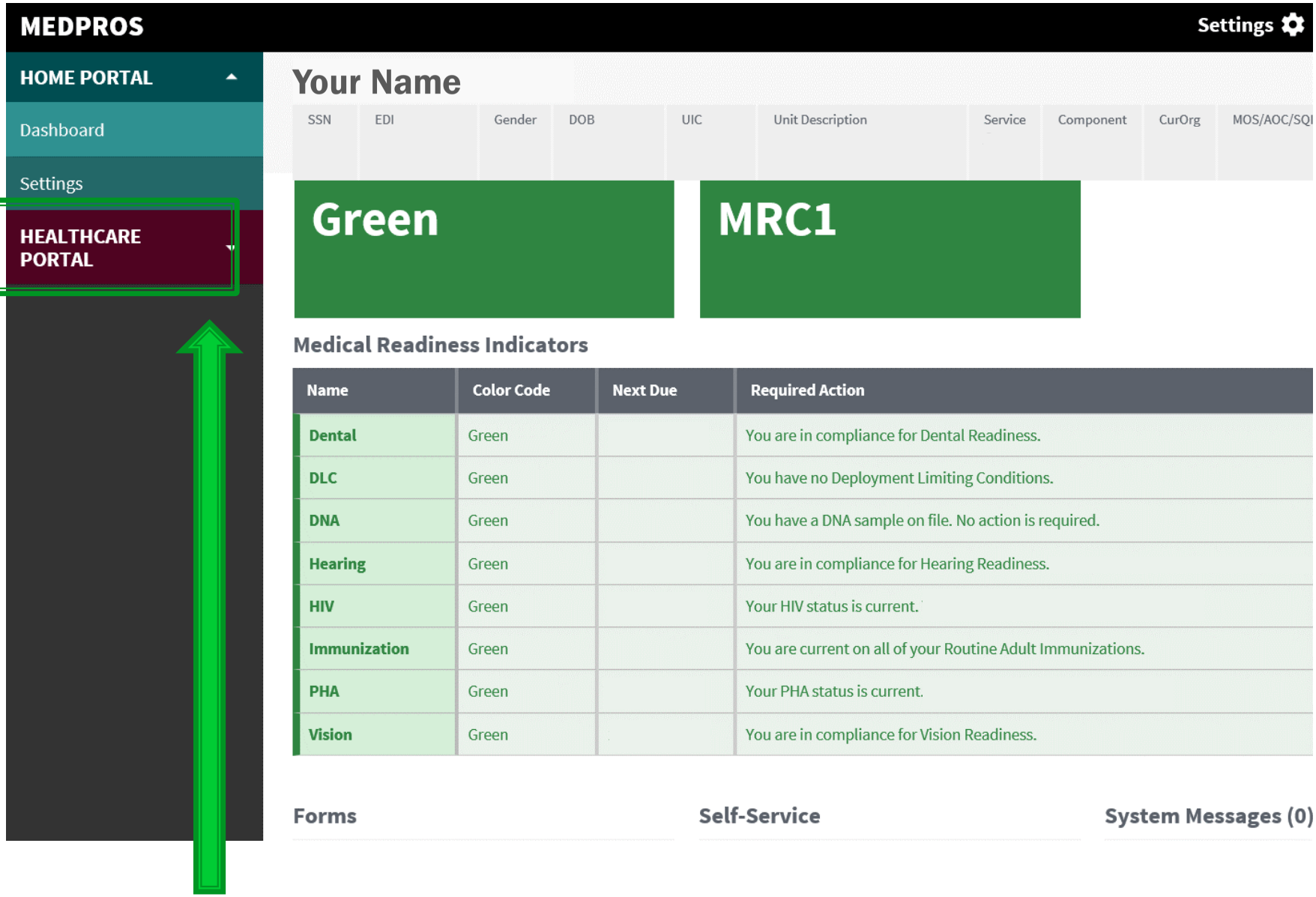


To access eProfile in AHLTA, select the "Army Readiness" folder and then open "eProfile."

Accessing eProfile in MODS

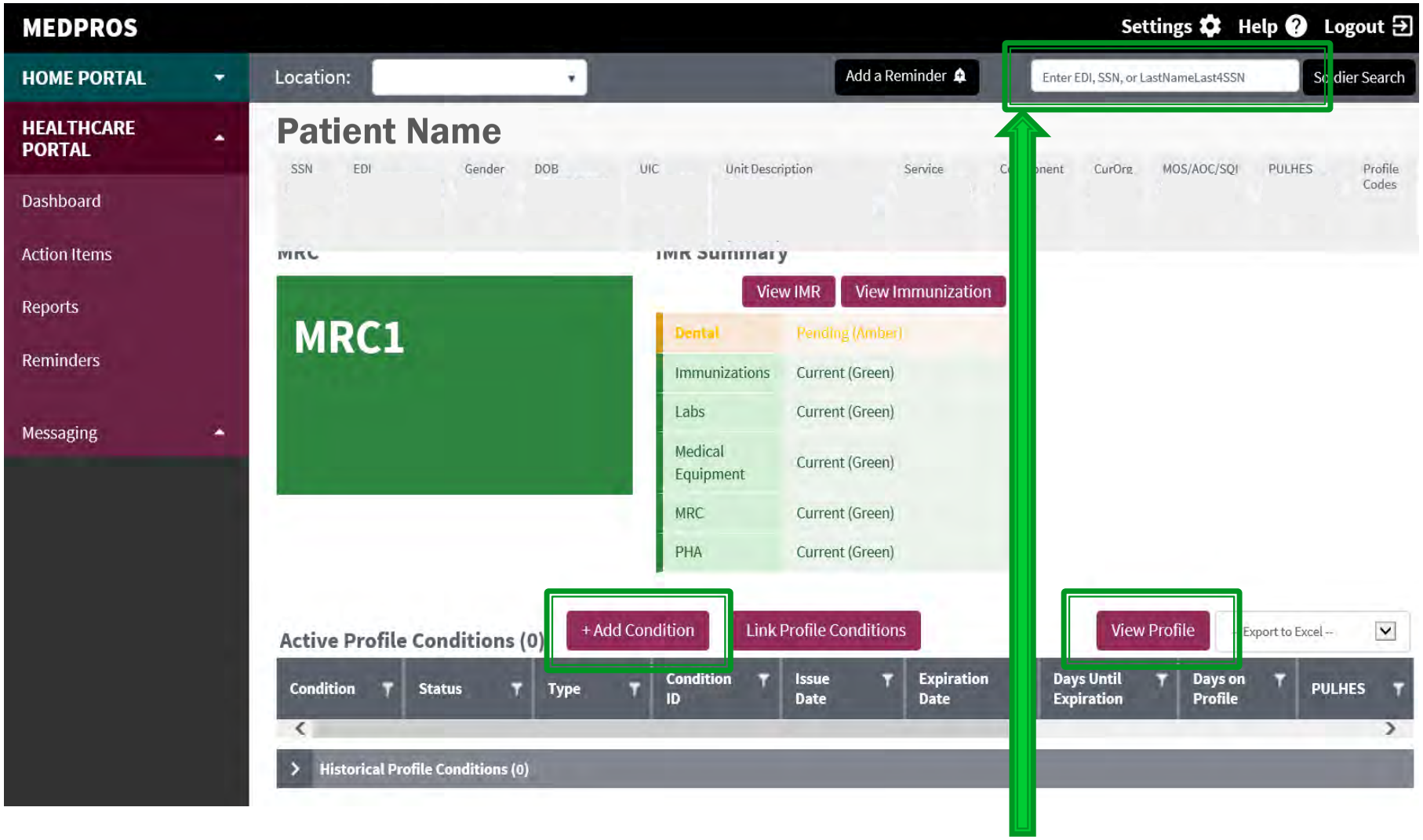
To access eProfile in MODS, select the "Medical Readiness Portal."

