No. 19-1410

IN THE UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

RICHARD ROE, et al.,

Plaintiffs-Appellees,

v.

UNITED STATES DEPARTMENT OF DEFENSE, et al.,

Defendants-Appellants.

On Appeal from the United States District Court
for the Eastern District of Virginia

JOINT APPENDIX VOLUME 2 OF 5

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Personnel

FORCE SUPPORT READINESS PROGRAMS

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

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This instruction implements Department of Defense Directive (DoDD) 3025.14, *Evacuation of US Citizens and Designated Aliens from Threatened Areas Abroad*, Department of Defense Instruction (DoDI) 1325.02, *Desertion and Unauthorized Absence,* and Air Force Policy Directive Air Force Policy Directive (AFPD) 10-2, *Readiness* and supports AFPD 36-29, *Military Personnel Standards*, AFPD 36-38, *Personnel Readiness Reporting and Accountability,* AFPD 36-26, *Military Force Management*, and AFPD 34-1, *Air Force Services*. This publication applies to all civilian and military members of the Regular Air Force, the Air Force Reserve, and the Air National Guard, except where noted otherwise. In collaboration with the Chief of Air Force Reserve (AF/RE) and the Director of the Air National Guard (NGB/CF), the Deputy Chief of Staff for Manpower, Personnel, and Services (HAF/A1) develops Total Force (Regular Air Force [RegAF], Air Force Reserve [AFR], and Air National Guard [ANG]) personnel guidance as outlined in the following chapters of this instruction. Ensure all records created as a result of processes prescribed in this publication are maintained in accordance with AF Manual (AFMAN) 33-363, Management of Records, and disposed of in accordance with the AF Records Disposition Schedule located in the AF Records Information Management System. This instruction directs the

collecting and maintaining of information by the Privacy Act of 1974 authorized by Title l0, United States Code (USC) 8013 and Executive Order 9397. System of Records Notice, F036 Air Force Personnel Center (AFPC) C Military Personnel Records System applies. The authorities to waive wing/unit level requirements in this publication are identified with a Tier ("T-0, T-1, T-2, T-3") number following the compliance statement. See Air Force Instruction (AFI) 33-360, Publications and Forms Management, for a description of the authorities associated with the Tier numbers. Submit requests for waivers through the chain of command to the appropriate Tier waiver approval authority, or alternately, to the requestors commander for non-tiered compliance items This instruction may be supplemented at any level, but all supplements that directly implement this publication must be routed to the OPR, Headquarters United States Deputy Chief of Staff for Manpower, Personnel and Services, AF Career Field Management and Readiness Division (HAF/A1XO) for coordination, and all Major Command-level supplements must be approved by the Human Resource Management Strategic Board prior to certification and approval. Major Commands, field operating agencies, and direct reporting units must send one copy of their published and or posted supplement to Headquarter Air Force (HAF)/A1XO, 1040 AF Pentagon, Washington DC 20330-1040. Refer recommended changes and questions about this publication to HAF/A1XO, 1040 AF Pentagon, Washington DC 20330-1040 on AF Form 847, *Recommendation for Change of Publication*. Route AF Form 847 from the field through Major Command publications managers. The use of the name or mark of any specific manufacturer, commercial product, commodity, or service in this publication does not imply endorsement by the AF.

SUMMARY OF CHANGES

This document has been substantially revised and needs to be completely reviewed. This instruction consolidates guidance from previous instructions: AFI 10-214, *Force Support Readiness Programs*; AFI 10-216, *Evacuation and Repatriation of US Citizens and Designated Aliens from Threatened Areas Abroad*; AFI 36-2134, *AF Strength Accounting Duty Status Program*; AFI 36-2911, *Desertion and Unauthorized Absence*; AFI 36-3103, *Identification Tags* AFI 36-3802, *Personnel Readiness Operations*; and AFI 36-3803, *Personnel Accountability in Conjunction with Natural Disasters or National Emergencies*. Other major changes in this rewrite include reducing the use of acronyms, limiting the scope of this publication to AF guidance by removing "how to" procedural references, which can be found in the Personnel Services Delivery Guides on MyPers website, and lowering compliance tiers where possible.

CHAPTER 1

FORCE SUPPORT READINESS PROGRAMS

1.1. Overview

1.2. This instruction provides guidance for managing the Force Support Readiness Program which organizes, trains, and equips personnel to meet Combatant/Geographic Commander needs for wartime, contingency, and installation incident response requirements.

1.3. It establishes guidance and assigns responsibilities for evacuation of Air Force members, dependents, other U. S. citizens and designated aliens from threatened areas abroad or in anticipation of, or in response to any natural or man-made disaster. It requires all commanders to develop plans for evacuating people from their installations, as well as for receiving and repatriating evacuees.

1.4. It outlines when and how identification (ID) tags are issued to Air Force service members and when they are to be worn (or in the individual's possession).

1.5. It provides guidance on the collection and maintenance of strength accounting duty status information.

1.6. It establishes standard procedures for dealing with desertion and unauthorized absence. It outlines Air Force procedures to reduce absents and return the absentees to military control.

1.7. It provides policy and guidance for on Personnel Readiness Operations. It gives Air Force personnel agencies and deployed commanders supporting contingency, wartime, exercise, and emergency operations processes and information. This instruction also provides guidance for (PERSCO) from pre-planning through employment and redeployment actions. Additional guidance is available in Air Force Instruction (AFI) 10-403, *Deployment Planning and Execution*; AFI 10-404, *Base Support and Expeditionary Site Planning* and AFI 10-401*, Air Force Operations Planning and Execution*.

1.8. It provides guidance for establishing and maintaining personnel accountability in the event of natural disasters or national emergencies for Air Force (AF) personnel in accordance with Department of Defense Instruction (DoDI) 3001. 02, *Personnel Accountability in Conjunction with National Emergencies or Natural Disasters*. It applies to both the continental United States (CONUS) and locations outside the continental United States (OCONUS).

CHAPTER 2

ROLES AND RESPONSIBILITIES

2.1. Roles and Responsibilities

2.2. Headquarters United States AF Deputy Chief of Staff Manpower, Personnel and Services (HAF/A1):

2.2.1. Provides overarching guidance and oversight to the Force Support Readiness program.

2.2.2. Ensures the Force Support Readiness program complies with Office of the Secretary of Defense, Joint Staff, Secretary of the AF, and Headquarters AF direction including AF Policy Directive (AFPD) 10-2, *Readiness*.

2.2.3. Advises the Chief of Staff of the AF on A1 Air Force-wide execution of Mission Essential Functions regarding Continuity of Operations and on matters related to Force Support functions and capabilities to ensure support for warfighter objectives.

2.3. The Deputy Chief of Staff for Operations (HAF/A3):

2.3.1. Is the AF OPR for evacuation and repatriation operations.

2.3.2. Ensures overall command, control and status reporting of evacuation operations.

2.3.3. Appoints a member to the Washington Liaison Group to coordinate the execution of evacuation responsibilities.

2.3.4. Measures and reports on the readiness of military forces and the supporting infrastructure to execute evacuations.

2.3.5. Provides air transportation, including theater, strategic, and intra-continental U.S. as well as aeromedical evacuation in accordance with the mission and priorities assigned by United States Transportation Command.

2.3.6. Responsible for evacuation operations and repatriation planning in coordination with Joint Staff and Geographic/Combatant Commands.

2.4. Headquarters United States AF Directorate of Plans and Integration (HAF/A1X):

2.4.1. Establishes Force Support doctrine and guidance and manages the Force Support Readiness program.

2.4.2. Appoints, by name, an individual from HAF/A1XOR as the Force Support Functional Area Manager (FAM). FAM responsibilities are provided in AFI 10-401, *Air Force Operations Planning and Execution*.

2.4.3. Assigns personnel to the AF Crisis Action Team in coordination with HAF Directorate of Plans, Operations and Requirements, War Planning and Policy Division (HAF/A3O).

2.4.4. Provides operational status and situational reporting to AF Senior Leaders on the status of the Force Support contingency and wartime operations.

2.4.5. Advises the AF Crisis Action Team and reports status of A1 functions and capabilities to senior AF leaders as required.

2.4.6. Ensures all guidance is written and includes content provided by Total Force components (RegAF, ANG, and AFR).

2.4.7. Directs the Force Support Squadron (FSS) Military Personnel Flight (MPF) offices to continue to follow established procedures for producing identification tags in accordance with this instruction.

2.4.8. Provides policy on identification tags to include Red Medical Alert identification tags. Policy will be coordinated with AF/SG3/5 to ensure policy and procedures continue to adhere to governing guidance.

2.5. Director of Civilian Force Management (HAF/A1C): provides human resource guidance and entitlement/compensation information to/for AF civilians relating to evacuation operations.

2.6. Director of Military Force Management Policy (HAF/A1P):

2.6.1. Provides personnel program and policy guidance and entitlement/compensation information to/for AF members/families, i.e., STOP MOVEMENT.

2.6.2. Serves as the functional OPR for policy aspects of the Absence without Leave (AWOL)/Deserter program.

2.6.3. Directs AF policy for AWOL/Deserter duty status reporting.

2.7. Director of Services, Force Sustainment Division (HAF/A1S):

2.7.1. Provides guidance on assistance and support to AF Family members (military and civilian).

2.7.2. Ensures required Force Support Services/Sustainment capabilities/programs are in place for evacuation reception and repatriation operations, according to Geographical Combatant Commander evacuation plans and policies.

2.8. Director of Civil Engineers (HAF/A4C): will provide guidance for contingency response planning that includes evacuation considerations.

2.9. Director of Logistics (HAF/A4L):

2.9.1. Is responsible for transportation of personnel/equipment for evacuation operations.

2.9.2. Ensures installation reception and support plans adequately identify support for evacuation, reception and repatriation plans. The OPR for the Base Support Plan Part I is the installation Site Manager located within the Logistics Readiness Squadron.

2.10. HAF Force Support Career Field Management and Readiness Division (HAF/A1XO):

2.10.1. Has overall responsibility for AF personnel readiness and accountability programs and directives. Develops concepts and policies to ensure Total Force accountability.

2.10.2. Serves as the OPR for personnel readiness and PERSCO policy and provides guidance to all Major Commands (MAJCOMs), AF Installation and Mission Support Center, Component Numbered AFs, Direct Reporting Units, and Field Operating Agencies on the posturing, scheduling, coding and the use of personnel assets 38F and 3FXXX to support the full range of military operations.

2.10.3. Develops and oversees USAF personnel readiness and PERSCO policy for all levels of command. Provides policy oversight to all MAJCOMs, Component Numbered AFs, Direct

Reporting Units, and Field Operating Agencies on personnel readiness and PERSCO. Monitors implementation of policy across MAJCOMs, Component Numbered AFs, Direct Reporting Units, and Field Operating Agencies to ensure consistent application and provides feedback where necessary.

2.10.4. Provides headquarters oversight of PERSCO Team After-Action Report corrective actions.

2.10.5. Assigns Manpower and Equipment Force Packaging responsible command to manage Force Support Unit Type Codes (UTCs) to include PERSCO UTCs.

2.10.6. Serves as the AF Crisis Action Team A1 cell when activated.

2.10.7. Advises AFPC Operations Center when a contingency operation begins. Refer to the AF Continuity of Operations Plan for next in line for continuity purposes.

2.10.8. Serves as the AF personnel policy OPR for Deliberate and Crisis Action Planning and Execution Segments, repatriation and Evacuation Operation, Augmentation Duty Program, and FSS (or equivalent) Defense Readiness Reporting Tool.

2.10.9. Is the HAF/A1 OPR for evacuation operations.

2.10.10. Provides guidance on accounting, tracking, and reporting of personnel throughout the evacuation process.

2.10.11. Monitors accountability and visibility of all AF personnel (military and civilian) during all phases of evacuation to include evacuation to a safe haven, in accordance with Geographical Combatant Commander evacuation plans and policies.

2.10.12. Provides status of Force Support reception and beddown capabilities to support evacuation operations, i.e., providing meals and temporary lodging, according to Geographical Combatant Commander evacuation plans and policies.

2.11. Director of Surgeon General (HAF/SG3/5) will:

2.11.1. Subject to availability of Congressional appropriations, fund the purchase of Red Medical Alert identification tags for all AF Medical Treatment Facilities.

2.11.2. Direct all Air Force Medical Treatment Facilities, to include Reserve and Guard Medical Units equipped to produce Red Medical Alert identification tags, to continue production as long as funding is provided. Ensure medical staff will adhere to Department of Defense (DoD) Instruction (DoDI) 6025.18-R, *DoD Health Information Privacy Regulation.*

2.11.3. Develop a process and standardized form for all Medical Treatment Facilities to ensure the proper information is placed on the Red Medical Alert identification tag.

2.12. HAF Directorate of Plans and Integration Force Support Career Field Management and Readiness Division, Readiness Branch (HAF/A1XOR):

2.12.1. Serves as the Force Support Readiness FAM and the OPR for the Force Support Readiness program and guidance.

2.12.2. Submits, advocates, and defends Program Objective Memorandum to organize, train and equip the Force Support community to build capability for contingency and wartime.

2.12.3. Chairs the Force Support War Fighter Requirements Review working group.

2.12.4. The Force Support War Fighter Requirements Review is comprised of individuals listed in **Table 2.1**.

Table 2.1. Members of the Force Support War Fighter Requirements Review.

Force Support War Fighter Requirements Review Members
HAF/A1 FAMs
Force Support Career Field Managers
AF Installation and Mission Support Center (AFIMSC)
MAJCOMs
Component MAJCOMs
Component and ANG Force Support Readiness FAMs
Advisors
Air Force Personnel Center (AFPC)
Directorate of Personnel Operations (AFPC/DP2)
Air Force Services Activity (AFSVA/SVORR)
Force Support Silver Flag sites
Installation-level Readiness Officers/Non-Commissioned Officers as required

2.12.5. The War Fighter Requirements Review working group meets biannually via conference or virtually and makes recommendations to the Readiness and Training Council on policy, training, and resource allocation issues.

2.12.6. Lead AF representative for the Force Support equipment management program.

2.12.7. Chairs the Field Integrated Research and Modernization working group which focuses on Force Support equipment research, development and fielding.

2.12.8. The Field Integrated Research and Modernization working group will meet biannually via conference, virtually, or as needed but usually just prior to the War Fighter Requirements Review working group.

2.12.9. Coordinates on all Operation Plans with HAF/A3O.

2.12.10. Develops Force Support planning guidance in doctrine, determining Force Support wartime manpower requirements/capabilities and the War and Mobilization Plan, Force Support Supplement.

2.12.11. Establishes guidance and provides oversight for Force Support capabilities regarding evacuation operations.

2.12.12. Establishes broad, Total Force Manpower, Personnel, and Services guidance related to all aspects of the contingency and wartime deployment and redeployment process.

2.12.13. Conducts risk assessments and provides courses of action regarding Force Support capability to deploy.

2.12.14. Develops Force Support UTC posturing guidance in in accordance with codified AF UTCs posturing guidance.

2.12.15. Serves as the functional OPR for the Personnel aspects of Deliberate and Crisis Action Planning and Execution Segments.

2.12.16. Provides guidance for reporting Force Support status via Resource and Capability Readiness reports. Updates and maintains the AF Tables in Defense Readiness Reporting System in accordance with AFI 10-201, *Force Readiness Reporting*.

2.12.17. Monitors MAJCOM posturing and coding efforts to ensure compliance with Force Support UTCs posturing guidance.

2.12.18. Reviews after-action reports from deployed Force Support teams and/or members and coordinates corrective actions.

2.12.19. Provides coordination and subject matter expertise for the readiness curriculum in all Force Support courses.

2.12.20. Oversees Force Support readiness training requirements and provides inputs for the annual call for formal school quotas for Air University Force Support Readiness courses.

2.12.21. Ensures Total Force matters are represented across the spectrum in Force Support Readiness.

2.12.22. Is the AF OPR for personnel accountability and the Strength Accounting Duty Status Program.

2.12.23. Develops and oversees personnel accountability and duty status reporting policy and guidance.

2.12.24. Notifies AFPC to create and activate an event in the disaster/emergency personnel accountability system upon direction from the Office of the Secretary of Defense, the Joint Staff, HAF leadership, or at the request of MAJCOM or installation commanders.

2.12.25. Notifies HAF Airman & Family Readiness Policy (HAF/A1SAA) to include Needs Assessments related information to active events.

2.12.26. Monitors personnel accountability systems to track progress and provide status report as directed.

2.13. AF Office of Special Investigation (AFOSI/ICON):

2.13.1. Is responsible for updating AF Deserter information in the Federal Bureau of Investigations (FBI) National Crime Information Center.

2.13.2. Updates the National Crime Information Center for all AF deserters upon receipt of a valid Department of Defense Form (DD Form) 553/616. In cases of desertion under aggravated circumstances as defined below, AFOSI works with the FBI or other appropriate law enforcement agency to expedite the investigation and to find and arrest the absentee. **(T-1).** Examples of cases in which the AF requests FBI assistance include those in which the individual is a deserter and:

2.13.2.1. Is wanted for an offense punishable under the Uniform Code of Military Justice (UCMJ). Consult with the local Judge Advocate (JA) to determine if offense and circumstances warrant the classification of desertion.

2.13.2.2. Had access to classified information which, if disclosed, would jeopardize United States security interests.

2.13.2.3. Is an escaped prisoner.

2.13.2.4. Is an officer.

2.13.3. Oversees local servicing police units' inquiries into UAs on commander's request.

2.14. Director of Personnel Operations (AFPC/DP2) is responsible for:

2.14.1. Tracking, accounting, reporting, and ensuring follow-up support is provided.

2.14.2. Utilizing the Air Force Personnel Accountability and Assessment System (AFPAAS) to report members evacuated/displaced, to contact their leadership, keep them informed of their location, and account for Defense Enrollment Eligibility Reporting System enrolled family members who physically reside in the Geographical Area of Interest and had to evacuate.

2.14.3. Utilizing all systems available to include the Noncombatant Evacuation Operation Tracking System in conjunction with the AFPAAS to identify and track evacuees throughout the continuum of evacuation operations.

2.15. Director of Airman and Family Care (AFPC/DPF) will:

2.15.1. Disseminates policy, plans, and operational guidance for Airman and Family Readiness response to evacuation operations and repatriation. **(T-1)**.

2.15.2. Provide guidance/coordination to the installation Airman & Family Readiness Centers at evacuating locations, the temporary safe haven or intermediate stop (if applicable), and the repatriation sites processing families back into the U.S. **(T-1).**

2.15.3. Is responsible, through Airmen and Family Readiness Centers, for contacting, reporting, and coordinating information and referral for required support. **(T-1).**

2.15.4. Ensures all Airmen and Family Readiness Centers contact, report, and coordinate information & referral for evacuation and repatriation operations. **(T-1)**.

2.16. AFPC Air and Space Expeditionary Force Operations and Readiness Division (AFPC/DP2W):

2.16.1. Serves as the OPR for deployment availability codes and contingency duty status reporting program. **(T-1).**

2.16.2. Ensures HAF-level personnel series instructions and revisions contain accurate wartime guidance. **(T-1)**.

2.16.3. Activates the Personnel Readiness Center function upon activation of the HAF Manpower and Personnel Readiness Center/Personnel Readiness Center network or as directed by the AFPC Commander or Operations Center Director during emergencies. **(T-1).**

2.16.4. Responsible for all Personnel Readiness Center functions of AFPC Operations. **(T-1).** The Personnel Readiness Center can be reached at Digital Switched Network 665-2020, toll free at 1-800-435-9941, or e-mailed at Non-secure Internet Protocol Router: **afpc.dp2wr.workflow@us.af.mil** or secure Internet Protocol Router: **usaf.jbsa.afpc.mbx.afpc-dp2wr-workflow@mail.smil.mil**.

2.16.5. Develops procedures to implement USAF policy for personnel readiness and PERSCO. **(T-1)**.

2.16.6. Ensures Total Force accountability is maintained for all AF personnel supporting contingency, wartime, exercise, and emergency operations. **(T-1)**.

2.16.7. Monitors when PERSCO teams are established at new locations during contingency or wartime operations. **(T-1).** Works with component commands to ensure PERSCO teams obtain Secure Internet Protocol Router Network connectivity to Deliberate and Crisis Action Planning and Execution Segments. **(T-1).** Ensures the PERSCO teams submit required reports and submits deployed PERSCO Deliberate and Crisis Action Planning and Execution Segments account requests. **(T-1)**. Works with component commands and deployed PERSCO teams to correct accountability data. **(T-1).**

2.16.8. Analyzes accountability data and identifies trends/deficiencies and reports to HAF/A1XO, Component Numbered AFs, AF Installation and Mission Support Center and supporting MAJCOMs. **(T-1).**

2.16.9. Reviews After Action Reports and provides a cross-feed program for MAJCOMs, Component Numbered AFs, AFPC, AF Installation and Mission Support Center, Military Personnel Elements and PERSCO teams. **(T-1)**.

2.16.10. Develops and manages changes to Personnel Readiness training in coordination with HAF/A1XO, AF Installation and Mission Support Center, and all MAJCOM counterparts. **(T-1)**.

2.16.11. Assists HAF/A1XO in the development of Total Force concepts, policies, and plans to support Air Reserve Component activation and mobilization, deployment, employment, base reception, Evacuation Operation and Repatriation Operations, accountability reporting, and demobilization.

2.16.12. Serves as the Program Management Office for Deliberate and Crisis Action Planning and Execution Segments personnel applications, Global Command and Control-Air Force (GCCS-AF) systems. **(T-1).** Manages access to and prepares procedures for use of GCCS-AF systems, Deliberate and Crisis Action Planning and Execution Segments updates and distribution of Deliberate and Crisis Action Planning and Execution Segments hardware and accounts. **(T-1).** Assists customers with problems with Deliberate and Crisis Action Planning and Execution Segments personnel applications, communications, or readiness-type questions. **(T-1).**

2.16.13. Coordinates with AFPC/DP0, DP3 and the AF Personnel Operations Activity to manage day-to-day operations, sustainment and future development of Air and Space Expeditionary Force IT systems. **(T-1).**

2.16.14. Serves as the personnel accountability systems program manager and Strength Accounting Duty Status Program Manager. **(T-1).**

2.16.15. Develops, coordinates, and executes personnel accountability guidance and approves procedural guidance for the management of personnel accountability and duty status reporting programs. **(T-1)**.

2.16.16. Assigns AF Personnel Accountability Assessment System Commanding Officer Representatives access to MAJCOM readiness staffs and to AF Crisis Action Team A1 members as required. **(T-1)**.

2.16.17. Ensures all assigned MAJCOM personnel readiness offices are trained on the use of the AFPAAS. **(T-1)**.

2.16.18. Creates and activates an AFPAAS event when notified by HAF and provides event management in support of AF-wide personnel accountability operations. **(T-1).** Requests for a real-world event that is not AF-wide will be initiated by an installation commander or MAJCOM leadership. **(T-1).** HAF will determine if the event remains local or if the event will be AF-wide.

2.16.19. Coordinates with the AFPC Public Affairs Office on personnel accountability events, news releases, and media outreach capabilities. **(T-1).**

2.16.20. Conducts a monthly quality review of the "Duty Status Change" application in the Case Management System to ensure all applicable fields are filled in correctly, and that members' strength accounting duty status/lost time are appropriately updated. **(T-1)**.

2.16.21. Develops guidance and manages the AWOL/Deserter Program. **(T-1)**.

2.16.22. In the event reporting MAJCOM cannot perform their duties as MAJCOM Commanding Officer Representative, AFPC/DP2WR will assume reporting responsibilities until the MAJCOM can resume their duties. **(T-1)**.

2.16.23. Ensures operational execution of the Force Support Readiness program by establishing procedures and implementing standards/program guidance approved by HAF/A1. **(T-1)**.

2.16.24. Provides functional and subject matter expertise for Manpower, Personnel and Services operations and capabilities. **(T-1).**

2.16.25. Develops content to update the War and Mobilization Plan in conjunction with HAF/A1XO to meet AF milestones. **(T-1)**.

2.16.26. Develops content as the subject matter experts for Tactics, Techniques, and Procedures and develops Force Support readiness plans content, as required, for Force Support functions, capability and mission. **(T-1)**.

2.16.27. Primary office to provide technical guidance to units deployed or in training regarding the employment of all Force Support capabilities. **(T-1).**

2.16.28. Maintains web-based Readiness guidance for use by Force Support planners and deployed teams and manages any SharePoint®/related websites and updates material as needed. **(T-1).**

2.16.29. Provides support to MAJCOMs, Component MAJCOMs, and field units on all readiness issues. **(T-1).**

2.16.30. Assists Component MAJCOMs and Component Numbered AF planners with planning responsibilities and factors for operation plan requirements and UTCs sourcing. **(T-1).**

2.16.31. Along with HAF representatives, plans and hosts the War Fighter Requirements Review and Readiness and Training Council. **(T-1).**

2.16.32. Works with field units regarding management of the readiness program. **(T-1).**

2.17. AFPC Airman and Family Division (AFPC/DPFF)

2.17.1. Serves as AFPAAS Needs Assessment Program Manager. **(T-1).**

2.17.2. Assigns AF Accountability Assessment System Needs Assessments to Case Managers. **(T-1)**.

2.17.3. Monitors AFPAAS evacuation/emergency events to track Needs Assessments of personnel and families. **(T-1).**

2.18. Airman and Family Care, Missing Persons Branch (AFPC/DPFCM):

2.18.1. Serves as the AF Deserter Information Point and program manager providing policy oversight and administration of the AWOL/Deserter program for RegAF, AFR and ANG who are serving on ACTIVE DUTY orders. **(T-1).**

2.18.2. Develops procedures to implement AF policy for AWOL/Deserter duty status reporting. **(T-1)**.

2.18.3. Maintains statistics on AWOL, Deserter and Returned to Military Control. **(T-1)**.

2.18.4. Updates duty status in MilPDS for AWOL, Deserter, and civilian/military confinement as a result of AWOL/Deserter duty status. **(T-1)**.

2.18.5. Provides management information to higher headquarters identifying the number of absentees and deserters returned to military control as outlined in DoDI 1325.02, *Desertion and Unauthorized Absence (UA)*. **(T-1)**. Information includes, as a minimum, the following:

2.18.5.1. Surrendered to military or civilian authorities. **(T-1).**

2.18.5.2. Apprehended by military or civilian authorities. **(T-1).**

2.18.6. Follows DoD requirement to send Absentee and Deserter Statistics to the Office of Special Investigation**. (T-1).** Submits to AF OSI ICON/ICW monthly, a current roster of AF deserters. **(T-1).**

2.18.7. Provides guidance to all military personnel units on management of the AWOL/Deserter Strength Accounting Duty Status Program. **(T-1).**

2.18.8. Conducts a quality review of Human Resources (HR) type Personnel Processing Application Duty Status Change (AWOL/Deserter) Case Management System case and other required documents and updates or corrects duty status in Military Personnel Data System (MilPDS). **(T-1)**. Forwards HR Type Personnel Processing Application Duty Status Change (AWOL/Deserter) Case Management System to the Total Force Service Center for coordination. **(T-1)**.

2.18.9. Coordinates and distributes procedures for managing UAs. Forwards DD Form 553/DD Form 616 to AFOSI/ICON/ICW for update in National Crime Information Center. **(T-1)**.

2.18.10. Monitors disposition of absentees returned to military control and provides guidance as needed.

2.18.11. Maintains a case file for each member declared AWOL or deserter and ensures documents received are reviewed and are sent to AFPC/DPSIR, Automated Records Management System Office, for filing in the member's Master Personnel Record. **(T-1)**.

2.18.12. Maintains Medical and Dental records for all AF Deserters dropped from unit rolls until the member is returned to military control at which time AFPC/DPFCM will forward the records to the servicing MPF. **(T-1)**.

2.18.13. Maintains access to electronic master personnel records via Automated Records Management System Office from AFPC/DPSIR. **(T-1).**

2.18.14. Ensures member's MilPDS file is dropped from unit rolls and reassigned to AFPC/DPFCM personnel accounting symbol code on the 180th day of absence. **(T-1)**.

2.19. Air Force Total Force Service Center (AFPC/DP1OS):

2.19.1. Reviews HR Type Personnel Program Application (AWOL/Deserter) Case Management System cases and forwards to appropriate offices for coordination. **(T-1).**

2.19.2. Forwards completed HR Type Personnel Processing Application (AWOL/Deserter) Case Management System case to MPF or member's commander for closure. **(T-1)**. Sends Case Management System product AF Form 2098 to AFPC/DPSIR (Automated Records Management System Office) for filing in the member's Master Personnel Record. **(T-1)**.

2.20. Air Force Security Forces Center (AFSFC/SFC):

2.20.1. Assists base-level Security Forces units with issues related to escort of pretrial detainees and post-trial inmates for confinement transfers. **(T-1).**

2.20.2. Procedures for secure transportation (if necessary) are outlined in AFI 31-105, *Air Force Corrections System* and AFMAN 31-127, *Security Forces Armed/Unarmed Transfer Team Procedures*.

2.21. AF Installation and Mission Support Center:

2.21.1. Ensures FAM's UTCs are aligned in accordance with codified AF Policy and HAF/A1X posturing guidance. **(T-1).** Guidance is posted on the HAF/A1XO Readiness SharePoint® page located at: **https://cs2.eis.af.mil/sites/11603/default.aspx**.

2.21.2. Centrally manages the Air Expeditionary Force (AEF) Force Support UTC capability portfolio and ensures the appropriate Force Support UTC capability is apportioned in each Air and Space Expeditionary Force period.

2.21.2.1. Updates the Manpower Force Packaging System with Force Support UTC detail in Deliberate and Crisis Action Planning and Execution Segments. **(T-1)**.

2.21.2.2. Maintains respective UTC Manpower Force Packaging System and Logistics Detail data. **(T-1).**

2.21.2.3. Designated as the Manpower and Equipment Force Packaging system responsible agency for appointed UTC. **(T-1).**

2.21.3. Executes HAF/A1 Force Support UTC posturing guidance. **(T-1)**.

2.21.4. Monitors Force Support organizations' Resource and Capability readiness report inputs. **(T-1).**

2.21.5. Conducts quarterly analysis to identify and provide guidance to resolve negative trends involving personnel, training and equipment resourcing. **(T-1)**.

2.21.6. Provides reports to MAJCOM/A1s and HAF/A1X on readiness status of the Force Support community. **(T-1)**.

2.21.7. Serves as the central repository for Force Support readiness measurement data. **(T-1).**

2.21.8. Ensures Force Support capabilities are prepared to meet Combatant Commander requirements. **(T-1).**

2.21.8.1. Ensures all AEF Force Support members/teams are structured in the Institutional Forces, warfighting, home-station, and Combatant Commander/Other Government Agencies guidance to meet wartime and contingency requirements. **(T-1).**

2.21.8.2. Coordinates proposed Air and Space Expeditionary Force UTC posturing and/or any deviations with the HAF FAM(s) and MAJCOMs, as required, and updates the AF UTC Availability data. **(T-1)**.

2.21.9. Evaluates training effectiveness by measuring deployment and employment capabilities and equipment availability through the Force Readiness Reporting Program. **(T-1).**

2.21.10. Provides Installation Personnel Readiness (IPR) oversight to all regular component IPR offices and coordinates with Component MAJCOMs when Air and Space Expeditionary Force forces work in support of non-Air and Space Expeditionary Force organizations such as special operations. **(T-1)**.

2.22. AF Installation and Mission Support Center Training and Support Division (AFIMSC/XZT):

2.22.1. Manages Force Support Readiness training (i.e. Deliberate and Crisis Action Planning and Execution Segments) by conducting data calls for formal training requirements and manages quotas by distributing quotas to units based on established priorities. **(T-1)**. Priorities will be based on mission needs and coordinated with Component MAJCOMs. **(T-1).** In addition, consideration will be given to tour lengths and date eligible for return from overseas for overseas installations. **(T-1).**

2.22.2. Reviews unit requests for Force Support functional equivalent Silver Flag credit; based on exercises and coordinates them for approval by HAF/A1XO. **(T-1)**.

2.22.3. Ensures operational execution of the Force Support Readiness program by establishing procedures and implementing standards/program guidance approved by HAF/A1. **(T-1)**.

2.22.4. Provides functional and subject matter expertise for Manpower, Personnel and Services operations and capabilities. **(T-1).**

2.22.5. Develops content to update the War and Mobilization Plan in conjunction with HAF/A1XO to meet AF milestones. **(T-1)**.

2.22.6. Develops content as the subject matter experts for Tactics, Techniques, and Procedures and develops Force Support readiness plans content, as required, for Force Support functions, capability and mission. **(T-1)**.

2.22.7. Primary office to provide technical guidance to units deployed or in training regarding the employment of all Force Support capabilities.

2.22.8. Maintains web-based Readiness guidance for use by Force Support planners and deployed teams and manages any SharePoint®/related websites and updates material as needed. **(T-1).**

2.22.9. Provides support to MAJCOMs, Component MAJCOMs, and field units on all readiness issues. **(T-1).**

2.22.10. Assists Component MAJCOMs and Component Numbered AF planners with planning responsibilities and factors for operation plan requirements and UTC sourcing. **(T-1).**

2.22.11. Along with HAF representatives, plans and hosts the War Fighter Requirements Review and Readiness and Training Council. **(T-1).**

2.22.12. Works with field units regarding management of the readiness program. **(T-1).**

2.23. Director of Operations, Air Force Services Activity (AFSVA/SVO): is responsible for providing operational and resourcing guidance to affected installations during evacuation operations in support of emergency feeding and beddown actions **(T-1).**

2.24. AF Services Activity (AFSVA/SVOR):

2.24.1. Provides technical expertise and guidance to AF contractors and AF components utilizing AF contractors in support of Force Support bed down and sustainment augmentation. **(T-1)**.

2.24.2. Coordinates with installations regarding contingency contracts and/or Nonappropriated Fund Memorandums of Agreement to sustain Force Support operations when military personnel are deployed. **(T-1)**.

2.24.3. Serves as the functional/subject matter expert to review Allowance Standards for Force Support War Reserve Material and Home Station Readiness Training requirements. **(T-1).**

2.24.4. Administers the Field Integrated Research and Modernization Program; ensures modernization initiatives are executed based on War Fighter Requirements Review direction. **(T-1)**.

2.24.5. Coordinates with AFSVA/SVOFA and MAJCOMs to conduct the annual update for War Reserve Material Wartime Consumable Distributed Objective with AF logistics planners. **(T-1)**.

2.24.6. Represents the Force Support readiness community in forums, councils and working groups for Basic Expeditionary Airfield Resources, home station readiness equipment and equipment modernization efforts. **(T-1).**

2.24.7. Maintains examples of contract templates for use by component planners to support contingency locations and reviews contractual Statements of Work as required. **(T-1)**.

2.24.8. Consolidates and distributes contracted operation after-action reports. **(T-1)**.

2.24.9. Tracks contingency contract costs and usage figures for historical reporting purposes. **(T-1)**.

2.24.10. Ensures operational execution of the Force Support Readiness program by establishing procedures and implementing standards/program guidance approved by HAF/A1. **(T-1)**.

2.24.11. Provides functional and subject matter expertise for Manpower, Personnel and Services operations and capabilities. **(T-1).**

2.24.12. Develops content to update the War and Mobilization Plan in conjunction with HAF/A1XO to meet AF milestones. **(T-1)**.

2.24.13. Develops content as the subject matter experts for Tactics, Techniques, and Procedures and develops Force Support readiness plans content, as required, for Force Support functions, capability and mission. **(T-1)**.

2.24.14. Primary office to provide technical guidance to units deployed or in training regarding the employment of all Force Support capabilities. **(T-1).**

2.24.15. Maintains web-based Readiness guidance for use by Force Support planners and deployed teams and manages any SharePoint®/related websites and updates material as needed. **(T-1).**

2.24.16. Provides support to MAJCOMs, Component MAJCOMs, and field units on all readiness issues. **(T-1).**

2.24.17. Assists Component MAJCOMs and Component Numbered AF planners with planning responsibilities and factors for operation plan requirements and UTC sourcing. **(T-1).**

2.24.18. Along with HAF representatives, plans and hosts the War Fighter Requirements Review and Readiness and Training Council. **(T-1).**

2.24.19. Works with field units regarding management of the readiness program. **(T-1).**

2.25. AFPC AEF Readiness Branch (AFPC/DP2WR) and AFSVA/SVOR:

2.25.1. Responsible for equipment management, research and development to support Force Support capabilities. **(T-1).**

2.25.2. Conducts staff assistance visits as requested for FSS unit readiness programs. **(T-1)**.

2.25.3. Provides guidance to Force Support community and pilot units on readiness equipment. **(T-1)**.

2.25.4. Plans and hosts the Field Integrated Research and Modernization working group. **(T-1)**.

2.25.5. Reviews readiness training curriculum and provides subject matter expertise. **(T-1)**.

2.25.6. Conducts site certification of Force Support training at Silver Flag sites to ensure proper standardization and resources to support the program are in place. **(T-1)**.

2.25.7. Provides field activities support for Deliberate and Crisis Action Planning and Execution Segments or other automated systems. **(T-1)**.

2.26. Field Operating Agencies (FOAs) – i.e. AFPC AEF Readiness Branch (AFPC/DP2WR) and AFSVA Training and Development Division (AFSVA/SVXT):

2.26.1. Develops, prepares, reviews, publishes and implements Force Support Readiness training programs to ensure Force Support capabilities are trained to meet requirements approved by respective Career Field Managers. **(T-1)**.

2.26.2. Provides subject matter expertise to the AF Career Field Managers on Headquarters Air Education and Training Command developed specialty-training standards and provide recommendations based on subject matter expertise. **(T-1).**

2.26.3. Collaborates with AF Career Field Managers and MAJCOM functional advisors to ensure readiness training requirements determined by the Utilization and Training Workshop or Training Planning Teams meet the needs of the Force Support Readiness community. **(T-1).**

2.26.4. Validates site certification checklists and ensures readiness training requirements are properly documented for HAF/A1XO approval. **(T-1)**.

2.27. Headquarters Air Force Reserve Command and Headquarters Individual Reservist Readiness and Integration Organization (HQ RIO):

2.27.1. HQ RIO provides for utilization and accountability of Individual Reservists.**(T-1).**

2.27.2. Follows GCCS-AF system user responsibilities. **(T-1)**.

2.27.3. Monitors Deliberate and Crisis Action Planning and Execution Segments to ensure integrity and validity of assigned data. **(T-1).**

2.28. Headquarters Air Force Reserve Center (AFRC/A1K):

2.28.1. Serves as the functional OPR for administering the operational aspects of the AWOL/Deserter program for Reserve members.

2.28.2. Ensures AWOL/Deserter program is implemented within Reserve units.

2.28.3. Develops, coordinates, and approves personnel policies and procedures for duty status management.

2.29. Headquarters National Guard Bureau (NGB/A1X):

2.29.1. Serves as the functional OPR for administering the operational aspects of the AWOL/Deserter program for ANG members.

2.29.2. Ensures AWOL/Deserter program is implemented within ANG units.

2.29.3. Develops, coordinates, and approves personnel policies and procedures for duty status management.

2.30. MAJCOM Directorates of Manpower, Personnel and Services (MAJCOM/A1)

2.30.1. Responsible for Command and Control to support contingency and wartime operations as required in their Command.

2.30.2. Responsible for accountability for personnel assigned to the command.

2.30.3. The AFR and ANG provide support to their respective IPR offices.

2.30.4. Serves as MAJCOM Manpower and Equipment Force Packaging system manager for appointed command UTCs and other manpower readiness programs per AFI 38-205,

Expeditionary Manpower Management and AFI 10-401, *AF Operations Planning and Execution.*

2.30.5. Provides functional and subject matter expertise for Manpower, Personnel and Services operations and capabilities.

2.30.6. Maintains accountability of personnel assigned to the Command.

2.31. MAJCOM Director of Operations (MAJCOM/A3/4/5). MAJCOM A3/4/5s will:

2.31.1. Prepare plans to support DOD Directive (DoDD) 3025.14, *Evacuation of US Citizens and Designated Aliens from Threatened Areas Abroad,* DoDI 3001.02, *Personnel Accountability in Conjunction with Natural or Manmade Disasters,* and Joint Publication (JP) 3-68, *Noncombatant Evacuation Operations* and this AFI.

2.31.2. Ensure all subordinate commanders/units prepare evacuation, reception, and repatriation plans.

2.31.3. Utilize the Noncombatant Evacuation Operation Tracking System in conjunction with the AFPAAS to identify and track evacuees.

2.32. AF Component MAJCOM/Component Numbered AF:

2.32.1. Develops adaptive and crisis action plan requirements for their respective areas of responsibility.

2.32.2. Utilizes the Force Support supplement to War Mobilization Plan to conduct wartime and contingency planning.

2.32.3. Determines command staff augmentation requirements using Force Support UTCs (i.e., AF Forces Staffs in support to Component Numbered AF).

2.32.4. Supports forward operating locations by planning and deploying Force Support personnel, equipment and rations to meet Combatant Commander requirements.

2.32.5. Ensures deployed/contingency sites complete periodic situation reports.

2.32.6. Tracks movement of Force Support UTCs for both personnel and equipment from the UTC origin until it reaches the theater destination and redeployment from forward operating locations to home station.

2.32.7. Oversees force accountability within the theater of operation, including deployed AF civilian and contract employees.

2.32.8. Develops Force Support inputs for Annex E (Manpower/Personnel/Services Annex) and Annex D (Food/Lodging/Mortuary/Laundry) for each tasked operation plan for Base Support Plans and Expeditionary Site Plans.

2.32.9. Coordinates proposed UTC posturing and/or any deviations with the HAF FAM(s), as required, and coordinates updates to the AF UTC Availability data.

2.32.10. Ensures after-action reports, lessons learned from exercises, real world contingencies and Air Reserve Component deployments, end of tour reports and unit after-action reports are completed and shared with AFSVA/SVORR for final action.

2.32.11. Will maintain accountability of their personnel assigned to any base or living in an outlying area impacted by natural disaster or national emergency and any personnel on Leave/ Temporary Duty (TDY) in the Geographical Area of Interest.

2.32.12. Will develop plans and procedures for delegation of personnel accountability responsibilities in accordance with Emergency Management or Continuity of Operations Plans.

2.32.13. Ensures units accurately and timely report personnel accounting duty status within 48 hours of disaster or national emergency in compliance with this instruction.

2.32.14. Grant appropriate access and ensure needed training is provided to all assigned IPR offices, Geographically Separated Units and Tenant Units located on other MAJCOM's installation(s).

2.32.15. AF District of Washington will function as the MAJCOM responsible for the accountability of AF members assigned to HAF and AF Elements.

2.33. Supported Component Command (Contingency and Exercise Support) Director of Manpower, Personnel, and Services:

2.33.1. Serves as the supported component command 38FX/3FXXX Functional Manager.

2.33.2. Provides personnel support to forces assigned or attached to the component command.

2.33.3. Uses standard UTCs during Time-Phased Force Deployment Data to manage, plan and execute personnel requirements for all possible contingencies.