Accessing eProfile in MODS



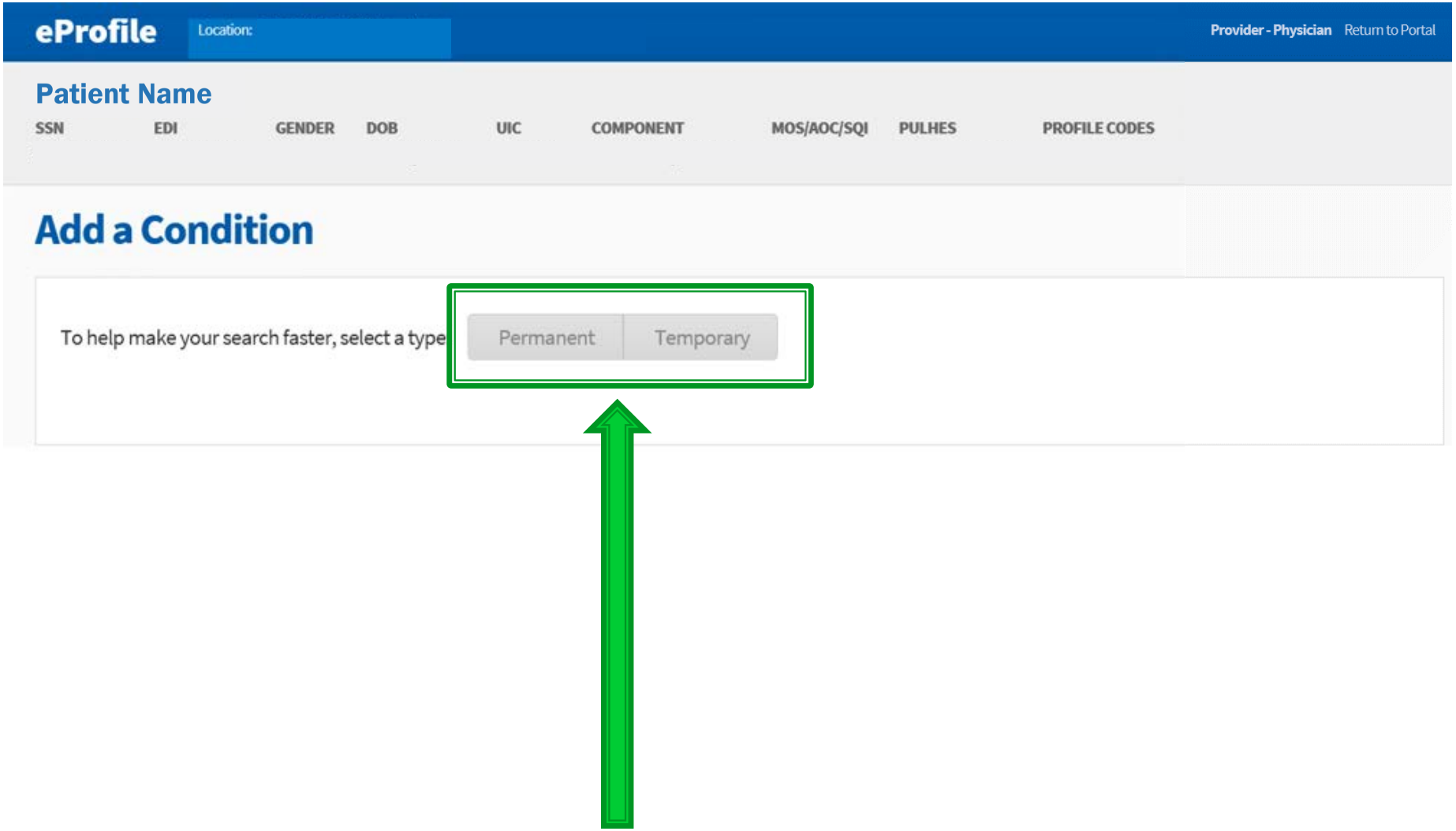
Next, select the "Healthcare Portal."

Accessing eProfile in MODS



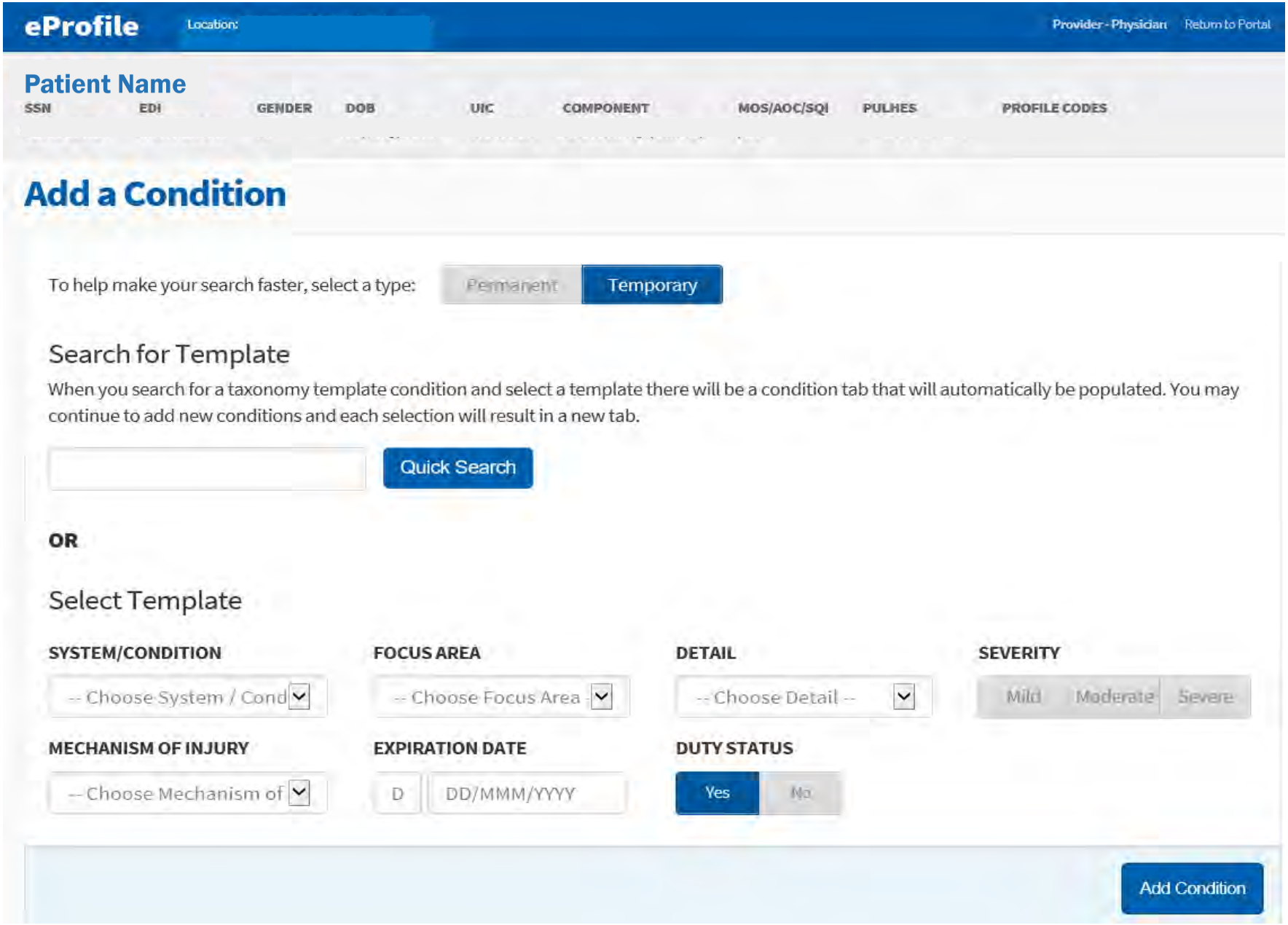
In the "Healthcare Portal," search for a Soldier using the search bar in the upper right-hand corner. Then, select "+Add Condition" to draft a new profile in eProfile or select "View Profile" to open an existing profile.

eProfile Home Screen



In eProfile, select whether the new profile will be permanent or temporary.

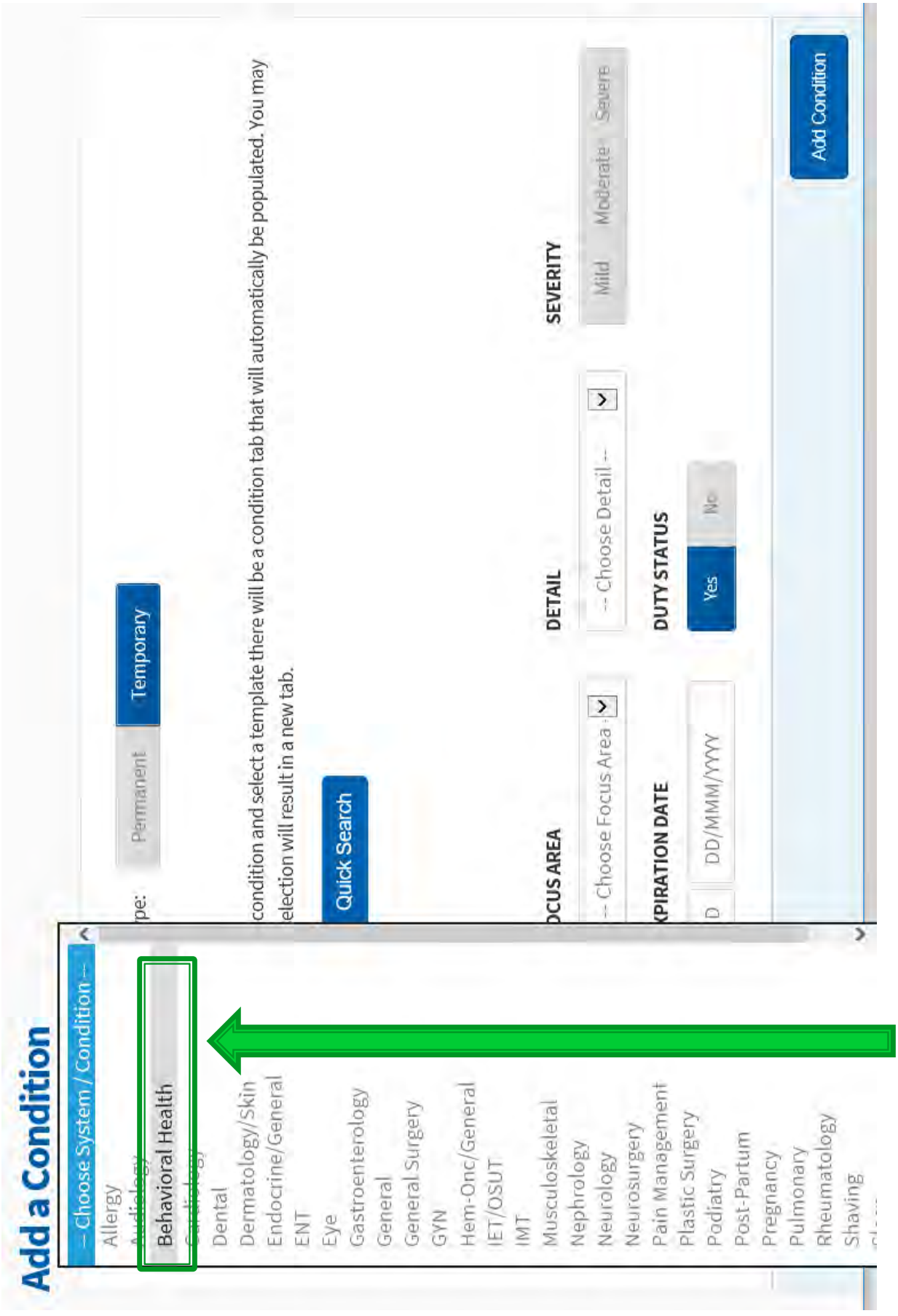
Specify Profile Type



To specify the profile type, search for a profile template OR manually enter the fields below.

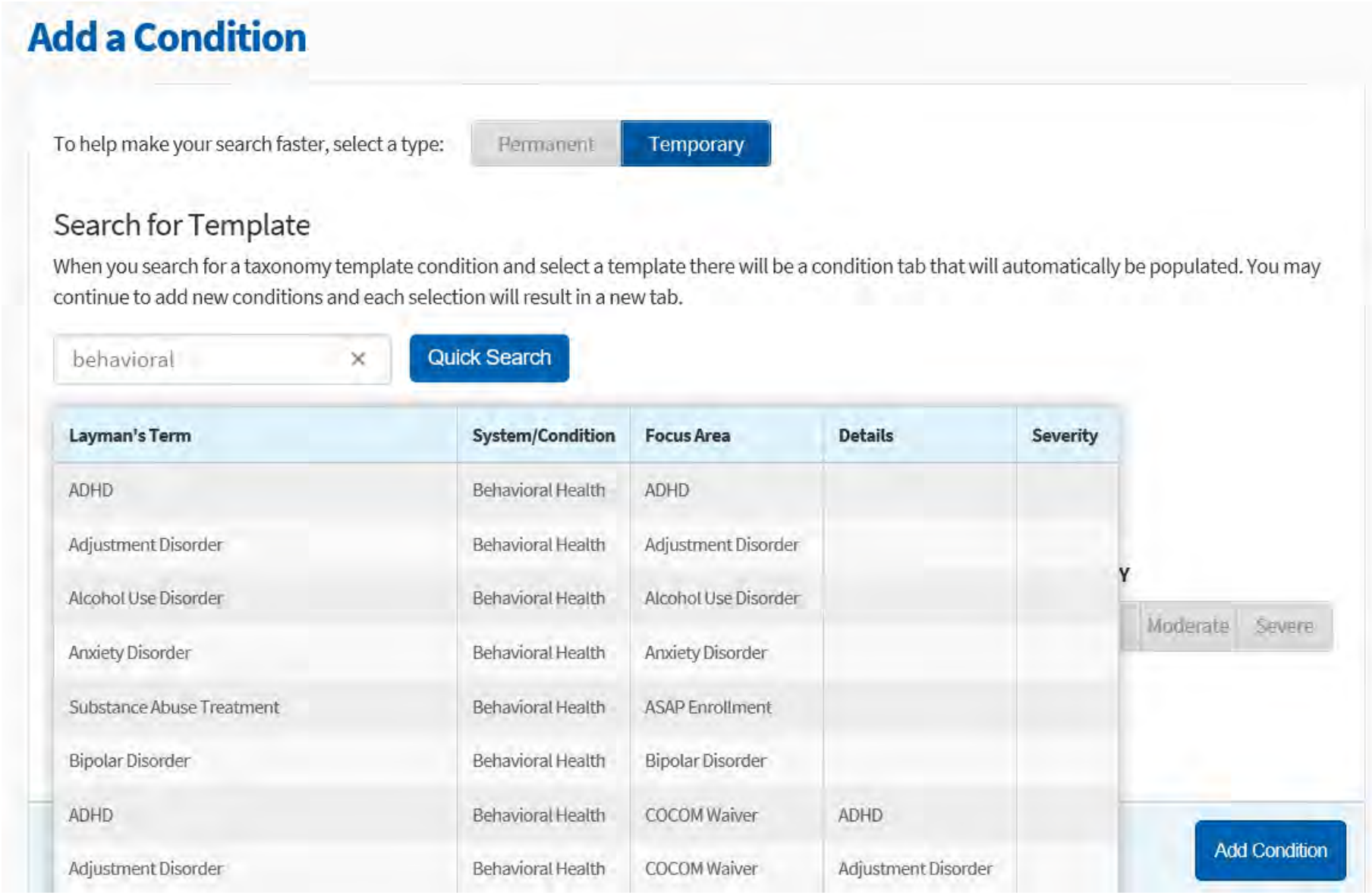
B-REDI

Template Search (1 of 2)



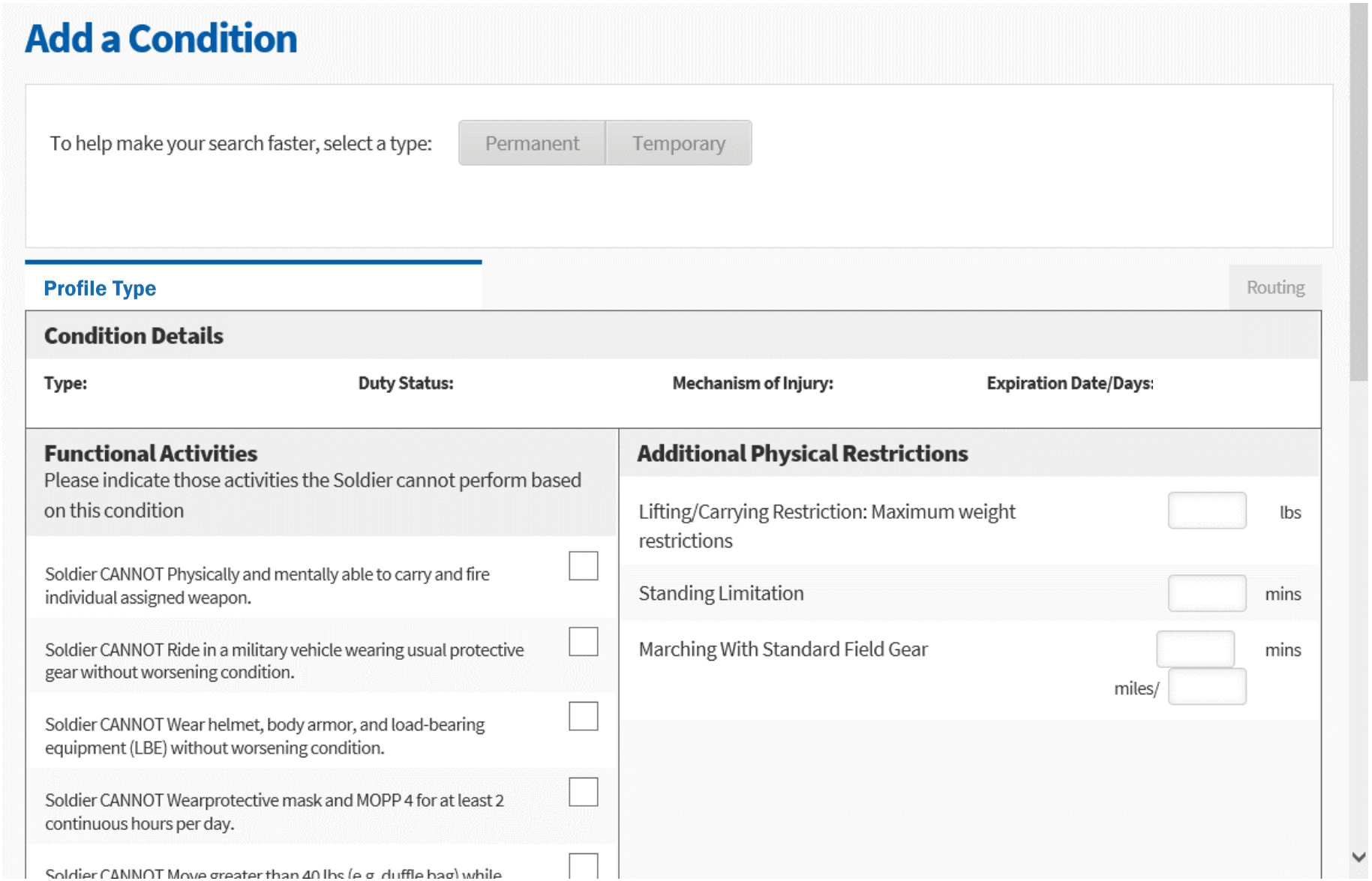
When using the template search feature, specify "Behavioral Health."