2.33.4. Develops concepts, plans, and procedures to support force accountability, personnel deployment, repatriation, Noncombatant Evacuation Operation (or Order), and reception processing at all installations under their control.

2.33.5. Develops the Personnel Annex for all Operations Plans, Contingency Plans, and a PERSCO Concept of Operations (if insufficient time to fully develop an annex) to meet combatant commanders' intent.

2.33.6. Incorporates policies and procedures in the operation's personnel reporting instructions.

2.33.7. Describes command-unique reports and outlines complete instructions on format, content, addressees, frequency of reporting, and classification guidelines.

2.33.8. Maintains Total Force accountability by tracking and managing deployed personnel data for personnel deployed to their area of responsibility by using GCCS-AF systems utilizing Deliberate and Crisis Action Planning and Execution Segments.

2.33.9. Develops and publishes procedures for reviewing and validating replacement requests.

2.33.10. Realigns command resources to fill 38FX/3FXXX validated requirements for AF-wide sourcing.

2.33.11. Develops and implements theater-unique personnel programs and procedures to support sustainment deployments.

2.33.12. Manages PERSCO teams in AORs and resolves limiting factors identified by teams that limit or hinder their operational capabilities.

2.33.13. Coordinates the management of deployable systems with AFPC/DP2WR and maintains operational control of all GCCS-AF systems in their theater(s) of operation.

2.33.14. Follows and ensures FSS and PERSCO teams comply with the GCCS-AF system user responsibilities.

2.33.15. Provides staff assistance to PERSCO as requested.

2.33.16. Ensures HAF/A1XO, AFPC Operations Center, supporting commands, applicable FSS and PERSCO teams in the Area of Responsibility receive correspondence on all command personnel programs.

2.33.17. Reviews all PERSCO incident reporting located on AFPC Secret Internet Protocol Router Network SharePoint® found at: https://intelshare.interlink.sgov.gov/sites/personnel-readiness-operations/SitePages/Home/aspx.

2.33.18. Monitors the status of messages sent by all PERSCO teams requesting information or action from FSSs or the supporting command to ensure the responses are timely and accurate.

2.33.19. Performs data reconciliation on Military Personnel Data System and Deliberate and Crisis Action Planning and Execution Segments deployed personnel data.

2.34. Silver Flag Training Force Support Readiness Superintendent:

2.34.1. Trains Force Support capabilities based on Combatant Commander needs and requirements identified in the War Fighter Requirements Review and approved by HAF/A1XO. **(T-1).**

2.34.2. Executes the Force Support Training program using current HAF/A1XO approved Force Support training curriculum. **(T-2).**

2.34.3. Complies with current HAF/A1XO approved Force Support training site certification checklist. **(T-1).**

2.34.4. Participates in the War Fighter Requirements Review panel and Force Support functional training for Silver Flag curriculum review sessions as required. **(T-1).**

2.34.5. Provides status on items identified as deficient in the site certification report to their host MAJCOM/A1 and/or AFIMSC. **(T-1).**

2.35. Commanders at all levels:

2.35.1. Establish management practices and programs to deter absenteeism and desertion. **(T-3).**

2.35.2. Publicize the AWOL/deserter apprehension program to deter potential absentees. **(T-3).**

2.35.3. Develop programs to make sure that the maximum number of absentees or deserters, who return to the military and have the potential for continued service, continue to serve. **(T-3).**

2.35.4. Ensure timely reporting of UAs of assigned personnel utilizing the Human Resources (HR) type Personnel Program Application-Duty Status Change (AWOL/Deserter) request in Case Management System. **(T-3).**

2.36. Installation Commander:

2.36.1. Ensures a Force Support Readiness program is established. **(T-2).**

2.36.2. Coordinates with their MAJCOM or AFIMSC as applicable to fund Force Support Readiness equipment and training requirements. **(T-2).**

2.36.3. Organizes, trains and equips UTCs to support Air and Space Expeditionary Force deployment requirements. **(T-2).**

2.36.4. Ensures funds for UTC training and equipment purchase are budgeted annually. **(T-2).**

2.36.5. Meets Readiness and Resource Reporting requirements. **(T-2).**

2.36.6. Direct use of the AFPAAS during a disaster/emergency by assigned, tenant, and Geographically Separated Units in the Geographical Area of Interest to obtain and report accountability until 100% accountability is achieved or reporting is suspended. **(T-2). Exception**: accountability of AF Office of Special Investigations (AF OSI) personnel is accomplished by AFOSI/XRW and are not to be accounted by the host unit/wing. **(T-2).**

2.36.7. Ensure all unit commanders identify at least two (2) individuals to serve as the AFPAAS Commanding Officer Representatives and personnel accountability duty status monitors. **(T-2).** (**Note:** May appoint the same two people or four different people.)

2.36.8. Ensure all assigned personnel are familiar with the AFPAAS and their responsibility, if displaced, to contact their leadership, keep them informed of their location, and account for Defense Enrollment Eligibility Reporting System enrolled family members who physically reside in the Geographical Area of Interest. **(T-2).**

2.36.9. Identifies support for evacuation, reception and repatriation plans in the installation reception and support plans. **(T-2).** Installations will refer to the Base Support Plan Part I, **Chapter 9**, for Repatriation and Safe Haven Operations for the installations processes and procedures. **(T-2).** The OPR for the Base Support Plan Part I is the installation Site Manager located within the Logistics Readiness Squadron.

2.37. Installation Commanders (Continental United States (CONUS) or non-foreign area (e. g., Hawaii, Alaska, etc.)) (Wing Plans) will:

2.37.1. Determine the need for an evacuation and issue such orders considered necessary to ensure the safety, health, and well-being of personnel and their family members. **(T-1).**

2.37.2. Tailor evacuation order to meet the specific circumstances. **(T-1). Note**: Evacuation orders must have a beginning and projected end date. **(T-1).**

2.37.3. Evacuation orders will be coordinated with tenant units on the installation. **(T-1).**

2.37.4. Ensure military members are only allowed to draw evacuation benefits if they are escorting others being evacuated. **(T-2).**

2.37.5. Place military members on TDY or permanent change of station orders, if members are required to move out of a disaster area. **(T-2).Note**: Verbal evacuation orders are authorized but must be confirmed in writing as soon as possible. **(T-2).**

2.37.6. Prepare plans to support DoDD 3025.14, *Evacuation of US Citizens and Designated Aliens from Threatened Areas Abroad,* DoDI 3001.02, *Personnel Accountability in Conjunction with Natural or Manmade Disasters,* and Joint Publication (JP) 3-68, *Noncombatant Evacuation Operations (NEO)* and this AFI. **(T-1).**

2.38. Unit Commanders/Directors will:

2.38.1. Using the AFPAAS, account for assigned military, Department of AF and Non-appropriated Fund civilians, Defense Enrollment Eligibility Reporting System enrolled family members, family members of Department of AF and Non-appropriated Fund employees (when receiving evacuation entitlements) and overseas assigned contractors and their family members as expeditiously as possible, after personnel accountability is directed. **(T-2).** RegAF unit commanders must ensure they are accounting for Individual Mobilization Augmentees and Active Guard Reserve assigned to their units. **(T-2).** Ensure assigned personnel update their status in the AFPAAS as soon as they reach a safe location and have access to the system or the event is over. **(T-2).**

2.38.2. Identify in writing at least two (2) individuals to serve as the AFPAAS Commanding Officer Representatives and personnel accountability duty status monitors. (**Note:** May appoint the same two people or four different people.) **(T-2).**

2.38.3. Ensure all civilian personnel whose family members are receiving evacuation entitlements report the status of those family members to their supervisor or commander/director until entitlements cease. **(T-2).**

2.38.4. Ensure unit members verify addresses in the Defense Enrollment Eligibility Reporting System annually. **(T-2).**

2.38.5. Establish procedures to ensure personnel accountability is maintained for all duty status changes of assigned personnel and are reported to the office responsible for making updates to the Military Personnel Data System. **(T-2).**

2.38.6. Establish unit TDY in- and out-processing procedures to accurately maintain personnel accountability. **(T-2).**

2.38.7. Refer to AFI 36-3002, *Casualty Services,* for guidance and contact local Casualty Assistance Representatives for assistance if unable to account for members after all reasonable efforts have been made to do so. **(T-2).**

2.38.8. Ensure one set of identification tags are issued to each individual. **(T-1).**

2.38.9. Ensure each individual understands when and how identification tags are worn. **(T-1).**

2.38.10. Inspect the accuracy of identification tags annually to ensure information contained on them is accurate and complete. **(T-1).**

2.39. Commander's Support Staff or MPF (Force Management Section). Organizations and units that retain authorization(s) for the purpose of performing MPF work do not receive the MPF services outlined under the FSS/MPF structure. Those duties continue to be performed by the unit unless they establish an agreement with the MPF to service that population in a particular program.

(T-2). Without formalized agreements between both parties, MPF responsibilities/functions will only be provided by the MPF to commanders and military/IMA populations that did not retain MPF manning as indicated during the MAJCOM/FOA/DRU validation via Change 1 to Program Action Directive (PAD) 07-11, A1 Transformation. **(T-2).**

2.39.1. Establish contact with AFPC/DPFCM to notify of the UA. **(T-3).**

2.39.2. Assist unit commander and first sergeant in determination of member's duty status. **(T-3).** Prepares the Duty Status Change Request using Case Management System and immediately forward to the commander for approval to place member into AWOL or deserter status. **(T-3).** Ensure the remarks section includes a brief explanation of the circumstances of the absence. **(T-3).**

2.39.3. Training squadrons and geographically separated training units forward Duty Status Change Requests to the MPF duty status monitor for review prior to forwarding to unit commander for approval. **(T-3).**

2.39.4. Provide the Financial Services Office (FSO) a copy of the AF Form 2098, *Duty Status Change*. **(T-1).** Unit/MPF cannot update MilPDS. **(T-2).** Only AFPC/DPFCM can change or remove AWOL/Desertion duty status codes in MilPDS. **(T-2).**

2.39.5. Assist commanders to prepare and process required documents (e.g. 72-Hour Status Report; 31st Day and 60th Day Status Reports, DD Form 553, *Deserter/Absentee Wanted by the Armed Forces*, and DD Form 616, *Report of Return of Absentee,* and forward to AFPC/DPFCM. **(T-3).**

2.39.6. Work with the commander and MPF to obtain a current, identification-quality photograph of the deserter to be distributed with DD Form 553. **(T-3). Note:** Photograph does not have to fit in box for item 8. **(T-2).** When available, send photograph with DD Form 553 or as soon as possible.

2.39.7. On the 31st day of AWOL, create a new Duty Status Change Request using Case Management System and forward to the commander for approval. **(T-2).**

2.39.8. On the 180th day of the member's UA, obtain the member's medical and dental records and mails them to AFPC/DPFCM. **(T-2).** Servicing MPF provides assistance as needed. If medical and dental records are not available, the commander will prepare a memorandum for AFPC/DPFCM explaining the reason why the records are not available. **(T-2).**

2.39.9. Ensure any disclosures concerning the member meet the requirements of the Privacy Act as set forth in AFI 33-332, *Air Force Privacy and Civil Liberties Program*. **(T-2).**

2.40. Financial Services Office (FSO):

2.40.1. Ensures accurate and timely AWOL/Deserter duty status reporting for updates to members Master Military Pay Account. **(T-2)**.

2.40.2. Ensures accurate and timely notification to Defense Finance and Accounting Service. **(T-2)**.

2.40.3. Provides assistance to commanders as needed. **(T-2).**

2.40.4. Stops the absentee's pay and allowances after the unit's initial notification that the absentee is AWOL or a deserter. **(T-2)**.

2.40.5. Provides commander and MPF/CSS assistance with all funding questions in accordance with AFMAN 65-116, Volume 1, *Defense Joint Military Pay System Active Component (DJMS-AC) FSO Procedures*, and AFI 65-601,Volume 1, *Budget Guidance and Procedures*. **(T-3)**.

2.41. Commanders of local Military Treatment Facilities, Reserve Medical Units, RegAF, AFR and ANG Aeromedical Evacuation Squadrons, and Guard Medical Units will:

2.41.1. Work with the Installation Deployment Officer to establish local guidance regarding identification tag issuance based on policy and directives for Red Medical Alert identification tags. **(T-1).**

2.41.2. Codify the process for producing the Red Medical Alert identification tag in either the Installtion Deployment Plan (IDP) or through an Memorandum of Understanding (MOU) with the Installation Deployment Officer and the FSS Commander. **(T-1).** Details will include the frequency of production and distribution to members' readiness folders. **(T-1).**

2.41.3. Designate a medical point of contact (i.e. medical readiness) who will be responsible for making the Red Medical Alert identification tags, ensure the correct medical information is printed on the tags (i.e. medical abbreviations), Aeromedical Services Information Management Systems is updated and the Red Medical Alert identification tags are taken back to the Medication Treatment Facilities for distribution to the proper units. **(T-1).**

2.41.4. Develop a process for the medical Unit Deployment Manager (UDM) to get the Red Medical Alert identification tags to other base organization UDMs. **(T-1).**

2.41.5. Geographically Separated Units should contact the nearest AF Medical Treatment Facility to obtain their Medical Alert identification tags.

2.42. Servicing Security Forces:

2.42.1. Coordinate search efforts with Unit commander and 1st Sergeant; servicing AF OSI unit; and local law agencies. **(T-2).** Provide results to commander. **(T-2).**

2.42.2. Assist the unit commander in finding and returning the absentee to military control using current information or initial information in DD Form 553. **(T-2).** This action includes notifying civilian and other military agencies.

2.42.3. Assist the unit commander and MPF in determining distribution of the DD Form 553. **(T-3). Note:** DO NOT update the National Crime Information Center for deserters. **(T-1).** Upon receipt of DD Form 553 from AFPC/DPFCM, AFOSI/ICON/ICW will ensure appropriate National Crime Information Center update.

2.43. Force Support Squadron (FSS) Commander/Director

2.43.1. Executes the installation Force Support Readiness program. **(T-2).**

2.43.2. Ensures a Total Force approach to train/prepare Force Support capability for deployment during wartime and contingency response. **(T-2).**

2.43.3. Budgets and requests funding for all Home Station Readiness Training, formal training, equipment UTC and other UTC requirements. **(T-2)**.

2.43.3.1. Ensures Home Station Readiness Training requirements are met each Air and Space Expeditionary Force cycle (AFR/ANG every 24 months), approves the annual readiness training plan, and receives bi-annual comprehensive updates on training status of team members. **(T-2)**.

2.43.3.2. Monitors and ensures Force Support Readiness teams are fully staffed, trained and equipped to meet requirements. **(T-2).**

2.43.4. Budgets and plans for contingency contracts and/or Nonappropriated Fund Memorandum of Agreement. **(T-2).** These are available to sustain Force Support operations when military personnel are deployed. Examples include contingency contracting, civilian over-hires, Individual Mobilization Augmentation, etc.

2.43.4.1. Budgets for travel and per diem to fund Force Support manning assistance from all outside sources (i.e. Individual Mobilization Augmentee support on Military Personnel Appropriation man-day tours, if available, other AF units, etc.) **(T-2).**

2.43.4.2. Plans for temporary civilian appointments in the event civilians deploy from the unit. **(T-2).**

2.43.5. Ensures the readiness of their assigned personnel, equipment is ready for deployment and the squadron can meet the mission capability of all assigned UTCs (e.g., Single Pallet Expeditionary Kitchen UTC logistics detail supply and equipment requirements). **(T-2).**

2.43.6. Reviews Designed Operational Capability statement annually. **(T-2).**

2.43.7. Serves as the local resource manager supporting wing postured Force Support personnel UTCs. **(T-2).**

2.43.8. Serves as the base functional manager for all AF Specialty Code 3FXXX and 38F contingency taskings and other matters. **(T-2).**

2.43.9. Ensures equitable distribution of Force Support personnel between Air and Space Expeditionary Force on-call windows, allowing maximum deployment of capabilities. **(T-2).**

2.43.10. Assists unit commanders with updating personnel Air and Space Expeditionary Force assignments in Military Personnel Data Systems in accordance with policy. **(T-3).**

2.43.11. Develops contingency plans outlining military workload mitigation factors supporting maximum personnel contribution during rotational and surge deployment operations while still maintaining home-station personnel service support. **(T-2).**

2.43.11.1. At a minimum, contingency plans will include assumptions and planning factors outlined in the Personnel Functional Area Prioritization and Sequencing Guidance located at the AEF Online website. **(T-2).**

2.43.11.2. Contingency plans will include supporting Noncombatant Evacuation Operation \repatriation, wing-level augmentation requirements, and individual augmentation taskings. **(T-2).**

2.43.12. Develops a training plan ensuring all task certifications on PERSCO and GCCS-AF system identified operators UTCs for monthly reporting in accordance with AFI 10-201, *Force Readiness Reporting*. **(T-2).**

2.43.13. Approves the award and revocation of Personnel Readiness related Special Experience Identifiers in accordance with the *Air Force Officer Classification Directory and the Air Force Enlisted Classification Directory,* both located on the myPers website at https://mypers.af.mil/app/categories/c/1363/p/9. **(T-3).**

2.43.14. Work with the Installation Deployment Officer and Installation Medical Commander to develop a Memorandum of Understanding to outline processes for producing the Red Medical Alert identification tag, the frequency of production and distribution to members' readiness folders. **(T-3).**

2.43.15. Ensure the IPR office has the funding to maintain, repair and replace as needed the identification tag embosser at the IPR office, subject to availability of Congressional appropriations. **(T-1).**

2.43.16. Ensure IPR offices provide training to designated Medical Treatment Facility personnel on the use of the identification tag embosser located at the IPR office. **(T-3).**

2.43.17. Ensure IPR offices provide access to the identification tag embosser at the IPR office for designated medical personnel. **(T-3).**

2.44. Chief, Civilian Personnel Flight or Equivalent:

2.44.1. Upon request, assists the FSS IPR Element and Installation Deployment System with developing and implementing local civilian personnel policy and procedures. **(T-3).**

2.44.2. Assists with Department of the Air Force and Nonappropriated Fund employee accountability. **(T-2).**

2.44.3. Provides the needed data to IPR for preparation of Contingency, Exercise, Deployment orders and the generation of Deliberate and Crisis Action Planning and Execution Segments updates for civilian personnel tasked to deploy in support of contingency support operations. **(T-2).**

2.44.4. Identifies in the base support plans how personnel support is provided to employees and supervisors during contingencies. **(T-3).**

2.45. Military Personnel Section Commander or Equivalent:

2.45.1. Ensures the Military Personnel Section provides prompt support to deployed/deploying commanders and base personnel during contingency, wartime, exercise, and emergency operations. **(T-3).**

2.45.2. Provides trained personnel and equipment to support emergency operations such as repatriation of Department of Defense personnel, natural disasters, etc. **(T-2).**

2.45.3. Ensures personnel assigned to the IPR Element complete Deliberate and Crisis Action Planning and Execution Segments training within 12 months of assignment to the IPR Element. **(T-2).**

2.45.4. Provides personnel planning inputs to base deployment plans, base support plans, Continuity of Operations Plan plans and emergency action plans to in- and out-process and account for all in- and out-bound forces. **(T-2).**

2.45.5. Assigns, equips, and trains personnel to operate the Personnel Deployment Function in accordance with AFI 10-403 and this instruction. **(T-2).**

2.45.6. Ensures the MPF Strength Accounting Duty Status Program Manager is appointed and trained on the AF Strength Accounting Duty Status Program. **(T-3).**

2.45.7. Ensures accurate and timely duty status reporting for all personnel assigned to their MPF ID. **(T-2).**

2.45.8. Ensure MPF and Commander's Support Staff (CSS) (if applicable) personnel are informed of local operating procedures. **(T-3).**

2.45.9. Ensure procedures are in place for preparation and issuance of identification tags as required by this instruction. **(T-1).**

2.45.10. Ensure procedures are established to dispose of improperly prepared or surrendered identification tags in the most economical method locally available according to AFI 33-332, *Air Force Privacy and Civil Liberties Program.* **(T-1).**

2.46. Force Support Squadron (FSS) Operations Officer:

2.46.1. Manages and provides oversight of day-to-day unit readiness program operations. **(T-2).**

2.46.2. Ensures planning for installation emergency and incident response AFI 10-2501, *AF Emergency Management Program*. **(T-2)**.

2.46.3. Coordinates, reviews, and develops Force Support content in Adaptive, Crisis Action, and the Base Support and Expeditionary Plans. **(T-2).**

2.46.4. Oversees the unit Individual Mobilization Augmentee Program and ensures Individual Mobilization Augmentees are fully qualified to perform wartime duties. **(T-2).**

2.46.5. Briefs the FSS Commander/Director on Designed Operational Capability statements annually. **(T-3)**.

2.46.6. Ensures annual budget and resources for readiness program management and execution are submitted to Resource Management. **(T-3)**.

2.46.7. Provides management and oversight of UDM. **(T-3).**

2.46.8. Oversees all unit readiness training. **(T-3).**

2.46.9. Reviews Force Support Readiness and Capability reports for accuracy based on criteria established in AFI 10-201. **(T-3).**

2.46.10. Develops and implements home station military workload mitigation plans to maximize deployable capability during Air and Space Expeditionary Force rotational and surge operations. **(T-2).**

2.46.10.1. Details the planning of contingency contracts, Air Reserve Component force utilization and temporary civilian appointments, hours of operation, etc. **(T-2).**

2.47. Unit Deployment Managers will:

2.47.1. Retain identification tags for individuals assigned to deployment positions as required by local policy. **(T-3).**

2.47.2. Optionally, keep identification tags in a central location within the assigned unit when not in use by the individual.

2.47.3. Ensure procedures are in place to check out identification tags when needed by the individual. **(T-3).**

2.48. Force Support Squadron Readiness Manager/UDM (or Unit Readiness Manager):

2.48.1. Ensures all assigned Force Support personnel are assigned to the appropriate AEFI. **(T-2).**

2.48.2. Ensures the Force Support Readiness program complies with prescribed directives to organize, train, and equip the unit. **(T-2).**

2.48.3. Primary liaison to the Unit Training Manager, flight/squadron leadership, and wing training functions regarding deployment related issues. **(T-3).**

2.48.4. Maintains UDM continuity binder and associated electronic files that includes at minimum copies of appointment letters in accordance with AFI 10-403, *Deployment Planning and Execution*. **(T-3).**

2.48.5. Maintains a deployment folder on each member in accordance with AFI 10-403. **(T-2).**

2.48.6. Submits after-action reports to the Commander/Director when required. **(T-3).**

2.48.7. Ensures individuals are briefed on their team member responsibilities for deployment. **(T-3)**.

2.48.8. Maintains Force Support UTC equipment as prescribed by the UTC Logistics Detail. **(T-3).**

2.48.9. Procures, maintains and prepares equipment/supplies in a safe and serviceable condition (including calibrated, if required) for postured UTCs. **(T-2)**.

2.48.10. Trains and equips assigned personnel to accomplish the mission essential tasks required as defined by the Mission Capability Statement of postured UTCs. **(T-2)**.

2.48.11. Maintains unit Designed Operational Capability statement. **(T-2).**

2.48.11.1. Coordinates new Designed Operational Capability statement with applicable wing agencies upon receipt. **(T-3).**

2.48.11.2. Postures Force Support teams according to the Designed Operational Capability statement. **(T-2).**

2.48.12. Notifies their wing Installation Deployment Readiness Center/Deployment Control Center within established timelines when UTC taskings cannot be supported. **(T-3).**

2.48.13. Ensures Force Support team members assigned to RFL, RFM, RFP and RFS series UTCs are functionally aligned to their functional account code (e.g., Personnel Functional Account Code 1600, Food Service Functional Account Code 45D1, Fitness Functional Account Code 45D8, etc.). **(T-3).**

2.48.14. Reviews UTC Mission Capability, Manpower Force Packaging System, and Logistics Detail on a quarterly basis or as changes occur in order to identify changes in unit posturing that will facilitate readiness reporting and monitoring. **(T-3).**

2.48.15. Determines and coordinates annual training plan requirements with the squadron training office and operations officer to ensure the unit is prepared for wartime and contingency operations (Silver Flag and Home Station Readiness Training). **(T-3).**

2.48.16. Conducts and/or schedules all readiness training classes in accordance with **paragraph 1.3** of this AFI. **(T-2).**

2.48.17. Maintains and services all assigned equipment UTCs (depending on base level equipment; e.g., Single Pallet Expeditionary Kitchen) at least quarterly to ensure proper utilization and to train Force Support members. **(T-2).**

2.48.18. Prepares the Resource and Capability readiness report in accordance with AFI 10-201. **(T-2).**

2.48.19. Assigns and maintains functional UTCs (in coordination with their respective commanders) as postured by FAMs using available unit assets. **(T-2).**

2.48.20. Monitors UTC/Unit Manpower Document authorization mismatches and notifies unit leadership when corrective actions have been taken. **(T-3).**

2.49. Force Support Squadron (FSS) Activities/Sections:

2.49.1. All activities support the Force Support readiness program by ensuring planning, exercising, and preparing for contingency operations.

2.49.1.1. Ensures contingency procedures are executed when directed by the FSS Readiness section. **(T-3).** These procedures include antiterrorism measures, accountability, incident response and any other contingency as directed.

2.49.2. Sections are directly responsible for preparing Force Support UTC capability. **(T-3).**

2.50. MPF Strength Accounting Duty Status Program Manager:

2.50.1. Ensures accurate and timely AWOL/Deserter duty status reporting for all personnel assigned to their MPF ID. **(T-2).**

2.50.2. Ensures unit Strength Accounting Duty Status Program managers receive AWOL/Deserter initial training within 30 days of appointment and training. **(T-3).**

2.50.3. Provides initial and refresher training to unit Commanders and First Sergeants on AWOL/Deserter program. **(T-3).**

2.50.4. Ensures unit commanders have Case Management System access and provides assistance with reporting of absentees. **(T-3).**

2.50.5. Notifies the unit of assignment when permanent change of station, TDY and Reserve/Guard members ordered to active duty fail to report at the time specified on their orders. **(T-2).** Exception: Reserve members ordered to active duty for training on an annual tour.

2.50.6. Provides guidance to the unit commander and unit CSS (if applicable) on the preparation of Duty Status Change (AWOL/Deserter) Case Management System case and in the preparation and distribution of DD Form 553 (refer to myPers) and DD for 616 (Figure 4.1). **(T-3).**

2.50.7. Establishes contact with AFPC/DPFCM to notify of the UA, as needed. **(T-3).**

2.50.8. Assists unit CSS and unit commander in obtaining the member's medical and dental records and forwards them to AFPC/DPFCM. **(T-3).** If medical and dental records not available, assists unit CSS and/or unit commander with memorandum explaining why medical and dental records are not available. **(T-3).**

2.51. IPR offices will:

2.51.1. Be the OPR regarding Personnel Accountability. **(T-2).**

2.51.2. Update strength accounting duty status Code 20, TDY, Contingency, and strength accounting duty status Code 21, Palace Trip Manning Assistance Contingency or Exercise, for all personnel deploying in support of a contingency operation or TDY manning assistance as appropriate. **(T-2).**

2.51.3. Monitor and manage daily Deliberate and Crisis Action Planning and Execution Segments and Military Personnel Data System Transaction Registers. **(T-3).** Take corrective action in both systems, if necessary. **(T-3).** Update projected or confirmed contingency, exercise, mobility, rotational, or manning assistance TDYs using Deliberate and Crisis Action Planning and Execution Segments and/or the Military Personnel Data System for those rejected during daily Deliberate and Crisis Action Planning and Execution Segments to Military Personnel Data System interface. **(T-2).**

2.51.4. Grant AFPAAS access to Commanding Officer Representatives designated in writing by unit commanders or directors for all supported units to include Tenant Units, Geographically Separated Units and AF Elements. **(T-2).**

2.51.5. Conduct an annual review to track and monitor Commanding Officer Representative assignments and remove access when designated Commanding Officer Representatives are reassigned. **(T-2).**

2.51.6. Provide annual personnel accountability and AFPAAS training to all designated Commanding Officer Representatives. **(T-2).**

2.52. PERSCO Team Chief:

2.52.1. Receives Team Chief responsibilities briefing upon UTC assignment. **(T-3).**

2.52.2. Coordinates/communicates with deployed forward locations and teamed UTCs prior to deployment. **(T-3).**

2.52.3. Advises headquarters rear staff, and home station of UTC whereabouts during deployment and redeployment. **(T-3).** It is especially important to notify the home station unit control center as soon as possible after reaching the deployed location.

2.52.4. Ensures their UTC is properly trained, equipped and prepared to deploy by meeting all training requirements, reporting instructions and any other deployed location-specific requirements. **(T-3).**

2.52.5. Submits after-action reports in accordance with this AFI. **(T-3).**

2.53. Supervisors/Trainers: Supervisors/Trainers plan, conduct, evaluate, and document training. **(T-3).**

2.54. Trainee: The trainee is the focal point of the AF training program. Trainees must become qualified to perform in their AF Specialty. **(T-3).**

2.55. Force Support UTC Team Members:

2.55.1. Ensures personal affairs (financial, legal, administrative, etc.), are in order at all times, and obtains required uniform items, personal clothing, and hygiene items in accordance with AFI 10-403, and MAJCOM/Wing requirements. **(T-3).**

2.55.2. Understands their AEFI, deployment UTC/Team assignment, and response time to meet deployment and mission capabilities requirements. **(T-3).**

2.56. Regular Air Force, Selected Reserve, Department of Air Force and Non-appropriated Air Force Civilians will:

2.56.1. Use the AFPAAS to account for themselves and family members when directed. **(T-2).**

2.56.2. Maintain realistic and actionable shelter-in place or evacuation plans in anticipation of national crises or natural disasters. **(T-2).**

2.56.3. Account for family members living in the Geographical Area of Interest (e.g., dependent children living with a former spouse) even though the sponsor may live outside the impacted area. **(T-2).** This includes Airmen deployed or on a remote assignment. **(T-2).**

2.56.4. Military members and Department of the AF civilians will ensure the Defense Enrollment Eligibility Reporting System is updated with current contact information to include home, mailing address and phone number. **(T-2).**

2.56.5. Civilian personnel whose family members are receiving evacuation entitlements will report the status of those family members in the AFPAAS or to their supervisor or commander/director. **(T-2).**

2.56.6. Nonappropriated Fund civilians will ensure their supervisor's record of employee folder contains current emergency point of contact information. **(T-2).**

2.56.7. Notify unit commander support staff before departure of a TDY and upon return. **(T-2).**

2.56.8. Notify unit commander support staff, supervisor and/or First Sergeant of any other change to personnel accountability duty status (e.g. hospitalization, confinement, etc.). **(T-2).**

2.56.9. Wear or have identification tags in their possession while performing duty as an aircrew member. **(T-1).**

2.56.10. Wear identification tags while participating in a contingency or contingency exercise. **(T-1).**

2.56.11. Wear or have identification tags in their possession when otherwise directed by their supervisor or commander. **(T-3).**

CHAPTER 3

FORCE SUPPORT READINESS PLANNING

3.1. Planning and Posturing UTC Force Support Capabilities

3.2. Planning and Posturing. The premise for the Force Support personnel UTC is based on the lead/follow concept and is the foundation for the way capability is built, postured, trained and deployed to support the warfighter. UTCs will be postured based on the organization and mission of the Force Support unit using the HAF/A1 Force Support UTC posturing guidance. **(T-1)**. Guidance is posted on the HAF/A1XO Readiness SharePoint® page located at: https://cs2.eis.af.mil/sites/11603/default.aspx.

3.2.1. The Force Support Force Module is a tool for planners to use in adaptive and crisis planning. This population driven Force Module layout can be used for incrementally building Air Expeditionary Wings up to 3,300 personnel. Force Support readiness planners will tailor UTC planning based on the mission and the capabilities required at execution. **(T-1)**.

3.2.2. Contingency Planning. Units must develop local checklists or operating instructions to outline actions and procedures to support base operation plans and contingency situations. **(T-2)**. These should include mobility deployments, major accident response, natural disaster response (including emergency sheltering of off-base civilians), terrorist attack response, Force Protection Condition changes, Chemical, Biological, Radiation and Nuclear attacks, reception and beddown of incoming forces, and non-combatant evacuation.

3.3. Installation Level Planning. Force Support units are responsible for planning at the installation level for Force Support capabilities. Specifically, units will ensure Force Support requirements are updated in the Base Support and Expeditionary Site Plan, installation level emergency response plans, operation plans, and local plans as directed by the parent wing. **(T-2)**.

3.3.1. Unit Control Center. Units must establish a unit control center, as outlined in AFI 10-2501, with the capability for Command and Control of unit resources for response to actual or exercise situations. **(T-1)**. Control centers must have clear, concise, and complete checklists and status boards for command and control. **(T-1)**. They should be located in a specifically designated area and be ready for immediate operation. Force Support units will have base and local area maps (including current base grid map), and have adequate communications systems (and backups). **(T-1).**

3.3.2. Deployment planning. Squadrons with deployment missions must have checklists, status boards and Command and Control systems prepared to deploy and operate a unit control center at a forward operating location. **(T-1)**. Deployable checklists and status boards should include bed down planning, all field Force Support operations, emergency response, mortuary/mass casualty, base attack response, and Ability to Survive and Operate actions. The squadron must track status of critical assets, resources, and capabilities. **(T-1)**.

3.4. Posturing Guidance. Force Support UTCs are postured to support Defense Planning Guidance using the established structure in **Attachment 2**. The HAF/A1 FAM publishes posturing guidance in the Global Force Management cycle to ensure proper capability is postured. UTCs are postured at a level consistent with the most stringent demand for surge and post-surge operations in the Defense Planning Guidance. Posturing guidance contains all other specific missions where capability is required outside of the Defense Planning Guidance.

3.4.1. UTC Posturing Guidance. The HAF/A1 FAM determines the appropriate deployable capability needed to support Defense Planning Guidance. The Force Support UTC guidance is used to determine deployable, home station support and combatant commander in-place capabilities. The guidance is used to determine Force Support forces available for rotational deployments.

3.4.2. FSS leadership will develop and implement home station workload mitigation plans to offset deployed capability during deployment operations. **(T-2)**. Mitigation plans should include contractual support, contingency Nonappropriated Fund Memorandum of Agreements, utilization of available Air Reserve Component capabilities, civilian over hires, delay of non-essential training and exercises and lastly a reduction in facilities and/or service.

3.4.3. Manpower and Equipment Force Packaging System. Force Support UTCs are registered in the Manpower and Equipment Force Packaging System under the alphanumeric series “RF" Mission capability statements and manpower force element listings for each UTC are contained in the Manpower Force Packaging system of the Manpower and Equipment Force Packaging System. A Logistics Detail for each UTC is maintained in the Logistics Force Packaging System.

3.4.4. UTC Response Times. Regular component Force Support teams must be available for worldwide deployment within 24 hours after initial notice. **(T-1)**. Air Reserve Component teams must be available for deployment within 72 hours after initial notice and activation. **(T-1)**. Force Support teams must deploy with team kits as specified in the applicable Logistics Detail. **(T-1)**.

3.5. Force Providers. As referenced in AFI 10-401, *AF Operations Planning and Execution*, force providers will posture the maximum number of manpower authorizations from warfighting organizations into standard deployable UTCs. **(T-1).** The specific UTCs to posture will be based on the HAF/A1 FAM posturing and sequencing guidance. **(T-1).** This guidance provides the functional area concepts of operation and the UTC structure that supports it. **(T-1).** The HAF/A1 FAM provides guidance on which UTCs should be postured and made available for planning purposes based on component headquarters’ requirements and the Air Expeditionary Task Force force modules.

CHAPTER 4

FORCE SUPPORT READINESS EDUCATION AND TRAINING

4.1. Force Support Readiness Education and Training

4.2. Force Support Readiness Training. Commanders are responsible for ensuring effective education and training programs are established and executed. **(T-1).** Personnel assigned to Force Support UTC s are required to complete ancillary and all non-AF Specialty Expeditionary Readiness Training as outlined in AF Guidance Memorandum 2018-10-01, AFI 10-405, *AF Guidance Memorandum for Expeditionary Readiness*, as necessary, to maintain individual readiness. **(T-1).** Personnel assigned to institutional force positions must complete readiness training as required to meet the mission needs of their organization. **(T-1).** Members assigned to institutional force positions will attend readiness training as required when they are tasked to fill a wartime tasking. **(T-1).**

4.2.1. Training Requirements. This section contains the Force Support training requirements for readiness. A significant portion of the training will be required from Force Support Officers (38F), Services (3F1), and Personnel (3F0) career fields. This is based on the role of these AF Specialty Codes in the lead RFLX UTC makeup in the Force Support Force Module in **Attachment 3**. Education and Training (3F2), Manpower (3F3), Equal Opportunity (3F4), Admin (3F5), Protocol (8A3), and Airmen and Family Readiness (8C0) will receive targeted mission specific education and training as required to meet the mission capability statement on the UTC. **(T-1).** Commanders at all levels will ensure Force Support personnel will be trained to their wartime, contingency and home station positions. **(T-1)**. Reserve and Guard commanders will ensure Individual Mobilization Augmentees will be trained in wartime positions during annual tours and inactive duty training periods. **(T-1)**.

4.3. Force Support Home Station Pre-Deployment Training. Training requirements are determined by AF Specialty Code and will be completed by all members every 18 months (24 months for AFR/ANG). **(T-1)**. The mandatory blocks for each AF Specialty Code are outlined in the Force Support Expeditionary Readiness Training matrix posted on the HAF/A1XO Readiness SharePoint® page located at: **https://cs2.eis.af.mil/sites/11603/default.aspx**. **(T-1).** Home Station Readiness Training requirements are updated as needed and disseminated by HAF/A1XO. A team from HAF/A1XO, in coordination with AFPC and AFSVA, determines steps to review Home Station Readiness Training to ensure the community is meeting the intent and preparing teams/members as necessary. Scheduling training is covered in **paragraph 4.28**. of this AFI.

4.4. Force Support Vehicle Training. 3F1 personnel assigned to lead RFLX UTCs and follow-on sustainment RFSRB UTCs will be trained in specific vehicle operations as outlined in the Force Support Expeditionary Readiness Training matrix posted on the HAF/A1XO Readiness SharePoint® page located at: **https://cs2.eis.af.mil/sites/11603/default.aspx**. **(T-1)**. Training frequency/reoccurrence will be based on guidance outlined in AFI 24-301, *Vehicle Operations.* **(T-1).**

4.5. Force Support Silver Flag.

4.5.1. All Force Support military personnel assigned to lead UTCs (RFLX1, RFLX2, RFLX3, RFLX4 and RFLX5) must complete Force Support training at a certified Silver Flag Training site on opening/establishing the base functions to stand up an Expeditionary FSS. **(T-1)**. Any

Force Support member may be directed to attend Silver Flag training as required by deployment tasking levied by the component. Officers assigned to sustainment UTCs train as required for that capability and may attend Silver Flag on a space/funding-available basis. This requirement will also be reported in readiness reporting systems to ensure measurement. The Component MAJCOM determines the number of units with open/establish the base lead, follow-on functional and sustainment UTCs in coordination with their MAJCOM/A3 and the HAF/A1 FAM. CONUS Combatant Commander in-place with Force Support deployable capability posture functional follow-on and sustainment UTCs (i.e., Peterson, F.E. Warren, Malmstrom) to meet capability needs prescribed in the posturing and sequencing guidance. Although these forces are in-place, CONUS Combatant Commander with this UTC capability will be postured and trained as they are required to meet Defense Planning Guidance surge and Air and Space Expeditionary Force rotational requirements defined by combatant commander needs. **(T-1).**

4.5.2. Force Support Silver Flag Training Frequency. All Force Support personnel assigned to lead UTCs (RFLX1, RFLX2, RFLX3, RFLX4 and RFLX5) must attend Force Support training at Silver Flag every 36 months (48 months for AFR/ANG.) **(T-1)**. Officers assigned to warfighting or in-place overseas units will attend Force Support training at Silver Flag every 36 months (every 48 months for AFR/ANG) from the completion of Officer Field Education. **(T-1)**. Field grade officers will attend Force Support training at Silver Flag one time while assigned to a warfighting or in-place overseas unit. **(T-1).** Officers in Institutional Force or in-place home station units may attend Force Support training at Silver Flag one time while assigned to a warfighting or in-place overseas unit. Overseas Combatant Commander In-Place (PACAF/USAFE) units and members (except for Short Tour locations) will attend Force Support training at Silver Flag at the same frequency as warfighting units in the CONUS, every 36 months (every 48 months for AFR/ANG). **(T-1)**.

4.6. Silver Flag Training Assessment and Certification. Silver Flag site certification criteria for Force Support training will be reviewed to ensure it meets the intent of delivering the highest standard of field training. **(T-1).** A joint readiness training team from AFPC, AFSVA, and owning MAJCOM/A1R representatives will visit each site using the HAF/A1XO approved guidance and checklist every 24-36 months. **(T-1).** When changes to certification criteria are made, an appropriate grace period for implementation will be determined by HAF/A1XO. An HAF/A1XO representative will attend certification visits when deemed necessary.

4.6.1. Silver Flag site certification for Force Support training is pass/fail. Pass/fail conditions will be outlined in the HAF/A1XO certification guidance and/or certification checklist and adjusted as needed to ensure the highest standard of training. An official site certification report will be prepared by the certification team and forwarded to HAF/A1XO for distribution to the host MAJCOM/A1, AFIMSC and the Force Support staff at the Silver Flag site within 30 calendar days after completion of the visit. **(T-1)**. The training site owning MAJCOM/A1 and/or AFIMSC (as appropriate) is required to coordinate on the completed certification report and address all findings (critical and non-critical) within 60 days of receipt and execute corrective actions. The host MAJCOM/A1 and/or AFIMSC will also provide a report to HAF/A1XO indicating corrective action at this time. If a Silver Flag site fails a certification, it will be reevaluated no earlier than 30 days and no later than 90 days from the completed certification report. **(T-1).** If the reevaluation results in a second failure, HAF/A1XO will determine the appropriate course of action.

4.7. Selected Force Support Training. There are 4 courses included in this subcategory, Force Support Basic Contingency Course (MFSS100 Air University Distance Learning Course), Force Support Contingency Course (MFSS275 Air University Resident Course), Deliberate and Crisis Action Planning and Execution Segments (Wing Level Operators course taught at Keesler AFB), and the Expeditionary Manpower Management Course (Manpower Readiness Course taught at Tyndall Rapid Engineer Deployable Heavy Operations Repair Squadron Engineer (RED HORSE) Site).

4.7.1. All 38Fs, E6 and above 3F0s, 3F1s assigned to the RFLX1, RFLX2, RFLX5 UTCs, Silver Flag instructors, and Unit Readiness Managers must complete the Force Support Basic Contingency Course (MFSS100). **(T-1)**. This course is computer based training on the Air Education and Training Command Course List, an Advanced Distributed Learning System (ADLS) derivative site. The Force Support Basic Contingency Course is designed to prepare both personnel assigned to unit readiness section as well as a prerequisite for personnel attending the MFSS275 course assigned to the RFLX1 and RFLX2 UTCs. It focuses on fundamentals of readiness as well as specifics for conducting bed down operations with Force Support capabilities. Force Support personnel assigned readiness planner positions such as MAJCOM/Component Numbered AF/Air Force Forces staffs must complete this course within 6 months of being assigned on the staff. **(T-1)**.

4.8. Force Support Contingency Course (MFSS275). Force Support Officers (38FX) in grades O-4 and O-5 assigned to lead (RFLX) UTCs, E-7 and above in AF Specialty Codes 3F0 and 3F1 tasked to deploy on the RFLX1 and RFLX2 UTCs, and Silver Flag instructors must attend the Force Support Contingency Course (MFSS275). **(T-1)**. The Force Support Contingency Course consists of objectives on general Force Support contingency operations and addresses areas of concern to leaders in contingency situations, such as force bed down and base recovery planning.

4.9. Deliberate and Crisis Action Planning and Execution Segments. Individuals assigned to Manpower Office, IPR, those personnel that are assigned to the UTCs that require a 295 Special Experience Identifier and those preparing to deploy in a UTC that requires Deliberate and Crisis Action Planning and Execution Segments access must attend the Deliberate and Crisis Action Planning and Execution Segments course. **(T-1)**. Upon completion of the Deliberate and Crisis Action Planning and Execution Segments course, personnel must continue their training and complete the Manpower, IPR or PERSCO Deliberate and Crisis Action Planning and Execution Segments Job Qualification Standard. **(T-1)**.

4.10. Expeditionary Manpower Management Course. All enlisted Manpower personnel (3F3) must complete this course every 36 months. **(T-1)**. This course measures the student's Expeditionary Manpower Management capabilities, while preparing them for expeditionary operations.

4.11. Sustainment/Mission Specific UTC Training. The Force Support community organizes, trains, and equips capability to support specific geographic and Combatant Commander's requirements based on the Defense Planning Guidance and other planning guidance. **(T-1).** In order to support these needs, the community structures capability for special missions through both posturing UTCs and coding manpower authorizations to perform these functions. **(T-1).** Examples of this include Mortuary, Protocol, and Airman and Family Readiness, which are identified in **Attachment 3**. HAF/A1XO manages this capability based on wartime needs with the UTCs' Functional Area Manager from that respective community. Training for these UTCs is

determined by the program functional authority (i.e. Sexual Assault Response Coordinator, Manpower, or Mortuary, etc.) with HAF/A1XO determining additional readiness training required. HAF/A1XO, in coordination with Career Field Managers, determines the mandatory courses for pre-deployment training and other training for any postured UTCs in the particular AF Specialty Codes. Training for sustainment and mission specific UTCs consists of classroom and hands-on training held at AF formal schools, training sites or at other venues determined by the functional authority or as outlined by HAF/A1XO. The basic requirements for each of these UTCs are laid out below.

4.12. Rapid Engineer Deployable Heavy Operations Repair Squadron Engineers (RED HORSE). Force Support personnel assigned to RED HORSE UTCs will be trained for their specific requirements to support that capability. **(T-1).** They will attend Silver Flag Training and incorporate Home Station Readiness Training into their unit readiness training plan/schedule as required. **(T-1).** Force Support personnel assigned to RED HORSE units will work with their squadron's leadership to create realistic training scenarios developed to compliment the units mission and response time. **(T-1).**

4.13. Mortuary. While personnel are assigned to Mortuary UTCs, their primary responsibility is to train and deploy for the Mortuary mission. These individuals are not required to attend Force Support Silver Flag training. They will attend training that supports the Port Mortuary Mass Fatality Plan and the Fatality Search and Recovery Plan implemented by the ANG. **(T-1)**. Personnel will train in Home Station Readiness Training to remain current on wartime tasks. **(T-1)**.

4.14. Port Mortuary. Personnel assigned to the Port Mortuary will attend training as outlined in the Force Support Expeditionary Readiness Training matrix posted on the AF/A1XO Readiness SharePoint® page located at: **https://cs2.eis.af.mil/sites/11603/default.aspx**. **(T-1)**. This training is determined by AF Mortuary Affairs Operations in coordination with HAF/A1XO and AF Reserve Command/A1 and supports the Mass Fatality plan to use a time-phased approach to employ capability at the Port Mortuary. Units postured with the RFSRJ and RFSRK UTCs will ensure their training plan is designed based on guidance from AF Mortuary Affairs Operations to prepare UTC capability. **(T-1)**. Port Mortuary personnel will complete initial ancillary and vehicle training as required and Port Mortuary orientation on a just-in-time basis. **(T-1)**. They must accomplish Home Station Readiness Training every 18 months to ensure they remain current on Services wartime tasks. **(T-1)**. Personnel may receive credit for training if they have accomplished a real world deployment at the Port Mortuary and it is validated by AF Mortuary Affairs Operations for records documentation. Additional information on Port Mortuary operations is available on their website at: **www.mortuary.af.mil**.

4.15. Fatality Search and Recovery Team. Personnel assigned to Fatality Search and Recovery Team UTCs (ANG only) will be trained and prepared to respond to contingency situations. **(T-1).** Personnel assigned to Fatality Search and Recovery Team UTCs are not required to attend Force Support training at Silver Flag. They will attend Fatality Search and Recovery Team training that is required to certify teams and meet designated response times. **(T-1)**. Personnel assigned to these UTCs will accomplish Home Station Readiness Training every 24 months to remain current on wartime tasks. **(T-1)**.

4.16. Protocol. Protocol UTCs are postured on the wing staff. Members assigned to a Protocol UTC must meet requirements outlined in the Mission Capability. **(T-1)**. The functional oversight at HAF/A1 level is HAF/A1S.

4.17. Sexual Assault Response Coordinator. Requirements for Sexual Assault Response Coordinator education, training and certification rests with HAF/CVS, which is the office with functional oversight for Sexual Assault Response Coordinators. HAF/A1XO, in coordination with HAF/CVS, determines deployment qualification requirements.

4.18. Nonappropriated Fund Accounting. Personnel assigned to Nonappropriated Fund accounting UTCs will train on appropriate items in the 3F1X1 Career Field Education and Training Plan. **(T-1)**. All 3F1s deploying on a Nonappropriated Fund accountant UTC (RFSRL) will attend a Nonappropriated Fund accounting course/orientation at the respective Air Force Forces/Component Numbered AF staff. **(T-1)**. This training will be conducted to familiarize the members with the status of the funds as well as processes and procedures for the Area of Responsibility. **(T-1).**

4.19. Equal Opportunity. Requirements for Equal Opportunity education, training and certification rests with HAF/A1V which has functional oversight. HAF/A1XO, in coordination with HAF/A1V, determines deployment qualification requirements.

4.20. Institutional Forces. With the exception of those in the Manpower AF Specialty Code (3F3), Institutional Forces are not required to attend Force Support Readiness training. Members assigned to these positions must attend training for their specific contingency/wartime duty as required by their unit. **(T-1)**. Examples of this include responding to crisis action teams/cells as required and executing the AF Forces staff functions.

4.21. Combatant Commander In-Place Training. Other forces assigned outside of FSS as Combatant Commander In-Place/Other Government Agencies, such as missile chefs and personnel specialists, train for their contingency/wartime mission determined by their unit and identified on their Designed Operational Capability statement. **(T-1)**. They must participate and document the training in their AF Training Record to ensure wartime preparedness as an in-place unit. **(T-1)**.

4.22. Installation Response Training Requirements. Force Support personnel are part of the installation response team as outlined in AFI 10-2501. Each Force Support unit will follow their installation-specific plans and training requirements to meet this mission. **(T-2).** Some key areas that Force Support might be involved in are: assisting families, mortuary/search and recovery, providing food support and ensuring mission continuity.

4.22.1. Proper training is required for all Force Support Readiness personnel to execute their duties. In order to meet the mission needs, Force Support Readiness personnel will receive the following training based on the position they are assigned to. **(T-1).**

4.23. Unit Readiness Manager (or UDM if they are fulfilling the readiness manager role). The Unit Readiness Manager will complete the MFSS 100 Force Support Readiness Basic Contingency Course, the Unit Control Center course and the AF Emergency Management Program Course (ZZ133131) on ADLS. **(T-1)**.

4.24. Operations Officer. The Operations Officer will complete the MFSS 100 Force Support Readiness Basic Contingency Course and the Unit Control Center course and AF Emergency Management Program Course (ZZ133131) on ADLS. **(T-1)**.

4.25. C-MAJCOM/ Component Numbered AF Planner Air Force Forces Staff. Those assigned as readiness planners and on staff will, within 12 months of assignment (pending class quota availability), complete the Contingency Wartime Planning Course at Maxwell, the MFSS 100 Force Support Readiness Basic Contingency Course on ADLS and the MFSS 275 Force Support Readiness Contingency course at Maxwell.

4.26. Field Operating Agencies/Intermediate Headquarters (AFPC/AFSVA/AF Installation and Mission Support Center). Those assigned to Field Operating Agencies/intermediate headquarters will, within 12 months of assignment (pending class quota availability), complete the MFSS 100 Force Support Readiness Basic Contingency Course on ADLS and Contingency Wartime Planning Course at Maxwell. **(T-1).**

4.27. HAF/A1XO Readiness. Those assigned to the HAF/A1XO Readiness office, within 12 months of assignment (pending class quota availability), will complete Contingency Wartime Planning Course at Maxwell.

4.27.1. The requirements laid out in this AFI are only the minimum established for Force Support readiness positions. Additional training required is determined by the unit based on the position to which the member is assigned.

4.28. Scheduling Readiness Training. Unit commanders are responsible for ensuring readiness training programs are executed at a level to bring realism to training classes and scenarios. **(T-2).** Each unit will assess the overall readiness training requirement and develop a training plan by 1 April each year. **(T-2)**.

4.28.1. The training plan will cover a minimum 24 month period; this will cover 30-90 days training window prior to the unit's availability window. **(T-2)**.

4.28.2. The plan will ensure Home Station Readiness Training is accomplished for all members assigned to lead UTCs as well as follow-on functional UTCs such as the current RFLX2 Lead C2 Team and RFSRB Services Follow-On every 18 months. (**T-1).** Example: If the unit is publishing the training plan for fiscal year 2020 and fiscal year 2021, it must be published by 1 Apr 19.

4.28.3. Each unit can determine the most appropriate format and layout. The training plan must contain forecasted training quotas for schools/ Force Support Silver Flag and any other training requirements, Temporary Duty (TDY) budget, equipment budget, any other budgetary needs (exercise costs, etc.) and a comprehensive training schedule based on all AF Specialty Code/ UTC requirements outlined in the Force Support Expeditionary Readiness Training matrix posted on the HAF/A1XO Readiness SharePoint® page located at: **https://cs2.eis.af.mil/sites/11603/default.aspx**. **(T-1)**.

4.28.4. All members assigned to lead and follow-on UTCs will attend training in a field exercise (except Short Tour locations, which will not have a requirement) once every 18-24 months (every 36 months for AFR/ANG). **(T-1)**. When assigned to a different/new UTC position, a member will have six months to accomplish core responsibility training (Air

Reserve Component members receive 12 months). **(T-1)**. If formal courses are needed, it is understood the member may not receive training until the next course is offered.

4.29. Budgeting for Force Support Readiness Training. The Operations Officer is responsible for ensuring unit's readiness training requirements are aggregated and inserted in the annual budget. **(T-2).** The budget should consider all aspects of the training requirements.

4.30. Equipment, Supplies and Funding

4.30.1. **Purpose.** Force Support units will plan for equipment, supplies, and funding annually to ensure program success. **(T-2)**. The plan must address budgetary needs to maintain and acquire equipment for home station use as well as deployment requirements. **(T-2)**. The plan will be done in conjunction with the budget for training requirements outlined in the Force Support Expeditionary Readiness Training matrix posted on the HAF/A1XO Readiness SharePoint® page located at: **https://cs2.eis.af.mil/sites/11603/default.aspx**. Force Support units will published the plan for unit compliance by 1 April for a 24 month period. **(T-2)**.

4.30.2. **Deployment Equipment Requirements.**

4.30.2.1. Equipment UTCs. Force Support UTCs must be equipped with equipment UTCs as postured in the UTC Availability. **(T-1)**. Equipment is built to be deployed based on the lead and follow-on concept. RFLX UTCs will deploy with appropriate equipment as required for the open/establish the base portion of the Force Module. **(T-1)**. Other equipment UTCs, such as the RFSEK, are deployed when the mission calls for that capability. Specific line item requirements can be found in the Logistics Detail.

4.30.2.2. Weapons. The M-4 is the primary weapon for all Force Support enlisted personnel and they will be trained accordingly. **(T-1)**. The M-9 is the primary weapon for all Force Support officers and they will be trained accordingly. **(T-1)**.

4.30.2.3. Deployment Equipment. Force Support UTCs will prepare and deploy according to AFI 10-403, and locally defined installation deployment guidance. **(T-1)**. Force Support units should provide input to local deployment guidance to ensure the deployment guidance meets requirements. Other base agencies/units may need to procure, store, maintain, and issue deployment equipment, for the Force Support teams to meet their deployment commitment.

4.31. Prime Readiness in Base Services Decals. Units are authorized to use Prime Readiness in Base Services decals for identification of supplies and equipment. The AF visual aid numbers are:

4.31.1. AF Visual Aid 10-215, Two-Inch Prime Readiness in Base Services Decal.

4.31.2. AF Visual Aid 10-216, Four-Inch Prime Readiness in Base Services Decal.

4.31.3. AF Visual Aid 10-217, Eight-Inch Prime Readiness in Base Services Decal.

4.32. Force Support Program Funding. Force Support programs (personnel, training, equipment, and supplies) are funded through appropriated funds.

4.32.1. **Force Support Silver Flag Funding.** Force Support training at Silver Flag will be centrally funded for Regular Air Force members. **(T-1)**. AF Installation and Mission Support Center will consolidate all requirements annually for inclusion in the Program Objective Memorandum. **(T-1)**. Funding requirements will be determined based on guidance outlined in

the Force Support Expeditionary Readiness Training matrix posted on the HAF/A1XO Readiness SharePoint® page located at: **https://cs2.eis.af.mil/sites/11603/default.aspx**. AFR/ANG command policies will determine their funding.

4.32.2. **Other Readiness training.** The unit readiness office is responsible for consolidating all readiness training quotas and requirements annually for submission to the Operations Officer. **(T-3)**.

4.32.3. **Basic Recreational Program Funding.** Authorized basic recreational programs while deployed, except for resale, should be funded with appropriated funds since these programs are usually provided at no cost to personnel. Additional guidance can be found in AFI 65-106, *Appropriated Fund Support of Morale, Welfare, and Recreation and Nonappropriated Fund Instrumentalities*.

4.32.4. **Funding for Nonappropriated Fund resale operations.** The Component Numbered AF/Component responsible for deployed installations will coordinate funding for Nonappropriated Fund resale operations with AFSVA/FM. **(T-1).** This funding includes requirements for startup operations as well as sustained and enduring programs in the deployed Area of Responsibility.

4.32.5. **Equipment and Supplies.** The Operations Officer will budget annually for equipment and supplies to ensure proper resources are available for deployments and exercises. (**T-3)**.

CHAPTER 5

PERSONNEL ACCOUNTABILITY

5.1. Purpose, Background and Scope.

5.2. Purpose. Provide guidance for establishing and maintaining personnel accountability. Personnel accountability provides commanders, planners, and managers with the status of the force and can be used in making force management decisions. This instruction also provides guidance for quickly obtaining personnel accountability and reporting it to comply with DoD requirements in DoDD 1100.4, *Guidance for Manpower Management*, DoDI 1336.07, *Reporting of Personnel Tempo (PERSTEMPO) Events*, and DoDI 3001.02, *Personnel Accountability in Conjunction with Natural or Manmade Disasters*.

5.3. Background. The AF is required to provide the deployment information on all Temporary Duties (TDYs) performed and to provide accountability status to the Personnel Accountability and Reporting System when directed upon the occurrence of a disaster or national emergency. The objectives of personnel accountability programs are to capture and report all changes in a member's strength accounting duty status, and to ensure these changes, regardless of length, are reported immediately. Personnel accountability is the primary conduit for collecting data impacting AF personnel and operations tempo information and is often used when making force management decisions.

5.4. Scope. The roles and responsibilities of involved agencies are fully explained in this instruction. Understanding and accomplishing these roles and responsibilities are crucial for ensuring the accurate and timely actions necessary to establish personnel accountability. Central to accountability during a disaster event or national emergency is a commander's inherent responsibility to ensure awareness of the status of personnel under their command.

5.4.1. Specifically, this chapter applies to:

5.4.1.1. RegAF members and their Defense Enrollment Eligibility Reporting System enrolled family members.

5.4.1.2. Selected Reserve:

5.4.1.2.1. ANG, Active Duty United States Code (USC) Title 10, Active Duty Title 32, State Active Duty, Drilling Guardsmen (Traditional and ANG Technicians), and Defense Enrollment Eligibility Reporting System enrolled family members of these Guard categories.

5.4.1.2.2. Reserve on USC Title 5 and 10 AD, Drilling Reservist (Traditional and Air Reserve Technicians), Individual Mobilization Augmentees, and the Defense Enrollment Eligibility Reporting System enrolled family members of these Reserve categories.

5.4.1.3. AF members assigned to Joint or Defense organizations.

5.4.1.4. Department of AF and Non-appropriated Fund AF civilian employees.

5.4.1.5. Family members of Department AF and Non-appropriated Fund employees when those family members are receiving evacuation entitlements.

5.4.1.6. Personnel on TDY, on leave, or on a pass.

5.4.1.7. When the impacted area is outside the continental United States, all Department of the AF sponsored military, civilians, contractors to include all family members. Foreign nationals are excluded.

5.4.2. Wherever and whenever possible, personnel accountability procedures should follow the chain of command. **(T-1).** If regular reporting channels are not viable, individuals and units must use any available means to report accountability information.

5.4.3. In the event of a disaster or national emergency (real world or exercise) and when directed by AF leadership, AFPAAS is the system used to attain and report Total Force accountability.

5.4.3.1. The AFPAAS utilizes data from the Defense Manpower Data Center's Personnel Accountability Reporting System database to identify members assigned, living, or temporarily in the affected area.

5.4.3.2. The AFPAAS provides valuable information to the AF chain of command, enabling commanders at all levels to make strategic decisions and facilitating a return to normal operations after a disaster or national emergency.

5.4.3.3. MAJCOM and installation commanders may request a real-world event in lieu of AF leadership directing local accountability events. Requests will be submitted through AFPC/DP2WR to AF/A1XO for approval.

5.4.4. The AF Strength Accounting Duty Status Program is used to depict the current status of the force and is designed to provide commanders, planners, and managers with strength-affecting information via updates in the Military Personnel Data System.

CHAPTER 6

IPR AND PERSCO

6.1. Purpose, Background, Introduction, Scope and Concepts

6.2. Purpose. PERSCO is the collection of manual and automated procedures, systems, hardware, personnel agencies, and deployable individuals or teams to accomplish Total Force accountability and reporting, casualty reporting, and personnel program advice.

6.3. Background. The primary missions of the personnel community are Total Force accountability, casualty reporting and personnel program support.

6.4. Introduction. This chapter provides personnel readiness program guidance for AF personnel agencies and commanders supporting contingency, wartime, emergency operations, and exercises.

6.5. Scope. The roles and responsibilities of personnel agencies at all levels involved in readiness operations are explained in this instruction. As an essential element within agile combat support, the personnel community contributes to the Air and Space Expeditionary Force by providing mission-ready personnel forces as well as providing Total Force accountability, casualty reporting, and personnel program support and advice to all levels of command involved in readiness operations. Understanding and accomplishing these roles and responsibilities are crucial for ensuring the Personnel Readiness mission is met.

6.6. Personnel accountability. Personnel accountability is defined as the accurate accounting for personnel at all times regardless of location.

6.6.1. Additional personnel accountability guidance can be levied by the combatant commander or the component command to include the requirement to report other Department of Defense civilians, other Department of Defense-essential contractor personnel, other Services, allied forces, coalition forces and/or other personnel. Commanders, at all levels, are ultimately responsible for maintaining accountability of their forces. PERSCO is a tool to assist commanders in obtaining and maintaining accountability. Commanders must establish procedures to account for their forces when there is no PERSCO at the deployed location. **(T-1).**

6.6.2. Personnel accountability enables planners and managers to support the commander's concept of operations by providing strength and casualty information essential for the commander to make informed decisions concerning force allocation and capabilities. At the unified command level and above, this information also assists senior leaders in making informed decisions.

6.6.3. Accounting for deployed and residual forces provides senior military and civilian leadership visibility of the human resources committed to contingency operations.

6.6.4. The historical capture of personnel accountability data (e.g., Gulf War Syndrome, follow-up treatment, medical counseling, state bonuses and entitlements) is provided by AFPC Directorate of Personnel Operations (AFPC/DP2) on a regular basis to the chain of command (who was deployed where and for how long). This allows the tracking and analysis of personnel and their association to specific military operations for future programs and initiatives.

6.6.5. Force accountability. Force accountability is accomplished with GCCS-AF Systems, Deliberate and Crisis Action Planning and Execution Segments. This system uses a series of business rules to alert users to changes in deployment requirements and the status of deployed persons. This system is also programmed to generate Military Personnel Data System transactions to inform home-station commanders of the whereabouts and status of their deployed personnel. PERSCO maintains accountability of deployed personnel using this system. **(T-1).** The Employment Requirements Manning Document lists the requirements for a particular deployed location. PERSCO monitors these requirements and coordinates with deployed commanders and servicing Manpower office to determine if requirements are valid. **(T-1).** There are several elements of Force accountability that must be tracked:

6.6.5.1. Strength accountability. PERSCO teams will maintain accountability over all personnel on the ground, including transients, at their deployed and designated geographically separated locations, regardless of status, in accordance with component command policies. **(T-1).** All geographical locations serviced by PERSCO teams can be located in Deliberate and Crisis Action Planning and Execution Segments under Personnel Functions utilizing the Headquarters AF/MAJCOM routing application

6.6.5.2. Unit accountability. The deployed unit commander will maintain accountability for the unit personnel assigned and/or attached. **(T-1).** This accountability includes knowing where assigned personnel are at any given time, where they live and where they work.

6.6.5.3. Replacement accountability. Deployed commanders will initiate replacement actions to replace a deployed individual that departs prior to completing the specified tour length. **(T-2).** PERSCO will track the status of all incoming and/or departing personnel as well as their arrival and departure plans. **(T-1).**

6.6.5.4. Transient accountability. Transient forces are those that spend at least one night at a location but their final duty location is elsewhere. PERSCO, in coordination with deployed services (lodging) and transportation, will track arrival and departure of transient personnel. **(T-1).**

6.6.5.5. Tasked Wing accountability. Unit commanders and IPR Elements will maintain accountability over their deployed personnel until they have returned to home station. **(T-1)**.

6.7. Contingency, Exercise, and Deployment Orders

6.7.1. **Administrative Orders.** This section establishes guidance for preparation, issuance, numbering, funding, authentication, distribution, and maintenance of Contingency, Exercise, Deployment orders. Only IPR or designated individuals on an activated Personnel Deployment Function are authorized to publish Contingency, Exercise, and Deployment orders.

6.7.1.1. Contingency, Exercise, Deployment orders published by the IPR Element are the only type of orders authorized for deployment of AF personnel assigned to AF units in support of contingency, humanitarian or disaster relief operations or Chairman of the Joint Chiefs of Staff or Command exercises that require a Time-Phased Force Deployment Data.

6.7.1.2. Use of the computer-generated Contingency, Exercise, Deployment orders in lieu of the DD Form 1610, *Request and Authorization for TDY Travel of DoD Personnel*, is authorized according to AFI 65-103, *Temporary Duty Orders*.

6.7.1.3. Ensure the information appearing on computer-generated Contingency, Exercise, and Deployment orders complies with guidelines outlined in the Joint Travel Regulations (JTR) *Uniformed Service Members and DoD Civilian Employees*. **(T-2).**

6.7.1.4. Do not authenticate Contingency, Exercise, and Deployment orders for local exercises where movement is simulated. **(T-2).**

6.7.1.5. Generate North Atlantic Treaty Organization orders to fulfill treaty requirements (refer to AFI 65-103). **(T-2).**

6.7.1.6. The FSS commander will appoint an orders-issuing or approving official for Contingency, Exercise, Deployment orders in writing. **(T-2).** This official must sign manually prepared orders; however, computer-generated orders do not need to be signed as long as adequate controls are in place to ensure proper approval before orders are authenticated (e.g., orders logs, electronic copies of orders, etc.). **(T-3).**

6.7.1.7. Do not issue verbal orders unless absolutely necessary. **(T-2).** Verbal orders are authorized only when time or error prevented written orders from being published in advance of travel. Confirm verbal orders (in writing) as soon as possible. Include in the written orders the date and who issued the verbal orders along with a statement on why written orders were not issued earlier. **(T-3).**

6.7.1.8. Changes to Orders/Amendments, Rescissions, and Revocations. To amend, rescind, or revoke Contingency, Exercise, Deployment orders, use a composed amendment (Deliberate and Crisis Action Planning and Execution Segments generated) or an AF Form 973, *Request and Authorization for Change of Administrative Orders.* Publish amendments, rescissions, and revocations in the "TE" series. **(T-1).** Do not use blanket statements such as "previous orders are rescinded" or "this order supersedes all previously published orders." **(T-3).**

6.7.1.9. Orders shall be amended, rescinded, or revoked only by the organization publishing the original orders. **(T-2).**

6.7.1.9.1. Publish an amendment to add, delete, or change pertinent data to read as originally intended. **(T-2).** Correct inaccurate first or middle names and initials and other personal data when required for an individual to enter a foreign country. **(T-2).** Add or change a travel advance payment statement or to authorize leave outside the local area prior to or after deployment. **(T-2).**

6.7.1.9.2. Do not publish an amendment to delete an individual, to rescind or revoke in part the original orders pertaining to the person, or to change an effective date after it has passed. **(T-2).** Revoke or rescind an expired order and publish a new order (see below for guidance on revoking versus rescinding). **(T-2).** Do not publish an amendment to include leave taken in the local area prior to or after deployment. **(T-2).**

6.7.1.10. Rescind an order when some action has been taken on the published order, such as issuance of airline tickets or issuance or receipt of a travel advance. **(T-2).**

6.7.1.11. Revoke an order when no action occurs against the original order such as before it has gone into effect. **(T-2).** If an effective date has passed and no action has occurred, revoke the original order and publish a new order. **(T-2).** The orders approving official determines when to revoke "TE" series orders. **(T-2).**

6.7.1.12. Retroactive amendments to increase or decrease the amount of money due to the traveler must be fully explained and justified. **(T-2).** Written requests for such amendments must clearly show the original order was unclear, incomplete, or lacked necessary information. **(T-2).**

6.7.1.13. Contingency, Exercise and Deployment Orders will be produced unclassified. **(T-2).** For classified deployments, use "****" to data mask information on all Contingency Exercise and Deployment Orders. **(T-2).**

CHAPTER 7

EVACUATION OF US CITIZENS AND DESIGNATED ALIENS FROM THREATENED AREAS ABROAD

7.1. Overview. The AF will support evacuation and repatriation operations, as well as assigned safe haven locations.

7.2. Noncombatant Evacuation Operation Mission. Noncombatant Evacuation Operation is defined in JP 3-68, *Noncombatant Evacuation Operations*, an operation whereby noncombatant evacuees are evacuated from a threatened area abroad, which includes areas facing actual or potential danger from natural or manmade disaster, civil unrest, imminent or actual terrorist activities, hostilities, and similar circumstances, that is carried out with the assistance of the Department of Defense. As used by Department of State, a Noncombatant Evacuation Operation is an ordered departure from a threatened area abroad that is carried out with the assistance of DoD, as opposed to ordered departures that do not require DoD assistance, but are carried out using commercial or chartered transportation. The Department of State may declare a Noncombatant Evacuation Operation based on the nature of the threat or the lack of availability of alternative forms of transportation. Diplomatic or other considerations may make the use of the term "NEO" inadvisable and require the use of the terms for the operation instead. The U.S. Government will consider evacuating host nation and other country nationals on a case-by-case, space available/reimbursable basis. Although normally considered in connection with hostile action, evacuation may also be conducted in anticipation of, or in response to, any natural or man-made disaster. Due to the nature of Noncombatant Evacuation Operations, which may require a broad U.S. Government agency approach, interagency coordination needs to be established early in the planning of the Noncombatant Evacuation Operation, preferably before the crisis begins, between DoS, DoD, and any other U.S. Government agencies, if involved, to ensure success. Appropriate DoD, Joint Staff, and AF offices will be contacted prior to Service-level interagency coordination.

7.3. Repatriation. Repatriation is the procedures through which US citizens are officially processed back into the US following evacuation from overseas. Repatriation is not a part of, but subsequent to a Noncombatant Evacuation Operation. Commander, US Northern Command, and Commander, US Indo-Pacific Command are identified as offices of primary responsibility for repatriation. Commander, US Northern Command is responsible for receiving evacuees in the continental US, Alaska, and the US territories within the Caribbean during repatriation. Commander, US Indo-Pacific Command is responsible for receiving evacuees in Hawaii and US territories within the Pacific during repatriation. AF installations within these combatant commands will develop and maintain a plan for use during repatriation as necessary. **(T-1).** Installations will use the DD Form 2585, *Repatriation Processing Center Processing Sheet,* as directed. **(T-1).** Instructions for completion are included on the form. Additionally, installations may use the needs assessment surveys in the AFPAAS to determine and track evacuee needs.

7.4. Evacuation Planning and Processing. In the CONUS, emphasis should be on evacuations for natural and man-made disasters. In overseas areas, include evacuation situations involving political or military conflict. Ensure accountability of personnel as they depart and arrive at the evacuation location, and develop procedures to provide this information to higher headquarters on request. **(T-0).**

7.4.1. Evacuation orders will not be used solely to create an entitlement to disaster-related benefits. **(T-1).**

7.4.2. Evacuation benefits will be used only to pay for evacuation-related costs not covered by other sources of federal funding. **(T-0).**

7.4.2.1. Ensure evacuees understand they are not entitled to receive payments from more than one federal source for the same disaster-related expense. **(T-0).** For example, if an evacuee receives Federal Emergency Management Agency relocation assistance to pay for emergency lodging, that lodging assistance may be deducted from any evacuation lodging assistance provided by the AF.

7.4.3. Ensure that all requests for payment submitted by evacuated military family members and/or civilian employees contain a statement that they understand they are not entitled to dual federal payments for the same disaster-related expenses; and should they receive payments from another federal agency, such payments will be deducted from any payments made by the AF for the same expense. **(T-0).**

7.5. Reception Plans and Assistance in CONUS and in Temporary Safe Haven Overseas. Commanders overseas, and those at ports of entry and other CONUS locations, must be ready to respond to requests for help from evacuees. **(T-2).** Installations will coordinate with their MAJCOM A4/Air Component to determine their reception/repatriation role. **(T-2).** MAJCOM A4 will coordinate with NORTHCOM/J3/5 and the appropriate Air Component to ensure installations plan for reception/repatriation. Coordination with other government agencies (such as the Department of State, Department of Health and Human Services, and applicable state offices) may be required to develop reception/repatriation procedures. Appropriate DoD, Joint Staff, and AF offices will be contacted prior to Service-level interagency coordination. **(T-2).**

CHAPTER 8

DESERTION AND UNAUTHORIZED ABSENCE

8.1. Unauthorized Absence

8.2. Purpose. The AF Strength Accounting Duty Status Program exists to enhance personnel accountability and improve crisis responsiveness. Unauthorized Absences are pay-effecting actions and also directly impact a unit's personnel accountability/readiness; therefore, it is imperative that commanders and supervisors act promptly when a member is not present for duty. This instruction establishes guidance, assigns responsibilities, and prescribes procedures designed to reduce Unauthorized Absences of military personnel.

8.3. Objective: The objective of the Strength Accounting Duty Status Program is to capture and report all changes in a member's duty status to ensure these changes, regardless of length are reported immediately. Specifically, this instruction defines procedures for the accurate and timely reporting of AF absentees and to support apprehension efforts of military and civilian law enforcement authorities.

8.4. When Unauthorized Absences Begins and Ends. The commander, first sergeant, and/or supervisor will investigate a member's absence to determine whether or not the absence is voluntary or involuntary. **(T-2).** An Unauthorized Absence is when an Airman voluntarily absences themselves from where they are ordered or otherwise required to be present. An Unauthorized Absence ends when the absentee or deserter returns to military control. An Unauthorized Absence of 24 hours or less is classified administratively as "failure to go". **Note:** If the commander determines the member's absence may be involuntary, contact the FSS Casualty Assistance Representative immediately for possible Duty Status Whereabouts Unknown reporting in accordance with AFI 36-3002, *Casualty Services*. **(T-2).**

8.4.1. When to classify as AWOL. A voluntary Unauthorized Absence of more than 24 hours and less than 30 days is classified administratively as "absence without leave" or AWOL (UCMJ, Article 86). **(T-1).**

8.4.2. When to classify as a Deserter. A member who has been AWOL for more than 30 consecutive days will be classified administratively as a deserter (UCMJ, Article 85). **(T-1). Example:** AMN Doe has been AWOL since 1 Jan 2018. He remains AWOL through 2400 on the 30th consecutive day and his status is changed to Deserter on the 31st day (10th day during times of National Emergency or war declared by the President or Congress) with an effective date and time of 31 January 2018 at 0001. **Note:** An absentee does not have to be placed in AWOL status prior to being classified as a Deserter status if the member is absent without authority, regardless of the length of the absence, and meets any of the eligibility criteria listed below.

8.4.2.1. The commander has determined that the member remains absent from his or her unit, organization, or place of duty with no intention of returning.

8.4.2.2. Is under the duty or travel restrictions that AFMAN 16-1405, *Air Force Personnel Security Program,* imposes.

8.4.2.3. Has had access in the past 12 months to Top Secret information or other classified information that requires special access authority (see **paragraph 8.7.8**.). **Note:** Do not

classify a person who appears to be a casualty as a deserter solely because the person has had access to classified material described herein.

8.4.2.4. Has gone to, or stayed in, a foreign country and, while there, has asked for or taken any type of asylum or resident permit from that country or its governmental agencies.

8.4.2.5. Has action pending on a previous Unauthorized Absence that has not been completed.

8.4.2.6. Is an escaped prisoner.

8.4.2.7. Is under investigation for violating the UCMJ as listed in **Attachment 2** or against whom charges for any offense have been referred to a General Court-Martial.

8.4.2.8. Is believed likely to commit violent acts, or may harm themselves or the general public.

8.4.2.9. AFPC/DPFC has determined member is a deserter.

8.5. Reporting Unauthorized Absences

8.6. Reporting Responsibilities. Unauthorized Absences must be reported immediately. **(T-1).** Supervisors must promptly notify the chain of command of all Unauthorized Absences. Unit commanders have the primary responsibility to determine the cause of absence and to find and return the individual to military control.

8.7. Duty Status Reporting. The Case Management System is used to report all Duty Status Changes requests for AWOL and Deserter as well as when the member is returned to military control (i.e., Present for Duty, confinement, etc.). Specific processing guidelines can be found in the Personnel Service Delivery Guide – Strength Accounting Duty Status Program on the AFPC myPers webpage.

8.7.1. A new Duty Status Change request in Case Management System is required for each Duty Status Change (e.g., one Case Management System case to place the member in AWOL status; a second Case Management System case to return inactive the member Present for Duty). **(T-1).**

8.7.2. Commanders will initiate the Duty Status Change request in Case Management System within 1 duty day of the commander's conclusion of the member's voluntary absence. **(T-1).** The date the Case Management System case is initiated is considered the date of the commander's determination of status regardless of the effective date of the member's AWOL/Deserter status date. Only a G-series commander may sign/approve the Duty Status Change request in Case Management System. If the member's commander is unavailable to sign due to TDY, deployment, or leave, the section commander (if on G-series orders) or next level G-series commander may sign/approve in their place.

8.7.2.1. For Air Reserve Component members, commanders contact ANGSC/MPP (for ANG members), or Headquarters AFRC/A1K (for AFR members), and ask for instructions. For ANG record types AG/BG, after updating the duty status, no transaction flows from MilPDS to FSO to update the member's Master Military Pay Account.

8.7.3. Unit Commander's 72-Hour Status Report. When a member has been absent for 72-hours, the commander reports information related to the member's absence and status of investigation to local leadership and AFPC/DPFCM. **(T-3).** The unit commander ensures a

copy of the letter is sent to AFPC/DPFCM and the installation's chief of security forces. **(T-3).** The 72-hours begins the first day of the member's absence. (See PSD guide for detailed instructions for completing this report)

8.7.4. Next-of-Kin Letter. The unit commander writes a Next-of-Kin Letter to family members and payees of allotments (e.g. former spouse receiving alimony or child support allotments) about the Unauthorized Absence when evidence shows the absentee planned or spoke to others of a plan to leave without authorization, or the unit commander administratively declares an absentee a deserter, or when the Unauthorized Absence has lasted 10 consecutive days. **(T-3).** (See PSD guide for detailed instructions for completing this letter.)

8.7.5. 31-and 60-Day Status Reports. On the 31st and 60th days of absence, the unit commander submits status reports, in writing, to AFPC/DPFCM. **(T-3).** (See PSD guide for detailed instructions for completing these reports.)

8.7.5.1. On the 31st day of AWOL, the commander notifies the MPF Force Management Office or CSS (if applicable) to initiate a new Duty Status Change Request in Case Management System to change the member's status from AWOL to Deserter. **(T-2).**

8.7.5.2. Upon receipt of the Duty Status Change Request, the commander logs into Case Management System to approve the request and refer Case Management System case to AWOL/Deserter Program Manager (AFPC/DPFCM). **(T-2).**

8.7.6. DD Form 553, *Deserter/Absentee Wanted by the Armed Forces*. Upon determination of deserter status, the commander, with assistance from the MPF/CSS, Security Forces Squadron (SFS), and AFPC/DPFCM (if needed), immediately prepares and distributes a DD Form 553 to place member in deserter status. **(T-0).** (See PSD guide for detailed instructions for completing this form.)

8.7.7. Action in Cases Involving Security. When an absentee is administratively classified as a deserter for a reason in **paragraph 8.4.2.3**., the unit commander will:

8.7.7.1. Refer the case for investigation to the AF OSI unit servicing the absentee's installation. **(T-1).**

8.7.7.2. As soon as possible, account for classified material that the absentee had access to and notifies AF OSI of any missing material. **(T-1).**

8.7.7.3. As soon as possible, assess how much damage to national security could result from unauthorized disclosure of the information, and provides assessment to AFOSI/ICON/ICW. **(T-1).**

8.7.7.4. Consider appointing an inquiry officer under DoDI 5200.1, *Information Security Program,* and AFI 16-1404, *Air Force Information Security Program* if the absentee had access to classified information. **(T-1).**

8.7.8. War and Mobilization Absence without Leave (AWOL) Reporting Procedure. When Congress or the President declares a National Emergency or war, reporting procedures are accelerated to involve law enforcement agencies to assist in returning absent members to the military. If this occurs, immediately prepare and distribute DD Form 553 on the 10th day of AWOL, not the 31st day. **(T-1).** Also due on the 10th day are the Notice to Next of Kin Letter(s) and 31-Day (10-Day) Status Report. **(T-1).**

8.7.9. Upon determination of Deserter status, the commander notifies the FSO of the duty status change and retrieves all dependent Identification (ID) card(s) (ref: AFI 36-3026, *Identification Cards for Members of the Uniformed Services, Their Eligible Family Members, and Other Eligible Personnel*, Table 8.3). **(T-3).**

8.7.10. On the 180th day of the member's Unauthorized Absence, ensures the CSS or MPF obtains the member's medical and dental records and forwards them to AFPC/DPFCM. **(T-2).** If medical and dental records are not available, forward a memorandum to AFPC/DPFCM via the MPF explaining the reason why the records are not available. **(T-2).**

8.8. After-The-Fact Reporting. Commanders ensure timely reporting of absentees to expedite their return to military control as well as for pay-affecting transactions in MilPDS. **(T-2).** If circumstances result in reporting unauthorized absentees after the member has been returned to military control, the commander must submit a memorandum to AFPC/DPFCM explaining the circumstances of the absence, return to military control, and reasons for delayed reporting. **(T-2).** The memorandum includes (but is not limited to):

8.8.1. Circumstances of the absence. **(T-2).**

8.8.2. Explanation of actions taken to locate and return the absentee, including circumstances of absentees return to military control. **(T-2).**

8.8.3. Reason for late reporting. **(T-2).**

8.9. General Apprehension Information and Cooperation with Civil Authorities

8.9.1. **Apprehension Procedures.** Commanders start investigating the case and begin apprehension efforts as soon as an Unauthorized Absence occurs. **(T-2).** These efforts not only assist return absentees to the military sooner, they also deter others from Unauthorized Absence.

8.9.2. **Who Has Authority To Apprehend:**

8.9.2.1. Military law enforcement personnel and commissioned, warrant, petty, and non-commissioned officers may apprehend absentees and deserters. See Article 7, UCMJ, and Rules for Courts-Martial 302(b)(1) and 302(b)(2). Commanders should consult the local JA and SFS concerning apprehension authority.

8.9.2.2. Civil officers authorized to arrest offenders under federal and state laws may arrest a deserter and deliver the offender into the custody of the Armed Forces (see Article 8 of the UCMJ and the Rules for Courts-Martial 302[b][3]). These officers may also arrest absentees at the request of military or federal authorities.

8.9.3. United States authorities may arrest absentees and deserters in foreign countries only:

8.9.3.1. When an international agreement with the country authorizes it.

8.9.3.2. Under an agreement with appropriate local authorities that does not violate an existing international agreement.

8.9.3.3. In these cases, carefully consider and consult with the servicing JA about possible international implications and adverse foreign relations.

8.9.3.4. If apprehension is impossible, or in any case of unclear apprehension authority, report the facts to HAF/JAO at DSN 225-9631 or 703-695-9631 to expedite submission to the Assistant Secretary of the AF for Manpower and Reserve Affairs for resolution.

8.10. Notice of Air Force Deserters to Civil Authorities:

8.10.1. Within the Jurisdiction of the United States. The unit commander, working with security forces and the MPF, if needed, promptly sends DD Form 553 for a member administratively classified as a deserter to Armed Forces and civilian law enforcement agencies most likely to help apprehend the absentee. **(T-1).** AFPC/DPFCM sends notices to AFOSI/ICON and to the Department of State in certain cases (i.e., those in which others know or strongly suspect the absentee has gone to a foreign country). **(T-1).**

8.10.2. Outside the Jurisdiction of the United States. MAJCOMs act as needed, respecting the primacy of international agreements to secure cooperation in apprehending absentee and/or deserted members.