Template Search (page 2 of 2)



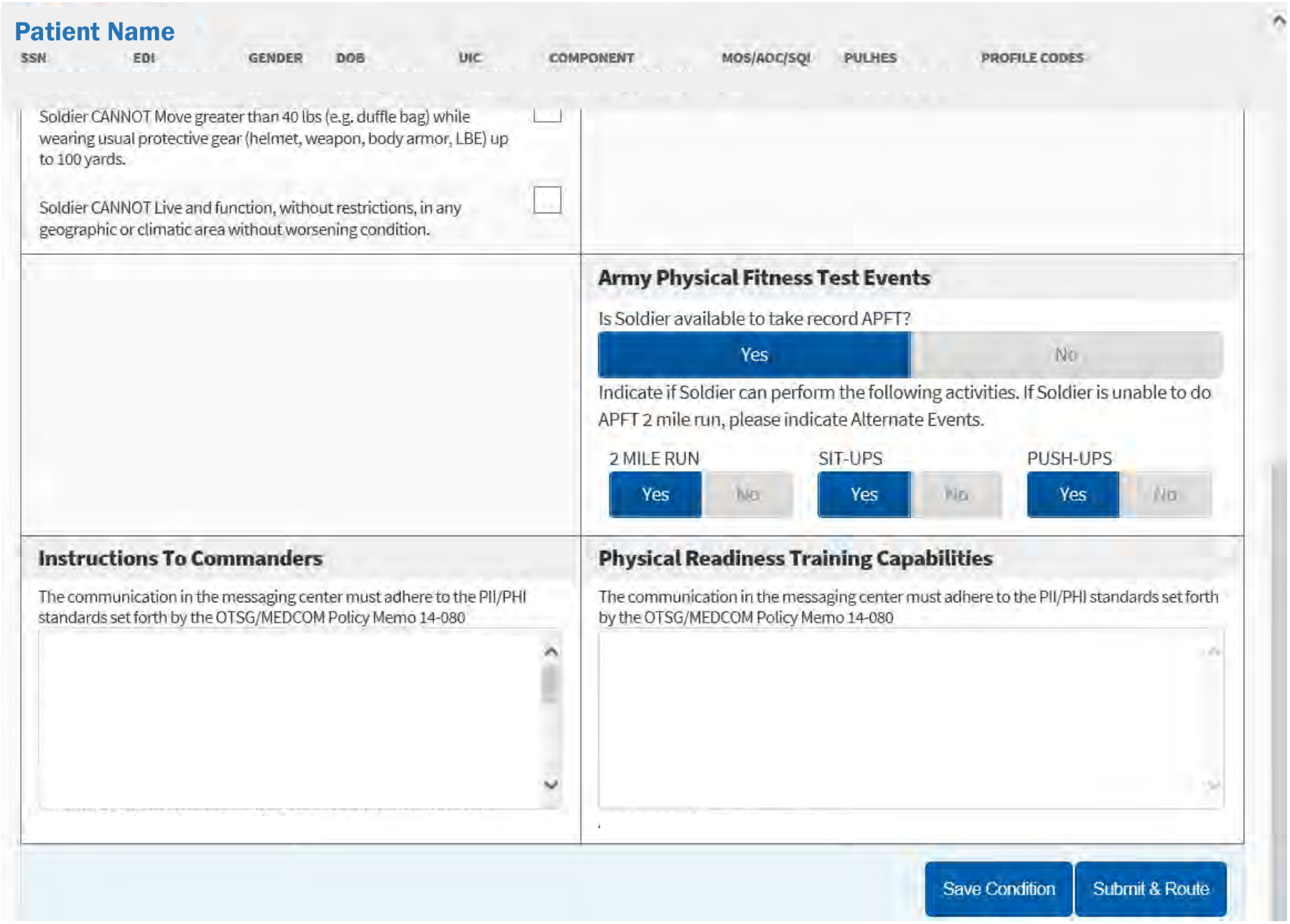
Next, select the appropriate behavioral health condition.

Profile Information (1 of 2)



Enter the appropriate fields and scroll down to continue.

Profile Information (2 of 2)



Enter the remaining fields and select "Submit & Route" to submit the profile.

MOD 15 TAB C **CENTCOM Medical Waiver Request**

Patient Name (Last, First): DOB: SSN(Last 4):

Previous Deployments: Destination (country): Diagnosis (Lay term):

Age: Sex: Grade: Service: Home Station:

Years of Service: Active/Reserve/Guard/Civilian: MOS/Job Description:

Deployment Length: Previous Waivers (Y/N): Currently Deployed (Y/N):

Waiver POC Name/E-mail/Phone:

Case Summary (To be completed by provider, including clinical information necessary to make a disposition. See most recent updated MOD 15 and accompanying MOD 15-TAB A for required information. Attach supporting medical documentation (Lack of necessary supporting documentation will result in disapproval):

I have reviewed the case summary and hereby submit this request.

Signature:_____ **Commander Approval:**_____

CENTCOM Surgeon / Component Surgeon Response

Waiver Approval: ☐ **YES** ☐ **NO**

Signature:_____ **Date:**_____

CENTCOM Command Surgeon

Comments:

USAFRICOM Medical Waiver Request

Using encrypted email, send this form and all scanned documentation to email address identified in ACI 4200.09A, Enclosure D.
For assistance DSN Contact Phone Numbers: AFAFRICA: 314-480-4698; CJTF HOA: 311-824-4282; MARFORAF: 314-431-3565; NAVAF: 314-626-4690; SOCAFRICA: 314-421-3474; USARAF: 314-637-8371; USAFRICOM HQ: 314-421-2263.

Patient Name (Last, First):		DOB:	SSN (last 4):
Age:	Sex: Male	Rank/ Grade:	Service:
Deployment/Travel Date:		Travel Duration (days):	Destination (country):
MOS/AFSC/Skill Identifier/Job Description:			Home Station/Unit:
Active/Reserve/Civilian/Contractor: Active Duty			
Requester POC(Medical Personnel)Name/E-mail/Phone:			
Summary of medical condition(s):			

I understand the potential risks associated with this deployment limiting condition. For this individual, I am requesting a waiver of the health requirement for travel to the USAFRICOM Area of Operation.

Commander or Designee Signature: **Date:** STAMP / PRINTED NAME AND TITLE

Required documentation for waiver evaluation in addition to this form:
DD Form 2766, Adult Preventive and Chronic Care Flow sheet, with full medical history including all medical conditions, surgeries, medications, and summary of Deployment Limiting Condition(s). DoD Civilians/Contractors who are age 40 and older must have a 10-year atherosclerotic cardiovascular disease (ASCVD) risk percentage calculated. (http://tools.acc.org/ASCVD-Risk-Estimator-Plus/#!/calculate/estimate/)

Case Summary (To be completed by healthcare provider): Include all clinically relevant information necessary to make a disposition including, but not limited to: Diagnosis (ICD-10), history of the condition, date of onset, prior treatments, current treatments, limitations imposed by the condition and/or medications, prognosis, and required follow-up. *(Use additional sheets, if needed. The more clinical information provided, the better.)*

Supplemental documentation (include information relevant for deployability determination):

a. Specialty consults results establishing diagnosis, treatment, monitoring plan and prognosis.
b. Recent and relevant surgery, laboratory, pathology and tissue examination reports.
c. Reports of studies (radiographs, pictures, films or procedures).
d. Summaries and past medical documents (e.g. hospital summary).
e. Reports of proceedings (e.g. Tumor Board, Medical Evaluation Boards, etc.)
f. Job requirements (physical condition, exertion level, etc.)

I have reviewed the case summary and hereby submit this request

Provider's Signature: **Date:** STAMP / PRINTED NAME AND TITLE

FOR SURGEON'S OFFICE USE ONLY

Waiver Approved: YES ◯ NO ◯

Waiver Authority Signature: **Date:** STAMP / PRINTED NAME AND TITLE

Comments:

AC FORM 43, 15 January 2019

US ARMY EUROPE (USAREUR) Medical Waiver Request Form as of 1 JUN 2020

This waiver form is used for all ARMY Military and Civilians seeking entrance into the USEUCOM Area of Responsibility for more than > 30 consecutive days, excluding PCS (regardless of assigned COCOM). Submit electronically per routing instructions at least 30 days prior to arrival

Submit all materials to: usarmy.wiesbaden.usareur.mbx.g4-ocsurg-medical-waivers@mail.mil

SECTION 1: PATIENT DEMOGRAPHICS

Name (Last, First and MI): | **DOB:** | **Age:** | **Sex:** | **Ht/Wt/BMI:**

Status: | **Rank/Grade:** | **Service:** Dept. of the Army | **Unit/Post and State:**

Home Station Departure Date: | **Report Date:** | **Tasking Duration (days):** | **PHA Date:**

Requesting entry to the following countries: | **DoD ID:**

MOS/AOC AND Brief Job Description that the individual will be performing while deployed (i.e. 11B/Infrantry, Conducting Force Protection)

Unit POC Information for this Waiver (Name, Title/Position, E-mail and Phone Number): | **DATE:** | **Digital Signature:**

SECTION 2: MEDICAL SUMMARY

Healthcare Provider Only: Include all clinically relevant information necessary to make a disposition including, but not limited to:

1) Deployment Limiting Condition/s:
2) Current Medications/Treatment and Specialty Care provided:
3) Other pertinent diagnoses needing care (IAW ICD10)
4) Limitations imposed by any of the above conditions/meds:
5) Prognosis/required follow-up:
6) Provide a case summary that includes **date of onset, condition history, previous treatments, provider recommendation for or against deployment/ tasking** and other relevant information necessary to determine whether the member can perform duties in a deployed environment with minimal medical burden. **Summary should include status updates for all Behavioral Health conditions from a Behavioral Health Officer (BHO) and/or Specialist.**

- Is an O-5/O-6 Commander's memo/risk assessment mitigating residual risk included with this waiver?
- Are supporting documents (i.e. profiles, etc.) included?
- Has the individual secured at least 180-days of medication for deployment?
- Is medical equipment dual voltage & world-wide capable?
- Is the waiver URGENT <7 days?

SECTION 3: ADJUDICATION

Digital Signature of Medical Provider Requesting Waiver: | **DATE:** | NAME, TITLE/POSITION, E-MAIL & PHONE NUMBER OF PROVIDER

APPROVED ○ NO ○ N/A ○

Medical Waiver Authority Recommendation and Digital Signature | **DATE:**

APPROVED HIGH RISK ○ NO ○ N/A ○

Medical Waiver Appeal Authority Recommendation and Digital Signature | **DATE:**

Comments:

DoD Guidance Documents: DoDI 6490.07 - Deployment Limiting Medical Conditions for Service Members
ASD Policy Memo - Clinical Practice Guidelines for Deployment-Limiting Mental Disorders and Psychiatric Medications
AR 40-501 - Standards of Medical Fitness

Last Opened: 22-Sep-21

ECI 4202.01
3 July 2019

Commander Endorsement Letter Templates
(Army Example)

(Agency Letterhead)
(Office Symbol) DD MMYYYY

MEMORANDUM FOR: ***EUCOM/SG***

SUBJECT: Deployment Medical Waiver Request

1.Request medical waiver for, ***Rank, Full Name, Last 4 of SSN***, for deployment to ***Unit, Base, Country***.

2.***Rank Last Name*** has been diagnosed with ***Deployment limiting condition***. The soldier is currently prescribed Medication(s). The soldier's symptoms are well controlled with this medication.

3. Rank, Last Name has demonstrated the ability to perform all mission-related duties at home station and during multiple field training exercises despite the medical condition. I have every confidence that this Soldier can perform all duties in a deployed environment with little or no risk to personal safety or mission effectiveness.

4. The Commander understands the risks of deploying this service member (SM) and accepts full responsibility for any unfavorable health outcomes resulting from deploying this SM for the indicated waiver.

5. The point of contact for this memorandum is the undersigned at DS *XXX-XXX-XXX*, *email.address*.mil@mail.mil.

Signature Block of O5/O6

NNCI44-163 27 FEB 2018

USNORTHCOM MEDICAL WAIVER REQUEST

Patient Name: SSN (Last 4):
DOB: Age: Sex:
Diagnosis (ICD9): Rank: Service:
Status: Years of Service:
MOS/NEC/Job Description:
Home Station/Unit: # of Previous Deployments:
Previous Waiver (Y/N): Previous Deployment Locations:
Anticipated Deployment Date: Length of Deployment:
NORTHCOM Unit/Mission Supported:
Deployment Location: Deployment Medical Capabilities Available:
POC:
Case Summary:

I have reviewed the case summary and hereby submit this request.
Signature:

USNORTHCOM Surgeon / Component Surgeon Response Waiver
Approval: ☐ YES ☐ NO
Signature:

NAME, MD MPH
CDR MC USN
Chief, Preventive Medicine
NORAD-USNORTHCOM SG Directorate

Comments:

A4.2. Cover Sheet Instructions.

1. Patient Name – enter patient's name in last, first, middle initial format.
2. SSN – enter only the last four digits of the patient's social security number.
3. DOB – enter the date of birth in a *DDMMMYYYY* format.
4. Age – age in years.
5. Sex – M or F.
6. Diagnosis – enter the ICD9 codes for each of the patient's medical conditions.
7. Status – enter active/reserve/civilian.
8. Rank – enter the patient's rank or rate.
9. Service – list the applicable service the patient belongs to. For civilians, list their organization such as the Centers for Disease Control and Prevention (CDC), the Food and Drug Administration (FDA), USNORTHCOM, etcetera.
10. MOS/NEC/Job Description – enter the military job designation or a brief job description (e.g. 2100 physician, communications technician, data analyst).
11. Years of Service – enter the number of years of service the patient has completed.
12. Home Station/Unit – list the patient's home station and the unit they are attached to.
13. # of Previous Deployments – list the number of deployments the patient has previously completed.
14. Locations – list the locations of the previous deployments.
15. Previous Waivers – did the patient have a previous waiver for these deployments.
16. Deployment Date – list the deployment date for the deployment for this waiver request.
17. Deployment Location – list the location for the deployment for this waiver request.
18. Length of Deployment – list the anticipated length for this deployment.
19. Unit Medical Capabilities – list the medical capabilities that the unit will have (e.g. physician, Independent Duty Corpsman, medic, none, etcetera).
20. Waiver POC – list the name, phone number and e-mail of the provider submitting the waiver request.
21. Case Summary – this is to be completed by the healthcare provider and is to include the clinical information necessary to make a case disposition as noted in **A3.2.1.1.** through **A3.2.1.7.** Use additional sheets as necessary.

LETTER OF STABILITY 10 December 2019

The things your physician needs to include in his/her letter for you are as follows:

1. MEDICATIONS: Include detailed history of medication(s) use. Include specific dosages, length of use on current dosages, frequency of use with prn medications, need for monitoring (labs, EKG, etc.), ability to function without (if lost). If sedatives/ sleep medication, include effects of daytime performance and ability to arouse self from sleep in case of emergency.

2. BEHAVIORAL HEALTH EVALUATIONS: Initial (when diagnosis was made), disability evaluation, and subsequent evaluations (including recent).

3. COURSE OF DIAGNOSIS: Include history of stability, relapses, lethality, and response to stressors/ major changes/deployments.

4. COURSE OF TREATMENT: Include treatment from initial diagnosis to present day. Include therapy, medications, level of treatment required (ie inpatient vs. outpatient), compliancy, response, recent changes/additions (<90 days), ongoing treatment required, success of treatment, and length of stability with/without treatment.

5. PROGNOSIS: Include statement on prognosis based on total medical picture and how they will respond to an austere environment. Include how they will be effected by deployment-related stressors (ie sleep deprivation, heat, exposure to trauma, and separation from support systems), and you won't need to follow-up with them until after your deployment.