8.11. Investigations, Apprehension, and Cooperation with Civilian Law Enforcement Authorities:

8.11.1. Unit commanders work closely with local security forces and AF OSI field units to pursue every avenue possible to locate and ensure the apprehension of absentees. **(T-1).** Leads developed as to the location of absentees shall be conveyed as expeditiously as possible to appropriate civilian law enforcement authorities who shall be asked to assist in the return of such persons to military control. **(T-1).**

8.11.2. In cases where the member has been dropped from unit rolls, AFPC/DPFCM and AFOSI/ICON work together to resolve the case. **(T-1).** AFOSI/ICON and local field units establish liaison and maintain a level of coordination with civilian law enforcement agencies necessary to encourage active participation in apprehension efforts. **(T-1).** AFPC/DPFCM provides any leads to AFOSI/ICON for further pursuit. **(T-1).**

8.11.3. Absentees detained by civilian law enforcement authorities. In some cases, AFPC/DPFCM and/or AFOSI/ICON may be the first AF agencies contacted by civilian law enforcement authorities regarding the apprehension of an AF absentee. **(T-1).** If AFPC/DPFCM is the first agency contacted, they will notify AFOSI/ICON (if a deserter) and:

8.11.3.1. Contact the nearest AF installation SFS within 1 duty day of the apprehension to expedite the absentee's return to military control. **(T-1).** The SFS coordinates with civilian law enforcement as well as other military law enforcement, as necessary, to expedite the absentee's return to the closest military installation with appropriate facilities. **(T-1).**

8.11.3.2. For member's absent for less than 1 year, AFPC/DPFCM contacts the unit commander within 1 duty day of the apprehension in order to coordinate with security forces to expedite the absentee's return to military control. **(T-1).**

8.11.4. Civilian law enforcement authorities arrest and hold absentees to assist military departments. **(T-1).** The commander of the installation nearest where the absentee is being detained is responsible for taking custody of the absentee from civilian law enforcement authorities. **(T-1).**

8.11.5. Do not ask civilian law enforcement authorities to hold absentees longer than necessary. **(T-1).** Make every attempt to pick up absentees within 48 hours after civilian law

enforcement authorities agree to their release. **(T-1).** Consult with the JA if clarification is needed.

8.11.6. If foreign authorities hold the absentee, consult with the JA before acting. **(T-1).**

8.11.7. Pick up all absentees, regardless of Service, from civilian law enforcement authorities in the CONUS.

8.11.7.1. Take absentees or deserters to the nearest military installation having facilities to process them. **(T-1).**

8.11.7.2. Inter-Service agreements will be used to facilitate the transfer of custody of absentees and deserters of all Military Services. **(T-1).**

8.11.8. If Air Force officials cannot pick up any absentees or deserters from another Service who are being held by civilian law enforcement authorities, notify the relevant Services of those individuals remaining in civilian custody before leaving the confinement facility. **(T-3).**

8.12. Rewards and Reimbursements:

8.12.1. Any authorized communication, oral or written, from a military or federal law enforcement official or agency, requesting active cooperation in apprehending or delivering to military control an absentee or deserter wanted by a military department constitutes the basis for a reward. After this communication, the AF rewards or reimburses (but not both) persons or agencies apprehending, detaining or delivering absentees, deserters, escaped military prisoners, or parole violators to military control under an AF Centrally Managed Allotment Account. If a non-AF military absentee/deserter/escapee is brought to an AF installation and a reward or reimbursement is due, the apprehendee's parent military department Military Personnel Pay Account pays, not the AF Centrally Managed Allotment.

8.12.1.1. Payment of a reward shall not exceed that named in 10 USC Section 956. Contact the base FSO for specific guidance. (Reference AFI 65-601, Volume 1, *Budget Guidance and Procedures*)

8.12.2. To request reward or reimbursement, persons or agencies must submit DD Form 553 to the FSO where the deserter is returned to AF control. **(T-1).** The remarks section of DD Form 553 must include the name, address and phone number for the persons or agencies requesting reward or reimbursement. **(T-1).**

8.13. Actions Taken When an Absentee Returns to Military Control

8.14. Notice of Return to Military Control. The unit CSS, MPF, or commander at the AF installation taking initial control of the absentee must notify AFPC/DPFCM immediately of the apprehension. **(T-1).** In accordance with AFI 31-105, *AF Corrections System*, installation commanders maintain the capability to house pretrial detainees and adjudged inmates with sentences up to 1 year, through organic confinement facilities, adjacent DoD facilities, civilian contracts, or a combination of organic, Support Agreement, or contract derived bed space.

8.15. Where Absentees Return to Military Control:

8.15.1. At any military installation staffed by AD personnel, immediately transfer an individual to the nearest installation of the individual's branch of military Service that has facilities to process absentees. **(T-1).** Military authorities will take absentees and deserters

being detained temporarily in the hands of civil authorities into custody within 48 hours after receiving notification of the absentee's or deserter's place of detention. **(T-1).**

8.15.2. In foreign countries, military attachés, the chief of the Military Assistance Advisory Group, or similar organizations, may not help an absentee who asks to return to military control unless the US is directly responsible for the individual's presence in the country. **(T-1).**

8.15.2.1. Generally, these organizations advise such absentees to report, at their own expense, to a proper US military installation in the US or overseas.

8.15.2.2. Unless absentees are citizens of the country in which US assistance is requested, they must be reported to the country's proper authorities with a view toward deportation. **(T-1).**

8.15.2.3. If the individual leaves or is deported from the foreign country, the military attaché or chief of the Military Assistance Advisory Group arranges for the individual's custody upon arriving in a territory where US military officers have arresting authority. **(T-1).**

8.16. Defining an Absentee's Return to Military Control. An absentee in the hands of civilian law enforcement authorities is no longer considered to be at large when AF authorities lodge a detainer with civil authorities. A detainer is a written or verbal request to hold the member for AF authorities when his or her presence is no longer required by civilian law enforcement authorities. The detainer ensures civilian law enforcement authorities inform military authorities when they are ready to release the absentee.

8.16.1. An absentee's return to military control occurs at the date and hour that:

8.16.1.1. An absentee surrenders to, is delivered to, or is apprehended by military authorities.

8.16.1.2. A civilian law enforcement authority informs the military that it holds the absentee for some reason other than the military's request.

8.16.1.3. An absentee otherwise comes under the control of military personnel.

8.17. Disposition of Absentee Returned to Military Control:

8.17.1. Absentees gone for less than 1 year are returned to the unit they were assigned to at the time of their Unauthorized Absence. **(T-1).**

8.17.2. Members absent for 1 year or more are transferred to the nearest AF installation with facilities to handle the case. **(T-1).**

8.17.3. For members in a permanent change of station status, refer to AFPC/DPFCM procedural guidance.

8.17.4. In some cases, the rules outlined above (**paragraph 8.17.1** through **8.17.3**) may not be appropriate. Under these circumstances, contact AFPC/DPFCM for further guidance and determination of unit of assignment. **(T-1).**

8.17.5. The detaining unit contacts AFPC/DPFCM to make notification of the return of a deserter to military control. **(T-1).**

8.17.6. For deserters requiring escort, do not release the deserter except to identify escort(s). **(T-1).** See **paragraph 8.18** for escort delineation.

8.17.7. For deserters who do not require escorts, the detaining security forces unit will issue a DD Form 460, *Provisional Pass*, and the member will travel to their duty station. **(T-1).**

8.17.8. In accordance with AFI 65-601, Volume 1, *Budget Guidance and Procedures*,-leave, desertion, or escaped-military-prisoner status (under apprehension) the necessary transportation and meal tickets to return to their duty station or as determined in paragraph 4.4.1 through 4.4.4. **(T-1).** Contact the local FSO for specific guidance. The travel and expenses of the apprehended member are funded by the Military Personnel Centrally Managed Allotment account. The base FSO provides the necessary Centrally Managed Allotment. **(T-1).**

8.17.9. The detaining unit processes a one-way TDY order or memorandum for the deserter in accordance with AFI 65-103, *Temporary Duty Orders,* table 2.1 and the Joint Travel Regulation. **(T-1).** In the Remarks section (Block 16), type the following statement: "Member is a deserter returned to military control." **(T-1).**

8.18. Escorts. The action unit commander coordinates with security forces to determine if absentees need escorts. **(T-1).** Use security forces escorts only when an armed escort is needed as determined by the installation chief, Security Forces. **(T-1).** Prisoners not considered being a threat to themselves or the general public can be escorted by unarmed personnel such as supervisors and first sergeants. The commander authorizes escorts for members detained outside their country of assignment only after consulting the servicing JA. **(T-1).**

8.18.1. Generally, use escorts if the member:

8.18.1.1. Escaped from prison. **(T-1).**

8.18.1.2. Has been charged with other serious offenses. **(T-1).**

8.18.1.3. Was apprehended by civil authorities. **(T-1).**

8.18.1.4. Is a repeat offender. **(T-1).**

8.18.1.5. Has a history of disciplinary infractions. **(T-1).**

8.18.2. To ensure the absentee's prompt return, on-duty escorts must not take leave or delay en-route. **(T-1).**

8.18.3. Transportation and travel expenses for AF personnel acting as guards or escorts of AF or other Military Service absentees, deserters or escaped military prisoners are provided in accordance with AFI 65-601, Volume 1, *Budget Guidance and Procedures*, paragraph 12.7 and 12.8. Contact the local FSO for specific guidance.

8.19. Actions Taken after an Absentee is returned to a Servicing Air Force Installation. The following items are an *integral* part of an absentee's return to the AF:

8.19.1. Notification of return of absentee to the military. The unit CSS or commander with the assistance from the MPF immediately notifies AFPC/DPFCM of the member's return to military control. **(T-2).**

8.19.2. DD Form 616, *Report of Return of Absentee* (Applies to Deserters when a DD Form 553 was processed). The unit commander, with CSS, MPF and SFS assistance as needed,

completes and forwards the DD Form 616 (refer to myPers) to AFPC/DPFCM and all agencies in receipt of the associated DD Form 553 within 1 duty day of the member's return to military control. **(T-2).**

8.19.3. AFOSI/ICON/ICW removes the member's name from the National Crime Information Center upon receipt of the DD Form 616 confirming the member's return to military control. **(T-2).**

8.19.4. The unit CSS, commander or MPF immediately prepares a Duty Status Change Request using Case Management System reporting the member's returned to military control. **(T-2).**

8.19.5. Deserters dropped from unit rolls (i.e., deserter for 180 days or more) are assigned to an AFPC personnel accounting symbol code. Upon notification of return to military control, AFPC/DPFCM coordinates with the MPF to determine the unit of assignment based on duration of deserter status (see **paragraph 8.17.1** through **8.17.3**.) and reassign the member to the appropriate unit personnel accounting symbol code. **(T-2).**

8.19.5.1. Once the personnel accounting symbol code is updated in MilPDS, the unit commander, CSS, or MPF completes processing a HR Type Personnel Program Application-Duty Status Change (AWOL/Deserter) Case Management System case to AFPC/DPFCM to update the member's duty status in MilPDS accordingly. **(T-2).**

8.19.5.2. AFPC/DPFCM forwards the returned deserter's medical and dental records to the assigned MPF. **(T-2).** If the member's personnel record is not in Automated Records Management System Office, AFPC/DPFCM will forward the Unit Personnel Record Group to the MPF. **(T-2).**

8.19.5.3. MPF forwards the medical and dental records to local military treatment facility for filing. **(T-2).**

8.19.6. Financial Service Office will coordinate with Defense Finance and Accounting Service to have member's Master Military Pay Account updated accordingly. **(T-1).**

8.20. Commander's Determination. The action unit commander:

8.20.1. Takes responsibility for disposition of Unauthorized Absence. **(T-1).**

8.20.2. Reviews case circumstances and consults with JA to determine if the absence was avoidable or unavoidable. **(T-1).**

8.20.3. A commander who finds that an absence was:

8.20.3.1. Avoidable, consults with JA and takes appropriate disciplinary action as warranted. **(T-1).**

8.20.3.2. Unavoidable, excuses the absence. The period of absence does not count as lost time to be made good. **(T-1).** Charge it to leave if not authorized for another reason (ref: AFI 36-3003, *Military Leave Program*). A new HR type Personnel Processing Application AWOL/Deserter Case Management System case is required to revoke the Unauthorized Absence report. **(T-3).** Examples of excused absences not charged to leave include, but are not limited to:

8.20.3.2.1. When a member's lack of mental capacity causes the absence.

8.20.3.2.2. When civilian law enforcement authorities hold, try and acquit a member.

8.20.4. If a member dies during an Unauthorized Absence, the commander of the unit of assignment makes a new status determination. **(T-2).** After considering all available facts, the commander determines if the member was in duty status, absent on leave, absent without leave, or a deserter. **(T-2).**

8.21. Erroneous Reports of Unauthorized Absence. When a commander determines that a desertion or Unauthorized Absence was reported in error, contact AFPC/DPFCM immediately to revoke the absence and remove the associated documents from the member's Master Personnel Record. **(T-1).**

8.21.1. If DD Forms 553 and 616 were distributed, another DD Form 616 must be accomplished. Provide a full explanation of the error in item 9, remarks section, and forwarded to AFPC/DPFCM. **(T-1).**

8.21.2. The commander sends new letters explaining the error to the next of kin, dependents, and others notified of the Unauthorized Absence. **(T-1).**

8.21.3. An HR type Personnel Processing Application AWOL/Deserter Case Management System case must be accomplished revoking or changing the HR type Personnel Processing Application AWOL/Deserter Case Management System case placing member into or removing Unauthorized Absence. **(T-1).**

8.21.4. Only AFPC/DPFCM can delete or change duty status codes of 06 (Deserter) and 07 (AWOL).

8.21.5. Financial Services Office will coordinate with Defense Finance and Accounting Service to have member's Master Military Pay Account updated accordingly. **(T-1).**

8.22. Special Requirements for ANG and AFR Members

8.23. General. This section applies to ANG or AFR members ordered to extended active duty voluntarily or involuntarily per AFI 36-2110, *Total Force Assignments*.

8.23.1. When an extended active duty order calls an Air Reserve Component (ARC) member to active duty, the active duty unit the member is temporarily assigned to processes the absentee only after coordination with the unit of assignment. **(T-1).**

8.24. Determining Unauthorized Absences. An ARC member voluntarily or involuntarily called or recalled to active duty or active duty for training who fails to report is an absentee if strong evidence exists that the member received the orders (Title 10 orders).

8.24.1. Per DODI 1215.13 *Reserve Component Member Participation Policy*. When members of the Selected Reserve are ordered to active duty for training or transferred to the Individual Ready Reserve because of unsatisfactory participation, copies of the orders will be furnished to the Service member. **(T-1).** Military Services will obtain acknowledgment of receipt, either written or electronic, and maintain a trackable record. **(T-1).** Service members ordered to active duty for training who fail to report will be processed pursuant to policy and procedures established by the Secretary of the AF. **(T-1).**

8.25. Reporting Unauthorized Absences. The unit to which the member is attached for active duty coordinates with the home unit before processing the AWOL/Deserter action. **(T-1).** If Special Activities Branch (AFPC/DP3SP) or Headquarters USAF Academy, Cadet Accessions

(HAFA/A1A) ordered the member to extended active duty, contact the appropriate office immediately to determine if substantial proofs of delivery of orders exist before taking any Unauthorized Absence action. **(T-1).** The unit of assignment completes appropriate actions. Include the Military Personnel Division, National Guard Bureau, NGB/A1PR (for ANG members) and the Personnel Utilization Branch, AF Reserve Command, AFRC/A1KK (for AFR members) on the distribution of all reports and the DD Form 553 when classifying a member ordered to active duty for training as a deserter. If questions arise, contact AFPC/DPFCM. **(T-1).**

8.26. Return to Military Control Responsibilities. When an ARC member ordered to active duty for training returns to military control, actions in **paragraphs 8.9**. and **8.13**. apply, except **paragraph 8.17**. The detaining unit:

8.26.1.1. Contacts AFPC/DPFCM and the member's respective headquarters: Military Personnel Division, National Guard Bureau, NGB/A1XR (for ANG members); or Personnel Utilization Branch, AF Reserve Command, AFRC/A1KK (for AFR members). **(T-1).**

8.26.1.2. Gives the member a non-chargeable transportation request if no escort is used. **(T-1).**

8.26.2. Disposition Instructions:

8.26.2.1. Absentees gone for less than 180 days are returned to their unit of assignment or to another unit with court-martial jurisdiction as determined by the unit of assignment commander. **(T-1).**

8.26.2.2. Absentees gone for 180 days or more are no longer carried on unit rolls and are sent to the nearest AF installation with facilities for handling the case. **(T-1).**

8.26.2.3. In some cases, the rules outlined above may not be appropriate. Under these circumstances, contact AFPC/DPFCM for further guidance.

8.26.3. The commander of the disposition unit takes the actions outlined in **paragraph 8.13**. **(T-1).** When completing the DD Form 616, include as information addressees: the Military Personnel Division, National Guard Bureau, NGB/A1XR (for ANG members); or the Personnel Utilization Branch, AF Reserve Command, AFRC/A1KK (for AFR members). **(T-1).**

8.27. Special Instructions for the United States Army, United States Navy, or United States Marine Corps Members Who Are Returned to or Surrender to An Air Force Installation

8.28. Instructions for a Service Member's Return or Surrender: Upon notification of the return or surrender of an Army, Navy, or Marine Corps AWOL member or deserter to an AF installation, detain the member by any means available (coordinate with SFS and JA regarding the use of force). **(T-1).** The disposition of the member will be determined by their respective Service's Deserter Information Point. **(T-1).** The respective Deserter Information Point will provide fund cities and take all of the necessary actions to return the member to appropriate control in the most expedient fashion. **(T-1).**

8.29. United States Army: Immediately contact the Army Deserter Information Point, Fort Knox, Kentucky (DSN 536-3711/3712/3713 or Commercial: 502-626-3711/3712/3713). **(T-1).**

8.30. United States Navy: Immediately contact the Navy Deserter Information Point, Naval Station Great Lakes, Great Lakes, Illinois (DSN: 882-2522 or Commercial: 901-874-2522 or 1-877-663-6772). **(T-1).**

8.31. United States Marine Corps: Immediately contact the Marine Corps Deserter Information Point, Arlington, Virginia (DSN 664-3667/0395 or Commercial: 703-604-3667/0395). **(T-1).**

8.32. United States Air Force Deserter Information Point: If you are unable to reach the other Service Deserter Information Point, contact AFPC/DPFCM (DSN 665-3727 or Commercial: (210) 565-3727, or 1-800-433-0048). **(T-1).**

CHAPTER 9

IDENTIFICATION TAGS

9.1. Issuance of Identification Tags. Issue identification tags:

9.1.1. Upon entrance into Regular AF or Air Reserve Component. **(T-2).**

9.1.2. When information contained on identification tags are invalid or identification tags are missing. **(T-2).**

9.1.3. Upon notification of deployment for civilian personnel. **(T-2).**

9.2. An identification tag set will be comprised of two tags, one long-length neck chain, and one short-length chain. (T-2).

9.3. Red Medical Alert Tags. Home station Medical Treatment Facilities will provide deploying personnel, with a documented medical allergic condition, a Red Medical Alert ID tag. **(T-1)**.

9.4. Reissuing Limitations.

9.4.1. Reissue identification tags only to replace lost tags or to correct changed or erroneous data. **(T-2).** Do not reissue identification tags to correct administrative errors. **(T-2).**

9.5. Wear of Identification Tags.

9.5.1. Wear identification tags (regular or medical) around the neck, underneath the appropriate garment, unless such wear creates a valid safety problem. **(T-1).** Identification may be carried in the pocket when safety factors preclude wear around the neck.

9.5.2. One tag is placed on the longer length necklace and one tag on the shorter chain. The shorter chain with tag is suspended from the longer length necklace with tag.

9.6. Information on Identification Tags. Each tag will consist of five lines of type:

9.6.1. First line – Last name

9.6.2. Second line – First name and middle initial

9.6.3. Third line – DoD ID Number/Electronic Data Interchange Personal Identifier

9.6.4. Fourth line – Blood type.

9.6.5. Fifth line - Religious preference.

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Assistant Secretary
(Manpower and Reserve Affairs)

Attachment 1

GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION

References

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AFMAN 33-363, *Management of Records*, 1 March 2008

AFMAN 65-116 Vol 1, *Defense Joint Military Pay System Active Component (DJMS-AC) FSO Procedures*, 1 April 2007

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AFPAAS Personnel Services Delivery Guide, 12 July 2011

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AF Form 847, *Recommendation for Change of Publication* (22 September 2009)

AF Form 973, *Request and Authorization for Change of Administrative Orders,* (1 October 1983)

AF Form 2098, *Duty Status Change* (30 June 2003)

DD Form 460, *Provisional Pass* (March 1951)

DD Form 553, *Deserter/Absentee Wanted By the Armed Forces* (1 March 2015)

DD Form 616, *Report of Return of Absentee* (1 December 1999)

DD Form 1610, *Request and Authorization for Temporary Duty Travel of Department of Defense Personnel* (1 May 2013)

DD Form 2585, *Repatriation Processing Center Processing Sheet* (1 September 2014)

Abbreviations and Acronyms

AD—Active Duty

ADLS—Advanced Distributed Learning System

AEF—Air and Space Expeditionary Force

AEFI—Air and Space Expeditionary Force Indicator

AFI—Air Force Instruction

AFMAN—Air Force Manual

AFOSI—Air Force Office of Special Investigations

AFPC—Air Force Personnel Center

AFPAAS—Air Force Personnel Accountability and Assessment System

AFPD—Air Force Policy Directive

AFR—Air Force Reserve

AFRC—Air Force Reserve Command

AFSVA—Air Force Services Activity

ANG—Air National Guard

ARC—Air Reserve Component

AWOL—Absent Without Leave

CONUS—Continental United States

DD Form—Department of Defense Form

DoD—Department of Defense

FBI—Federal Bureau of Investigation

FSO—Financial Services Office

FSS—Force Support Squadron

GCCS-AF—Global Command and Control-Air Force

HAF—Headquarters Air Force

HQ—Headquarters

HR—Human Resources

ID—Identification

IPR—Installation Personnel Readiness

JA—Judge Advocate

LOGFOR—Logistics Force Packaging System

MAJCOM—Major Command

MILPDS—Military Personnel Data System

MPF—Military Personnel Flight

NEO—Noncombatant Evacuation Operation

NGB—National Guard Bureau

OPR—Office of Primary Responsibility

PERSCO—Personnel Support for Contingency Operations

RED HORSE—Rapid Engineer Deployable Heavy Operations Repair Squadron Engineers

RegAF—Regular Air Force

SFS—Security Forces Squadron

TDY—Temporary Duty

UCMJ—Uniform Code of Military Justice

UDM—Unit Deployment Manager

USC—United States Code

UTC—Unite Type Code

Terms

295 Special Experience Identifier—Signifies completion of "Deliberate and Crisis Action Planning and Execution Segments Wing Level Operators Course" and updated in MilPDS.

Abroad—In a foreign area; outside the United States, its territories, or possessions. (DoDD 3025.14)

Absentee—Any member of the Armed Forces not administratively classified as a deserter who is absent without authority from the assigned unit, organization, or other place of duty where the member is required to be. This does not include confinement.

Absent without Authority—The status of a member absent from the assigned unit, organization, or other place of duty where the member is required to be.

Absent Without Leave (AWOL)—See Absent Without Authority.

Accounted For—Personnel are considered "accounted for" when any of the following occur: 1) The individual is physically present, 2) The individual has been contacted or has made contact (e.g. by telephone or other means) or 3) The individual is in an official status of Unauthorized Absence, desertion, deceased, or missing.

Action Unit—For administration of Unauthorized Absence, the unit of assignment. After the absentee returns to the military, the organization that makes disposition of the Unauthorized

Absence. The action unit for the absence is not necessarily the action unit for disposition of the Unauthorized Absence.

Active Duty for Training—A tour of active duty used to train members of the Air Reserve Components to provide trained units and qualified persons to fill the needs of the Armed Forces in time of war or national emergency and other times as national security requires. The member is under orders which provide for return to non-active duty status when the active duty for training is completed. It includes annual training, special tour of active duty for training, school tours, and the initial duty for training performed by no prior service enlistees.

Air and Space Expeditionary Force (AEF)—The United States Air Force methodology for organizing, training, equipping and sustaining rapidly responsive air and space forces to meet the defense strategy requirements. Through the Air and Space Expeditionary Force, the Air Force supports defense strategy requirements using a combination of both permanently assigned and rotational forces. The Air Force organizes Air and Space Expeditionary Task Forces to meet defense strategy requirements using both Continental United States-based and forward-stationed units. AETFs are capability based to generate desired effects and sized to meet the mission. AETFs are assigned or attached to a combatant commander through the Joint allocation scheduling process, Joint Strategic Capabilities Plan, Forces for Combatant Commanders Memorandum or Deployment Order.

Air Force Elements—Administrative devices designed solely to account for Air Force authorizations and personnel serving in non-Air Force activities, such as defense agencies, joint and unified commands, international activities and government agencies worldwide.

Air Reserve Component (ARC) Members—Members of the Air National Guard of the United States (ANG) or the United States Air Force Reserve (AFR).

Beddown—The provision of expedient facilities for troop support to provide a platform for the projection of force. From the Force Support perspective, beddown includes reception processing, accountability, providing meals and temporary lodging according to Combatant Commander plans and policies.

Career Field Education and Training Plan—Comprehensive document that identifies life-cycle education/training requirements, training support resources, and minimum wartime task requirements for the Force Support career field.

Casualty—Any person lost to the organization by reason of having been declared dead, duty status-whereabouts unknown, missing, ill, or injured (JP 1-02) (AFI 36-3002).

Component Command—One of the subordinate organizations that constitute a Joint force. Normally a Joint force is organized with a combination of Service and functional components.

Concept of Operations—A verbal or graphic statement, in broad outline, of a commander's assumptions or intent in regard to an operation or series of operations. The concept of operations frequently is embodied in campaign plans and operation plans, in the latter case, particularly when the plans cover a series of connected operations to be carried out simultaneously or in succession. The concept is designed to give an overall picture of the operation. It is included primarily for additional clarity of purpose; it is also called a commander's concept.

Contingency—An emergency involving military forces caused by natural disasters, terrorists, subversives, or by required military operations. Contingencies require plans, rapid response, and special procedures to ensure the safety and readiness of personnel, installations, and equipment.

Contingency Operations—Operations involving the use of US military forces to achieve US objectives, usually in response to an emerging or unexpected crisis. Contingency operations may evolve into sustained military operations.

Defense Manpower Data Center—Collects and maintains an archive of automated manpower, personnel, training, and financial databases; operates personnel programs and conducts research and analysis.

Deliberate and Crisis Action Planning and Execution Segments—The Air Force standard automated data processing subsystem of the Joint Operation Planning and Execution System, which is used by operations, logistics, manpower and personnel planners at all command levels to develop and maintain force packages and task requirements for Operation Plan Time-Phased Force Deployment Data.

Deployment—The relocation of forces to designated areas of operations.

Deserter Information Point (DIP)—A central focal point each military Service establishes to control, account for and pass on information about deserters and unauthorized absentees.

Desertion under Aggravated Circumstances—Desertion cases in which the individual is an officer, is wanted for offenses punishable under the UCMJ, or had access to classified defense information that, if disclosed, would jeopardize United States security.

Designed Operational Capability-—A mission for which a measured unit has been equipped, organized, designed, tasked, and trained.

Designed Operational Capability (DOC) Statement—The document prepared by the parent Major Command that outlines each measured unit's DOC and contains the unit's identification, mission tasking narrative, mission specifics, and measurable resources.

Detaining Unit—The unit that accepts an absentee's return to the military. To return, absentees may surrender to or be apprehended by military authorities, the FBI, or other civilian authorities.

Disposition of the Unauthorized Absence—Administrative actions taken when an Unauthorized Absence ends. Includes selection of the action unit, decisions about the member's status during the absence, and administrative or punitive action against the member, when appropriate.

Drilling Unit Reservists—Unit members who participate in unit training activities on a part-time basis.

Dropped from the Rolls (DFR) of the Organization—An administrative procedure that removes a member from the unit of assignment and reduces the unit's strength. It does not end the member's military status.

Duty Status-Whereabouts Unknown—A transitory casualty status, applicable only to military personnel, that is used when the responsible commander suspects the member may be a casualty whose absence is involuntary but does not feel sufficient evidence currently exists to make a definite determination of missing or deceased.

Employment Requirements Manning Document—A product providing total manpower requirements to be employed at a Temporary Duty location.

Evacuation—Withdrawal from a threatened area. Evacuation normally consists of four phases (departure, safe haven reception, safe haven support, and return). (DoDD 3025.14)

Failure to Go—An Unauthorized Absence of 24 consecutive hours or less.

Family Member—Family members who are enrolled in Defense Enrollment Eligibility Reporting System in an active file status. For Department of Air Force and Non-appropriated Fund employees, family members should be accounted for if they are receiving evacuation entitlements.

Force Module—A force module is a planning and execution tool that provides a means of logically grouping records, which facilitates planning, analysis and monitoring. Force modules may include both forces and sustainment.

Geographical Area of Interest (GAOI)—Continental United States or overseas area of concern affected by the disaster or national emergency.

Global Command and Control System (Air Force)—A system providing the planning community the ability to share the workload among computer centers and rapidly query programs and data files at remote locations, update and transfer files remotely, send messages and already-formatted data, and teleconference.

Individual Mobilization Augmentee—An individual filling a military billet identified as augmenting the active component structure of the Department of Defense [DoD] or other departments or agencies of the U.S. Government.

Installation Deployment Officer—The individual acting for the installation commander in the overall direction and control of deployments from a base.

Limiting Factor—A factor or condition that either temporarily or permanently impedes mission accomplishment (e.g., transportation network deficiencies, lack of in-place facilities, mal traffic positioned forces or materiel, extreme climatic conditions, distance, transit or overflight rights, political conditions, etc. [Joint Pub 1-02]).

Major Command (MAJCOM)—A subdivision of the Air Force that is assigned a major part of the Air Force mission. Major commands report directly to HAF. Includes MAJCOM of assignment for the absentee and the MAJCOM of the servicing MPF, unless otherwise specified. For purposes of this instruction, the Air Force Office of Special Investigations (AFOSI), a field operating agency, is treated as a MAJCOM.

Military Personnel Flight (MPF)—The flight within the Force Support Squadron that services the action unit, unless otherwise specified.

Mission Capability—A short paragraph that describes the mission capabilities that planners expect of a specific UTC at execution. The statement usually contains pertinent information such as the type of base where commanders will deploy the unit, the unit's functional activities, and other augmentation requirements necessary to conduct specific missions.

National Crime Information Center—A computerized information system established by the FBI to serve law enforcement agencies. Using computers, data transmission over communication lines and terminal devices, it makes timely and complete information about deserters available to law enforcement agencies.

National Emergency—A condition declared by the President or the Congress by virtue of powers previously vested in them that authorize certain emergency actions to be undertaken in the national interest. Action to be taken may include partial, full, or total mobilization of national resources.

Natural Disaster—All domestic emergencies except those created as a result of enemy attack or civil disturbance.

Noncombatant—In accordance with (DoDD 3025.14), U.S. citizens who may be ordered to evacuate by competent authority include: Civilian employees of U.S. Government agencies and their dependents, except Civilian employees of U.S. Government agencies and their dependents, who are legal residents in the country concerned but have expressed the willingness to be evacuated. Military personnel of the U.S. Military Services specifically designated for evacuation as noncombatants. Dependents of members of the U.S. Military Services.

US (and non—US) -citizens who may be authorized or assisted in evacuation (but not necessarily ordered to evacuate) in accordance with (DoDD 3025.14), by competent authority include: Civilian employees of U.S. Government agencies and their dependents who are legal residents in the country concerned, but have expressed the willingness to be evacuated.

Private U.S. citizens and their dependents—(Note: Private U.S. citizens cannot be ordered to evacuate.)
Military personnel—and dependents of members of the U.S. Armed Forces outlined in **subparagraph a (3)** of DoDD 3025.14, short of an ordered evacuation.
Designated others—including dependents of civilian employees of U.S. Government agencies and their dependents, except civilian employees of U.S. Government agencies and their dependents, who are legal residents in the country concerned, but have expressed the willingness to be evacuated; military personnel of the U.S. Military Services specifically designated for evacuation as noncombatants; and dependents of members of the U.S. Military Services, as prescribed by DoS.

Noncombatant Evacuation Operation—Operation directed by the Department of State whereby noncombatants are evacuated from areas of danger overseas to a safe haven.

Operation Plan—Any plan for the conduct of military operations prepared in response to actual and potential contingencies. A complete and detailed joint plan containing a full description of the concept of operations, all annexes applicable to the plan, and a time-phased force and deployment data. (JP 5-0)

Ordered Departure—Mandatory departure of some or all categories of personnel and dependents (such as military dependents, nonessential DoD civilian employees and their families, families of essential DoD civilian employees, and DoDDS staff and faculty) to designated safe havens is directed by DoS, with implementation of the theater evacuation plan. Historically, DoS accomplishes most ordered evacuations using commercial transportation (scheduled or chartered), without the use of military personnel or assistance. However, DoS may request a DoD-assisted Noncombatant Evacuation Operation (using DoD organic or chartered transportation assets) based on the nature of the threat or the lack of availability of alternative forms of transportation. (JP 3-68)

Overseas—All locations, including Alaska and Hawaii, outside the continental United States.

Personnel Accountability—The accurate accounting for personnel at all times regardless of location.

Repatriation—Procedure whereby American citizens and their families are officially processed back into the United States subsequent to an evacuation. Evacuees are also provided various services to ensure their well-being and onward movement to their final destination. (DoDD 3025.14)

Replacement accountability—Tracking of replacement actions in accordance with applicable instructions when necessary to replace a deployed individual that departs prior to completing the specified tour length.

Replacements—Personnel required to take the place of others who depart a unit (Joint Pub 1-02).

Return to Military Control—End of an Unauthorized Absence.

Safe Haven—Designated area(s) to which noncombatants under the U.S. Government's responsibility may be evacuated during an emergency. A location within or outside the United States to which noncombatants are authorized to travel for the purpose of temporarily remaining there until they are authorized to return to the location from which evacuated, or until they are authorized to travel to their final destination. Safe havens are normally designated by DoS, in coordination with DoD. (DoDD 3025.14)

Selected Reserve—Those units and individuals within the Ready Reserve designated by their respective services and approved by the Joint Chiefs of Staff as so essential to initial wartime missions that they have priority over all other Reserves. All Selected Reservists are in active status. The Selected Reserve also includes persons performing initial Regular Air Force training.

Servicing Security Forces—The military police unit servicing the action unit, unless otherwise specified.

Stop Movement—DoD issues an order to stop forward movement of military members, their dependents, nonessential DoD civilian employees and their families, families of essential DoD civilian employees, and DoDDS staff and faculty. (JP 3-68)

Strength accountability—Accountability of all personnel on the ground, including transients, at their deployed and designated geographically separated locations, regardless of status, in accordance with component command policies.

Supervisor—A person, military or civilian, who oversees another's work. Unless otherwise specified, a member reports to the immediate supervisor for duty each workday.

Supported Component Command—The command having primary responsibility for all aspects of a task assigned by the Joint Strategic Capabilities Plan or other Joint operation planning authority. In the context of Joint operation planning, this term refers to the commander who prepares operation plans or operation orders in response to requirements of the Chairman of the Joint Chiefs of Staff. The supported command receives assistance from another commander's force or capabilities, and is responsible for ensuring that the supporting commander understands the assistance required.

Supporting Command—The command that provides augmentation forces or other support to a supported commander or who develops a supporting plan. Includes the designated combatant commands and Defense agencies as appropriate. The supporting command aids, protects,

complements, or sustains another commander's force, and is responsible for providing the assistance required by the supported commander.

Tasked Wing Accountability—Responsibility of unit commanders and IPR Elements to maintain accountability over their deployed personnel until they have returned to home station.

Threatened Areas—Includes areas facing actual or potential danger from natural or manmade disaster, civil unrest, imminent or actual terrorist activities, hostilities, and similar circumstances, as declared by competent authority. (DoDD 3025.14)

Total Force—For the purpose of this instruction, Total Force includes Regular Air Force, Air Force Reserve, Air National Guard, Department of the Air Force and Non-appropriated Fund civilians, Defense Enrollment Eligibility Reporting System enrolled family members, family members of Department of Air Force and Non-appropriated Fund employees (when receiving evacuation entitlements), and contractors and their family members when employed outside the continental United States.

Transient Accountability—Tracking of personnel that spend at least one night at a location but their final duty location is elsewhere.

Transient Personnel—Military member, Department of Defense civilian, or Department of Defense contractor who spend at least one night at a location but their final duty location is elsewhere.

Unauthorized Absence -—See Absent Without Authority.

Unit accountability—Tracking of deployed assigned and/or attached unit personnel. This accountability includes knowing where assigned personnel are at any given time, where they live and work.

Unit Commander—An officer in command of the action unit.

Unit of Assignment—The organization to which a member belongs and contributes strength, or the organization to which a member once belonged to and has now been dropped from rolls (DFR).

Unit Type Code—A Joint Chiefs of Staff developed and assigned code, consisting of five characters that uniquely identify a "type unit." (JP 1-02). A potential capability focused upon accomplishment of a specific mission that the military Service provides. It can consist of manpower force element (MFE) only, equipment (Logistics Detail) only, or both manpower and equipment. (AFI 10-401)

United States—The 50 states and all territories and possessions of the United States, including all waters and airspace subject to the territorial jurisprudence of the United States.

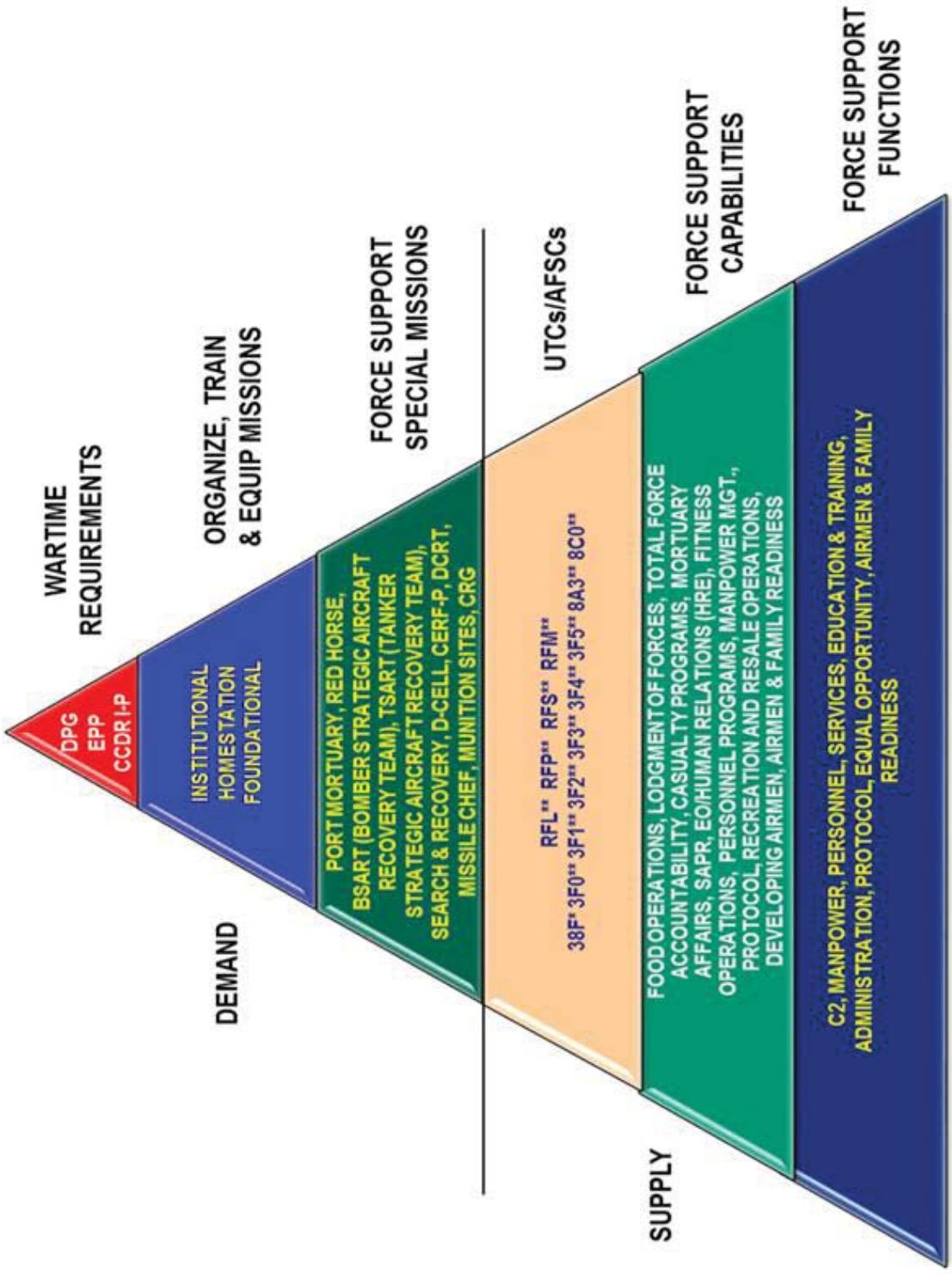
United States Civil Authorities—Those elected and appointed public officials and employees who constitute the governments of the 50 states, District of Columbia, Commonwealth of Puerto Rico, United States possessions and territories, and political subdivisions thereof.

War and Mobilization Plan—The Air Force supporting plan to the Joint Strategic Capabilities Plan. The War and Mobilization Plan provides current planning cycle policies and planning factors for the conduct and support of wartime operations. It establishes requirements for development of mobilization and production planning programs to support sustained contingency operations.