6. You do not have any active thoughts of homicide or suicide.

7. IAW AR 40-501 and CENTCOM MOD-14, PPGA.

8. If there are any questions concerning this information, please call 915.742.7229 or 915.742.7227.

Suggested Information to Include with Waiver Requests.

Please note this list isn't all inclusive and does not address all conditions that require waivers, but these are the most common ones we see. These are the documents we commonly send up with our waiver requests for supporting documentation. Please send any information with your waiver requests that would help the COCOM with their disposition.

Please note if you are going to EUCOM, they almost always require an O5/O6 memo accepting responsibility for the SM.

OSA

- Original Sleep Study

Behavioral Health

- Letter of stability
- Most recent BH provider notes.
- Command memo
- SRP Provider Note
- DA 3822/ Fit for duty

- Letter of Stability/Encounter documentation stating that SM is stable on current dosage with no adjustments over the past 90 days and okay to deploy to austere environment (Template Attached)
- Any information related to specific medication (labs, vital signs, etc)
- SRP Provider Note
- Command Memo

UNITED STATES ARMY PACIFIC
Medical Waiver Request

***Encrypt and email form with the deployment area in the subject line (e.g. Deployment Area: Korea)
***For USARPAC MSCs and TECs, send directly to your command surgeon. All others send to the following email: usarmy.shafter.usarpac.list.deployment-waiver@mail.mil

USARPAC DRU (Select parent unit): _____

Patient Name (Last, First)_____ DOB_____ Last-4SSN_____

#Previous Deployments: _____ Destination: _____

Diagnosis (ICD 9/ lay term): _____

Age_____ Sex_____ Grade MOS/Job Description_____

Home Station_____ Unit_____

Service_____ Years Service____ Active or Reserve Component/Civilian_____

Deployment Length (months) _____ PULHES_____ Previous waivers: ☐ Yes ☐ No

Waiver POC Name/ E-mail/Phone: _____

Case Summary (Completed by provider, include clinical information necessary to make a disposition). See most recent updated PACOM FHP for required information. Attach supporting medical documentation:

I have reviewed the case summary and hereby submit this request.

POC CAC Signature: _____

Approving Authority Response

Waiver Approval: ☐ YES ☐ NO

Approver's Unit: _____ CAC Signature: _____

Comments:

USINDOPACOM Medical Waivers Procedures (as of October 2018)

1. **Routine permanent change of station and temporary duty missions**: Service members and their associated family members should go through the necessary protocols to include their permanent change of station screening office IAW respective Service specific guidance to ensure suitability and availability of health care services.

2. **Military deployments**: Personnel must be screened and meet medical readiness standards prior to deployment. Active component, Reserve component and DoD civilian personnel with the following conditions should not deploy without a medical and/or dental waiver from their respective component surgeon (see para 2.h. for waiver submissions).

2.a. Conditions that prevent the wear of required personal protective equipment to include manufacturer permethrin pre-treated uniforms.

2.b. Conditions that prohibit required immunizations or medications.

2.c. Chronic conditions that require frequent clinical visits (more than semi-annually) or ancillary tests (more than twice/year); that require evaluation/treatment by medical specialists not readily available in theater; that fail to respond to adequate conservative treatment; that require significant limitation to physical activity; or that constitute increased risk of illness, injury, or infection.

2.d. Any unresolved acute illness or injury that would impair duty performance during the duration of the deployment.

2.e. Any medical condition that requires durable medical equipment (e.g., CPAP, TENS, catheters, etc.), repeated/scheduled medical management, logistical support, and/or infection control protocols for personal medical equipment that are not available at deployment location. Shipboard personnel not in support of land based operations may be exempt from this requirement per U.S. Navy/PACFLT policy.

2.f. Operational dental readiness below class 2 (these conditions are generally not waiverable).

2.g. ASD (HA) MEMO "Clinical Practice Guidance for Deployment-limiting Disorders and Psychotropic Medications", 7 OCT 2013, provides policy guidance for deploying service members with psychiatric disorders and/or who are prescribed psychotropic (psychiatric) medications. A member with a disorder in remission or whose residual symptoms do not impair duty performance may be considered for deployment, but service member must have been clinically stable for at least three months prior to pre-deployment assessment. No waivers will be granted for psychotic and bipolar disorders. service members cannot deploy on anti-psychotics, lithium or anti-seizure medications. However, off-label use of these medications for pain management, sleep disorders, PTSD, etc., will be considered by individual waiver request. a waiver request must be submitted to the respective component surgeon for personnel who are on psychotropic medications, including antidepressants, and have been stable for at least three months while on medication. A waiver request should also be submitted for those with a history

of inpatient psychiatric hospitalization or use of psychotropic medications for non-psychiatric conditions. Service members who deploy must have a 90-day supply of their medications to allow for continued stability until they can be followed by a provider in theater. Service members on psychotropic medications must obtain a small arms waiver IAW service component policy.

2.h. Waiver requests are submitted to respective component surgeon, who may delegate approval authority. For information contact as appropriate: USARPAC (DSN 315-437-5906 or 315-437-5894), PACAF (DSN 315-448-3422), PACFLT (DSN 315-474-6339), MARFORPAC (DSN 315-477- 8667), SOCPAC (DSN 315-477-7930), or Defense POW/MIA Accounting Agency (DSN 315-448-4500). All requests, IAW DODI 6490.07 "Deployment-Limiting Medical Conditions for Service Members and DOD Civilian Employees", are to be tracked and archived (as approved or denied), along with the medical condition(s) requiring a waiver by the respective component.

UNITED STATES FORCES KOREA MEDICAL WAIVER REQUEST

For use this form, see USFK Reg 40-9 and the proponent agency is USFK Surgeon.

Email this form and all scanned documentation to USFK Command Surgeon at pacom.yongsan.USFK.list.l47-hssd@mail.mil.
Do not send encrypted emails to this address. Use AMRDEC or contact DSN: 315-755-8450 for assistance.
DSN Contact Phone Numbers: 7AF Surgeon: 315-784-2002; 8A Surgeon: 315-755-2726/ usArmy.yongsan.8-Army.list.8a-surgeon@mail.mil; MARFORK POC: 315-737-1424; CNFK POC: 315-762-5415; SOKOR Surgeon: 315-723-8231

Patient Name (Last, First): DOB: SSN (last 4):

Age: Sex: Female Rank/ Grade: Service:

Deployment/Travel Date: Travel Duration (days): Destination (country):

MOS/AFSC/Skill Identifier/Job Description: Home Station/Unit:

Active/Reserve/Civilian/Contractor: Active Duty

Requester POC(Medical Personnel)Name/E-mail/Phone:

Summary of medical condition(s):

I understand the potential risks associated with this deployment limiting condition. For this individual, I am requesting a waiver of the health requirement for travel to the Korean Theater.

Commander or Designee Signature: Date: STAMP / PRINTED NAME AND TITLE

Required documentation for waiver evaluation in addition to this form:
DD Form 2766, Adult Preventive and Chronic Care Flow sheet, or OF Form 178, OPM Certificate of Medical Examination (Civilians), with full medical history including all medical conditions, surgeries, medications, and medical summary of Deployment Limiting Condition(s).

Case Summary (To be completed by healthcare provider): Include all clinically relevant information necessary to make a disposition including, but not limited to: Diagnosis (ICD10), history of the condition, date of onset, prior treatments, current treatments, limitations imposed by the condition and/or medications, prognosis, and required follow-up. *(Use additional sheets, if needed. The more clinical information provided, the better.)*

Supplemental documentation (include information relevant for deployability determination):

a. Specialty consults results establishing diagnosis, treatment, monitoring plan and prognosis.
b. Recent and relevant surgery, laboratory, pathology and tissue examination reports.
c. Reports of studies (radiographs, pictures, films or procedures).
d. Summaries and past medical documents (e.g. hospital summary).
e. Reports of proceedings (e.g. Tumor Board, Medical Evaluation Boards, etc.)
f. Job requirements (physical condition, exertion level, etc.)

I have reviewed the case summary and hereby submit this request.

Provider's Signature: Date: STAMP / PRINTED NAME AND TITLE

FOR SURGEON'S OFFICE USE ONLY

Waiver Approved: YES ◯ NO ◯

Waiver Authority Signature: Date: STAMP / PRINTED NAME AND TITLE

Comments:

USFK Form 722-E

15. Waiver Request Example: SOUTHCOM Waiver

B-REDI

SC REG- Attachment A **USSOUTHCOM Medical Waiver Request**

Patient Name : DOB: SSN(Last 4):

Deployments Destination (country): Diagnosis (Lay term):

Age: Sex: Grade: Service: Home Station:

Years of Service: Active/Reserve/Guard/Civilian: MOS/Job Description:

Deployment Length: Previous Waivers (Y/N): Currently Deployed (Y/N):

Waiver POC Name/E-mail/Phone:

Case Summary (To be completed by provider, including clinical information necessary to make a disposition. See most recent updated SOUTHCOM amplification of minimal standards and accompanying SC FHP Guidance for required information. Attach supporting medical documentation:

I have reviewed the case summary and hereby submit this request.

Signature:_____ **Commander Approval:**_____

Component Surgeon Response

Waiver Approval: ☐ **YES** ☐ **NO**

Signature:_____ **Date:**_____

Comments:

ANTIDEPRESSANTS AGENTS (180 DS WITH NO REFILLS)	Brand Name	Generic Name
CENTCOM FORMULARY	BUDEPRION SR	BUPROPION HCL
	BUPROBAN	BUPROPION HCL
	CELEXA	CITALOPRAM HYDROBROMIDE
	DESYREL	TRAZODONE HCL
	EFFEXOR XR	VENLAFAXINE HCL
	ELAVIL	AMITRIPTYLINE HCL
	PAMELOR	NORTRIPTYLINE HCL
	PAXIL	PAROXETINE HCL
	PROZAC	FLUOXETINE HCL
	REMERON	MIRTAZAPINE
	WELLBUTRIN SR	BUPROPION HCL
	ZOLOFT	SERTRALINE HCL
CENTCOM NON-FORMULARY	ADAPIN	DOXEPIN HCL
	AMOXAPINE	AMOXAPINE
	ANAFRANIL	CLOMIPRAMINE HCL
	APLENZIN	BUPROPION HBR
	ASENDIN	AMOXAPINE
	BUDEPRION XL	BUPROPION HCL
	CYMBALTA	DULOXETINE HCL
	EFFEXOR	VENLAFAXINE HCL
	ETRAFON	PERPHENAZINE/AMITRIPTYLINE HCL
	ETRAFON FORTE 4-2	PERPHENAZINE/AMITRIPTYLINE HCL
	LEXAPRO	ESCITALOPRAM OXALATE
	LIMBITROL	AMITRIP HCL/CHLORDIAZEPOXIDE
	LIMBITROL DS	AMITRIP HCL/CHLORDIAZEPOXIDE
	LUDIOMIL	MAPROTILINE HCL
	LUVOX	FLUVOXAMINE MALEATE
	LUVOX CR	FLUVOXAMINE MALEATE
	MARPLAN	ISOCARBOXAZID
	NARDIL	PHENELZINE SULFATE
	NORPRAMIN	DESIPRAMINE HCL
	PARNATE	TRANYLCYPROMINE SULFATE
	PAXIL CR	PAROXETINE HCL
	PEXEVA	PAROXETINE MESYLATE
	PRISTIQ	DESVENLAFAXINE SUCCINATE
	PROZAC WEEKLY	FLUOXETINE HCL
	SERZONE	NEFAZODONE HCL
	SURMONTIL	TRIMIPRAMINE MALEATE
	TOFRANIL	IMIPRAMINE HCL
	TOFRANIL-PM	IMIPRAMINE PAMOATE
	TRAZAMINE	TRAZODONE HCL/DIET8
	TRIAVIL	PERPHENAZINE/AMITRIPTYLINE HCL
	VIVACTIL	PROTRIPTYLINE HCL
	WELLBUTRIN	BUPROPION HCL
	WELLBUTRIN XL	BUPROPION HCL

180 day supply with no refills applies for all antidepressant agents.

BENZODIAZEPINES/ ANXIOLYTICS/ HYPNOTICS (180 DS with no refill)	Brand	Generic
CENTCOM FORMULARY	AMBIEN	ZOLPIDEM
	ATIVAN	LORAZEPAM
	KLONOPIN	CLONAZEPAM
	LUNESTA	ESZOPICLONE
	RESTORIL	TEMAZEPAM
	VALIUM	DIAZEPAM
	HALCION	TRIAZOLAM
	XANAX	ALPRAZOLAM
CENTCOM NON-FORMULARY	NIRAVAM	ALPRAZOLAM
	AMBIEN CR	ZOLPIDEM
	DALMANE	FLURAZEPAM HCL
	DIASTAT	DIAZEPAM
	DORAL	QUAZEPAM
	EQUANIL	MEPROBAMATE
	LIBRAX	CHLORDIAZEPOXIDE/METH
	LIBRIUM	CHLORDIAZEPOXIDE HCL
	NIRAVAM	ALPRAZOLAM
	PAXIPAM	HALAZEPAM
	PROSOM	ESTAZOLAM
	SERAX	OXAZEPAM
	SILENOR	DOXEPIN
	SONOTA	ZALEPLON
	TRANXENE T-TAB	CLORAZEPATE DIPOTASSIUM
	XANAX XR	ALPRAZOLAM

NON-BENZODIAZEPINES/ANXIOLYTICS (180 DS WITH NO RF)	Brand	Generic
CENTCOM FORMULARY	BUSPAR	BUSPIRONE
	ATARAX	HYDROXYZINE HCL
	VISTARIL	HYDROXYZINE HCL

ANTICONVULSANTS
(WHEN USED FOR PSYCHIATRIC CONDITIONS 180 DS WITH NO RF)

FOR NON-PSYSCHIATRIC CONDITION, INDICATION MUST BE ON PRESCRIPTION for 180 DS & REFILL From MOP
NO WAIVER GRANTED IN THE TREATMENT OF PSYCHOTIC OR BIPOLAR DISORDERS

	Brand	Generic
CENTCOM FORMULARY	EPITOL*	CARBAMAZEPINE
	TEGRETOL*	CARBAMAZEPINE
	DEPAKOTE ER*	DIVALPROEX SODIUM
	NEURONTIN	GABAPENTIN
	TOPAMAX	TOPIRAMATE
CENTCOM NON-FORMULARY	CARBATROL*	CARBAMAZEPINE
	EQUETRO*	CARBAMAZEPINE
	TEGRETOL XR*	CARBAMAZEPINE
	DEPAKOTE*	DIVALPROEX SODIUM
	DEPAKOTE SPRINKLE	DIVALPROEX SODIUM
	FELBATOL	FELBAMATE
	LAMICTAL**	LAMOTRIGINE
	KEPPRA	LEVETIRACETAM
	TRILEPTAL	OXCARBAZEPINE
	LYRICA	PREGABALIN
	GABITRIL	TIAGABINE HCL
	DEPACON*	VALPROATE SODIUM
	DEPAKENE*	VALPROATE SODIUM
	ZONEGRAN	ZONISAMIDE
	VIMPAT	LACOSAMIDE

* Waiver Required
** No Waiver Granted

ANTIPSYCHOTICS AGENTS (NON-DEPLOYABLE MEDICATION) Used only to stabilize for AEROEVAC	Brand Name	Generic Name
CENTCOM FORMULARY	HALDOL	HALOPERIDOL
	HALDOL	HALOPERIDOL LACTATE
	PROCHLORPERAZINE	PROCHLORPERAZINE MALEATE
	PROLIXIN DECANOATE	FLUPHENAZINE DECANOATE
	RISPERDAL	RISPERIDONE
	SEROQUEL*	QUETIAPINE FUMARATE
	ZYPREXA ZYDIS	OLANZAPINE
CENTCOM NON-FORMULARY	ABILIFY	ARIPIPRAZOLE
	ABILIFY DISCMELT	ARIPIPRAZOLE
	CLOZARIL	CLOZAPINE
	ESKALITH	LITHIUM
	FANAPT	ILOPERIDONE
	FAZACLO	CLOZAPINE
	HALDOL DECANOATE 100	HALOPERIDOL DECANOATE
	HALDOL DECANOATE 50	HALOPERIDOL DECANOATE
	INVEGA	PALIPERIDONE
	LATUDA	LURASIDONE
	LOXITANE	LOXAPINE HCL
	LOXITANE	LOXAPINE SUCCINATE
	LOXITANE C	LOXAPINE HCL
	MELLARIL	THIORIDAZINE HCL
	MELLARIL-S	THIORIDAZINE HCL
	MOBAN	MOLINDONE HCL
	NAVANE	THIOTHIXENE
	ORAP	PIMOZIDE
	PROLIXIN	FLUPHENAZINE HCL
	RISPERDAL CONSTA	RISPERIDONE MICROSPHERES
	SAPHRIS	ASENAPINE
	SERENTIL	MESORIDAZINE BESYLATE
	SEROQUEL XR	QUETIAPINE FUMARATE
	SPARINE	PROMAZINE HCL
	STELAZINE	TRIFLUOPERAZINE HCL
	SYMBYAX	OLANZAPINE/FLUOXETINE HCL
	TARACTAN	CHLORPROTHIXENE
	THIORIDAZINE HCL	THIORIDAZINE HCL
	THORAZINE	CHLORPROMAZINE HCL
	TRILAFON	PERPHENAZINE
	ZYPREXA	OLANZAPINE