ATTACHMENT 2

FORCE SUPPORT SUPPLY AND DEMAND PYRAMID

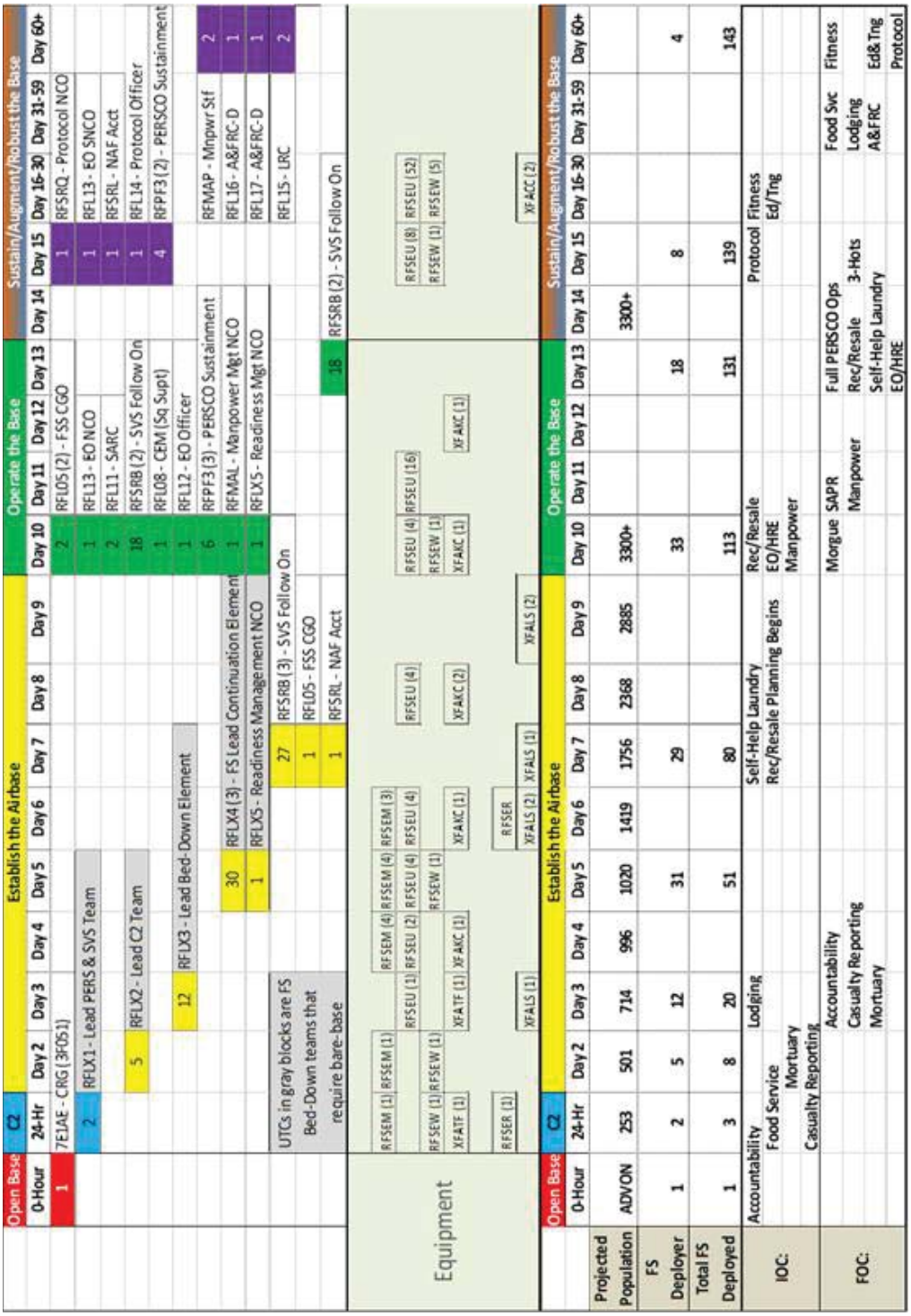
Figure A2.1. Force Support Supply and Demand Pyramid.



ATTACHMENT 3

FORCE SUPPORT FORCE MODULE (FY18-20)

Figure A3.1. Force Support Force Module (FY18-20).



BY ORDER OF THE SECRETARY OF THE AIR FORCE

AIR FORCE INSTRUCTION 44-178

4 MARCH 2014
Certified Current 28 June 2016
Medical

HUMAN IMMUNODEFICIENCY VIRUS PROGRAM

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

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This instruction implements AFPD 44-1, *Medical Operations,* and Department of Defense (DoD) Instruction 6485.01, *Human Immunodeficiency Virus*, June 7, 2013. It outlines the Air Force Human Immunodeficiency Virus (HIV) Program including responsibilities and procedures for identification, surveillance, and administration of Active Duty Air Force personnel. The Air National Guard (ANG) and Headquarters Air Force Reserve Command (HQ AFRC) utilize this instruction along with supplements to provide specific guidelines for the administration of Air Reserve Component (ARC) personnel infected with HIV. Headquarters Air Reserve Personnel Center (HQ ARPC) utilizes AFI 44-175 as guidance for Individual Mobilization Augmentees (IMAs), with local MTFs as the notifying agent. This instruction requires collecting and maintaining information protected by the Privacy Act of 1974. This is authorized by 10 U.S.C., Chapter 55, *Medical and Dental Care*, 10 U.S.C., Sec. 8013, *Power and Duties of the Secretary of the Air Force,* and Executive Order 9397 (SSN) as amended by Executive Order 13478, Amendments to Executive Order 9397 Relating to Federal Agency Use of Social Security Numbers, November 18, 2008. Systems Record Notices F044 AF SG E, *Electronic Medical Records System*, and R, *Reporting of Medical Conditions of Public Health and Military Significance*, apply. Ensure that all records created as a result of processes prescribed in this publication are maintained IAW Air Force Manual (AFMAN) 33-363, Management of Records, and disposed of IAW Air Force Records Information Management System (AFRIMS) Records Disposition Schedule (RDS).

Send comments and suggested improvements on AF Form 847, **Recommendation for Change of Publication**, through channels, to AFMSA/SG3PM. See **Attachment 1** for a glossary of

references, abbreviations, acronyms, and terms. This publication may be supplemented at any level, but all direct Supplements must be routed to the OPR of this publication for coordination prior to certification and approval. The authorities to waive wing/unit level requirements in this publication are identified with a Tier ("T-0, T-1, T-2, T-3") number following the compliance statement. See AFI 33-360, Publications and Forms Management, for a description of the authorities associated with the Tier numbers. Submit requests for waivers through the chain of command to the appropriate Tier waiver approval authority, or alternately, to the Publication OPR for non-tiered compliance items.

SUMMARY OF CHANGES

This document has been substantially revised and must be completely reviewed. Major changes include condensed sections describing the requirements for a positive HIV test and algorithms for determining HIV infection which reference current guidelines by the American Public Health Laboratories (APHL) and Centers for Disease Control (CDC). The location of the USAF HIV Medical Evaluation Unit was updated to San Antonio Military Medical Center (SAMMC) and the location of HIV laboratory testing was updated to the USAF School of Aerospace Medicine (USAFSAM) HIV Testing Services, Wright-Patterson Air Force Base. The clinical evaluation visit structure was modified, with HIV evaluations performed at SAMMC for initial visits, followed by a second visit in 6 months, then yearly thereafter while the patient remains on active duty (AD) status. Interim clinical visits will be performed as necessary in the local area based on recommendations from the USAF HIV Medical Evaluation Unit. The sections detailing the components of HIV clinical evaluations have been condensed with all elements of HIV clinical evaluations to be performed according to current clinical guidelines.

Chapter 1

ROLES AND RESPONSIBILITIES

1.1. HQ USAF/SG. Provides facilities, manpower, and funds to collect HIV testing specimens of Air Force (AF) personnel, to medically evaluate all HIV positive AD members including IMAs, and to ensure spouses and contacts of HIV infected AD members are notified, counseled, and tested appropriately.

1.2. HQ AFRC/SG. Ensures reserve personnel are HIV tested and spouses and contacts of HIV infected reserve personnel are notified appropriately.

1.3. HQ ANG/SG. Ensures ANG personnel are HIV tested and spouses and contacts of HIV infected ANG personnel are notified appropriately.

1.4. HQ AFMC/SG. Provides facilities, funds, and manpower to the USAFSAM HIV Testing Services to perform HIV testing and epidemiological analysis of all HIV tests performed on ADAF personnel and their dependents. Provides support to the DoD Serum Repository.

1.5. HQ AETC/SG. Provides facilities, funds, and manpower to medically evaluate all HIV positive ADAF members.

1.6. USAF HIV MEDICAL EVALUATION UNIT. Located in the Joint Infectious Disease Service at SAMMC, medically evaluates all ADAF HIV positive members initially, at 6 months, and then every 12 months thereafter while on active duty. (T-1)

Chapter 2

HIV PROGRAM

2.1. General. The AF tests all members for human immunodeficiency virus, medically evaluates all AD infected members, and educates members on means of prevention.

2.2. Populations Tested.

2.2.1. Accessions. All applicants for enlistment or appointment to the ADAF or ARC are screened for evidence of HIV infection (**Attachment 3**). Applicants infected with HIV are ineligible for enlistment or appointment to the ADAF and the ARC. Waiver for HIV infection is not authorized.

2.2.2. ADAF personnel. All ADAF personnel are screened for serological evidence of HIV infection every two years, preferably as part of their Preventive Health Assessment (PHA). They are also tested for clinically indicated reasons, when newly diagnosed with active tuberculosis, during pregnancy, when diagnosed with a sexually transmitted infection (STI), upon entry to drug or alcohol treatment programs, or prior to incarceration. HIV testing is conducted IAW **Attachment 3**. (T-1)

2.2.3. ARC personnel. Air Force Reserve personnel are screened for serological evidence of HIV infection every two years, preferably during their PHA (Preventive Health Assessment). ARC members will have a current HIV test within two years of the date on which they are called to active duty for 30 days or more.HIV testing is conducted IAW **Attachment 3**. (T-1)

2.2.4. DoD Civilians. DoD Civilian employees are tested for serological evidence of HIV to comply with host nation requirements for screening of DoD employees (**Attachment 6**) and after occupationally related exposures. (T-1)

2.3. Initial Procedures for Positive Tests. All ADAF personnel testing positive are counseled by a physician regarding the significance of a positive test. They are given information on modes of transmission, appropriate precautions to mitigate transmission, and prognosis. ADAF members are administered an order to follow preventive medicine requirements as described in **Attachment 7**. ARC members will also be administered this order. The preventive medicine requirements/order will not be delayed pending any administrative action. All eligible beneficiaries are offered counseling. Contacts of HIV-infected members are notified of potential exposure to HIV infection according to state or local law. (T-0)

2.4. Clinical Evaluation, to Include Evaluation for Continued Military Service. All ADAF members, as well as ARC members on extended active duty, who test positive for HIV are referred to SAMMC for medical evaluation. Per AFI 48-123 and AFI 41-210, HIV-positive personnel must undergo medical evaluation for the purpose of determining status for continued military service. ARC members who are not on extended active duty or who are not on full-time National Guard duty, and who show serologic evidence of HIV infection, will be referred for a medical evaluation of fitness for continued service in the same manner as service members with other chronic or progressive illnesses in accordance with DoDI 1332.38. In the case of an ANG member, it is only required if the state identifies a nonmobility, nondeployable position in which the member can be retained. All ADAF members will have an initial evaluation at SAMMC, followed by a visit at 6 months, then yearly thereafter while remaining on AD status. ARC and

ANG members whose condition is determined to meet Line of Duty requirements may have initial and/or annual HIV evaluations performed at regional military facilities. ARC and ANG members not meeting Line of Duty requirements will have an initial evaluation by a civilian HIV specialist. The medical evaluation follows the standard clinical protocol outlined in **Attachment 8** and utilizes procedures for evaluating T-helper cell counts described in **Attachment 12**. ARC members not on extended active duty must obtain a medical evaluation that meets the requirements of **Attachment 8** from their civilian healthcare provider (in the case of the ANG, only if the state identifies a nonmobility, nondeployable position in which the member can be retained). An epidemiological assessment (including sexual contacts and history of blood transfusions or donations) is conducted to determine potential risk of HIV transmission (see **Attachment 11**). (T-1)

2.4.1. Outcome of Evaluation for Continued Military Service. HIV seropositivity alone is not grounds for medical separation or retirement for ADAF members. Members shall be retained or separated as outlined in **Attachment 9**. (T-1)

2.4.2. Periodic Re-evaluation. HIV infected ADAF members retained on active duty and ARC members retained in the Selected Reserve must be medically evaluated annually at SAMMC. Such personnel must be assigned within the continental United States (CONUS). Alaska, Hawaii, and Puerto Rico are also acceptable. ARC HIV infected members may not be deployed outside of CONUS (except for Alaska, Hawaii, and Puerto Rico). HIV-infected members shall not be assigned to OCONUS mobility positions, and those on flying status must be placed on Duty Not Including Flying (DNIF) status pending medical evaluation/waiver determination. Waivers are considered using normal procedures established for chronic diseases. Aeromedical waivers are considered according to the Aerospace Medicine Waiver Guide. Members on the Personnel Reliability Program (PRP) or other security sensitive positions shall evaluated for suspension or temporary decertification during medical evaluation, as determined by their Certifying Official/Unit Commander on the advice of a Competent Medical Authority. The Secretary of the Air Force may, on a case-by-case basis, further limit duties and assignment of members to protect the health and safety of the HIV-infected member or other members. Submit such requests to Office of the Secretary of the Air Force, Air Force Pentagon,Washington, DC 20330-1670. (T-1)

2.5. Limitations of Use of Information. Commanders and other personnel comply with limitations on the use of information obtained during the epidemiological assessment of HIV-infected members as outlined in **Attachment 10**. (T-1)

2.6. Public Health. Provides HIV education to all ADAF members, offers education to other eligible beneficiaries, maintains a list of HIV positive personnel to be gained, reports to gaining bases departing HIV positive personnel, and educates HIV positive members and their dependents. (T-1)

2.7. USAFSAM. USAFSAM performs HIV testing (PHE) of submitted specimens and conducts epidemiological surveillance (PHR) of HIV infection in Air Force members and dependents. (T-1)

2.8. AF Blood Centers. AF Blood Centers follow policies of the Armed Services Blood Program Office, Food and Drug Administration (FDA), and the accreditation requirements of the American Association of Blood Banks (AABB). (T-0)

2.9. Combat Zone Procedures. Routine HIV testing is suspended in declared combat zones, defined as those areas where hostile pay is authorized.

2.10. Work Restrictions. Force-wide, HIV-infected employees are allowed to continue working as long as they are able to maintain acceptable performance and do not pose a safety or health threat to themselves or others in the workplace. If performance or safety problems arise, managers and supervisors address such problems using existing personnel policies and instructions. HIV-infected healthcare workers, however, should be relieved from patient care responsibilities until an expert review panel has met to advise the healthcare worker on work restrictions. Recommendations to the panel will be made by HIV treatment experts during the individual's initial HIV evaluation at SAMMC in accordance with the most recent guidelines from the Centers for Disease Control and Society for Health Care Epidemiology of America. The panel should be encouraged to contact SAMMC for advice (via telephone conference call) to ensure organizational consistency. (T-1)

Chapter 3

HIV TESTING MEASUREMENT

3.1. HIV Testing Measurement. The AF's goal is to reduce the incidence of HIV infection in its personnel. USAFSAM tracks trends of HIV incidence in AF members. AF labs that do their own HIV testing must communicate test results and ship corresponding serum specimens to USAFSAM so they may ship samples to the DoD serum repository, and track trends. (T-1)

Chapter 4

FORMS

4.1. Forms. AF Form 1762, *HIV Log/Specimen Transmittal*, will be used for requesting HIV testing and specimen transmittal for those sites that do not have CHCS access (see **Attachment 4**). AF Form 3844, *HIV Testing Notification Form*, will be used to notify personnel of required HIV testing. AF Form 3845, *Preventive Medicine Counseling Record*, will be used to record counseling provided for HIV positive individuals. AF Form 74, *Communication Status Notice/Request*, is sent to MTF/CCs and Reserve Medical Unit (RMU)/CCs along with a copy of the patient's positive HIV testing screen and confirmation testing results. The MTF/CC and RMU/CC will document on AF Form 74 that the patient has been notified of the positive HIV results, then return the form to USAFSAM. Positive HIV results will not be finalized until USAFSAM/PHE receives the AF Form 74. (T-1)

THOMAS W. TRAVIS
Lieutenant General, USAF, MC, CFS
Surgeon General

Attachment 1

GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION

References.

Title 29, United States Code, Section 794, *Non-Discrimination Under Federal Grants and Programs,* current edition

DoD Directive 1332.18, *Separation or Retirement for Physical Disability*, 4 November 1996

DoD Instruction 1332.38, *Physical Disability Evaluation*, *CH 2*, 10 April 2013

DoD Instruction 6485.01, *Human Immunodeficiency Virus,* 7 June 2012

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AFI 36-3212*, Physical Evaluation for Retention, Retirement, and Separation, IC 2,* 27 November 2009 AFI 48-123, *Medical Examination and Standards*, *GM1*, 31 January 2011

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AFI 44-108, *Infection Control Program,* 1 March 2012

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CDC. Recommendations for Preventing Transmission of Human Immunodeficiency Virus and Hepatitis B Virus to Patients During Exposure-Prone Invasive Procedures. *MMWR*. 1991;40(RR08).

CDC. Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings. *MMWR.* 2006;55(RR14):1-17.

CDC. Sexually Transmitted Diseases Treatment Guidelines, 2010. *MMWR.* 2010;59(RR12):1-116.

Updated US Public Health Service Guidelines for the Management of Occupational Exposures to Human Immunodeficiency Virus and Recommendations for Postexposure Prophylaxis, 2013. Infect Control Hosp Epidemiol. 2013;34(9):875-92.

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SHEA. Guideline for Management of Healthcare Workers Who Are Infected with Hepatitis B Virus, Hepatitis C Virus,and/or Human Immunodeficiency Virus Infection Control and Hospital Epidemiology 2010;. 31, no. 3.

APHL. HIV Testing Algorithms A Status Report: aPublication from the Association of Public Health Laboratories and the Centers for Disease Control & Prevention. April 2009 with update January 2011.

Adopted Forms.

AF Form 1762, HIV Log/Specimen Transmittal

AF Form 3844, HIV Testing Notification Form

AF Form 3845, Preventive Medicine Counseling Record

AF Form 74, Communication Status Notice/Request

Abbreviations and Acronyms.

AABB—American Association of Blood Banks

ADAF—Active Duty Air Force

AETC—Air Education and Training Command

AFMC—Air Force Materiel Command

AFMOA—Air Force Medical Operations Agency

AFMOA/SGOC—Air Force Medical Operations Agency, Surgeon General's Office of Consultants

AFPC—Air Force Personnel Center

AFPC/DPANM—Air Force Personnel Center/Medical Retention Standards Branch

AFPD—Air Force Policy Directive

AFRC—Air Force Reserve Command

AIDS—Acquired Immunodeficiency Syndrome

ANGB—Air National Guard Bureau

APHL—American Public Health Laboratories

ARC—Air Reserve Component (Air Force Reserve and Air National Guard)

ASD—Assistant Secretary of Defense

CDC—Centers for Disease Control and Prevention

CHCS—Composite Healthcare System

CHN—Community Health Nurse

CONUS—Continental United States

COT—Consecutive Overseas Tour

CPO—Civilian Personnel Office

DAF—Department of the Air Force

DBMS—Director, Base Medical Services

DoD—Department of Defense

DoDSR—Department of Defense Serum Repository

DNIF—Duty Not Including Flying

DSN—Defense Switched Network

FDA—Food and Drug Administration

FM—Flight Medicine

FM & P—Force Management and Personnel

FMP—Family Member Prefix

HBV—Hepatitis B virus

HIV—Human Immunodeficiency Virus (the virus that causes AIDS)

HQ AETC—Headquarters Air Education and Training Command

HQ AFRC/SG—Headquarters Air Force Reserve Command Surgeon

HQ ANG/SG—Headquarters Air National Guard Command Surgeon

HQ USAF—Headquarters US Air Force

ICD-9—International Classification of Diseases, Revision 9

IMA—Individual Mobilization Augmentee

I-RILO—Initial Review in Lieu of Medical Board

MAJCOM—Major Command

MEB—Medical Evaluation Board

MTF/CC—Medical Treatment Facility Commander

MPF—Military Personnel Flight

MTF—Medical Treatment Facility

NGB—National Guard Bureau

OB—Obstetrics

OI—Opportunistic Infection

OS—Overseas

OSHA—Occupational Safety and Health Association

OTS—Officer Training School

PCS—Permanent Change of Station

PE—Physical Examination

PES—Physical Examination Section

PH—Public Health

PQAM—Program Quality Assurance Monitor

PRP—Personnel Reliability Program

ROTC—Reserve Officer Training Corps

SAF—Secretary of the Air Force

SAMMC—San Antonio Military Medical Center

SF—Standard Form

SG—Surgeon General

SHEA—Society for Healthcare Epidemiology of America

SSN—Social Security Number

STI—Sexually Transmitted Infection

TDY—Temporary Duty

USA—United States Army

USCG—United States Coast Guard

USMC—United States Marine Corps

USN—United States Navy

UCMJ—Uniform Code of Military Justice

USAFSAM—United States Air Force School of Aerospace Medicine

USUHS—Uniformed Services University of the Health Sciences

Terms.

Air Reserve Component—Air Force Reserve and Air National Guard components of the Air Force

Department of Defense Civilian Employees—Current and prospective DoD US civilian employees. Does not include members of the family of DoD civilian employees, employees of, or applicants for, positions with contractors performing work for DoD, or their families.

Enzyme Linked Immunosorbent Assay—A screening test read as 'reactive' if the results are above a calculated cutoff.

Epidemiological Assessment—The process by which personal and confidential information on the possible modes of transmission of HIV are obtained from an HIV-infected person. This information is used to determine if previous, present, or future contacts of the infected individual are at risk for infection with HIV and to prevent further transmission of HIV.

Host Nation—A foreign nation to which DoD US civilian employees are assigned to perform their official duties.

Human Immunodeficiency Virus—The virus that causes AIDS.

Positive—A true positive test is an indicator of a condition being present

Reactive—Reacts with the reagent antibody test to produce a visible result

Serologic Evidence of HIV Infection—A reactive result given by a FDA approved serologic test for HIV detection, such as an enzyme-linked immunosorbent assay (ELISA) or

Chemiluminescent Immunoassay (ChLIA) that is confirmed in by additional testing in a validated testing algorithm, for example by a diagnostic HIV Western Blot immunoelectrophoresis. For Western Blot tests with indeterminate results, an alternative FDA approved test can be used to resolve indeterminates such as a viral load-based assay (APTIMA).

Western Blot Test—A qualitative assay for the detection and identification of antibodies of HIV-1 contained in human serum. It is intended for use with persons of unknown risk as an additional more specific test on human serum specimens found to be repeatedly reactive using a screening procedure such as ELISA.

Attachment 2

PROCEDURES FOR SCREENING APPLICANTS

A2.1. Screen applicants to the USAF or ARC for serologic evidence of HIV infection. Test and interpret results, using the procedures in **Attachment 3**. Counsel applicants on the significance of test results and the need to seek treatment from a civilian physician. (T-1)

A2.2. Screen applicants for enlisted service at the Military Entrance Processing Stations (MEPS) or the initial point of entry to military service. Applicants who enlist under a delayed enlistment program who exhibit serologic evidence of HIV infection before entry on active duty may be discharged due to erroneous enlistment. (T-1)

A2.3. Screen applicants accepted for the Air Force Academy as part of the processing for entry into the Academy and again as part of their medical screening prior to appointment as officers. Screen other officer candidates during their preappointment or precontracting physical examination. (T-1)

A2.4. Screen applicants for ARC during the normal entry physical examinations or in the preappointment programs established for officers. Those individuals with serologic evidence of HIV infection, who must meet accession medical fitness standards to enlist or be appointed, are not eligible for service with the ARC. (T-1)

A2.5. Take the following actions on officer applicants who are ineligible for appointment due to serologic evidence of HIV infection:

A2.5.1. Disenroll enlisted members who are candidates for appointment through Officer Training School (OTS) programs immediately from the program. If OTS is the individual's initial entry training, discharge the individual. If the sole basis for discharge is serologic evidence of HIV infection, issue an honorable or entry-level discharge, as appropriate. A candidate who has completed initial entry training during the current period of service before entry into candidate status shall be administered in accordance with Service directives for enlisted personnel. (T-1)

A2.5.2. Disenroll individuals in preappointment programs, such as Reserve Officer Training Corps (ROTC) and Health Professions Scholarship Program (HPSP) participants. The head of the Military Service concerned, or the designated representative, may delay disenrollment until the end of the academic term in which serologic evidence of HIV infection is confirmed. Disenrolled participants retain any financial support through the end of the academic term in which the disenrollment takes place. Financial assistance received in these programs is not subject to recoupment, if the sole basis for dis-enrollment is serologic evidence of HIV infection. (T-1)

A2.5.3. Separate Air Force Academy cadets and personnel attending the Uniformed Services University of the Health Sciences (USUHS) from the Academy or USUHS and discharge them. The superintendent of the Academy may delay separation to the end of the current academic year. A cadet granted such a delay in the final academic year, who is otherwise qualified, may graduate without commission and then is discharged. If the sole basis for discharge is serologic evidence of HIV infection, issue an honorable discharge. (T-1)

A2.5.4. Disenroll commissioned officers in DoD-sponsored professional education programs leading to appointment in a professional military specialty (including medical, dental, chaplain, and legal or judge advocate) from the program at the end of the academic term in which serologic evidence of HIV infection is confirmed. Except when laws specifically prohibit it, waive any additional service obligation incurred by participation in such programs; do not recoup any financial assistance received in these programs. Apply the time spent by the officers in these programs towards satisfaction of any preexisting service obligation. (T-1)

A2.5.5. Counsel people disenrolled from officer programs who are to be separated; include preventive medicine counseling and advise the individual to seek treatment from a civilian physician. (T-1)

Attachment 3

AIR FORCE HIV TESTING PROCEDURES

A3.1. Responsibilities:

A3.1.1. Medical Treatment Facility Commander (MTF/CC). Is responsible for the HIV testing program. Appoints an HIV designated physician (and one or more alternates, if alternates are desired); ensures HIV positive individuals are notified and counseled as soon as possible following receipt of the positive test result; and ensures AD members are referred to SAMMC within 60 days of receipt of the HIV positive results notification from the USAFSAM HIV Testing Services to the base. Reserve medical unit commanders will immediately notify wing/unit commanders of any positive HIV test results. (T-1)

A3.1.2. Clinical Laboratory Manager**.** Draws, processes, and ships specimens for HIV testing. All specimens for HIV testing should be sent to USAFSAM HIV Testing Services, Epidemiology Laboratory Service, USAFSAM/PHE, 2510 Fifth Street, Bldg 20840, Wright-Patterson, OH 45433-7951 (DSN 798-4140). If, because of time considerations, local contract HIV testing is done for needlestick exposure, the laboratory manager must also ship a corresponding serum specimen, with HIV test request, to USAFSAM HIV Testing Services. If testing is done by an approved USAF laboratory, the laboratory manager must also ship corresponding serum specimen and results to USAFSAM HIV Testing Services. Upon completion of testing, USAFSAM HIV Testing Service will ship AD, Guard and Reserve samples to the Department of Defense Serum Repository (DoDSR). (T-1)

A3.1.3. Primary Care Management Team**.** Ensures HIV testing is accomplished in conjunction with appropriate Preventive Health Assessment or physical examinations (as described in paragraph **A3.2**). (T-1)

A3.1.4. Public Health (PH). Coordinates with MTF/CC's designee to ensure proper notification of the individual member. Is responsible for monitoring HIV positive ADAF members. Receives and reports to gaining public health personnel when HIV positive personnel are transferred. Informs the requesting laboratory of positive results so they can close out the test status in the computer system. The SAMMC HIV community liaison nurse performs additional case contact interviews, epidemiological follow-ups, and disease reporting procedures during SAMMC HIV evaluation visits. (T-1)

A3.1.5. HIV Testing Point of Contact. MTF shipping and receiving technician is responsible for shipping specimens; identifying supply deficiencies; maintaining results; and acting as the liaison with USAFSAM HIV Testing Services. (T-1)

A3.1.6. Civilian Personnel Office (CPO). Notifies by letter the clinical laboratory manager of any Department of the Air Force civilian employee requiring HIV testing. (T-1)

A3.1.7. Major Commands (MAJCOM). Deputy Command Surgeon (MAJCOM/SGP) or designee acts as liaison between USAFSAM HIV Testing Services and MTFs within the command.

A3.1.8. **USAFSAM**. Monitors and ensures that all active duty, guard and reserve positive HIV tests, as well as positive tests on dependants in the San Antonio area are reported to the HIV Program at SAMMC. Ensures that DoD mandated epidemiological studies are

accomplished on a periodic basis. The USAF HIV Medical Evaluation Unit Director or designee ensures that referred personnel on active orders are scheduled for evaluation within 30 days after being contacted by the referring base. (T-1)

A3.1.9. Reserve Medical Unit**.** Contacts the epidemiology lab to confirm positive test results before release of information, conducting counseling, or determining need for spousal or contact notification. (T-1)

A3.2. Preventive Health Assessment (PHA): Primary Care Manager ensures HIV testing is accomplished per the clinical testing requirements in the PHA for AD members or ARC members. (T-1)

A3.3. Sexually Transmitted Infection (STI) Clinic Testing:

A3.3.1. Providers counsel all STI patients regarding the need for HIV testing. Immediate HIV testing and follow-up testing IAW the most recent CDC recommendations. Informed consent laws are followed for dependents and civilians. (T-1)

A3.3.2. Providers refer all STI patients to PH for case contact interviews as soon as identified. (T-1)

A3.3.3. Test specimens IAW **A3.1.2** (T-1)

A3.3.4. MTF/CC or designee ensures all HIV positive individuals are properly notified and counseled, and all ADAF members are referred to the HIV Medical Evaluation Unit at SAMMC for medical evaluation. RMU/CC or designee ensures all HIV positive Reservists are properly notified and counseled, and all Reservists eligible for evaluation at the HIV Medical Evaluation Unit at SAMMC for medical evaluation are referred to the Unit for evaluation. (T-1)

A3.4. Drug and/or Alcohol Treatment Testing:

A3.4.1. The Alcohol and Drug Abuse Prevention and Treatment (ADAPT) Program Manager or designee notifies all AD members entering treatment programs of required HIV testing and provides the member with AF Form 3844. Local and state laws dictate availability of testing for family members and use of informed consent. Their testing is not mandatory. Individuals who are not DoD military health care beneficiaries (for example, civilian employees) are not HIV tested. (T-1)

A3.4.2. The treatment entrant reports to the MTF laboratory with AF Form 3844.

A3.4.3. Laboratory personnel obtain an HIV specimen and complete Part 2 of AF Form 3844.

A3.4.4. Accomplish the HIV testing IAW **A3.1.2** (T-1)

A3.4.5. The clinical laboratory manager forwards the completed AF Form 3844 to the ADAPT Program Manager or designee who ensures all AD members entering treatment have been HIV tested.

A3.4.6. MTF/CC or designee ensures all HIV positive individuals are properly notified and counseled, and all AD members are referred to the HIV Medical Evaluation Unit at SAMMC for medical evaluation. (T-1)

A3.5. Clinical Testing:

A3.5.1. All health care providers order HIV testing for those patients with clinical indications of HIV related diseases (e.g. active tuberculosis, incident HBV and HCV cases) and for patients with potential exposure to the virus. A confirmed positive result on a urinalysis drug test is a clinical indication for HIV testing. Providers inform patients of HIV testing for clinical indications. Local state informed consent laws are followed for family members and other beneficiaries (for example, retirees). Informed consent is not required for AD members. (T-0)

A3.5.2. Providers ordering HIV testing ensure test results are reviewed, HIV positive patients are counseled, and HIV positive AD members are referred to the HIV Medical Evaluation Unit at SAMMC for medical evaluation. Normally, the HIV designated physician in conjunction with public health personnel, provide counseling and referral services. (T-1)

A3.5.3. Providers will not routinely order HIV testing on all patients. (T-1)

A3.5.4. Clinical testing is accomplished IAW **A3.1.2** (T-1)

A3.6. Occupational Exposure Testing.

A3.6.1. Employees report to PH for occupational exposure testing and follow up IAW OSHA Blood-borne Pathogen Final Rule as implemented in the facility Infection Control Program/Employee Health Program. (T-0)

A3.6.2. Follow the latest CDC guidelines for blood and body fluid exposures to bloodborne pathogens as stated in the facility Infection Control Program/ Employee Health Program/Bloodborne Pathogen Program. Refer to AFI 44-108, *Infection Control Program*. (T-0)

A3.6.3. Personnel who perform exposure-prone procedures (to include, but not limited to, surgeons, pathologists, dentists, dental technicians, phlebotomists, emergency medical technicians, and physicians, nurses and technicians working in the emergency room, intensive care, surgery, and labor/ delivery) should know their HIV antibody status.

A3.6.4. Follow local state laws on HIV testing and informed consent for non-active duty individuals, including employees and patients. Informed consent is not required for active duty personnel. (T-0)

A3.6.5. Personnel testing is accomplished IAW **A3.1.2** (T-1)

A3.7. Prenatal Testing:

A3.7.1. Screen all AD obstetrics (OB) patients for evidence of HIV infection regardless of previous testing. (T-1)

A3.7.2. Encourage nonactive duty OB patients to be tested. Follow local state laws on informed consent for nonactive duty patients.

A3.7.3. Submit additional specimens as clinical specimens, not as OB specimens.

A3.7.4. Accomplish testing IAW **A4.1.2** (T-1)

A3.8. Results Reporting:

A3.8.1. Active Duty. The USAFSAM HIV Testing Services reports negative test results usually electronically to the submitting MTF within three workdays. First time positive notification letters are sent via FedEx Priority Overnight or by encrypted e-mail to the MTF/CC and base PH. Enclosed in each notification letter is an AF Form 74. The MTF/CC and PH officer write on their respective cards the date results were received, complete blocks (phone number, date and sign/organization/installation), document notification of the patient, and return to USAFSAM HIV Testing Services either by mail or by encrypted e-mail. Once the signed AF Form 74 is returned to the USAFSAM HIV Testing Service, the result will be certified in CHCS. Known positive patient's results are made available within 7 working days. (T-1)

A3.8.2. Air National Guard and Air Force Reserve. USAFSAM HIV Testing Services results for Air National Guard and Air Force Reserve units are reported the same as for Active Duty except that units not attached to an MTF with CHCS lab interoperability must log into the Wright-Patterson CHCS platform remotely to retrieve their results. (T-1)

A3.8.3. Clinical and Civilian Employee Samples. The USAFSAM HIV Testing Services report negative test results to the submitting MTF Laboratory Services within 3 working days. If positive, a notification letter is sent via FedEx Priority Overnight within seven workdays to PH. The letter has an AF Form 74 enclosed. The PH officer will write on AF Form 74 the date results were received, complete blocks (phone number, date and sign/organization/installation), document notification of the patient, and return to USAFSAM HIV Testing Services. (T-1)

A3.8.4. Results of HIV Testing Performed at DoD Labs Other Than Air Force**.** Occasionally, HIV testing will be done at Army or Navy laboratories on active duty Air Force personnel. When USAFSAM HIV Testing Services obtain first time positive results from other services, notification on AF members, USAFSAM HIV Testing Service will contact the submitting MTF's PH to ensure that notification has been performed. If notification has not been accomplished, USAFSAM HIV Testing Service will initiate notification as outlined in **A3.9.1**. (T-1)

A3.9. Blood Bank Testing. If a military member is identified as HIV positive through blood donation or other blood bank or outside laboratory testing, a specimen must be sent to USAFSAM HIV Testing Services for confirmation. (T-1)

A3.9.1. All military members with a positive HIV screening test should be referred to public health for appropriate counseling and follow-up instructions regarding further testing. (T-0)

A3.10. Problem Resolution:

A3.10.1. Inform USAFSAM HIV Testing Services of difficulties obtaining supplies or test results.

A3.10.2. The USAFSAM HIV Testing Services handles all test inquiries.

NOTE: Assess HIV risk at every preventive health assessment (PHA) and screen for serologic evidence of HIV infection during their PHA as required (minimum testing every 2 years). ARC personnel are screened during their periodic long flying physical every three years or nonflying physical every five years or as per the PHA clinical testing requirements. DoD mandated testing continues to include sexually transmitted disease (STI) clinic patients, drug and alcohol treatment entrants, prior to PCS OS assignments, prenatal patients, and host country requirements before deployment. (T-1)

Attachment 4

COMPLETION OF FORMS FOR REQUESTING HIV TESTING AND SPECIMEN TRANSMITTAL

A4.1. Composite Healthcare System.

A4.1.1. Submitting labs with Composite Healthcare System (CHCS) have the capability to create and send a list of specimens which can be sent to the receiving lab.

A4.1.1.1. Create a shipping/transmittal list in Composite Healthcare System (CHCS).

A4.1.1.2. Include a copy of the shipping/transmittal list in each specimen package sent to the receiving lab.

A4.1.1.3. Send the shipping/transmittal list electronically (if applicable) to the receiving lab through CHCS.

A4.2. AF FORM 1762 Completion (to be used ONLY by sites without CHCS access):

A4.2.1. AF Form 1762 is used to request HIV Screen Testing when CHCS is not available. The following information is mandatory: the facility/organization and address at the top of each form submitted. If not, specimens will be processed as NBI (no base identification) which will delay results until submitting activity can be ascertained. (T-1)

A4.2.2. For each request**,** the Full Name (last name, first name, middle initial) not nick-names, Full SSN (not last 4) with an FMP, Date of Birth (dates are to be entered as DD-MMM-YY, e.g., October 19, 1948 = 19 Oct 48), Duty Code (see **A5.3**) and Source Code (see **A5.4**). [Force Testing no longer exists. All periodic testing is done in conjunction with **"**P" (physicals) unless meeting one of the other source codes. See **A5.4** Source Codes.] (T-1)

A4.2.3. Testing will not proceed until all information is provided. Additionally, the individual being tested will not receive a test date in the master AFPC records if the name, FMP/SSN, or date of birth, do not match. (T-1)

A4.2.4. Fill out forms LEGIBLY. If entered by hand, the individual responsible for verifying the identity of personnel being screened, not the person being drawn, will print the information. Typewritten or computer generated forms are preferred. If you have computer support, call USAFSAM HIV Testing Services for available software programs to help produce a computer generated AF Form 1762. The AF Form 1762 is available through e-Publishing (**http://www.e-publishing.af.mil/shared/media/epubs/af1762.xfd**).

A4.2.5. At the bottom of the form, fill in date shipped, name of shipping person, or someone USAFSAM HIV Testing Services can contact if there are problems, and a DSN phone number or commercial number only if DSN is unavailable.

A4.2.6. MTF's that use the Composite Healthcare System (CHCS), refer to ADHOC A98 1011, Automated HIV Shipping Form, which can be downloaded from the Brooks web site: **http://www.tmssc.brooks.af.mil**.

A4.2.7. Guard and Reserve bases not utilizing CHCS can use developed software from US AFI HIV Testing Service (phone number DSN 240-8934). Guard and Reserve sites that access the Wright-Patterson CHCS remotely will use the CHCS ad hoc "ASL" (USAFSAM (Epi) Lab Referral Shipping List) function to generate their shipping list(s). This ad hoc

function is given to all Guard and Reserve users who request CHCS access through the Epidemiology Laboratory Information Systems Department.

A4.2.8. Common Errors in filing out AF Form 1762:

A4.2.8.1. Not putting Base ID/Submitting Activity at the top of each form

A4.2.8.2. Name - incomplete or not legible. Has name recently changed or is there a suffix (e.g. "Jr." or "III") after the name?

A4.2.8.3. SSN - more or less than 9 digits; not legible. Failure to include FMP with SSN.

A4.2.8.4. No Duty Code, no Source Code, or entry of unauthorized code.

A4.2.8.5. No Date or Shipping official to contact in case of problems.

A4.2.8.6. No DSN phone or commercial number if DSN unavailable.

A4.2.8.7. Failure to retain copy of AF Form 1762. A4.2.9. Forward the first two copies of the AF Form 1762 to USAFSAM HIV Testing Services along with the specimens. Keep the third copy in the laboratory for MTF record keeping purposes to track timely return of results. If test results have not been received within three days, contact USAFSAM HIV Testing Services for assistance.

A4.2.8.8. The MTF/CC reviews the reports and provides copies of positive results to the physician designated to advise and counsel HIV antibody positive individuals. (T-1)

A4.2.8.9. DoD laboratories authorized to perform HIV antibody clinical screening in-house use AF Form 1762 as a log for all HIV antibody ELISA screenings performed. All five items of information are to be completed. By the fifth working day of the month, forward all results from the previous month electronically or by floppy disc to USAFSAM HIV Testing Services. Forward specimens tested negative to USAFSAM HIV Testing Services marked “DoDSR” for placement in the DoDSR. Forward a specimen from each individual who screens positive for HIV in local testing to USAFSAM HIV Testing Services for confirmatory testing. (T-1)

A4.3. AF Form 4 is used only to request Western Blot Confirmation Testing. Do not use this form for HIV screening requests; use an AF Form 1762 as required in section **A5.1.1** For bases who perform local clinical testing and MTF Blood Banks that screen donors, all specimens that screen positive must be sent to the HIV Testing Services for FDA confirmation algorithm testing. Complete the form as follows: Fill out the top of the form with **all** required information. Blocks 13 and 14 must be completed with Duty Code and Source Code or testing will delayed until information is obtained.

A4.4. Duty Codes: To obtain the most accurate information possible, submitting laboratories must use the patient category code (pat cat code) from CHCS for duty codes on the AF Form 1762 to identify the status of the individual being tested. This is an Alpha, two numeric code which is a mandatory field when registering members into CHCS. Therefore, this information should be available to download to an ADHOC report when computer generating the CHCS AF Form 1762. These codes closely emulate the DEERS codes for status of individual member being tested. For submitting activities not on CHCS, use the Pat Cat that closely defines the status of the individual. The following are the most commonly used:

PAT CATs DEFINITION.

A11 Army, Active Duty A12 Army, Reserve A13 Army, Recruits A14 Army, Academy Cadet A15 Army, National Guard

PAT CATs DEFINITION.

A21 Army, ROTC A23 Army National Guard A26 Army, Applicants-Enlistment's A31 Army, Retired A41 Army, Dependent of Active Duty A43 Army, Dependent of Retiree A45 Army, Dependent of Deceased Active Duty A47 Army, Dependent of Deceased Retiree A48 Army, Unmarried former Spouse

F11 Air Force, Active Duty F12 Air Force, Reserve F13 Air Force, Recruits F14 Air Force, Academy Cadet F15 Air Force, National Guard F21 Air Force, ROTC F23 Air Force National Guard F26 Air Force, Applicants-Enlistment's F31 Air Force, Retired F41 Air Force, Dependent of Active Duty F43 Air Force, Dependent of Retiree F45 Air Force, Dependent of Deceased Active Duty F47 Air Force, Dependent of Deceased Retiree F48 Air Force, Unmarried former Spouse M11 Marine Corps, Active Duty M12 Marine Corps, Reserve M13 Marine Corps, Recruits M14 Marine Corps, Academy-midshipmen M21 Marine Corps, ROTC M26 Marine Corps, Applicants-Enlistment's M31 Marine Corps, Retired M41 Marine Corps, Dependent of Active Duty M43 Marine Corps, Dependent of Retiree M45 Marine Corps, Dependent of Deceased Active Duty M47 Marine Corps, Dependent of Deceased Retiree M48 Marine Corps, Unmarried former Spouse

N11 Navy, Active Duty N12 Navy, Reserve N13 Navy, Recruits N14 Navy, Academy-Midshipmen N21 Navy, ROTC N26 Navy, Applicants-Enlistment's N31 Navy, Retired N41 Navy, Dependent of Active Duty N43 Navy, Dependent of Retiree N45 Navy, Dependent of Deceased Active Duty N47 Navy, Dependent of Deceased Retiree N48 Navy, Unmarried former Spouse

C11 Coast Guard, Active Duty C12 Coast Guard, Reserve

PAT CATs DEFINITION

C31 Coast Guard, Retired C41 Coast Guard, Dependent of Active Duty C43 Coast Guard, Dependent of Retiree

P11 Public Health Svs, Active Duty P12 Public Health Svs, Reserve P31 Public Health Svs, Retired P41 Public Health Svs, Dependent of Active Duty P43 Public Health Svs, Dependent of Retiree

K53 Civil Service Employee/Other Federal Agencies K57 Civilian Employee, Occupational

Health K59 Federal Government Employees, Overseas K61 VA Sharing Agreement/VA beneficiary K64 Other Federal Agency (DAF employee) K66 Federal Prisoners

Table A4.1. PAT CATs Definition.

A11	Army, Active Duty
A12	Army, Reserve
A13	Army, Recruits
A14	Army, Academy Cadet
A15	Army, National Guard
A21	Army, ROTC
A23	Army National Guard
A26	Army, Applicants-Enlistment's
A31	Army, Retired
A41	Army, Dependent of Active Duty
A43	Army, Dependent of Retiree
A45	Army, Dependent of Deceased Active Duty
A47	Army, Dependent of Deceased Retiree
A48	Army, Unmarried former Spouse

F11	Air Force, Active Duty
F12	Air Force, Reserve
F13	Air Force, Recruits
F14	Air Force, Academy Cadet
F15	Air Force, National Guard
F21	Air Force, ROTC
F23	Air Force National Guard
F26	Air Force, Applicants-Enlistment's
F31	Air Force, Retired
F41	Air Force, Dependent of Active Duty
F43	Air Force, Dependent of Retiree
F45	Air Force, Dependent of Deceased Active Duty
F47	Air Force, Dependent of Deceased Retiree
F48	Air Force, Unmarried former Spouse

M11	Marine Corps, Active Duty
M12	Marine Corps, Reserve
M13	Marine Corps, Recruits
M14	Marine Corps, Academy -midshipmen
M15	Marine Corps, National Guard
M21	Marine Corps, ROTC
M23	Marine Corps National Guard
M26	Marine Corps, Applicants-Enlistment's
M31	Marine Corps, Retired
M41	Marine Corps, Dependent of Active Duty
M43	Marine Corps, Dependent of Retiree
M45	Marine Corps, Dependent of Deceased Active Duty
M47	Marine Corps, Dependent of Deceased Retiree
M48	Marine Corps, Unmarried former Spouse

N11	Navy, Active Duty
N12	Navy, Reserve
N13	Navy, Recruits
N14	Navy, Academy Cadet
N15	Navy, National Guard
N21	Navy, ROTC
N23	Navy National Guard
N26	Navy, Applicants-Enlistment's
N31	Navy, Retired
N41	Navy, Dependent of Active Duty
N43	Navy, Dependent of Retiree
N45	Navy, Dependent of Deceased Active Duty
N47	Navy, Dependent of Deceased Retiree
N48	Navy, Unmarried former Spouse

C11	Coast Guard, Active Duty
C12	Coast Guard, Reserve
C31	Coast Guard, Retired
C41	Coast Guard, Dependent of Active Duty
C43	Coast Guard, Dependent of Retiree

P11	Public Health Svs, Active Duty
P12	Public Health Svs, Reserve
P31	Public Health Svs, Retired

K53	Civil Service Employee/Other Federal Agencies
K57	Civilian Employee, Occupational Health
K59	Federal Government Employees, Overseas
K61	VA Sharing Agreement/VA beneficiary
K64	Other Federal Agency (DAF employee)
K66	Federal Prisoners

P41	Public Health Svs, Dependent of Active Duty
P43	Public Health Svs, Dependent of Retiree

A4.5. Source Code. The only authorized codes used in the appropriate block on the AF Form 1762 are listed below. These codes identify the reason that the individual is being screened. They were adopted for use throughout DoD by the Reportable Disease Data Base (RDDB) Working Group. A single code is entered on the AF Form 1762. Multiple codes for an individual are not authorized:

Table A4.2. Source Codes.

A	Alcohol and Drug Treatment
B	Blood Donor (Authorized for use on specimens or confirmation specimens)
C	Contact Testing (Referral)
F	Force Screening (routine screening of personnel)
I	Indicated for Clinical Reasons
J	Prisoners or Detained Persons
M	Medical Admissions (Including Psychiatric)
N	Pre-deployment
O	OB Clinic/Pregnancy Related
P	Physical Examinations
R	Requested by Individual
S	Surgical Admission (Including Invasive Procedures and ER)
T	Post-deployment
V	STI Clinic Visit
X	Any Other Source (used only in extremely rare cases)

A4.6. Shipment of Specimen Requirements.

A4.6.1. Ship specimens using instructions provided by USAFSAM HIV Testing Services. It is very important that the MTFs follow these instructions. Deviation could cause rejection of a shipment and necessitate redrawing each individual.

A4.6.2. USAFSAM HIV Testing Services will only accept 12x75 mm polypropylene tubes. If the whole shipment arrives in anything other than these type tubes, the shipment will be returned to the submitting MTF at their expense to process in the correct tubes. Single specimens will have to be redrawn. Tubes and caps can be ordered from most laboratory supply catalogues (see below) or can be obtained by completing a supply order form and submitting to our Customer Service Team via email at **usafsam.phe.cst@wpafb.af.mil.** This order form can be found on our website at **https://kx.afms.mil/epi.calling** the Epidemiology Laboratory Services at DSN 240-8751 or 8378. If the submitting MTF's stock runs out, it will have to hold specimens until a supply of the correct tubes are received.

Test Tubes, 12x75 mm, polypropylene, round bottom

FSN 6640-01-264-2362

Curtin-Matheseon Scientific (CMS) #289-657

S/P-Baxter T-1226-12

Plug Cap for 12x75 test tubes

FSN 6640-01-2222963

CMS #148-346

S/P-Baxter T1226-32

Tubes and caps in one order

S/P-Baxter T1226-42

Double sided Plastic Bags

Fisher Cat #01-824 Lab Safety Supply Cat #TL-23805

VWR Cat #11216-783

A4.6.3. Label tubes with a CHCS generated label. If CHCS is unavailable, write FULL NAME (Last name, first name, middle initial), and the FULL SSN with FMP, and collection date on label, then place label long-wise without covering the bottom of tube. (Pre/Post deployment specimens need draw date). Secure with a plastic plug cap. DO NOT USE PARAFILM.

A4.6.4. Place patient samples in a foam tube rack in the order listed on the shipping/transmittal list or AF Form 1762. Wrap foam tube rack containing specimens in absorbent material and place in a large plastic shipping bag. Place patient samples (amount for 1 AF Form 1762/no more than 22) with absorbent material in large portion of plastic shipping bag. Place one copy of the shipping/transmittal list or one copy and original of AF Form 1762. Place original and one copy of AF Form 1762 inside the outer pouch of the shipping bag corresponding to samples and tear off plastic strip covering the adhesive and to SEAL THE BAG. If foam tube racks are not available, place no more than 10 specimens in a small plastic shipping bag containing absorbent material. Place one copy of the shipping/transmittal list or one copy and original of AF Form 1762 in the outer pouch of the shipping bag and SEAL THE BAG. Repeat for each batch of 10 specimens. In shipping

HIVs specimens with other EPI specimens, place HIV specimens in a separate ziplock plastic shipping bag marked: "HIV"

A4.6.5. The following common errors could be avoided if a quality control program exists.

A4.6.6. Common errors in Specimen Preparation:

A4.6.6.1. Not spinning specimen down causing hemolyzed specimens

A4.6.6.2. Putting specimens in the wrong tubes; only polypropylene 12x75 mm will be accepted.

A4.6.6.3. Over-filling tubes, causing tube cap to come off when the specimen is frozen.

A4.6.6.4. Not putting tube caps on tightly.

A4.6.6.5. Tape or parafilm around the cap of the tube.

A4.6.6.6. Omitting the individual's full name/full SSN on tube

A4.6.6.7. Only last four of SSN on the transport tube.

A4.6.6.8. Name on tube does not match name on shipping/paperwork transmittal list or AF Form 1762.

A4.6.6.9. No shipping/transmittal list or AF Form 1762 accompanying the specimen tube.

A4.6.7. Common Errors in Specimen Packaging:

A4.6.7.1. Not wrapping tubes with absorbent paper material.

A4.6.7.2. Not maintaining a cold environment (use ice, cold packs, or dry ice as appropriate).

A4.6.7.3. Not separating shipping/transmittal lists or AF Forms 1762 from specimens, causing forms to get wet if leakage occurs.

A4.6.7.4. Not sealing the shipping bag completely causing specimens to be lost in transit.

A4.6.7.5. Not packing specimens in foam shipping rack or separating them into batches of ten.

Attachment 5

HIV TESTING AND INTERPRETATION OF RESULTS

A5.1. Laboratories:

A5.1.1. Use only approved MTF laboratories or the USAFSAM HIV Testing Services to perform the initial screening test on specimens collected from Service members. (T-1)

A5.1.2. All approved Air Force MTF laboratories that perform in-house HIV testing must send a serum sample for testing to USAFSAM HIV Testing Services IAW **A3.1.2** This sample will be forwarded to the DoD serum repository after testing by the USAF HIV Testing Service. (T-1)

A5.1.3. The USAFSAM HIV Testing Services, USAFSAM, Wright-Patterson Air Force Base, maintains specimens for seven days after testing then discarded. Specimens from Reserve and Guard units are sent to the DoD serum repository. (T-1)

A5.2. Specimen Collection and Handling:

A5.2.1. Collect blood samples with appropriate vacutainer tubes.

A5.2.2. Label tubes with a CHCS generated label. As a minimum, each sample is labeled with three unique patient identifiers such as; the individual's full name, FMP/SSN, date of birth or a laboratory assigned number. Also include the date and time of collection.

A5.2.3. Samples are centrifuged and serum separated within six hours of collection.

A5.2.4. Specimens should be refrigerated before the initial test. If the initial test is cannot be conducted within seven days, or the date at which the sample was collected is unknown, the specimen must be frozen (≤ -20°C).

A5.2.5. Use cold packs to keep specimens at refrigerated temperatures (2 – 8°C) or shipped on dry ice if the samples are frozen (≤ -20°C) during transit between laboratories.

A5.2.6. Ship specimens according to US (or foreign) biological agent shipping requirements.

A5.3. Initial Test:

A5.3.1. Conduct the initial test using a FDA-approved screening test. Interpret results according to the manufacturer's package insert.

A5.3.2. The laboratory establishes an internal quality control program.

A5.3.3. All controls will be 100 percent correct before the entire batch results are considered acceptable.

A5.4. Supplemental/Confirmatory Tests:

A5.4.1. All HIV testing will follow an APHL/CDC-approved algorithm. (T-0)

A5.4.2. Perform a FDA-approved confirmatory test, such as a Western Blot (WB) test. For Western Blot tests with indeterminate results, an alternative FDA approved test can be used to resolve indeterminates such as a viral load-based assay (APTIMA) or other FDA approved testing platform. (T-0)

A5.4.3. The laboratory validates its procedure using a protocol that establishes accuracy, precision, and reproducibility.

Attachment 6

HIV TESTING OF DOD CIVILIAN EMPLOYEES

A6.1. Direct requests for authority to screen DoD civilian employees for HIV to the Assistant Secretary of Defense (ASD)/Force Management and Personnel (FM&P). Only requests that are based on a host nation HIV screening requirement are accepted. Requests based on other concerns, such as sensitive foreign policy or medical health care issues, are not considered under this instruction. Approvals are provided in writing by the ASD/FM&P and apply to all the DoD Components that may have activities located in the host nation. (T-0)

A6.2. Specific HIV screening requirements may apply to DoD civilian employees currently assigned to positions in the host nation and to prospective employees. When applied to prospective employees, HIV screening is considered a requirement imposed by another nation, that must be met before the final decision to select the individual for a position, or before approving temporary duty or detail to the host nation. Individuals who refuse to cooperate with HIV screening requirements or those who cooperate and are diagnosed as HIV seropositive, may not be considered further for employment in host nations with HIV screening requirements. (T-0)

A6.3. DoD civilian employees who refuse to cooperate with the screening requirements are treated, as follows:

A6.3.1. Those who volunteered for the assignment, whether permanent or temporary, are retained in their official position without further action and without prejudice to employee benefits, career progression opportunities, or other personnel actions to which those employees are entitled under applicable law or instruction.

A6.3.2. Those who are obligated to accept assignment to the host nation under the terms of an employment agreement, regularly scheduled tour of duty, or similar and/or prior obligation may be subjected to an appropriate adverse personnel action under the specific terms of the employment agreement or other authorities that may apply.

A6.3.3. Host nation screening requirements, which apply to DoD civilian employees currently located in that country, must be observed. Appropriate personnel actions may be taken, without prejudice to employee rights and privileges to comply with the requirements. (T-0)

A6.4. Individuals who are not employed in the host nation, who accept the screening, and who are evaluated as HIV seropositive shall be denied the assignment on the basis that evidence of seronegativity is required by the host nation. If denied the assignment, such DoD employees shall be retained in their current positions without prejudice. Appropriate personnel actions may be taken, without prejudice to employee rights and privileges, on DoD civilian employees currently located in the host nation. In all cases, employees shall be given proper counseling and shall retain all the rights and benefits to which they are entitled, including accommodations for the handicapped as in the applicable ASD/FM&P Memorandum, and for employees in the United States (29 U.S.C. 794). Non-DoD employees are referred to appropriate support service organizations. (T-0)

A6.5. Some host nations may not bar entry to HIV seropositive DoD civilian employees, but may require reporting of such individuals to host nation authorities. In such cases, DoD civilian employees who are evaluated as HIV seropositive shall be informed of the reporting

requirements. They shall be counseled and given the option of declining the assignment and retaining their official positions without prejudice or notification to the host nation. If assignment is accepted, the requesting authority shall release the HIV seropositive result, as required. Employees currently located in the host nation may also decline to have seropositive results released. In such cases, they may request and shall be granted early return at government expense or other appropriate personnel action without prejudice to employee rights and privileges. (T-0)

A6.6. A positive HIV screening test must be confirmed by an FDA approved confirmatory test according to an APHL/CDC approved algorithm. A civilian employee may not be identified as HIV antibody positive, unless the confirmatory test is positive. The clinical standards in this instruction shall be observed during initial and confirmatory testing. (T-0)

A6.7. Provide tests at no cost to the DoD civilian employees, including applicants. (T-0)

A6.8. Counsel DoD civilian employees infected with HIV. (T-0)

Attachment 7

GUIDELINES FOR ADMINISTERING THE ORDER TO FOLLOW PREVENTIVE MEDICINE REQUIREMENTS TO INDIVIDUALS INFECTED WITH HIV

A7.1. After the member is notified by a health care provider that he or she has tested positive for HIV infection, and the significance of such a test, the MTF/CC expeditiously notifies the member's unit commander of the positive test results. For active duty members, the member's unit commander issues an order to follow preventive medicine requirements. For unit assigned reservists, this order is issued only after their immediate commander determines the member will be retained in the Selected Reserve. When the order is given, a credentialed provider is present to answer any medical concerns of the member. Use the order at **Attachment 13**. It is signed and dated by the commander and member. If the member refuses to sign, the commander notes that the member refused to sign in the acknowledgment section. The order is securely stored to protect the member's privacy and confidentiality. A copy of the order is provided to the member. Upon the individual's reassignment, the unit commander forwards the order in a sealed envelope to the gaining commander. The envelope is marked "To Be Opened By Addressee Only." Upon the individual's separation from the Air Force, the order is destroyed. (T-1)

A7.2. AD members testing positive for HIV infection undergo a complete medical evaluation at SAMMC. Upon arrival, all HIV positive members are counseled by a health care provider or by the HIV Community Health Nurse (CHN) assigned to the HIV Medical Evaluation Unit at SAMMC. Use AF Form 3845, **Preventive Medicine Counseling Record,** or similar form. The CHN signs the form. The member signs the counseling record acknowledging receipt of the counseling. One copy of the record is given the member and one copy filed in the records of the HIV CHN. (T-1)

A7.3. If the member is returned to duty from the HIV Medical Evaluation Unit to a different unit from which he or she came, the gaining unit commander issues an additional order to follow preventive medicine requirements to the member. A copy of this order is given to the member. Use the order at **Attachment 13**. The commander may request the MTF/CC or other health care provider is present when the order is administered to answer any medical concerns of the member. The commander and member sign and date the order. If the member refuses to sign, the commander notes the member refused to sign in the acknowledgment section. Securely store the order to protect the member's privacy and confidentiality. (T-1)

A7.4. It is unnecessary to recall members issued orders under former procedures. HIV seropositive members, who have not been previously issued preventive medicine requirement orders, must be counseled by a health care provider assigned to the local medical facility on AF Form 3845 and issued an order (**Attachment 13**) by his or her unit commander. (T-1)

NOTE: DoD requested the Military Departments standardize the administration of the order to follow preventive medicine requirements to individuals infected with HIV. The guidelines above standardize and simplify procedures.

Attachment 8

STANDARD CLINICAL PROTOCOL

A8.1. Medical Evaluation:

A8.1.1. Accomplish a complete medical evaluation of AF personnel with HIV infection with an initial visit, a second visit at 6 months, and subsequent visits every 12 months at SAMMC as long as the member is retained on active duty. HIV disease will be staged according to current CDC guidelines for every clinical visit. Interim medical visits will be performed as necessary in the member's local area in accordance with current DHHS Guidelines for Management of Adult HIV Infections. For unit assigned reservists not on extended active duty, this evaluation is not accomplished until after the commander's decision to retain the member. If the member is retained, the evaluation must be accomplished and documented IAW AFI 48-123, AFI 41-210, and AFRC medical guidance on nonduty related medical conditions. (T-1)

A8.1.2. Maintain a frozen serum specimen on all HIV positive individuals at a central serum bank for at least three years at -70 degrees Celsius. (T-1)

A8.1.3. Seek psychiatric consultation if there are concerns about fitness for duty or if the screening evaluation suggests more detailed psychiatric evaluation is needed. If the patient has persistent evidence of diminished intellectual skills, personality changes, and motor impairment, more specialized studies (neurologic studies, computed tomography or magnetic resonance imaging, lumbar puncture, psychiatric examination, and neuropsychiatric testing) may be required to evaluate the possible presence of a HIV-related mental or neurological syndrome. (T-1)

A8.1.4. Perform additional testing in both initial and follow-up epidemiologic/clinical assessments as indicated to maintain compliance with changes in accepted standards of care for management of HIV infection. (T-1)

A8.2. Medical Record Coding of HIV-1 Infections. Follow current ICD CM coding guidelines for medical record coding of HIV infection.

A8.3. Disposition of Members Infected:

A8.3.1. DoD Directive 1332.18, Separation From the Military Service by Reason of Physical Disability, November 4, 1996, and AFI 41-210, Medical Evaluations Boards (MEB) and Continued Military Service, provides guidelines for fitness for duty determinations. However, MEB pre-screening will occur with an Initial Review in Lieu of an MEB (I-RILO) under the guidelines of AFI 41-210, chapter 4, section 4k. This guidance provides I-RILO screening procedures for both ADAF members Air Reserve Component members. (T-0)

A8.3.2. Refer AD members infected with HIV for I-RILO in accordance with AFI 41-210, immediately following the initial evaluation. However, while I-RILOs usually require a letter from the member's Commander indicating the impact of a member's condition upon his/her duty performance, such a letter is not required in the case of HIV seropositive members because of the risk of Privacy Act violations while routing such letters through the Commander's support staff. I-RILOs will only be submitted from the HIV Medical

Evaluation Unit at SAMMC and individual home bases are not to submit I-RILOs or annual ALC-C RILOs for HIV infection. (T-1)

Attachment 9

RETENTION AND SEPARATION

A9.1. Retention:

A9.1.1. Members with laboratory evidence of HIV infection who are able to perform the duties of their office, grade, rank and/or rating, may not be separated solely on the basis of laboratory evidence of HIV infection. (T-0)

A9.1.2. HIV-infected members who have been evaluated for continued military service and are retained will receive an Assignment Limitation Code (ALC-C). Please refer to AFI 41-210 for ALC-C stratifications and for a list of waiver authorities for OCONUS TDY and/or assignment. (T-1)

A9.2. Separation:

A9.2.1. AFI 36-3212, *Physical Evaluation for Retention, Retirement, and Separation,* provides guidance for separation or retirement of AD members who are determined to be unfit for further duty.

A9.2.2. AD and Reserve members with laboratory evidence of HIV infection found not to have complied with lawfully ordered preventive medicine procedures are subject to administrative and disciplinary action, which may include separation.

A9.2.3. Separation of AD members with laboratory evidence of HIV infection under the plenary authority of the Secretary of the Air Force, if requested by the member, is permitted.

A9.2.4. The immediate commander of ARC members not on extended active duty who show serologic evidence of HIV infection will determine if the member can be utilized in the Selected Reserve. If the member cannot be utilized, he/she may be transferred involuntarily to the Standby Reserve or separated. If separated, the characterization of service shall never be less than that warranted by the member's service record. (T-1)

A9.2.5. Air Force members determined to have been infected with HIV at the time of enlistment or appointment are subject to discharge for erroneous enlistment or appointment. (T-1)

Attachment 10

LIMITATIONS ON THE USE OF INFORMATION FROM EPIDEMIOLOGICAL ASSESSMENTS

A10.1. Limitations of Results:

A10.1.1. Laboratory tests results performed under this instruction may not be used as the sole basis for separation of a member. The results may be used to support a separation based on physical disability or as specifically authorized by any section in this instruction. This instruction shall not preclude use of laboratory test results in any other manner consistent with law or instruction. (T-1)

A10.1.2. Laboratory test results confirming evidence of HIV infection may not be used as an independent basis for any adverse administrative action or any disciplinary action, including punitive actions under the Uniform Code of Military Justice (UCMJ) (10 U.S.C. 47, reference [j]). (T-1) However, such results may be used for other purposes including, but not limited to, the following:

A10.1.2.1. Separation under the accession testing program.

A10.1.2.2. Voluntary separation for the convenience of the Government.

A10.1.2.3. Other administrative separation action authorized by Air Force policy.

A10.1.2.4. In conducting authorized Armed Services Blood Program Look Back activities.

A10.1.2.5. Other purposes (such as rebuttal or impeachment) consistent with law or instruction (e.g., the Federal or Military Rules of Evidence or the Rules of Evidence of a State), including to establish the HIV seropositivity of a member when the member disregards the preventive medicine counseling or the preventive medicine order or both in an administrative or disciplinary action based on such disregard or disobedience.

A10.1.3. HIV infection is an element in any permissible administrative or disciplinary action, including any criminal prosecution (e.g., as an element of proof of an offense charged under the UCMJ or under the code of a State or the United States).

A10.1.4. HIV infection is a proper ancillary matter in an administrative or disciplinary action, including any criminal prosecution (e.g., as a matter in aggravation in a court-martial in which the HIV positive member is convicted of an act of rape committed after being informed that he or she is HIV positive).

A10.2. Limitations on the Use of Information Obtained in the Epidemiological Assessment Interview:

A10.2.1. Information obtained from a member during, or as a result of, an epidemiological assessment interview may not be used against the member in the following situations:

A10.2.1.1. A court-martial.

A10.2.1.2. Line of duty determination.

A10.2.1.3. Nonjudicial punishment.

A10.2.1.4. Involuntary separation (other than for medical reasons).

A10.2.1.5. Administrative or punitive reduction-in-grade.

A10.2.1.6. Denial of promotion.

A10.2.1.7. An unfavorable entry in a personnel record.

A10.2.1.8. A denial to reenlistment.

A10.2.1.9. Any other action considered by the Secretary of the Air Force concerned to be an adverse personnel action.

A10.2.2. The limitations in paragraph **A10.2.1** do not apply to the introduction of evidence for appropriate impeachment or rebuttal purposes in any proceeding, such as one in which the evidence of drug abuse or relevant sexual activity (or lack thereof) has been first introduced by the member or to disciplinary or other action based on independently derived evidence.

A10.2.3. The limitations in paragraph **A10.2.1** do not apply to nonadverse personnel actions on a case-by-case basis, such as: A10.2.3.1. Reassignment. A10.2.3.2. Disqualification (temporary or permanent) from a personnel reliability program. A10.2.3.3. Denial, suspension, or revocation of a security clearance. A10.2.3.4. Suspension or termination of access to classified information.

A10.2.4. Removal (temporary or permanent) from flight status or other duties requiring a high degree of stability or alertness, including explosive ordnance disposal or deep-sea diving.

A10.3. Entries in Personnel Records: Except as authorized by this instruction, if any such personnel actions are taken because of, or are supported by, serologic evidence of HIV infection or information described in paragraph **A10.1.2**, no unfavorable entry may be placed in a personnel record for such actions. Recording a personnel action is not an unfavorable entry in a personnel record. Additionally, information reflecting an individual's serologic or other evidence of infection with HIV is not grounds for an unfavorable entry in a personnel record.

Attachment 11

PERSONNEL NOTIFICATION, MEDICAL EVALUATION, AND EPIDEMIOLOGICAL INVESTIGATION

A11.1. Personnel Notification:

A11.1.1. Once a health care authority has been notified of an individual with serologic or other laboratory/clinical evidence of HIV infection, public health and or the HIV designated physician shall undertake preventive medicine intervention. The CHN and physician staff at the SAMMC HIV Medical Evaluation Unit will assist military and civilian blood bank organizations and preventive medicine authorities with blood donor look back tracing and referral and refer case-contact information to the appropriate military or civilian health authority. (T-0)

A11.1.2. All individuals with serologic evidence of HIV infection who are military healthcare beneficiaries shall be counseled by a physician or a designated healthcare provider on the significance of a positive antibody test. They shall be advised as to the mode of transmission, the appropriate precautions and personal hygiene measures required to minimize transmission through sexual activities and/ or intimate contact with blood or blood products, and of the need to advise any past or future sexual partners of their infection. Women shall be advised of the risk of perinatal transmission during past, current, and future pregnancies. The individuals shall be informed that they are ineligible to donate blood, sperm, organs or tissues and shall be placed on a permanent donor deferral list. (T-0)

A11.1.3. Service members identified to be at risk shall be counseled and tested for serologic evidence of HIV infection. Other DoD beneficiaries, such as retirees and family members, identified to be at risk, shall be informed of their risk and offered serologic testing, clinical evaluation, and counseling. The names of individuals identified to be at risk who are not eligible for military healthcare shall be referred to civilian health authorities in the local area where the index case is identified, unless prohibited by the appropriate State or host-nation civilian authority. Anonymity of the HIV index case shall be maintained, unless reporting is required by civil authorities. (T-0)

A11.1.4. Blood donors who demonstrate repeatedly reactive screening tests for HIV, but for whom confirmatory test(s) are negative or indeterminate are not eligible for blood donor pool, shall be appropriately counseled. (T-0)

A11.2. Medical Evaluation:

A11.2.1. Active duty personnel and ARC members on extended active duty who have tested positive for HIV shall be sent to the HIV Medical Evaluation Unit at SAMMC for medical evaluation. All DoD directed evaluations will be completed as an outpatient, coordinated by the HIV Evaluation Unit staff. All Active Duty HIV patients undertaking their initial evaluation will undergo mental health status screening by a SAMMC mental health provider. (T-1)

A11.2.2. Physically or mentally unstable HIV patients should have their conditions addressed and stabilized sufficiently for outpatient management prior to transport. Upon arrival, those patients exhibiting an active process requiring physician attention during non-duty hours will be admitted to the appropriate inpatient service. (T-1)

A11.2.3. SAMMC HIV Medical Evaluation Unit staff will conduct a confidential patient epidemiologic interview, repeat the contact notification process, and verify blood donation "lookback" process. The HIV Evaluation Unit CHN or designee will provide the disease education and risk reduction counseling during the patient interview, and complete two copies of the standardized medical counseling form ("Prevention Medicine Counseling Record"). One copy is given to the patient, and the other copy maintained in the HIV CHN's confidential patient files. If the patient refuses to sign, SAMMC Directorate of Medical Law will be notified. The "Order to Follow Preventive Medicine Requirements" is issued by the unit commander of an HIV infected person prior to the patient's initial evaluation by the HIV unit. (T-1)

A11.2.4. All HIV infected active duty and TDRL personnel arriving at SAMMC will receive medical evaluation and staging of their HIV disease by an assigned HIV unit staff physician. The physician will also provide disease specific patient education and appropriate treatment recommendations, and serve as liaison with consulting or inpatient services when necessary. The HIV unit physician will be available to the patient's primary care provider for ongoing patient management and any issues concerning scheduled reevaluations. (T-1)

A11.3. Epidemiological Investigation:

A11.3.1. Epidemiological investigation shall attempt to determine potential contacts of patients who have serologic or other laboratory or clinical evidence of HIV infection. The patient shall be informed of the importance of case-contact notification to interrupt disease transmission and shall be informed that contacts shall be advised of their potential exposure to HIV. Individuals at risk of infection include sexual contacts (male or female); children born to infected mothers; recipients of blood, blood products, organs, tissues, or sperm; and users of contaminated intravenous drug paraphernalia. At risk individuals who are eligible for healthcare in the military medical system shall be notified. The Secretaries of the Military Departments shall designate all spouses (regardless of the Service affiliation of the HIV infected Reservist) who are notified under this provision to receive serologic testing and counseling on a voluntary basis from MTFs under the Secretaries' of the Military Departments jurisdiction. (T-0)

A11.3.2. Communicable disease reporting procedures shall be followed consistent with this Directive through liaison between the public health authorities and the appropriate local, State, Territorial, Federal, or host-nation health jurisdiction. (T-0)

Attachment 12

PROCEDURE FOR EVALUATING T-HELPER CELL COUNT

A12.1. Analytical Procedure:

A12.1.1. Determine the percentage of CD4+ and CD3+ positive lymphocytes by immunophenotyping blood cells using flow-cytometry instrumentation per applicable CDC guidelines. Each laboratory performing T-helper cell counts maintains a current and complete standard operating procedure manual. The absolute T-helper cell count is a product of the percentage of T-helper cells (defined as CD4+ and CD3+ positive lymphocytes) and the absolute lymphocyte level.

A12.2. Internal Quality Control Program:

A12.2.1. Each laboratory maintains a comprehensive internal quality control program. Minimally, on each day of operation monitor the following flow-cytometry procedures or reagents:

A12.2.1.1. Optical focusing and alignment of all lenses and light paths for forward-angle light scatter, right-angle light scatter, red fluorescence, and green fluorescence if these functions are adjustable on the instrument.

A12.2.1.2. Standardize fluorescent intensity beads, particles, or cells with fluorescence in the range of biological samples.

A12.2.1.3. Verify fluorescent compensation beads, particles, or cells with fluorescence in the range of biological samples.

A12.2.1.4. A human blood control sample or equivalent.

A12.2.2. Each laboratory establishes tolerance limits for each of the procedures or reagents in paragraph **A12.1** Take corrective action and document when any quality control reagent exceeds established tolerance limits. Accomplish routine maintenance and function verification checks. The laboratory director regularly reviews corrective and quality control records.

A12.3. External Quality Control Program: The Army establishes and operates an external quality control program to evaluate the results reported by the flow-cytometry laboratories. The external quality control program includes a hematology survey to monitor the performance of the absolute lymphocyte count and a flow-cytometry survey to monitor the performance of each immunophenotyping procedure.

A12.4. Recording and Reporting Data: The laboratory director reviews and verifies the reported results. The laboratory report contains data from which absolute and relative values may be calculated for each lymphocyte subpopulation along with locally derived normal ranges inclusive of the fifth and ninety-fifth percentiles. The laboratory maintains permanent files of patient reports, internal and external quality control records, and instrument maintenance and performance verification checks.

A12.5. Personnel Qualifications:

A12.5.1. Properly train all personnel involved with the flow-cytometry instrumentation.

A12.5.2. Director of the flow-cytometry laboratory holds a doctoral degree in a biologic science or is a physician and possesses experience in immunology or cell biology.

A12.5.3. Technical supervisor holds a bachelor's degree in a biological science and has at least two years of experience in flow-cytometry.

A12.6. Safety: All laboratories comply with the CDC biosafety level 2 standards. All procedures having the potential to create infectious aerosols shall be conducted within the confines of a Class II biological safety cabinet. Although certain specimen processing procedures may inactivate infectious agents, all material is treated as infectious throughout all procedures. Decontaminate all material generated in the processing and evaluation of blood specimens and dispose of using established hazardous waste disposal policies.

Attachment 13

ORDER TO FOLLOW PREVENTIVE MEDICINE REQUIREMENTS

Because of the necessity to safeguard the overall health, welfare, safety, and reputation of this command and to ensure unit readiness and the ability of the unit to accomplish its mission, certain behavior and unsafe health procedures must be proscribed for members who are diagnosed as positive for HIV infection.

As a military member who has been diagnosed as positive for HIV infection, you are hereby ordered:

(1) to verbally inform sexual partners that you are HIV positive prior to engaging in sexual relations. This order extends to sexual relations with other military members, military dependents, civilian employees of DoD components or any other persons;

(2) to use proper methods to prevent the transfer of body fluids during sexual relations, including the use of condoms providing an adequate barrier for HIV (e.g. latex);

(3) in the event that you require emergency care, to inform personnel responding to your emergency that you are HIV positive as soon as you are physically able to do so.

(4) when seeking medical care, you may wish to inform the provider that you have HIV so that the provider can use that information to optimize your evaluation and treatment;

(5) not to donate blood, sperm, tissues, or other organs.

Violating the terms of this order may result in adverse administrative action or punishment under the Uniform Code of Military Justice for violation of a lawful order.

_____

Signature of Commander and Date

ACKNOWLEDGMENT

I have read and understand the terms of this order and acknowledge that I have a duty to obey this order. I understand that I must inform sexual partners, including other military members, military dependents, civilian employees of DoD components, or any other persons, that I am HIV positive prior to sexual relations; that I must use proper methods to prevent the transfer of body fluids while engaging in sexual relations, including the use of condoms providing an adequate barrier for HIV; that if I need emergency care I will inform personnel responding to my emergency that I am HIV positive as soon as I am physically able to do so; that when I seek medical or dental care I may wish to inform the provider that I have HIV in order to optimize my evaluation and treatment; and that I must not donate blood, sperm, tissues, or other organs. I understand that violations of this order may result in adverse administrative actions or punishment under the Uniform Code of Military Justice for violation of a lawful order.

_____

Signature of Member and Date

USCENTCOM 231245Z MAR 17 MOD THIRTEEN TO USCENTCOM INDIVIDUAL PROTECTION AND INDIVIDUAL-UNIT DEPLOYMENT POLICY

UNCLASSIFIED//

SUBJ/MOD THIRTEEN TO USCENTCOM INDIVIDUAL PROTECTION AND INDIVIDUAL/UNIT DEPLOYMENT POLICY//

REF/A/MSG/CDRUSCENTCOM/SG/032024ZOCT2001//
AMPN/ORIGINAL USCINCCENT INDIVIDUAL PROTECTION AND INDIVIDUAL UNIT DEPLOYMENT POLICY MESSAGE//

REF/B/MSG/CDRUSCENTCOM/SG/021502ZDEC2013//
AMPN/MOD TWELVE TO USCENTCOM INDIVIDUAL PROTECTION AND UNIT DEPLOYMENT POLICY MESSAGE. MOD TWELVE IS NO LONGER VALID AND IS SUPERSEDED BY MOD THIRTEEN//

REF/C/DOC/USD(P&R)/11AUG2006, CERTIFIED 30SEP2011//
AMPN/DODI 6490.03/DEPLOYMENT HEALTH//

REF/D/DOC/USD(P&R)/09JUN2014//
AMPN/DODI 6025.19/INDIVIDUAL MEDICAL READINESS//

REF/E/DOC/COMDT CG/22AUG2014//
AMPN/COMDTINST M6000.1F/COAST GUARD MEDICAL MANUAL//

REF/F/DOC/SECAF/AS UPDATED 27AUG2015//
AMPN/AFI 48-123/MEDICAL EXAMINATIONS AND STANDARDS //

REF/G/DOC/HQDA/14DEC2007 WITH RAR 04AUG2011//
AMPN/AR 40-501/STANDARDS OF MEDICAL FITNESS//

REF/H/DOC/BUMED/11JUN2015//
AMPN/NAVMED P-117/MANUAL OF THE MEDICAL DEPARTMENT//

REF/I/DOC/USD(P&R)/05FEB2010//
AMPN/DODI 6490.07/DEPLOYMENT-LIMITING MEDICAL CONDITIONS FOR SERVICE MEMBERS AND DOD CIVILIAN EMPLOYEES//

REF/J/DOC/USD(P&R)/20DEC2011//
AMPN/DODI 3020.41/OPERATIONAL CONTRACT SUPPORT//

REF/K/ORD/CFC/010458ZJUL2006//
AMPN/CFC FRAGO 09-1038/CONTRACTOR CARE IN THE USCENTCOM AOR//

REF/L/DOC/USD(P&R)/23JAN2009//
AMPN/DODD 1404.10/DOD CIVILIAN EXPEDITIONARY WORKFORCE//

REF/M/DOC/ASD(FMP)/11MAR2002, AS AMENDED 26DEC2002//
AMPN/DODI 1100.21/VOLUNTARY SERVICES IN THE DEPARTMENT OF DEFENSE//

REF/N/DOC/DEPSECDEF/12OCT2006//
AMPN/DEPUTY SECRETARY OF DEFENSE MEMO/ANTHRAX VACCINE IMMUNIZATION PROGRAM//

REF/O/DOC/ASD(P&R)/09OCT2004//
AMPN/DODD 6200.04/FORCE HEALTH PROTECTION (FHP)//

REF/P/DOC/USD(P&R)/09FEB2006//
AMPN/UNDER SECRETARY OF DEFENSE MEMO/POLICY GUIDANCE FOR MEDICAL DEFERRAL PENDING DEPLOYMENT TO THEATERS OF OPERATION//

REF/Q/DOC/HQDA/BUMED/SECAF/07OCT2013//
AMPN/AR 40-562, BUMEDINST 6230.15B, AFI 48-110 IP, CG COMDTINST M6230.4G/ IMMUNIZATIONS AND CHEMOPROPHYLAXIS FOR THE PREVENTION OF INFECTIOUS DISEASES//

REF/R/DOC/DEPSECDEF/12NOV2015//
AMPN/DEPUTY SECRETARY OF DEFENSE MEMO/CLARIFYING GUIDANCE FOR SMALLPOX AND ANTHRAX VACCINE IMMUNIZATION PROGRAMS//

REF/S/DOC/ASD(HA)/31JUL2009//
AMPN/ASSISTANT SECRETARY OF DEFENSE MEMO/CLINICAL POLICY FOR THE ADMINISTRATION OF THE ANTHRAX VACCINE ABSORBED//

REF/T/DOC/USD(P&R)/07JUN2013//
AMPN/DODI 6485.01/HUMAN IMMUNODEFICIENCY VIRUS (HIV) IN MILITARY SERVICE MEMBERS//

REF/U/DOC/ASD(HA)/14MAR2006//
AMPN/ASSISTANT SECRETARY OF DEFENSE MEMO/POLICY FOR PRE AND POST DEPLOYMENT SERUM COLLECTION//

REF/V/DOC/ASD(P&R)/17JUL2015//
AMPN/DODI 6465.1/ERYTHROCYTE GLUCOSE-6-PHOSPHATE DEHYDROGENASE DEFICIENCY (G6PD) AND SICKLE CELL TRAIT SCREENING PROGRAMS//

REF/W/DOC/ASD(HA)/12DEC2015//
AMPN/DODI 5154.30/ARMED FORCES INSTITUTE OF PATHOLOGY OPERATIONS//

REF/X/DOC/ASD(HA)/20APR2012//
AMPN/ASSISTANT SECRETARY OF DEFENSE MEMO/GUIDELINE FOR TUBERCULOSIS SCREENING AND TESTING//

REF/Y/DOC/ASD(HA)/26JUL2012//
AMPN/ASSISTANT SECRETARY OF DEFENSE MEMO/IMPLEMENTATION OF REVISED DEPARTMENT OF DEFENSE FORMS 2795, 2796 AND 2900//

REF/Z/DOC/USD(P&R)/11SEP2015//

AMPN/DODI 6490.13/COMPREHENSIVE POLICY ON TRAUMATIC BRAIN INJURY-RELATED NEUROCOGNITIVE ASSESSMENTS BY THE MILITARY SERVICES//

REF/AA/USD(P&R)/ 26FEB2013, AS AMENDED 25JAN2017//
AMPN/DODI 6490.12/MENTAL HEALTH ASSESSMENT FOR SERVICE MEMBERS DEPLOYED IN CONNECTION WITH A CONTINGENCY OPERATION//

REF/BB/USD(I)/20MAR2009, AS AMENDED 02SEP2014//
AMPN/DODI 6420.01/NATIONAL CENTER MEDICAL INTELLIGENCE (NCMI)//

REF/CC/DOC/ASD(HA)/15APR2013//
AMPN/GUIDANCE ON MEDICATIONS FOR THE PROPHYLAXIS OF MALARIA//

REF/DD/DOC/ASD(HA)/12AUG2013//
AMPN/ASSISTANT SECRETARY OF DEFENSE MEMO/NOTIFICATION FOR HEALTHCARE PROVIDERS OF MEFLOQUINE BOX WARNING//

REF/EE/DOC/ASD(HA)/18MAY2007//
AMPN/ASSISTANT SECRETARY OF DEFENSE MEMO/UPDATED POLICY FOR PREVENTION OF ARTHROPOD-BORNE DISEASES AMONG DEPARTMENT OF DEFENSE PERSONNEL DEPLOYED TO ENDEMIC AREAS//

REF//FF/DOC/J4/02NOV2007//
AMPN/MCM-0028-07/PROCEDURES FOR DEPLOYMENT HEALTH SURVEILLANCE//

REF/GG/DOC/CC/08MAR2016//
AMPN/CCR 40-2/DEPLOYMENT FORCE HEALTH PROTECTION//

REF/HH/DOC/AFHSC/MAR2012//
AMPN/ARMED FORCES REPORTABLE MEDICAL EVENTS GUIDELINES & CASE DEFINITIONS//

REF/II/ DOC/CENTCOM/OCT2012//
AMPN/UNITED STATES CENTRAL COMMAND HEALTHCARE INFORMATION SYSTEM USE POLICY//

REF/JJ/DOC/USD(P&R)/18SEP2012//
AMPN/DODI 6490.11/DOD POLICY GUIDANCE FOR MANAGEMENT OF MILD TRAUMATIC BRAIN INJURY/ AND CONCUSSION IN THE DEPLOYED SETTING//

REF/KK/DOC/ASD(HA)/07OCT2013//
AMPN/ASSISTANT SECRETARY OF DEFENSE MEMO/CLINICAL PRACTICE GUIDELINES FOR DEPLOYMENT LIMITING MENTAL DISORDERS AND PSYCHOTROPIC MEDICATIONS//

RMKS/1. (U) THIS IS MODIFICATION THIRTEEN TO USCENTCOM INDIVIDUAL PROTECTION AND INDIVIDUAL/UNIT DEPLOYMENT POLICY. IN SUMMARY, MODIFICATIONS HAVE BEEN MADE TO PARAGRAPH 15 FROM MOD TWELVE, REF B.
1.A. PARAGRAPH 15 REQUIRED NUMEROUS CHANGES; THEREFORE, IT IS BEING REPUBLISHED IN ITS ENTIRETY. MOD 13 SUPERSEDES ALL PREVIOUS VERSIONS.
1.B. PARAGRAPH 15 OF REF A HAS BEEN TOTALLY 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 IAW REF C. HOST NATION IMMUNIZATION AND MEDICAL SCREENING REQUIREMENTS APPLY. PORTIONS OF MOD 13 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 (MTFS).