*Seroquel (25MG PER DAY) for sleep

Limit to #180 with no refills

CNS STIMULANTS (CII) (90 DS No refill)	Brand	Generic
CENTCOM FORMULARY	ADDERALL	AMPHET ASP/AMPHET/D-AMPHET
	ADDERALL XR	AMPHET ASP/AMPHET/D-AMPHET
	AMPHETAMINE SALT COMBO	AMPHET ASP/AMPHET/D-AMPHET
	DEXEDRINE	DEXTROAMPHETAMINE SULFATE
	DEXTROAMPHETAMINE SULF	DEXTROAMPHETAMINE SULFATE
	DEXTROSTAT	DEXTROAMPHETAMINE SULFATE
	CONCERTA	METHYLPHENIDATE HCL
	METADATE ER	METHYLPHENIDATE HCL
	METHYLIN	METHYLPHENIDATE HCL
	METHYLIN ER	METHYLPHENIDATE HCL
	METHYLPHENIDATE ER	METHYLPHENIDATE HCL
	METHYLPHENIDATE HCL	METHYLPHENIDATE HCL
	METHYLPHENIDATE SR	METHYLPHENIDATE HCL
	RITALIN	METHYLPHENIDATE HCL
	RITALIN-SR	METHYLPHENIDATE HCL
CENTCOM NON-FORMULARY	OBETROL	AMPHET ASP/AMPHET/D-AMPHET
	DEXMETHYLPHENIDATE HCL	DEXMETHYLPHENIDATE HCL
	FOCALIN	DEXMETHYLPHENIDATE HCL
	FOCALIN XR	DEXMETHYLPHENIDATE HCL
	LIQUADD	DEXTROAMPHETAMINE SULFATE
	VYVANSE	LISDEXAMFETAMINE DIMESYLATE
	DAYTRANA	METHYLPHENIDATE
	METADATE CD	METHYLPHENIDATE HCL
	RITALIN LA	METHYLPHENIDATE HCL

Non C-II (180 DS WITH NO RF)

CENTCOM FORMULARY	STRATTERA	ATOMOXETINE
CENCOM NON-FORMULARY	PROVIGIL	MODAFINIL
	NUVIGIL	ARMODAFINIL

SMOKING CESSATION	Brand	Generic
CENTCOM FORMULARY	ZYBAN	BUPROPION HCL
CENTCOM NF	CHANTIX*	VARENICLINE TARTRATE

*No Waiver Granted

ARBs	Brand	Generic
CENTCOM FORMULARY	COZAAR	LOSARTAN
CENTCOM NF	MICARDIS	TELMISARTAN

References Cited in Training

Crouch, C., Curley, J. M., Carreno, J., & Wilk, J. E. (2018). Return to duty practices of Army behavioral health providers in garrison. *Military Medicine,* 183 (11-12), e617-e623. doi:10.1093/milmed/usy103

Curley, J. M., Crouch, C., & Wilk, J. E. (2018). Minor behavioral health readiness and profiling barriers in the U.S. Army. *Military Medicine*, 183 (9-10), e297-e301. doi:10.1093/milmed/usx194

Curley, J. M., & Warner, C. H. (2017). Improving awareness of behavioral health readiness. *Military Medicine, 182*, e1738-e1746. doi:10.7205/milmed-d-16-00343

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Warner, C. H., Appenzeller, G. N., Parker, J. R., Warner, C. M., & Hoge, C. W. (2011). Effectiveness of mental health screening and coordination of in-theater care prior to deployment to Iraq: A cohort study. *American Journal of Psychiatry, 168*, 378-385. doi:10.1176/appi.ajp.2010.10091303

Additional Resources

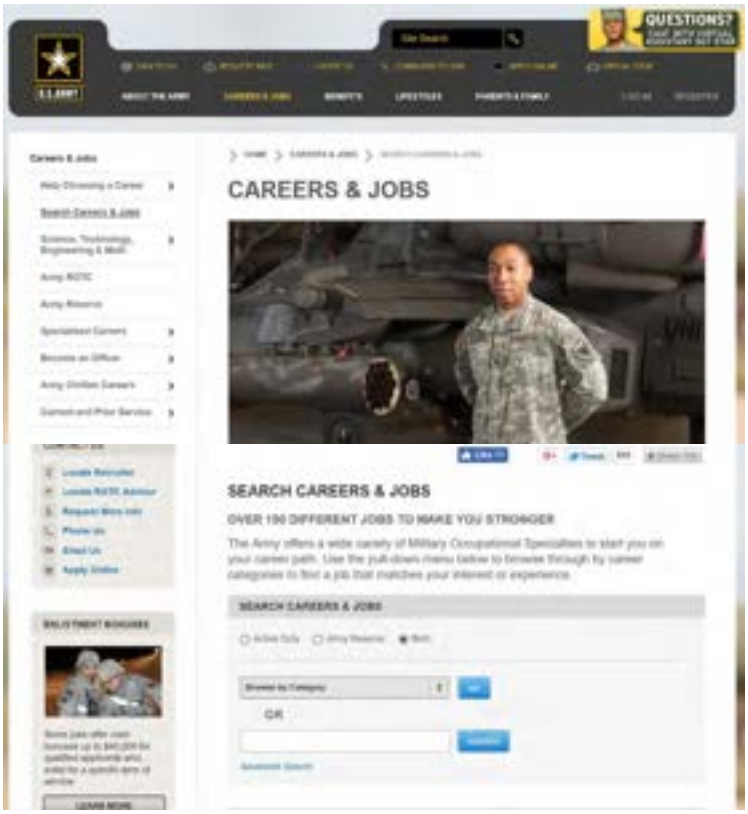
Conrath, C. M., Venezia, J., Rund, T. J., Cho, T. H., Solana, N. M., & Benincasa, J. A. (2017). Medical redeployment in Soldiers with and without medical deployment waivers. *Military Medicine, 182*, e1704-e1708. doi:10.7205/milmed-d-16-00182

Department of Defense. (2010). *Department of Defense instruction number 6490.07: Enclosure 3: Medical conditions usually precluding contingency deployment.* Retrieved from http://www.dcms.uscg.mil/Portals/10/CG-1/cg112/cg1121/docs/pdf/MedicalConditionsDeployments.pdf

Department of Defense. (2013). *Department of Defense instruction number 6490.04: Mental health evaluations of members of the military services.* Retrieved from http://www.esd.whs.mil/Portals/54/Documents/DD/issuances/dodi/649004p.pdf

Department of Defense. (2018). *Department of Defense instruction number 1332.45: Retention determinations for non-deployable service members.* Retrieved from http://www.esd.whs.mil/Portals/54/Documents/DD/issuances/dodi/133245p.pdf

United States Army. (2014). *Careers & jobs.* Retrieved from https://www.goarmy.com/careers-and-jobs/browse-career-and-job-categories.html



Additional Resources – For updated policies

Army Publishing Directorate - Army Regulations Page
https://armypubs.army.mil/ProductMaps/PubForm/AR.aspx

Defense Health Agency - Reference Center – Publications
https://health.mil/Reference-Center/Publications/

Defense Health Agency - Reference Center – Policies
https://health.mil/Reference-Center/Policies

Defense Health Agency - Command Force Health Protection References
https://info.health.mil/hco/phealth/deployment_health/DeploymentHealthProductLine/

Department of Defense Issuances
https://www.esd.whs.mil/Directives/issuances/dodi/

OTSG/MEDCOM Publications, Policy Memos, Forms
https://mitc.amedd.army.mil/sites/DC/Pages/DocumentDashboard.aspx

Fort Bliss CONUS Replacement Center - COCOM MEDICAL REQUIREMENTS
https://home.army.mil/bliss/index.php/units-tenants/crc/medical-requirements/medical-requirements-cocom-medical-requirements

USAFRICOM Theater Medical Clearance
https://www.africom.mil/staff-resources/theater-medical-clearance

USAREUR Office of the Command Surgeon - Medical Deployability Milbook Page
https://www.milsuite.mil/book/groups/usareur-ocsurg-medical-deployability

USINDOPACOM Theater Travel Requirements
https://www.pacom.mil/Resources/Travel-Requirements/

United States Forces Korea Publications
https://www.usfk.mil/Resources/USFK-Publications/

USSOUTHCOM MEDICAL ENTRY REQUIREMENTS
https://www.milsuite.mil/book/groups/ussouthcom-medical-entry-requirements

US SOUTHCOM Command Theater Clearance Info
https://www.southcom.mil/Military-and-Family-Services/Theater-Clearance-Info/