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) SHOULD MEET THE MINIMAL MEDICAL STANDARDS ADDRESSED IN SECTION 15.C.1.F.

15.C. MEDICAL DEPLOYABILITY. 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) TRAVELING TO THE CENTCOM AOR MUST BE MEDICALLY, DENTALLY AND PSYCHOLOGICALLY FIT. INDIVIDUALS DEEMED UNABLE TO COMPLY WITH CENTCOM DEPLOYMENT REQUIREMENTS ARE DISQUALIFIED FOR DEPLOYMENT IAW SERVICE POLICY AND MOD 13. 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 AND 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. THE FINAL AUTHORITY OF WHO MAY DEPLOY TO THE CENTCOM AOR RESTS WITH THE CENTCOM SURGEON AND/OR THE SERVICE COMPONENT SURGEON'S WAIVER AUTHORITY, NOT THE

INDIVIDUAL'S MEDICAL EVALUATING ENTITY OR DEPLOYING PLATFORM.

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 MOD13 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.

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 AND M 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 13. UNLESS SPECIFICALLY OBLIGATED BY CONTRACTUAL ARRANGEMENT, EXPEDITIONARY MILITARY MEDICAL ASSETS ARE NOT TO BE USED FOR RE-EVALUATION 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 13. CERTIFICATIONS MUST REMAIN VALID 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 SIMILAR STANDARDS OF FITNESS AS MILITARY AND DOD CIVILIAN PERSONNEL, 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 13. 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 DONE AT CONTRACTOR EXPENSE. THE SOLE EXCEPTION TO THIS POLICY IS ANTHRAX VACCINE, WHICH WILL BE PROVIDED AT MILITARY EXPENSE. SEE REF C, J, AND N. A DISQUALIFYING MEDICAL CONDITION, AS DETERMINED BY AN IN-THEATER COMPETENT MEDICAL AUTHORITY, WILL BE IMMEDIATELY REPORTED TO THE CONTRACTOR EMPLOYEE'S CONTRACTING OFFICER WITH A RECOMMENDATION THAT THE CONTRACTOR BE IMMEDIATELY REDEPLOYED AND REPLACED AT CONTRACTOR EXPENSE UNLESS AN APPROVED WAIVER IS OBTAINED. ALL THE ABOVE EXPENSES WILL BE COVERED BY THE CONTRACTOR UNLESS OTHERWISE SPECIFIED IN THE CONTRACT.

15.C.1.F. LN AND TCN EMPLOYEES. MINIMUM SCREENING REQUIREMENTS INCLUDE:

15.C.1.F.1. PRE-EMPLOYMENT AND ANNUAL MEDICAL SCREENING OF LN AND TCN EMPLOYEES IS NOT TO BE PERFORMED IN MILITARY MTFS. LOCAL CONTRACTING AGENCIES MUST KEEP DOCUMENTATION IAW PARA. 15.C.1.E.1.

15.C.1.F.2. ALL LN AND TCN EMPLOYEES WHOSE JOB REQUIRES CLOSE OR FREQUENT CONTACT WITH NON-LN/TCN PERSONNEL (E.G., DINING FACILITY WORKERS, SECURITY PERSONNEL, INTERPRETERS, ETC.) MUST BE SCREENED FOR TUBERCULOSIS (TB) USING AN ANNUAL SYMPTOM SCREEN. A TUBERCULIN SKIN TEST (TST) IS UNRELIABLE AS A STAND-ALONE SCREENING TEST FOR TB DISEASE IN LN/TCN PERSONNEL AND SHOULD NOT BE USED. SPECIFIC QUESTIONS REGARDING APPROPRIATE SCREENING OF DETAINEES, PRISON GUARDS AND OTHER HIGHER RISK POPULATIONS SHOULD BE REFERRED TO THE THEATER PREVENTIVE MEDICINE CONSULTANT THROUGH UNIT MEDICAL PERSONNEL.

15.C.1.F.3. LN AND TCN EMPLOYEES INVOLVED IN FOOD SERVICE, WATER, AND ICE PRODUCTION MUST BE SCREENED ANNUALLY FOR SIGNS AND SYMPTOMS OF INFECTIOUS DISEASE. CONTRACTORS MUST ENSURE EMPLOYEES RECEIVE TYPHOID AND HEPATITIS A VACCINATIONS AND THIS INFORMATION MUST BE DOCUMENTED IN THE EMPLOYEES' MEDICAL RECORD / SCREENING DOCUMENTATION.

15.C.1.F.4. FURTHER GUIDANCE REGARDING MEDICAL SUITABILITY OR FORCE HEALTH PROTECTION MAY BE PROVIDED BY THE LOCAL TASK FORCE COMMANDER OR EQUIVALENT IN CONSULTATION WITH THEIR MILITARY MEDICAL ASSETS.

15.C.2. UNFIT PERSONNEL. CASES OF IN-THEATER/DEPLOYED PERSONNEL IDENTIFIED AS UNFIT, IAW THIS MOD 13, 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, O, AND P, AND IS DELEGATED TO THE USCENTCOM COMPONENT SURGEONS FOR ALL DEPLOYING PERSONNEL WITHIN THEIR RESPECTIVE COMPONENT FOR ALL HEALTH CONDITIONS, EXCLUDING BEHAVIORAL HEALTH CONDITIONS. BEHAVIORAL HEALTH WAIVERS WILL INITIALLY BE EVALUATED BY THE RESPECTIVE SERVICE COMPONENT, BUT THE FINAL DETERMINATION FOR APPROVAL RESIDES WITH THE CENTCOM SURGEON. SENDING UNIT COMMANDERS ARE NOT AUTHORIZED TO OVERRIDE A MEDICAL DEPLOYABILITY DETERMINATION, HOWEVER, COMMAND ENDORSEMENT OF SERVICE MEMBER WAIVERS IS REQUIRED PRIOR TO SUBMISSION.

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. 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 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.A.4. ALL ADJUDICATING SURGEONS WILL MAINTAIN A WAIVER DATABASE AND RECORD ALL WAIVER REQUESTS.

15.C.3.A.5. ADJUDICATION SHOULD ACCOUNT FOR SPECIFIC MEDICAL SUPPORT CAPABILITIES IN THE LOCAL REGION OF THE AOR. THE COMPONENT SURGEON WILL RETURN THE SIGNED WAIVER FORM TO THE REQUEST ORIGINATOR FOR INCLUSION IN THE PATIENT'S DEPLOYMENT MEDICAL RECORD AND THE ELECTRONIC MEDICAL RECORD (EMR).

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, OR INDIVIDUAL MEMBER) WILL FORWARD A COMPLETED MEDICAL WAIVER REQUEST FORM (TAB C), TO BE ADJUDICATED BY THE APPROPRIATE SURGEON IAW PARAGRAPH 15.C.3.C. WAIVER SUBMISSION BY OR THROUGH A MEDICAL AUTHORITY IS STRONGLY ENCOURAGED TO AVOID UNNECESSARY ADJUDICATION DELAYS DUE TO INCOMPLETE INFORMATION. UNIFORMED PERSONNEL MUST OBTAIN COMMAND ENDORSEMENT OF THE WAIVER PRIOR TO SUBMISSION. 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. 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 SUBMITTED THROUGH THE CHAIN OF COMMAND TO THE CENTCOM CHIEF OF STAFF.
15.C.3.B.5. WAIVERS ARE APPROVED FOR A MAXIMUM OF 12 MONTHS OR FOR THE TIMEFRAME SPECIFIED ON THE WAIVER (TAB C). WAIVER COVERAGE BEGINS ON THE DATE OF THE INITIAL DEPLOYMENT AND REMAINS IN EFFECT FOR EITHER THE TIME PERIOD SPECIFIED ON THE WAIVER OR A MAXIMUM TIME OF 12 MONTHS.
15.C.3.B.6. WAIVERS MAY BE APPROVED, AT THE WAIVER AUTHORITY'S SOLE DISCRETION, FOR PERIODS OF TIME (E.G. 90 DAYS) SHORTER THAN THE SCHEDULED DEPLOYMENT DURATION IN 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.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. FORCE.SURGEON@MARCENT.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@SOCCENT.CENTCOM.MIL;
CML: 813.828.4351; DSN: 312.968.4351
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 BE CONSIDERED TO INCLUDE AN ADDITIONAL 28 DAYS AFTER

LEAVING THE MALARIA RISK AREA (FOR DOXYCYCLINE) OR 7 DAYS (FOR MALARONE) 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. IF REQUIRED, 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 FDA 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 WILL BE 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 USARMY.JBSA.MEDCOM-AMEDDCS.MBX.PHARMACOECONOMIC-CENTER@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-SCRIPTS.COM/TRICARE/TOOLS/DEPLOYEDRX.SHTML

15.E. MEDICAL EQUIPMENT.

15.E.1. PERMITTED EQUIPMENT. PERSONNEL WHO REQUIRE MEDICAL EQUIPMENT (E.G., CORRECTIVE EYEWEAR, HEARING AIDS) MUST DEPLOY WITH ALL REQUIRED ITEMS IN THEIR POSSESSION TO INCLUDE TWO PAIRS OF EYEGLASSES, PROTECTIVE MASK EYEGLASS INSERTS, BALLISTIC EYEWEAR INSERTS, AND HEARING AID BATTERIES. SEE REF D

15.E.2. NON-PERMITTED EQUIPMENT. PERSONAL DURABLE MEDICAL EQUIPMENT (NEBULIZERS, SCOOTERS, WHEELCHAIRS, CATHETERS, DIALYSIS MACHINES, INSULIN PUMPS, IMPLANTED DEFIBRILLATORS, SPINAL CORD STIMULATORS, CEREBRAL IMPLANTS, ETC.) IS NOT PERMITTED. MEDICAL MAINTENANCE, LOGISTICAL SUPPORT, AND INFECTION CONTROL PROTOCOLS FOR PERSONAL MEDICAL EQUIPMENT ARE NOT AVAILABLE AND ELECTRICITY IS OFTEN UNRELIABLE. A WAIVER FOR A MEDICAL CONDITION REQUIRING PERSONAL DURABLE MEDICAL EQUIPMENT WILL ALSO BE CONSIDERED APPLICABLE TO THE EQUIPMENT. DURABLE MEDICAL EQUIPMENT THAT IS NOT MEDICALLY COMPULSORY BUT USED FOR RELIEF OR

MAINTENANCE OF A MEDICAL CONDITION WILL REQUIRE A WAIVER. WAIVERS SHOULD COMPELLINGLY ARGUE FOR CONTINUED READINESS DESPITE PRESUMED FAILURE OF THE EQUIPMENT. MAINTENANCE AND RESUPPLY OF NON-PERMITTED EQUIPMENT IS THE RESPONSIBILITY OF THE INDIVIDUAL.

15.E.3. CONTACT LENSES.

15.E.3.A. ARMY, NAVY, AND MARINE PERSONNEL WILL NOT DEPLOY WITH CONTACT LENSES EXCEPT IAW SERVICE POLICY.

15.E.3.B. AIR FORCE PERSONNEL (NON-AIRCREW) WILL NOT DEPLOY WITH CONTACT LENSES UNLESS WRITTEN AUTHORIZATION IS PROVIDED BY THE DEPLOYING UNIT COMMANDER. CONTACT LENSES ARE LIFE SUPPORT EQUIPMENT FOR USAF AIRCREWS AND THEREFORE ARE EXEMPT IAW SERVICE GUIDELINES. AIR FORCE PERSONNEL DEPLOYING WITH CONTACT LENSES MUST RECEIVE PRE-DEPLOYMENT EDUCATION IN THE SAFE WEAR AND MAINTENANCE OF CONTACT LENSES IN THE DEPLOYED ENVIRONMENT. THEY MUST ALSO DEPLOY WITH TWO PAIRS OF EYEGLASSES AND A SUPPLY OF CONTACT LENS MAINTENANCE ITEMS (E.G., CLEANSING SOLUTION) ADEQUATE FOR THE DURATION OF THE DEPLOYMENT.

15.E.4. MEDICAL WARNING TAGS. DEPLOYING PERSONNEL REQUIRING MEDICAL WARNING TAGS (MEDICATION ALLERGIES, G6PD DEFICIENCY, DIABETES, SICKLE CELL DISEASE, ETC.) WILL DEPLOY WITH RED MEDICAL WARNING TAGS WORN IN CONJUNCTION WITH THEIR PERSONAL IDENTIFICATION TAGS.

15.E.4.A. MEDICAL PERSONNEL IDENTIFY NEED FOR MEDICAL WARNING TAGS AND PREPARE DOCUMENTATION.

15.E.4.B. INSTALLATION OR ORGANIZATION COMMANDERS WILL DIRECT EMBOSSING ACTIVITIES TO PROVIDE TAGS IAW SERVICE PROCEDURES.

15.F. IMMUNIZATIONS.

15.F.1. ADMINISTRATION. ALL IMMUNIZATIONS WILL BE ADMINISTERED IAW REF Q. REFER TO THE DHA-IMMUNIZATION HEALTHCARE BRANCH WEBSITE HTTP://WWW.HEALTH.MIL/MILITARY-HEALTH-TOPICS/HEALTH-READINESS/IMMUNIZATION-HEALTHCARE/VACCINE-RECOMMENDATIONS/VACCINE-RECOMMENDATIONS-BY-AOR OR CONTACT THE CENTCOM DHA-IMMUNIZATION HEALTHCARE BRANCH ANALYST BRIAN.D.CANTERBURY.CIV@MAIL.MIL FOR QUESTIONS AND CLARIFICATIONS.

15.F.2. REQUIREMENTS. ALL PERSONNEL (TO INCLUDE PCS AND SHIPBOARD PERSONNEL) TRAVELING FOR ANY PERIOD OF TIME TO THE THEATER WILL BE CURRENT WITH ADVISORY COMMITTEE ON IMMUNIZATION PRACTICES (ACIP) IMMUNIZATION GUIDELINES AND SERVICE INDIVIDUAL MEDICAL READINESS (IMR) REQUIREMENTS IAW REF C. CURRENT DOD IMMUNIZATIONS REQUIREMENTS AND RECOMMENDATIONS CAN BE FOUND AT THE DEFENSE HEALTH AGENCY WEBSITE, ON THE CENTCOM TAB, AT HTTP://WWW.HEALTH.MIL/MILITARY-HEALTH-TOPICS/HEALTH-READINESS/IMMUNIZATION-HEALTHCARE/VACCINE-RECOMMENDATIONS/VACCINE-RECOMMENDATIONS-BY-AOR . IN ADDITION, ALL TDY PERSONNEL MUST COMPLY WITH FOREIGN CLEARANCE GUIDELINES FOR THE COUNTRIES TO OR THROUGH WHICH THEY ARE TRAVELING. MANDATORY VACCINES FOR DOD PERSONNEL (MILITARY, CIVILIAN & CONTRACTORS) TRAVELING FOR ANY PERIOD OF TIME IN THEATER ARE:

15.F.2.A. TETANUS/DIPHTHERIA. RECEIVE A ONE-TIME DOSE OF TDAP IF NO PREVIOUS DOSE(S) RECORDED. RECEIVE TETANUS (TD) IF ≥ 10 YEARS SINCE LAST TDAP OR TD BOOSTER.

15.F.2.B. VARICELLA. REQUIRED DOCUMENTATION OF ONE OF THE FOLLOWING: BORN BEFORE 1980 (HEALTH CARE WORKERS MAY NOT USE THIS EXEMPTION), DOCUMENTED PREVIOUS INFECTION (CONFIRMED BY EITHER EPIDEMIOLOGIC LINK OR LABORATORY RESULT), SUFFICIENT VARICELLA TITER, OR DOCUMENTED ADMINISTRATION OF VACCINE (2 DOSES).

15.F.2.C. MEASLES / MUMPS / RUBELLA. REQUIRED DOCUMENTATION OF ONE OF THE FOLLOWING: BORN BEFORE 1957, DOCUMENTATION OF EFFECTIVE IMMUNITY BY TITER, OR DOCUMENTED ADMINISTRATION OF 2 LIFETIME DOSES OF MMR.
15.F.2.D. POLIO. REQUIRED FOR TRAVEL TO/THROUGH **AFGHANISTAN OR PAKISTAN FOR ≥4 WEEKS**.
15.F.2.D.1 BOOSTER DOSE OF EITHER ORAL (OPV) OR INACTIVATED (IPV) VACCINE (IPV IS THE ONLY POLIO VACCINE CURRENTLY AVAILABLE IN THE UNITED STATES) BETWEEN 4 WEEKS AND 12 MONTHS OF DEPARTURE FROM AFGHANISTAN OR PAKISTAN.
15.F.2.D.2. IMMUNIZATION SHOULD BE DOCUMENTED ON THE CDC-731 CERTIFICATE OF VACCINATION OR PROPHYLAXIS (YELLOW SHOT RECORD) IN ADDITION TO THE DD2766C TO MEET INTERNATIONAL STANDARDS.
15.F.2.D.3. MEDICAL ASSUMED (MA) AND MEDICAL IMMUNE (MI) EXEMPTIONS ARE NOT ACCEPTED FOR THIS REQUIREMENT.
15.F.2.D.4. IAW WORLD HEALTH ORGANIZATION (WHO) OR ACIP DISEASE OUTBREAK GUIDANCE, MORE STRINGENT VACCINATION REQUIREMENTS MAY BE RECOMMENDED.
15.F.2.E. SEASONAL INFLUENZA (INCLUDING EVENT-SPECIFIC INFLUENZA, E.G., H1N1).
15.F.2.F. HEPATITIS A. AT LEAST ONE DOSE PRIOR TO DEPLOYMENT WITH SUBSEQUENT COMPLETION OF SERIES IN THEATER.
15.F.2.G. HEPATITIS B. AT LEAST ONE DOSE PRIOR TO DEPLOYMENT WITH SUBSEQUENT COMPLETION OF SERIES IN THEATER.
15.F.2.H. TYPHOID. BOOSTER DOSE OF TYPHIM VI VACCINE IF GREATER THAN TWO YEARS SINCE LAST VACCINATION WITH INACTIVATED / INJECTABLE VACCINE OR GREATER THAN FIVE YEARS SINCE RECEIPT OF LIVE / ORAL VACCINE. ORAL VACCINE IS AN ACCEPTABLE OPTION ONLY IF TIME ALLOWS FOR RECEIPT AND COMPLETION OF ALL FOUR DOSES PRIOR TO DEPLOYMENT.
15.F.3. ANTHRAX. PERSONNEL WITHOUT A MEDICAL CONTRAINDICATION TRAVELING IN THE CENTCOM THEATER FOR 15 DAYS OR MORE WILL COMPLY WITH THE MOST CURRENT DOD ANTHRAX REQUIREMENTS, CURRENTLY A SERIES OF 5 VACCINES AND ANNUAL BOOSTER. SEE REF N, R, AND S AND EXCEPTIONS FOR VACCINATION IN 15.F.6.
15.F.3.A. MILITARY PERSONNEL. REQUIRED.
15.F.3.B. DOD CIVILIANS. REQUIRED AT GOVERNMENT EXPENSE, FOR EMERGENCY ESSENTIAL PERSONNEL IAW REF N.
15.F.3.C. DOD CONTRACTORS. REQUIRED AT GOVERNMENT EXPENSE AS DIRECTED IN THE CONTRACT.
15.F.3.D. VOLUNTEERS. VOLUNTARY AT GOVERNMENT EXPENSE.
15.F.4. SMALLPOX. AS OF 16 MAY 2014, SMALLPOX VACCINATION IS NO LONGER REQUIRED FOR THE CENTCOM AOR. SEE REF R.
15.F.5. RABIES. PRE-EXPOSURE VACCINATION SHOULD BE ACCOMPLISHED AS BELOW, OR OTHERWISE CONSIDERED FOR PERSONNEL WHO ARE NOT REASONABLY EXPECTED TO RECEIVE PROMPT MEDICAL EVALUATION AND RISK-BASED RABIES POST-EXPOSURE PROPHYLAXIS WITHIN 72 HOURS OF EXPOSURE TO A POTENTIALLY RABID ANIMAL. FOR ALREADY-VACCINATED PERSONNEL, BOOSTER DOSES ARE REQUIRED EVERY TWO YEARS OR WHEN TITERS INDICATE. EXCEPTIONS MAY BE IDENTIFIED BY UNIT SURGEONS.
15.F.5.A. HIGH RISK PERSONNEL: PRE-EXPOSURE VACCINATION IS REQUIRED FOR VETERINARY PERSONNEL, MILITARY WORKING DOG HANDLERS, ANIMAL CONTROL PERSONNEL, CERTAIN SECURITY PERSONNEL, CIVIL ENGINEERS AT RISK OF EXPOSURE TO RABID ANIMALS, AND LABORATORY PERSONNEL WHO WORK WITH RABIES SUSPECT SAMPLES.

15.F.5.B. SPECIAL OPERATIONS FORCES (SOF)/SOF ENABLERS: ALL PERSONNEL DEPLOYING IN SUPPORT OF SOF WILL BE ADMINISTERED THE PRE-EXPOSURE RABIES VACCINE SERIES AS INDICATED BELOW.
15.F.5.B.1. AFGHANISTAN. PERSONNEL WITH PRIMARY DUTIES OUTSIDE OF FIXED BASES.
15.F.5.B.2. PAKISTAN. ALL PERSONNEL.
15.F.5.B.3. OTHER AREAS. PER USSOCOM SERVICE-SPECIFIC POLICIES. CONTACT USSOCOM PREVENTIVE MEDICINE OFFICER AT DSN (312) 299-5051 FOR MORE INFORMATION.
15.F.6. EXCEPTIONS. REQUIRED IMMUNIZATIONS WILL BE ADMINISTERED PRIOR TO DEPLOYMENT, WITH THE FOLLOWING POSSIBLE EXCEPTIONS:
15.F.6.A. THE FIRST VACCINE IN A REQUIRED SERIES MUST BE ADMINISTERED PRIOR TO DEPLOYMENT WITH ARRANGEMENTS MADE FOR SUBSEQUENT IMMUNIZATIONS TO BE GIVEN IN THEATER.
15.F.6.B. IAW REF S, ANTHRAX MAY BE ADMINISTERED UP TO 120 DAYS PRIOR TO DEPLOYMENT. IT IS HIGHLY ADVISABLE TO GET THE FIRST TWO ANTHRAX IMMUNIZATIONS OR SUBSEQUENT DOSE/BOOSTER PRIOR TO DEPLOYMENT IN ORDER TO AVOID UNNECESSARY STRAIN ON THE DEPLOYED HEALTHCARE SYSTEM.
15.F.7. ADVERSE MEDICAL EVENTS RELATED TO IMMUNIZATIONS SHOULD BE REPORTED THROUGH REPORTABLE MEDICAL EVENTS (RME) IF CASE DEFINITIONS ARE MET. ALL IMMUNIZATION RELATED UNEXPECTED ADVERSE EVENTS ARE TO BE REPORTED THROUGH THE VACCINE ADVERSE EVENTS REPORTING SYSTEM (VAERS) AT HTTP://WWW.VAERS.HHS.GOV.
15.F.8. USCENTCOM AND COMPONENTS WILL MONITOR IMMUNIZATION COMPLIANCE VIA THE COCOM IMMUNIZATION REPORTING DATABASE. SUBORDINATE COMMANDS WILL REQUEST ACCESS TO THE COCOM IMMUNIZATION REPORTING DATABASE BY CONTACTING CCSG AT BRIAN.CANTERBURY2@CENTCOM.MIL OR CCSG-PMO@CENTCOM.SMIL.MIL.
15.G. MEDICAL / LABORATORY TESTING.
15.G.1. HIV TESTING. HIV LAB TESTING, WITH DOCUMENTED NEGATIVE RESULT, WILL BE WITHIN 120 DAYS PRIOR TO DEPLOYMENT OR DEPARTURE FOR ANY REQUIRED DEPLOYMENT TRAINING IF TRAINING IS EN ROUTE TO DEPLOYMENT LOCATION. IAW REF I AND T, THE COGNIZANT COMBATANT COMMAND SURGEON SHALL BE DIRECTLY CONSULTED IN ALL INSTANCES OF HIV SEROPOSITIVITY BEFORE MEDICAL CLEARANCE FOR DEPLOYMENT.
15.G.2. SERUM SAMPLE. SAMPLE WILL BE TAKEN WITHIN THE PREVIOUS 365 DAYS. IF THE INDIVIDUAL'S HEALTH STATUS HAS RECENTLY CHANGED OR HAS HAD AN ALTERATION IN OCCUPATIONAL EXPOSURES THAT INCREASES HEALTH RISKS, A HEALTH CARE PROVIDER MAY CHOOSE TO HAVE A SPECIMEN DRAWN CLOSER TO THE ACTUAL DATE OF DEPLOYMENT. SEE REF U.
15.G.3. G6PD TESTING. DOCUMENTATION OF ONE-TIME GLUCOSE-6-PHOSPHATE DEHYDROGENASE (G6PD) DEFICIENCY TESTING IS IAW REF V. ENSURE RESULT IS IN MEDICAL RECORD OR DRAW PRIOR TO DEPARTURE. PRE-DEPLOYMENT MEDICAL SCREENERS WILL RECORD THE RESULT OF THIS TEST IN THE SERVICE MEMBER'S PERMANENT MEDICAL RECORD, DEPLOYMENT MEDICAL RECORD (DD FORM 2766) AND SERVICE SPECIFIC ELECTRONIC MEDICAL RECORD. (REF V) IF AN INDIVIDUAL IS FOUND TO BE G6PD-DEFICIENT, THEY SHOULD BE ISSUED MEDICAL WARNING TAGS (SEE 15.E.4.) THAT STATE "G6PD DEFICIENT: NO PRIMAQUINE". IF PRIMAQUINE IS GOING TO BE ISSUED TO A DOD CIVILIAN OR DOD CONTRACTOR, COMPLETE THE TESTING AT GOVERNMENT EXPENSE.
15.G.4. HCG. REQUIRED WITHIN 30 DAYS OF DEPLOYMENT FOR ALL WOMEN, AS WELL THOSE FEMALE TO MALE TRANSGENDERED INDIVIDUALS WHO HAVE RETAINED FEMALE ANATOMY. ABOVE INDIVIDUALS WITH A DOCUMENTED HISTORY OF A HYSTERECTOMY ARE EXEMPT. PREGNANCY WILL BE RULED OUT PRIOR TO ANY IMMUNIZATION (EXCEPT INFLUENZA) AND

MEDICAL CLEARANCE FOR DEPLOYMENT.

15.G.5. DNA SAMPLE. REQUIRED FOR ALL DOD PERSONNEL, INCLUDING CIVILIANS AND CONTRACTORS. OBTAIN SAMPLE OR CONFIRM SAMPLE IS ON FILE BY CONTACTING THE DOD DNA SPECIMEN REPOSITORY (COMM: 301.319.0366, DSN: 285; FAX 301.319.0369); HTTP://WWW.AFMES.MIL . SEE REF C, D, AND W.

15.G.6. TUBERCULOSIS (TB) TESTING. SEE REF X.

15.G.6.A. TUBERCULOSIS TESTING FOR SERVICE MEMBERS WILL BE PERFORMED AND DOCUMENTED IAW SERVICE POLICY. CURRENT POLICY IS TO AVOID UNIVERSAL TESTING, AND INSTEAD USE TARGETED TESTING BASED UPON RISK ASSESSMENT, USUALLY PERFORMED WITH A SIMPLE QUESTIONNAIRE. DEPLOYMENT TO TB ENDEMIC COUNTRIES, EVEN FOR PERIODS IN EXCESS OF A YEAR, HAS NOT BEEN SHOWN TO BE A RISK FACTOR FOR TB FOR MOST AVERAGE-RISK SERVICE MEMBERS. TB TESTING FOR DOD CIVILIANS, CONTRACTORS, VOLUNTEERS, AND OTHER PERSONNEL SHOULD BE SIMILARLY TARGETED IAW CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC) GUIDELINES, WITH TESTING FOR TB TO BE ACCOMPLISHED WITHIN 90 DAYS OF DEPLOYMENT IF INDICATED. IF TESTING IS PERFORMED TUBERCULIN SKIN TEST (TST) OR AN INTERFERON-GAMMA RELEASE ASSAY MAY BE USED UNLESS OTHERWISE INDICATED.

15.G.6.B. POSITIVE TB TESTS WILL BE HANDLED IAW SERVICE POLICY AND CDC GUIDELINES. PERSONNEL WITH A POSITIVE TB TEST SHOULD BE EVALUATED AND COUNSELED. EVALUATION WILL INCLUDE AT LEAST A SYMPTOM QUESTIONNAIRE FOR ACTIVE TB DISEASE, EXPOSURE HISTORY, AND CHEST X-RAY.

15.G.6.C. THE DECISION TO TREAT LTBI IN U.S. FORCES AND CIVILIANS DURING DEPLOYMENT INSTEAD OF AFTER REDEPLOYMENT SHOULD INCLUDE CONSIDERATION OF THE RISKS AND BENEFITS OF TREATMENT DURING DEPLOYMENT, INCLUDING: RISK OF TB ACTIVATION, RISK OF ADVERSE EVENTS FROM LTBI TREATMENT, TIME REMAINING IN DEPLOYMENT, AVAILABILITY OF MEDICAL PERSONNEL TRAINED IN LTBI TREATMENT, AVAILABILITY OF FOLLOW-UP DURING TREATMENT, AND AVAILABILITY OF MEDICATION. LACK OF TREATMENT FOR LTBI IS NOT A CONTRAINDICATION FOR DEPLOYMENT INTO THE CENTCOM AOR AND NO WAIVERS ARE REQUIRED FOR A DIAGNOSIS OF LTBI IF APPROPRIATE EVALUATION AND COUNSELING, AS NOTED ABOVE, IS COMPLETED.

15.G.6.D. UNIT-BASED / LARGE GROUP OR INDIVIDUAL LTBI TESTING SHOULD NOT BE PERFORMED IN THE AOR EXCEPT AMONG CLOSE CONTACTS OF CASES OF KNOWN TB DISEASE.

15.G.6.E. U.S. FORCES AND DOD CIVILIANS WITH TB DISEASE WILL BE EVACUATED FROM THEATER FOR DEFINITIVE TREATMENT. EVALUATION AND TREATMENT OF TB AMONG U.S. CONTRACTORS, LOCAL NATIONALS (LN) AND THIRD COUNTRY NATIONAL (TCN) EMPLOYEES WILL BE AT CONTRACTOR EXPENSE. EMPLOYEES WITH SUSPECTED OR CONFIRMED PULMONARY TB DISEASE WILL BE EXCLUDED FROM WORK UNTIL CLEARED BY THE THEATER PREVENTIVE MEDICINE CONSULTANT FOR RETURN TO WORK.

15.G.7. OTHER LABORATORY TESTING. OTHER TESTING MAY BE PERFORMED AT THE CLINICIAN'S DISCRETION COMMENSURATE WITH RULING OUT OR MONITORING NON-DEPLOYABLE CONDITIONS AND ENSURING PERSONNEL MEET STANDARDS OF FITNESS IAW PARAGRAPH 15.C.2.

15.H. HEALTH ASSESSMENTS.

15.H.1. HEALTH ASSESSMENTS AND EXAMS. 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, J.

15.H.2. PRE-DEPLOYMENT HEALTH ASSESSMENT (DD FORM 2795).

15.H.2.A. ALL DOD PERSONNEL (MILITARY, CIVILIAN, CONTRACTOR) TRAVELING TO THE

THEATER FOR MORE THAN 30 DAYS WILL COMPLETE OR CONFIRM AS CURRENT A PRE-DEPLOYMENT HEALTH ASSESSMENT WITHIN 120 DAYS OF THE EXPECTED DEPLOYMENT DATE IAW REF Y. THIS ASSESSMENT WILL BE COMPLETED ON A DD FORM 2795 IAW REF C. THIS DOES NOT APPLY TO PCS PERSONNEL, SHIPBOARD PERSONNEL, OR PERSONNEL LOCATED WITH A DHP FUNDED FIXED MEDICAL TREATMENT FACILITY (E.G. BAHRAIN) IAW REF C.

15.H.2.A.1. PERSONNEL TRAVELING TO THE THEATER FOR 15 TO 30 DAYS MAY CONSIDER COMPLETING A PRE-DEPLOYMENT HEALTH ASSESSMENT IN ORDER TO DOCUMENT THEIR HEALTH STATUS AND ADDRESS ANY HEALTH CONCERNS PRIOR TO TRAVEL TO THEATER. THIS IS ESPECIALLY RELEVANT TO THOSE WHOSE POSITION REQUIRES FREQUENT TRAVEL TO THE AOR. THESE INDIVIDUALS ARE ENCOURAGED TO COMPLETE AT LEAST ONE PRE-DEPLOYMENT HEALTH ASSESSMENT EACH YEAR, ALONG WITH A CORRESPONDING POST-DEPLOYMENT HEALTH ASSESSMENT FOR THE SAME YEAR.

15.H.2.B. FOLLOWING COMPLETION OF THE DEPLOYER PORTION OF THE DD FORM 2795, THE DEPLOYER WILL HAVE A PERSON-TO-PERSON DIALOGUE WITH A TRAINED AND CERTIFIED HEALTH CARE PROVIDER (PHYSICIAN, PHYSICIAN ASSISTANT, NURSE PRACTITIONER, ADVANCED PRACTICE NURSE, INDEPENDENT DUTY CORPSMAN, SPECIAL FORCES MEDICAL SERGEANT, INDEPENDENT DUTY MEDICAL TECHNICIAN, OR INDEPENDENT HEALTH SERVICES TECHNICIAN) TO COMPLETE THE ASSESSMENT.

15.H.2.C. THE COMPLETED ORIGINAL DD FORM 2795 WILL BE PLACED IN THE DEPLOYER'S PERMANENT MEDICAL RECORD, A PAPER COPY IN THE DEPLOYMENT MEDICAL RECORD (DD FORM 2766), AND AN ELECTRONIC COPY TRANSMITTED TO THE DEFENSE MEDICAL SURVEILLANCE SYSTEM (DMSS) AT THE ARMED FORCES HEALTH SURVEILLANCE CENTER (AFHSC). CONTRACT PERSONNEL ARE NOT REQUIRED TO ELECTRONICALLY SUBMIT THE DD FORM 2795; A PAPER VERSION WILL SUFFICE.

15.H.3. AUTOMATED NEUROPSYCHOLOGICAL ASSESSMENT METRIC (ANAM).

ALL SERVICE MEMBERS AS DESIGNATED IN REF Z WILL UNDERGO ANAM TESTING WITHIN 12 MONTHS PRIOR TO DEPLOYMENT. ANAM TESTING WILL BE RECORDED IN APPROPRIATE 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 WITH 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). ASSESSMENTS WILL BE ACCOMPLISHED WITHIN 120 DAYS PRIOR TO DEPLOYMENT, ONCE DURING EACH 180-DAY PERIOD DURING WHICH A MEMBER IS DEPLOYED (IN-THEATER MENTAL HEALTH ASSESSMENT), AND AFTER REDEPLOYMENT WITHIN 3 TIMEFRAMES (3-6, 7-18, AND 18-30 MONTHS AFTER REDEPLOYMENT), OR AS REQUIRED BY SERVICE POLICY. ASSESSMENTS WILL BE ADMINISTERED AT LEAST 90 DAYS APART. 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 PSYCHOLOGICAL AND SOCIAL QUESTIONS IAW REF AA.

15.H.5.A. IN-THEATER MENTAL HEALTH ASSESSMENTS WILL BE CONDUCTED BY PERSONNEL IN DEPLOYED UNITS WHOSE RESPONSIBILITIES INCLUDE PROVIDING UNIT HEALTH CARE SERVICES IF SUCH PERSONNEL ARE AVAILABLE AND THE USE OF SUCH PERSONNEL FOR THE ASSESSMENTS WOULD NOT IMPAIR THE CAPACITY OF SUCH PERSONNEL TO PERFORM HIGHER PRIORITY TASKS.

15.H.5.A.1. PERSONNEL CONDUCTING ASSESSMENTS MUST MEET REQUIREMENTS IN PARAGRAPH 15.H.5.

15.H.5.A.2. SCHEDULING IN-THEATER MENTAL HEALTH ASSESSMENTS MUST BE MADE IN CONSIDERATION OF AND SEEK TO LESSEN POTENTIAL IMPACTS ON THE OPERATIONAL MISSION.

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 ON PRE- AND POST-DEPLOYMENT HEALTH ASSESSMENTS. CONTRACT PERSONNEL ARE NOT REQUIRED TO ELECTRONICALLY SUBMIT THE DD FORM 2900; A PAPER VERSION WILL SUFFICE.

15.I. MEDICAL RECORD. SEE REF C.

15.I.1. DEPLOYED MEDICAL RECORD. THE DD FORM 2766, ADULT PREVENTIVE AND CHRONIC CARE FLOWSHEET, OR EQUIVALENT, WILL BE USED INSTEAD OF DEPLOYING AN INDIVIDUAL'S ENTIRE MEDICAL RECORD. THE DEPLOYED DD FORM 2766 SHOULD BE RE-INTEGRATED INTO THE MAIN MEDICAL RECORD AS PART OF THE REDEPLOYMENT PROCESS.

15.I.1.A. DEPLOYED PERSONNEL (MORE THAN 30 DAYS). DD2766 IS REQUIRED.

15.I.1.B. TDY PERSONNEL (15 – 30 DAYS). DD FORM 2766 IS HIGHLY ENCOURAGED, ESPECIALLY FOR THOSE WHO TRAVEL FREQUENTLY TO THEATER, TO DOCUMENT THEATER-SPECIFIC VACCINES AND CHEMOPROPHYLAXIS, AS REQUIRED.

15.I.1.C. TDY PERSONNEL (LESS THAN 15 DAYS). DD2766 IS NOT REQUIRED.

15.I.1.D. PCS PERSONNEL. FOLLOW SERVICE GUIDELINES FOR MEDICAL RECORD MANAGEMENT.

15.I.2. MEDICAL INFORMATION. THE FOLLOWING HEALTH INFORMATION MUST BE PART OF AN ACCESSIBLE ELECTRONIC MEDICAL RECORD FOR ALL PERSONNEL (SERVICE MEMBERS, CIVILIANS AND CONTRACTORS), OR BE HAND-CARRIED AS PART OF A DEPLOYED MEDICAL RECORD:
15.I.2.A. ANNOTATION OF BLOOD TYPE AND RH FACTOR, G6PD, HIV, AND DNA.
15.I.2.B. CURRENT MEDICATIONS AND ALLERGIES. INCLUDE ANY FORCE HEALTH PROTECTION PRESCRIPTION PRODUCT (FHPPP) PRESCRIBED AND DISPENSED TO AN INDIVIDUAL.
15.I.2.C. SPECIAL DUTY QUALIFICATIONS.
15.I.2.D. ANNOTATION OF CORRECTIVE LENS PRESCRIPTION.
15.I.2.E. SUMMARY SHEET OF CURRENT AND PAST MEDICAL AND SURGICAL CONDITIONS.
15.I.2.F. MOST RECENT DD FORM 2795, PREDEPLOYMENT HEALTH ASSESSMENT.
15.I.2.G. DOCUMENTATION OF DENTAL STATUS CLASSES I OR CLASS II.
15.I.2.H. IMMUNIZATION RECORD. MEDICAL DEPLOYMENT SITES WILL ENTER IMMUNIZATION DATA INTO SERVICE ELECTRONIC TRACKING SYSTEMS, (ARMY-MEDPROS, AIR FORCE-AFCITA, COAST GUARD-MRRS, NAVY-MRRS (ASHORE) OR SAMS (AFLOAT) AND MARINE CORPS-MRRS).
15.I.2.I. ALL APPROVED MEDICAL WAIVERS.
15.J. PRE-DEPLOYMENT TRAINING. SEE REF C.
15.J.1. SCOPE. GENERAL ISSUES TO BE ADDRESSED. INFORMATION REGARDING KNOWN AND SUSPECTED HEALTH RISKS AND EXPOSURES, HEALTH RISK COUNTERMEASURES AND THEIR PROPER EMPLOYMENT, PLANNED ENVIRONMENTAL AND OCCUPATIONAL SURVEILLANCE MONITORING, AND THE OVERALL OPERATIONAL RISK MANAGEMENT PROGRAM.
15.J.2. CONTENT. SHOULD INCLUDE, BUT NOT BE LIMITED TO, THE FOLLOWING AREAS: COMBAT/OPERATIONAL STRESS CONTROL AND RESILIENCE; POST-TRAUMATIC STRESS AND SUICIDE PREVENTION; MILD TRAUMATIC BRAIN INJURY RISK, IDENTIFICATION AND TRACKING; NUCLEAR, BIOLOGICAL, CHEMICAL THREATS; ENDEMIC PLANT, ANIMAL, REPTILE AND INSECT HAZARDS AND INFECTIONS; COMMUNICABLE DISEASES; VECTORBORNE DISEASES; ENVIRONMENTAL CONDITIONS; SAFETY; OCCUPATIONAL HEALTH.
15.K. MEDICAL CBRN DEFENSE MATERIEL (MCDM) / CHEMICAL BIOLOGICAL RADIOLOGICAL NUCLEAR (CBRN) RESPONSE.
15.K.1. MCDM ITEMS. CJTF-OIR, USFOR-A, AND USCENTCOM SERVICE COMPONENT COMMANDS WILL DETERMINE MCDM AVAILABILITY REQUIREMENTS, BASED UPON BEST ESTIMATES OF RISK AND COMMAND POLICY, FOR ALL FORCES THAT FALL UNDER THEIR RESPECTIVE FORCE PROTECTION AUTHORITIES AS IDENTIFIED IN ANNEX J OF USCENTCOM OPORD 05-02, IN THE FOLLOWING MINIMUM ESSENTIAL QUANTITIES. CONTRACTORS WILL RECEIVE THESE ITEMS PER THEIR CONTRACT.
15.K.1.A. ANTIDOTE TREATMENT NERVE AGENT AUTOINJECTOR (ATNAA) (6505-01-362-7427); RECOMMEND THREE EACH PER AFFECTED INDIVIDUAL.
15.K.1.B. DIAZEPAM INJECTION (CONVULSANT ANTIDOTE NERVE AGENT - CANA) (6505-01-274-0951); RECOMMEND ONE EACH PER AFFECTED INDIVIDUAL.
15.K.1.C. M291A SKIN DECONTAMINATION KIT OR REACTIVE SKIN DECONTAMINATION LOTION (RSDL). RECOMMEND ONE M291A KIT OR ONE POUCH CONTAINING 3 PACKETS OF RSDL PER AFFECTED INDIVIDUAL.
15.K.1.D. CIPROFLOXACIN 500MG TABS OR DOXYCYCLINE 100MG TABS; RECOMMEND SIX TABS (BLISTER PACKS PREFERABLE) PER AFFECTED INDIVIDUAL OF EITHER MEDICATION.TO COVER INITIAL DOSAGE AND SUPPORT PROPHYLAXIS AND/OR TREATMENT FOR THREE DAYS PER INDIVIDUAL. AVAILABILITY OF COMPLETE 30-DAY COURSE OF MEDICATION (60 TABLETS) SHOULD BE CONSIDERED GIVEN MISSION REQUIREMENTS. INDIVIDUALS USING DOXYCYCLINE FOR MALARIA PROPHYLAXIS MAY BE CONSIDERED TO BE COVERED FOR THESE REMAINING DOSES.

15.K.1.E. INDIVIDUAL DEPLOYERS RECEIVING MCDM MEDICATIONS AND/OR EQUIPMENT DURING PRE-DEPLOYMENT PROCESSING SHOULD TURN IN THESE ITEMS TO THEIR UNIT UPON ARRIVAL IN THE AOR.

15.K.2. CBRN COUNTERMEASURES.

15.K.2.A. TO PROTECT AGAINST POSSIBLE AND POTENTIALLY INDICATED CBRN THREATS WITHIN THE AOR, SERVICE COMPONENTS WILL BPT ACQUIRE AND ISSUE, IAW SERVICE POLICY OR ON ORDER FROM THE CENTCOM COMMANDER, THE FOLLOWING TYPES AND QUANTITIES OF MCDM ITEMS FOR THEIR IN-THEATER FORCES.

15.K.2.B. PYRIDOSTIGMINE BROMIDE (PB) 30MG TABS (SOMAN NERVE AGENT PRETREATMENT PYRIDOSTIGMINE - SNAPP); 42 TABLETS PER AFFECTED INDIVIDUAL.

15.K.2.B.1. POTASSIUM IODIDE (KI) TABLETS (FOR BETA/GAMMA RADIATION EXPOSURE); 14 TABS PER AFFECTED INDIVIDUAL.

15.K.2.B.2. SERVICE COMPONENTS AND/OR JTFS WITH BASE OPERATING SUPPORT (BOS) RESPONSIBILITY FOR BASES IN THEATER THAT ARE KEY TRANSPORTATION AND SUPPORT NODES WILL ENSURE ADEQUATE AMOUNTS OF THE MCDM ITEMS LISTED IN PARAGRAPH 15.K. ARE PRE-POSITIONED AND STORED TO SUPPORT THE TRANSIENT POPULATION (NON DEPLOYERS, PCS PERSONNEL, ETC.) THAT MAY RESIDE OR BE PRESENT AT THESE LOCATIONS FOR ANY PERIOD OF TIME AND ANY INDIVIDUAL DEPLOYERS NOT ATTACHED TO A TROOP UNIT MOVEMENT.

15.L. THEATER FORCE HEALTH PROTECTION.

15.L.1. DISEASE RISK ASSESSMENT.

15.L.1.A. MALARIA RISK ASSESSMENT AND GUIDELINES. IN THE ABSENCE OF A LOCAL RISK ASSESSMENT CONDUCTED IAW THE GUIDANCE PROVIDED IN PARAGRAPH 15.L.1.B., THE FOLLOWING COUNTRIES AND TIMEFRAMES REQUIRE CHEMOPROPHYLAXIS. THESE ARE MINIMUM REQUIREMENTS.

15.L.1.A.1. AFGHANISTAN: YEAR ROUND.

15.L.1.A.2. PAKISTAN: YEAR ROUND.

15.L.1.A.3. TAJIKISTAN: APRIL THROUGH OCTOBER.

15.L.1.A.4. YEMEN: YEAR ROUND.

15.L.1.B. LOCAL COMPONENT/JTF SURGEONS ARE ENCOURAGED TO CONDUCT EVIDENCE-BASED ENTOMOLOGICAL AND EPIDEMIOLOGICAL ASSESSMENTS OF MALARIA RISK AT FIXED BASES WHERE SIGNIFICANT NUMBERS OF PERSONNEL ARE ASSIGNED FOR PROLONGED PERIODS. IN CONDUCTING SUCH A RISK ASSESSMENT, SURGEONS SHOULD REVIEW THE MOST RECENT ASSESSMENTS AND RISK MAPS PRODUCED BY THE NATIONAL CENTER FOR MEDICAL INTELLIGENCE (NCMI) AT HTTPS://WWW.NCMI.DETRICK.ARMY.MIL/ (UNCLASSIFIED) OR HTTPS://WWW.NCMI.DIA.SMIL.MIL (CLASSIFIED).

15.L.1.B.1. BASED ON NCMI RISK ASSESSMENTS AND IN CONSULTATION WITH THE THEATER PREVENTIVE MEDICINE CONSULTANT, RECOMMENDATIONS FOR MODIFIED CHEMOPROPHYLAXIS POLICY MAY BE PROVIDED TO COMMANDERS USING REF BB OR SIMILAR RISK ANALYSIS.

15.L.1.B.2. MANEUVER FORCES WITH INTERMITTENT AND UNPREDICTABLE EXPOSURES TO RISK AREAS SHOULD EMPLOY CHEMOPROPHYLAXIS BASED ON THE HIGHEST RISK AREAS. UNITS AND INDIVIDUALS WITH VERY SHORT TERM EXPOSURE (I.E., AIRCREW NOT STATIONED IN THE AOR) SHOULD HAVE RISK AND CHEMOPROPHYLAXIS USE DETERMINED IAW SERVICE POLICY.

15.L.2. MALARIA CHEMOPROPHYLAXIS UTILIZATION.

15.L.2.A. ALL THERAPEUTIC/CHEMOPROPHYLACTIC MEDICATIONS, INCLUDING ANTIMALARIALS AND MCDM WILL BE PRESCRIBED IAW FDA GUIDELINES, REF C, BB, CC, AND DD.

15.L.2.B. DOXYCYCLINE OR ATOVAQUONE/PROGUANIL (MALARONE®) ARE GENERALLY ACCEPTABLE AS A PRIMARY MALARIA CHEMOPROPHYLACTIC AGENT. MEFLOQUINE SHOULD BE CONSIDERED THE DRUG OF LAST RESORT FOR PERSONNEL WITH CONTRAINDICATIONS TO DOXYCYCLINE OR MALARONE®, SHOULD BE USED WITH CAUTION IN PERSONS WITH A HISTORY OF TBI OR PTSD, AND IS CONTRAINDICATED IN PERSONNEL WITH PSYCHIATRIC DIAGNOSES. EACH MEFLOQUINE PRESCRIPTION WILL BE ISSUED WITH A WALLET CARD AND CURRENT FDA SAFETY INFORMATION INDICATING THE POSSIBILITY THAT THE NEUROLOGIC SIDE EFFECTS MAY PERSIST OR BECOME PERMANENT IAW REF DD. OTHER FDA APPROVED AGENTS MAY BE USED TO MEET SPECIFIC SITUATIONAL REQUIREMENTS.
15.L.2.C. PERSONNEL SHOULD DEPLOY WITH EITHER THEIR ENTIRE PRIMARY PROPHYLAXIS COURSE IN HAND (EXCLUDING TERMINAL PRIMAQUINE) OR WITH ENOUGH MEDICATION TO COVER HALF OF THE DEPLOYMENT WITH PLANS TO RECEIVE THE REMAINDER OF THEIR MEDICATION IN THEATER BASED ON UNIT PREFERENCE. TERMINAL PROPHYLAXIS (PRIMAQUINE) SHOULD BE DISTRIBUTED UPON REDEPLOYMENT AND ONLY AFTER VERIFYING G6PD STATUS (SEE 15.G.3.). A COMPLETE COURSE OF PRIMARY PROPHYLAXIS BEGINS 2 DAYS PRIOR TO ENTERING THE RISK AREA FOR DOXYCYCLINE AND MALARONE®(2 WEEKS FOR MEFLOQUINE)AND COMPLETES AFTER 4 WEEKS OF DOXYCYCLINE OR MEFLOQUINE AFTER LEAVING THE AT RISK AREA, OR (1 WEEK OF MALARONE®). TERMINAL PROPHYLAXIS IS REQUIRED AND CONSISTS OF TAKING PRIMAQUINE FOR 2 WEEKS AFTER LEAVING THE RISK AREA. INDIVIDUALS WHO ARE NOTED TO BE G6PD-DEFICIENT, IAW PARAGRAPH 15.G.3., WILL NOT BE PRESCRIBED PRIMAQUINE.
15.L.2.D. MISSING ONE DOSE OF MEDICATION OR NOT USING THE DOD INSECT REPELLENT SYSTEM WILL PLACE PERSONNEL AT INCREASED RISK FOR MALARIA.
15.L.2.E. COMMANDERS AND SUPERVISORS AT ALL LEVELS WILL ENSURE THAT ALL INDIVIDUALS FOR WHOM THEY ARE RESPONSIBLE HAVE TERMINAL PROPHYLAXIS ISSUED TO THEM IMMEDIATELY UPON REDEPLOYMENT FROM THE AT RISK MALARIA AREA(S).
15.L.3. PERSONAL PROTECTIVE MEASURES. A SIGNIFICANT RISK OF DISEASE CAUSED BY INSECTS AND TICKS EXISTS YEAR-ROUND IN THE AOR. THE THREAT OF DISEASE WILL BE MINIMIZED BY USING THE DOD INSECT REPELLANT SYSTEM AND BED NETS; HTTP://WWW.AFPMB.ORG. SEE REF EE.
15.L.3.A. PERMETHRIN TREATMENT OF UNIFORMS. UNIFORMS ARE AVAILABLE FOR ISSUE WHICH ARE FACTORY-TREATED WITH PERMETHRIN. THE UNIFORM LABEL INDICATES WHETHER IT IS FACTORY TREATED. UNIFORMS WHICH ARE NOT FACTORY TREATED SHOULD BE TREATED WITH THE INDIVIDUAL DYNAMIC ABSORPTION (IDA) KIT (NSN: 6840-01-345-0237) OR 2 GALLON SPRAYER PERMETHRIN TREATMENT. BOTH ARE EFFECTIVE FOR APPROXIMATELY 50 WASHINGS. A MATRIX OF WHICH UNIFORMS MAY BE EFFECTIVELY TREATED IS AVAILABLE ON THE AFPMB WEBSITE AT HTTP://WWW.AFPMB.ORG .
15.L.3.B. APPLY DEET CREAM (NSN: 6840-01-284-3982) TO EXPOSED SKIN. ONE APPLICATION LASTS 6-12 HOURS; MORE FREQUENT APPLICATION IS REQUIRED IF HEAVY SWEATING AND/OR IMMERSION IN WATER. A SECOND OPTION IS 'SUNSECT CREAM' (20% DEET/SPF 15), NSN: 6840-01-288-2188.
15.L.3.C. WEAR TREATED UNIFORM PROPERLY TO MINIMIZE EXPOSED SKIN (SLEEVES DOWN AND PANTS TUCKED INTO BOOTS).
15.L.3.D. USE PERMETHRIN TREATED BEDNETS PROPERLY IN AT RISK AREAS TO MINIMIZE EXPOSURE DURING REST/SLEEP PERIODS. PERMETHRIN TREATED POP UP BEDNETS ARE AVAILABLE: NSN 3740-01-516-4415
15.L.4. HEALTH SURVEILLANCE. SEE REF C AND FF.
15.L.4.A. JOINT MEDICAL WORKSTATION (JMEWS) THROUGH MSAT AT HTTPS://MSAT.FHP.SMIL.MIL/PORTAL

15.L.4.A.1. DEPLOYED UNITS WILL USE JMEWS AS THE PRIMARY DATA ENTRY POINT FOR DISEASE AND INJURY (DI) REPORTING. UNITS WILL ENSURE ALL SUBORDINATE UNITS COMPLETE JOINING AND DEPARTING REPORTS AS REQUIRED WITHIN JMEWS. SHIPBOARD UNITS SHOULD UTILIZE SAMS OR TMIP-M FOR DI REPORTING AND FIXED MTF'S SHOULD UTILIZE AHLTA.
15.L.4.A.2. UNITS WILL COORDINATE JMEWS TRAINING PRIOR TO DEPLOYMENT FOR APPROPRIATE PERSONNEL TO THE MAXIMUM EXTENT POSSIBLE. CURRENTLY, THE ARMY USES MC4 TRAINERS TO TRAIN JMEWS, THE AIR FORCE USES THEATER MEDICAL INFORMATION PROGRAM (TMIP-AF). INFORMATION MANAGERS, OTHER SERVICES DO NOT HAVE DIRECTED TRAINERS AT THIS TIME.
15.L.4.B. DI SURVEILLANCE, SEE REF GG.
15.L.4.B.1. THE LIST OF DI REPORTING CATEGORIES, THEIR DEFINITIONS, AND THE ESSENTIAL ELEMENTS OF THE STANDARD DI REPORT CAN BE FOUND IN ENCLOSURE C OF REF FF.
15.L.4.B.2. COMPONENT AND JTF SURGEONS ARE RESPONSIBLE FOR ENSURING UNITS WITHIN THEIR AOR ARE COLLECTING THE PRESCRIBED DI DATA AND REPORTING THAT DATA THROUGH THE JMEWS OR OTHER STANDARDIZED REPORTING PROCESSES ON A WEEKLY BASIS.
15.L.4.B.3. MEDICAL PERSONNEL AT ALL LEVELS WILL ANALYZE THE DI DATA FROM THEIR UNIT AND THE UNITS SUBORDINATE TO THEM AND MAKE CHANGES AND RECOMMENDATIONS AS REQUIRED TO REDUCE DI AND MITIGATE THE EFFECTS OF DI UPON OPERATIONAL READINESS.
15.L.4.C. OCCUPATIONAL AND ENVIRONMENTAL HEALTH SURVEILLANCE (OEHSA)
15.L.4.C.1. AUTHORITY. AN OEHSA IS A JOINT APPROVED PRODUCT USED TO PROVIDE A COMPREHENSIVE ASSESSMENT OF BOTH OCCUPATIONAL AND ENVIRONMENTAL HEALTH HAZARDS ASSOCIATED WITH DEPLOYMENT LOCATIONS AND ACTIVITIES AND MISSIONS THAT OCCUR THERE ESTABLISHED BY REF D AND FF.
15.L.4.C.2 TIMEFRAME. AN OEHSA IS INITIATED WITHIN 30 DAYS OF DATE OF ESTABLISHMENT AND COMPLETED WITHIN THREE MONTHS FOR ALL PERMANENT AND SEMI-PERMANENT BASE CAMPS. OEHSA ARE CONDUCTED TO VALIDATE ACTUAL OR POTENTIAL HEALTH THREATS, EVALUATE EXPOSURE PATHWAYS, AND DETERMINE COURSES OF ACTION AND COUNTERMEASURES TO CONTROL OR REDUCE THE HEALTH THREATS AND PROTECT THE HEALTH OF DEPLOYED PERSONNEL.
15.L.4.C.3. CLASSIFICATION/PUBLICATION/ACCESS. OEHSA WILL BE SENT BY THE COMPLETING UNIT THROUGH THE DESIGNATED SERVICE COMPONENT OR JTF PM/FHP OFFICER FOR REVIEW AND SUBMITTED DIRECTLY TO THE DEFENSE OCCUPATIONAL AND ENVIRONMENTAL READINESS SYSTEM (DOEHRS) AT HTTPS://DOEHRS-IH.CSD.DISA.MIL/. SEE APPENDIX J TO REFERENCE EE FOR DOEHRS REQUIREMENTS. IF THE SUBMITTER DOES NOT HAVE ACCESS TO DOEHRS SUBMIT THE OEHSA TO THE MILITARY EXPOSURE SURVEILLANCE LIBRARY (MESL) HTTPS://MESL.APGEA.ARMY.MIL/MESL/. IF THE MESL IS NOT AVAILABLE, EMAIL THE DOCUMENT TO OEHS.DATA@US.ARMY.MIL. CLASSIFIED EXPOSURE DATA SHOULD BE SUBMITTED DIRECTLY TO MESL-S HTTPS://MESL.CSD.DISA.SMIL.MIL. IF ACCESS TO THE MESL-S IS NOT AVAILABLE, EMAIL THE DOCUMENT TO OEHS@USACHPPM.ARMY.SMIL.MIL.
15.L.4.C.4. RESPONSIBILITIES. SERVICE COMPONENTS AND JTFS ARE RESPONSIBLE FOR APPROVING OEHSA COMPLETION AND WILL SUBMIT A MONTHLY REPORT IAW PROCEDURES OUTLINED IN REFERENCE GG.
15.L.4.D. PERIODIC OCCUPATIONAL AND ENVIRONMENTAL MONITORING SUMMARY (POEMS).
15.L.4.D.1. AUTHORITY. POEMS IS A JOINT APPROVED PRODUCT USED TO ADDRESS ENVIRONMENTAL EXPOSURE DOCUMENTATION REQUIREMENTS ESTABLISHED BY REF D AND FF.

15.L.4.D.2. TIMEFRAME. POEMS WILL BE CREATED AND VALIDATED FOR EVERY MAJOR DEPLOYMENT SITE AS SOON AS SUFFICIENT DATA IS AVAILABLE. IN GENERAL, POEMS ARE A SUMMARY OF INFORMATION REFLECTING A YEAR OR MORE OF ENVIRONMENTAL AND OCCUPATIONAL HEALTH DATA TO ENSURE ADEQUATE COLLECTION OF EXPOSURE INFORMATION.
15.L.4.D.3. CLASSIFICATION/PUBLICATION/ACCESS. POEMS WILL BE UNCLASSIFIED BUT POSTED ON THE PASSWORD PROTECTED DEPLOYMENT OCCUPATIONAL AND ENVIRONMENTAL HEALTH SURVEILLANCE DATA PORTAL AT HTTPS://MESL.APGEA.ARMY.MIL/MESL/ WHERE JOINT OCCUPATIONAL AND ENVIRONMENTAL HEALTH SURVEILLANCE DATA AND REPORTS ARE STORED. THE POEMS TEMPLATE CAN BE FOUND AT HTTP://PHC.AMEDD.ARMY.MIL.
15.L.4.D.4. RESPONSIBILITIES. SERVICE COMPONENTS AND JTFS ARE RESPONSIBLE FOR ENSURING POEMS ARE COMPLETED FOR SITES IN THEIR RESPECTIVE AOR. THEY SHOULD DEVELOP SITE PRIORITIZATION LISTS AND ENLIST THE SUPPORT OF SERVICE PUBLIC HEALTH ORGANIZATIONS (E.G., U.S. ARMY PUBLIC HEALTH CENTER (USAPHC)) TO DRAFT THE CONTENT OF A SITE POEMS. THE USAPHC OVERSEES THE DATA ARCHIVAL WEBSITE FOR PUBLICATION OF FINAL POEMS AND ASSOCIATED DOCUMENTS; HOWEVER, APPROVAL OF "FINAL" POEMS MUST COME FROM THE SERVICE COMPONENT/JTF FHP OFFICER WITH INPUT FROM PREVENTIVE MEDICINE RESOURCES IN DIRECT OR GENERAL AREA SUPPORT.
15.L.5. REPORTABLE MEDICAL EVENT (RME) SURVEILLANCE. SEE REF O, GG.
15.L.5.A. THE LIST OF DISEASES AND CONDITIONS THAT MUST BE REPORTED CAN BE FOUND IN THE TRI-SERVICE REPORTABLE EVENTS GUIDELINES AND CASE DEFINITIONS AT HTTP://WWW.AFHSC.MIL OR REF HH.
15.L.5.B. COMPONENT AND JTF SURGEONS ARE RESPONSIBLE FOR ENSURING UNITS WITHIN THEIR AO ARE COLLECTING THE APPROPRIATE RME DATA AND REPORTING THAT DATA THROUGH THEIR SERVICE SPECIFIC REPORTING MECHANISMS.
15.L.5.B.1. IT IS ONLY REQUIRED TO COPY CCSG FOR THE FOLLOWING RMES AT CCSG-PMO@CENTCOM.SMIL.MIL OR CENTCOM.MACDILL.CENTCOM-HQ.MBX.CCSG-WAIVER@MAIL.MIL: ANTHRAX; BOTULISM; CBRN AND TOXIC INDUSTRIAL CHEMICAL/MATERIAL (TIC/TIM) EXPOSURE; SEVERE COLD WEATHER/HEAT INJURIES; DENGUE FEVER; HANTAVIRUS DISEASE; HEMORRHAGIC FEVER; HEPATITIS B OR C, ACUTE; HIV; MALARIA; MEASLES; MENINGOCOCCAL DISEASE; MIDDLE EASTERN RESPIRATORY SYNDROME CORONAVIRUS (MERS-COV); NOROVIRUS; OUTBREAK OR DISEASE CLUSTER; PLAGUE; PNEUMONIA, EOSINOPHILIC; Q- FEVER; RABIES, HUMAN; SEVERE ACUTE RESPIRATORY INFECTIONS (SARI); STREPTOCOCCUS, INVASIVE GROUP A; TETANUS; TUBERCULOSIS, ACTIVE; TULAREMIA; TYPHOID FEVER; VARICELLA
15.L.5.C. RME REPORTING IS TO OCCUR AS SOON AS REASONABLY POSSIBLE AFTER THE EVENT HAS OCCURRED. EVENTS WITH BIOTERRORISM POTENTIAL OR RAPID OUTBREAK POTENTIAL ARE CONSIDERED URGENT RME AND IMMEDIATE REPORTING IS REQUIRED (WITHIN FOUR HOURS).
15.L.6. HEALTH RISK COMMUNICATION. SEE REF C.
15.L.6.A. DURING ALL PHASES OF DEPLOYMENT, PROVIDE HEALTH INFORMATION TO EDUCATE, MAINTAIN FIT FORCES, AND CHANGE HEALTH RELATED BEHAVIORS FOR THE PREVENTION OF DISEASE AND INJURY DUE TO RISKY PRACTICES AND UNPROTECTED EXPOSURES.
15.L.6.B. CONTINUAL HEALTH RISK ASSESSMENTS ARE ESSENTIAL ELEMENTS OF THE HEALTH RISK COMMUNICATION PROCESS DURING THE DEPLOYMENT PHASE. MEDICAL PERSONNEL AT ALL LEVELS WILL PROVIDE WRITTEN AND ORAL RISK COMMUNICATION PRODUCTS TO

COMMANDERS AND DEPLOYED PERSONNEL FOR MEDICAL THREATS, COUNTERMEASURES TO THOSE THREATS, AND THE NEED FOR ANY MEDICAL FOLLOW-UP.

15.L.6.C. DI, RME, AND OCCUPATIONAL AND ENVIRONMENTAL HEALTH (OEH) RISK ASSESSMENTS WITH RECOMMENDED COUNTERMEASURES WILL BE PROVIDED TO COMMANDERS AND DEPLOYED PERSONNEL ON A REGULAR BASIS AS WELL AS A SITUATIONAL BASIS WHEN A SIGNIFICANT CHANGE IN ANY ASSESSMENT OCCURS.

15.L.7. HEALTH CARE MANAGEMENT.

15.L.7.A. JOINT TRAUMA SYSTEM (JTS) CLINICAL PRACTICE GUIDELINES (CPGS) MAY BE OBTAINED AT THE UNITED STATES ARMY INSTITUTE OF SURGICAL RESEARCH (USAISR) WEBSITE AT HTTP://WWW.USAISR.AMEDD.ARMY.MIL/CPGS.HTML.

15.L.7.B. DOCUMENTATION OF ALL MEDICAL AND DENTAL CARE RECEIVED WHILE DEPLOYED WILL BE IAW CENTCOM MEDICAL INFORMATION MANAGEMENT GUIDELINES. SEE REF II.

15.L.7.C. IT IS A COMMANDER'S RESPONSIBILITY TO ENSURE THAT ALL PERSONNEL POTENTIALLY AFFECTED BY A BLAST OR OTHER POTENTIALLY CONCUSSIVE EVENT (PCE) ARE EVALUATED FOR TRAUMATIC BRAIN INJURY (TBI) BY A MEDICAL PROVIDER AND DOCUMENTATION IS COMPLETED IAW REF JJ.

15.L.8. UNIT MASCOTS AND PETS.

15.L.8.A. PER CENTCOM GENERAL ORDER 1.C, DEPLOYED PERSONNEL WILL AVOID CONTACT WITH LOCAL ANIMALS (E.G., LIVESTOCK, CATS, DOGS, BIRDS, REPTILES, ARACHNIDS, AND INSECTS) IN THE DEPLOYED SETTING AND WILL NOT FEED, ADOPT, OR INTERACT WITH THEM IN ANY WAY.

15.L.8.B. ANY CONTACT WITH LOCAL ANIMALS, WHETHER INITIATED OR NOT, THAT RESULTS IN A BITE, SCRATCH OR POTENTIAL EXPOSURE TO THE ANIMAL'S BODILY FLUIDS (SALIVA, VENOM, ETC.) WILL BE IMMEDIATELY REPORTED TO THE CHAIN OF COMMAND AND MEDICAL PERSONNEL FOR EVALUATION AND FOLLOW-UP.

15.L.9. FOOD AND WATER SOURCES.

15.L.9.A. ALL WATER (INCLUDING ICE) IS CONSIDERED NON-POTABLE UNTIL TESTED AND APPROVED BY APPROPRIATE MEDICAL PERSONNEL (ARMY OR NAVY PREVENTIVE MEDICINE, AIR FORCE BIOENVIRONMENTAL ENGINEERING, INDEPENDENT DUTY MEDICAL TECHNICIAN/CORPSMAN). COMMERCIAL SOURCES OF DRINKING WATER MUST ALSO BE APPROVED BY THE U.S. ARMY PUBLIC HEALTH CENTER.

15.L.9.B. NO FOOD SOURCES WILL BE UTILIZED UNLESS INSPECTED AND APPROVED BY U.S. ARMY PUBLIC HEALTH CENTER (I.E. VETERINARY PERSONNEL).

15.L.9.C. COMMANDERS WILL ENSURE THE NECESSARY SECURITY TO PROTECT WATER AND FOOD SUPPLIES AGAINST TAMPERING BASED ON RECOMMENDATIONS PROVIDED IN FOOD/WATER VULNERABILITY ASSESSMENTS. MEDICAL PERSONNEL WILL PROVIDE CONTINUAL VERIFICATION OF QUALITY AND PERIODIC INSPECTION OF STORAGE AND PREPARATION FACILITIES.

15.L.10. ENVIRONMENTAL EXPOSURES OF CONCERN.

15.L.10.A. COLD INJURY RISK WILL DEPEND ON THE SPECIFIC REGION. HYPOTHERMIA, A LIFE-THREATENING CONDITION, MOSTLY OCCURS UP TO 55 DEGREES FAHRENHEIT AIR TEMPERATURE. RISK OF COLD INJURY INCREASES FOR PERSONS WHO ARE IN POOR PHYSICAL CONDITION, DEHYDRATED, WET, OR AT INCREASED ALTITUDE. COUNTERMEASURES INCLUDE PROPER WEAR OF CLOTHING AND COVER. EXPOSED SKIN IS MORE LIKELY TO DEVELOP FROSTBITE. ENSURE CLOTHING IS CLEAN, LOOSE, LAYERED, AND DRY. COVER THE HEAD TO CONSERVE HEAT.

15.L.10.B. HEAT STRESS/ SOLAR INJURIES/ILLNESS. HEAT INJURIES MAY BE THE GREATEST OVERALL THREAT TO MILITARY PERSONNEL DEPLOYED TO WARM CLIMATES. ACCLIMATIZATION TO INCREASED TEMPERATURE AND HUMIDITY MAY TAKE 10 TO 14 DAYS.

HEAT INJURIES CAN INCLUDE DEHYDRATION, SUNBURN, HEAT SYNCOPE, HEAT EXHAUSTION AND HEAT STROKE. ENSURE PROPER WORK-REST CYCLES, ADEQUATE HYDRATION, AND COMMAND EMPHASIS ON HEAT INJURY PREVENTION. ENSURE AVAILABILITY AND USE OF INDIVIDUAL PROTECTION SUPPLIES AND EQUIPMENT SUCH AS SUNSCREEN, LIP BALM, SUN GOGGLES/GLASSES, AND POTABLE WATER.

15.L.10.C. ALTITUDE. OPERATIONS AT HIGH ALTITUDES (OVER 9888 FT) CAN CAUSE A SPECTRUM OF ILLNESSES, INCLUDING ACUTE MOUNTAIN SICKNESS; HIGH ALTITUDE PULMONARY EDEMA, HIGH ALTITUDE CEREBRAL EDEMA, OR RED BLOOD CELL SICKLING IN SERVICE MEMBERS WITH SICKLE CELL TRAIT. ASCEND GRADUALLY, IF POSSIBLE. TRY NOT TO GO DIRECTLY FROM LOW ALTITUDE TO >9,888 FT (3,013 M) IN ONE DAY. A HEALTH CARE PROVIDER MAY PRESCRIBE ACETAZOLAMIDE (DIAMOX) OR DEXAMETHASONE (DECADRON) TO SPEED ACCLIMATIZATION IF ABRUPT ASCENT IS UNAVOIDABLE. TREAT AN ALTITUDE HEADACHE WITH SIMPLE ANALGESICS; MORE SERIOUS COMPLICATIONS REQUIRE OXYGEN AND IMMEDIATE DESCENT.

15.L.10.D. GOOD FIELD SANITATION PRACTICES ARE ESSENTIAL TO MAINTAIN FORCE HEALTH. THEY INCLUDE: FREQUENT HANDWASHING, PROPER DENTAL CARE, CLEAN AND DRY CLOTHING (ESPECIALLY SOCKS, UNDERWEAR, AND BOOTS), BATHING AND DENTAL CARE WITH WATER FROM A POTABLE SOURCE. CHANGE SOCKS FREQUENTLY, FOOT POWDER HELPS PREVENT FUNGAL INFECTIONS.

15.M. ALL OTHER INSTRUCTIONS AND GUIDANCE SPECIFIED IN INITIAL POLICY MESSAGE REMAIN IN EFFECT. MOD TWELVE IS NOW INVALID.

15.N. THE USCENTCOM POC FOR PREVENTIVE MEDICINE/FORCE HEALTH PROTECTION IS CCSG, DSN 312-529-0345; COMM: 813-529-0345; SIPR: CCSG-PMO@CENTCOM.SMIL.MIL OR KEVIN.CRON@CENTCOM.SMIL.MIL; NIPR: CENTCOM.MACDILL.CENTCOM-HQ.MBX.CCSG-WAIVER@MAIL.MIL OR KEVIN.M.CRON.MIL@MAIL.MIL//

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

1. General. This PPG-TAB A accompanies MOD THIRTEEN, 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, 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 in the parent MOD 13. See MOD THIRTEEN REF E, F, G, H, I, P, and KK.

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 (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 (REF J).

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. See REF I.

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 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 diagnoses that could result in or complicate medical care in theater following evacuation should be coordinated with and approved by the CENTCOM Surgeon prior to entering the AOR.

6. The general guidance from MOD THIRTEEN section 15.C applies 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, IAW Section 15.C.3, 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, IAW MOD THIRTEEN Section 15.C. 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 CENTCOM 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 $\leq$ 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 $\leq$ 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

should also have documentation of a complete initial diabetic evaluation (eye exam, foot exam, nutrition counseling, etc.).

4. History of heat stroke. Those with no multiple episodes, persistent sequelae, or organ damage, and no episode within the last 24 months, may be considered for waiver.

5. Meniere's disease or other vertiginous/motion sickness disorder, unless well controlled on medications available in theater.

6. Recurrent syncope for any reason. Waiver request should include the etiology and diagnosis of the condition.

7. Endocrine conditions requiring replacement or adjustment therapies must be stable, require no laboratory monitoring or specialty consultation, and require only routine follow-up which must be available in the deployed location or by specific arrangement. Hormonal preparations must be administered by oral or transdermal routes, be within clinically appropriate dose parameters, have no special storage requirements, and not produce side effects which interfere with the normal performance of duties or require additional medications to manage.

8. Any musculoskeletal condition that significantly impairs performance of duties in a deployed environment. If there are concerns, an official functional capacity exam (FCE) should be performed and results included with the waiver request.

9. Migraine headache, when frequent or severe enough to disrupt normal performance of duties. Waiver submission should note history, frequency, severity, and functional impact of headaches, as well previous and current treatment regimens. Neurology evaluation and endorsement encouraged.

10. Nephrolithiasis, recurrent or currently symptomatic.

11. Pregnancy.

12. Obstructive sleep apnea (OSA). The OSA is diagnosed with an attended, in-laboratory polysomnography (PSG) with a minimum of 2 hours of total sleep time, that yields an apnea-hypopnea index (AHI), and/or respiratory disturbance index (RDI), of greater than 5 / hour. Unattended, home PSG is not acceptable for deployment purposes. For individuals previously diagnosed with OSA, updated or repeat PSG is not required unless clinically indicated (i.e. significant change in body habitus, corrective surgery or return of OSA symptoms). Individuals treated with an oral appliance require PSG documentation that OSA is controlled with its use. Individuals who are treated with automatic positive airway pressure (APAP), continuous positive airway pressure (CPAP) and bi-level positive airway pressure (BPAP) are acceptable as long as the condition being treated is OSA and not a more complex respiratory disorder. Complex OSA, central sleep apnea or OSA that requires advanced modes of ventilation such as adaptive servo-ventilation (ASV) or average volume assured pressure support (AVAPS) is generally non-deployable. Individuals using PAP therapy should deploy with a machine that has rechargeable battery back-up and sufficient supplies (air filters, tubing and interfaces/masks) for the duration of the deployment. Individuals deploying with PAP therapy to a location where the sleep environment has unfiltered air will typically not be granted waivers if a waiver is otherwise required per the guidance below. The following guidelines are designed to ensure that individuals with OSA are adequately treated and that their condition is not of the severity that would pose a safety risk should they be required to go without their PAP therapy for a significant length of time.

a. Symptomatic OSA (i.e. excessive daytime sleepiness) of any severity, with or without any treatment**.**

b. Asymptomatic mild OSA (diagnostic AHI and RDI < 15/hr): Deployable with or without treatment (PAP or otherwise). **No waiver required.**

c. Moderate OSA (diagnostic AHI or RDI ≥15/hr and < 30/hr): **No waiver required** to deploy if successfully treated (CPAP or otherwise), except to Afghanistan, Iraq, or Yemen.

d. Severe OSA (AHI or RDI ≥ 30/hr): Once successfully treated (PAP or otherwise), requires a waiver for deployment to any location in the AOR.

e. For moderate and severe OSA, adherence to positive airway pressure (PAP) therapy must be documented prior to deployment. Adherence is defined as PAP machine data download (i.e. compliance report) that reveals the machine is being used for at least 4 hours per night for greater than 70% of nights over the previous 30-day period.

13. History of clinically diagnosed traumatic brain injury (mTBI/TBI) of any severity, including mild. Waiver may not be required, but pre-deployment evaluation, which may include both neurological and psychological components, is needed per ref HH.

a. Individuals who have a history of a single mild Traumatic Brain Injury may deploy once released by a medical provider after 24-hours symptom free.

b. Individuals who have sustained a second mTBI within a 12-month period, may deploy after seven days symptom free and release by a medical provider.

c. Individuals who have had three clinically diagnosed TBIs (of any severity, including mild) since their last full neurological and psychological evaluation are required to have such an evaluation completed prior to deployability determination.

14. BMI > 35 with or without any significant comorbidity. Military personnel in compliance with Service body fat guidelines do not require a waiver. Morbid obesity (BMI > 40 or weight greater than 300 pounds) can generally not be supported. Civilians and contractors should submit a body fat worksheet with the waiver request. A BMI calculator is located at http://www.nhlbi.nih.gov/guidelines/obesity/BMI/bmicalc.htm

15. Any medical conditions (except OSA-see 10 above) that require certain durable medical equipment or appliances (e.g., nebulizers, catheters, spinal cord stimulators) or that requires periodic evaluation/treatment by medical specialists not readily available in theater.

B. Cardiovascular Conditions:

1. Symptomatic coronary artery disease. Also, see B.8.

2. Myocardial infarction within one year of deployment. Also, see B.8.

3. Coronary artery bypass graft, coronary artery angioplasty, carotid endarterectomy, other arterial stenting, or aneurysm repair within one year of deployment. Also, see B.8.

4. Cardiac dysrhythmias or arrhythmias, either symptomatic or requiring medication, electro-physiologic control, or automatic implantable cardiac defibrillator or other implantable cardiac devices**.**

5. Hypertension if controlled with a medication or lifestyle regimen that has been stable for 90 days and requires no changes does not require a waiver. Single episode hypertension found on predeployment physical should be accompanied by serial blood pressure checks (3 day BP checks) to ensure hypertension is not persistent.

6. Heart failure or history of heart failure.

7. Civilian personnel who are 40 years of age or older must have a 10-year CHD risk percentage calculated (online calculator is available at http://tools.acc.org/ASCVD-Risk-Estimator/). If the individual's calculated 10-year CHD risk is 15% or greater, the individual should be referred for further cardiology work-up and evaluation, to include at

least one of the following: graded exercise stress test with a myocardial perfusion scintigraphy (SPECT scan) or stress echocardiography as determined by the evaluating cardiologist. Results of the evaluation (physical exam, Framingham results, etc.) and testing, along with the evaluating cardiologist's recommendation regarding suitability for deployment, should be included in a waiver request to deploy.

8. Uncontrolled hyperlipidemia. Lipid screening should be accomplished IAW Service specific guidelines for lipid assessment. All others (e.g. civilians, contractors) ≥35 years old should have a lipid screening profile performed prior to deployment. While hyperlipidemia should be addressed IAW clinical treatment guidelines, hyperlipidemia values that are outside any of the following (Total Cholesterol > 260, LDL > 190, Triglycerides > 500), either treated or untreated, requires a waiver to be submitted.

C. Infectious Disease:

1. Blood-borne diseases (Hepatitis B, Hepatitis C, HTLV) that may be transmitted to others in a deployed environment. Waiver requests for persons testing positive for a blood borne disease should include a full test panel for the disease, including all antigens, antibodies, viral load, and appropriate tests for affected organ systems**.**

2. Confirmed HIV infection is disqualifying for deployment, IAW References I and T, service specific policies, and agreements with host nations. Note that some nations within the CENTCOM AOR have legal prohibitions against entering their country(ies) with this diagnosis.

3. Latent tuberculosis (LTBI). Individuals who are newly diagnosed with LTBI by either TST or IGRA testing will be evaluated for TB disease with at least a symptom screen and chest x-ray, and will have documented LTBI evaluation and counseling for consideration of treatment. Those with untreated or incompletely treated LTBI, including those with newly diagnosed LTBI, previously diagnosed LTBI, and those currently under treatment for LTBI will be provided information regarding the risks and benefits of LTBI treatment during deployment (see paragraph 15.G.6.C). Individuals meeting the above criteria **do not require a waiver** for deployment. Active duty TST convertors who have documented completion of public health nursing evaluation for TB disease and counseling for LTBI treatment described above **may deploy without a waiver** as long as all Service specific requirements are met.

4. History of active tuberculosis (TB). Must have documented completion of full treatment course prior to deployment. Those currently on treatment for TB disease may not deploy.

5. A CENTCOM waiver cannot override host or transit nation infectious disease or immunization restrictions. Active duty must comply with status of forces agreements; civilian deployers should contact the nation's embassy for up-to-date information.

D. Eye, Ear, Nose, Throat, Dental Conditions:

1. Vision loss. Best corrected visual acuity which does not meet minimum occupational requirements to safely perform duties. Bilateral blindness or visual acuity that is unsafe for the combat environment per the examining provider.

2. Refractive eye surgery. Personnel who have had laser refractive surgery must have a satisfactory period for post-surgical recovery before deployment. There is a large degree of patient variability which prevents establishing a set timeframe for full recovery. The attending ophthalmologist or optometrist will determine when recovery is complete.

a. Personnel are non-deployable while still using ophthalmic steroid drops post-

procedure.

b. Personnel are non-deployable for three months following uncomplicated photorefractive keratectomy (PRK) or laser epithelial keratomileusis (LASEK), or one month for laser-assisted in situ keratomileusis (LASIK) unless a waiver is granted.

c. Waiver request should include clearance from treating ophthalmologist or optometrist.

3. Hearing loss. Service members must meet all Service-specific requirements. Individuals must have sufficient unaided hearing to perform duties safely, hear and wake up to emergency alarms unaided, and hear instructions in the absence of visual cues such as lip reading. If there is any safety question, Speech Recognition In Noise Test (SPRINT) or equivalent is a recommended adjunct.

4. Tracheostomy or aphonia.

5. Patients without a dental exam within 12 months of deployment, or those who are likely to require evaluation or treatment during the period of deployment for oral conditions that are likely to result in a dental emergency.

a. Individuals being evaluated by a non-DoD civilian dentist should use a DD Form 2813, or equivalent, as proof of dental examination.

b. Individuals with orthodontic equipment require a waiver to deploy. Waiver requests to deploy should include a current evaluation by their treating orthodontic provider and include a statement that wires with neutral force are in place.

E. Cancer:

1. Cancer for which the individual is receiving continuing treatment or which requires frequent subspecialist examination and/or laboratory testing during the anticipated duration of the deployment.

2. Precancerous lesions that have not been treated and/or evaluated and that require treatment/evaluation during the anticipated duration of the deployment.

3. All cancers should be in complete remission for at least a year before a waiver is submitted.

F. Surgery:

1. Any medical condition that requires surgery (e.g., unrepaired hernia) or for which surgery has been performed and the patient requires ongoing treatment, rehabilitation or additional surgery to remove devices (e.g., external fixator placement).

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. Cosmetic, bariatric, or gender reassignment procedures are disqualifying until fully recovered with all follow-up and revisions complete, to include adjuvant counselling, medical treatment, and Service requirements. Special dietary and hygienic requirements cannot be reliably accommodated and may be independently disqualifying.

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. 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 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 CENTCOM 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.

DEPARTMENT OF THE AIR FORCE
WASHINGTON DC

11 Oct 17

MEMORANDUM FOR AFPC/CC

FROM: HQ USAF/A1P

SUBJECT: Retention of Airmen with Asymptomatic HIV

Airmen with asymptomatic HIV infection, defined as laboratory evidence of Human Immunodeficiency Virus (HIV) infection without the presence of progressive clinical illness or immunological deficiency, shall be referred to Air Force Personnel Center (AFPC) Medical Standards Branch in the Medical Service Officer Management Division (DP2NP) for a case review.

AFPC/DP2NP will determine if the Airman may be returned to duty with an Assignment Limitation Code (ALC-C) or if medically necessary, be referred to the Integrated Disability Evaluation System (IDES). Asymptomatic HIV alone is not unfitting for continued service.

Airmen with laboratory evidence of HIV infection and with the presence of progressive clinical illness or immunological deficiency shall be referred into the IDES.

Our points of contact are Lt Col Matthew Huibregtse, AF/A1PPP (703-571-0827, matthew.j.huibregtse.mil@mail.mil) and Col Patrick Danaher, AFMOA/SGHM, (210-395-9140, patrick.j.danaher6.mil@mail.mil).

ROBERT D. LABRUTTA
Major General, USAF
Director, Military Force Management Policy

cc:
AFMOA/CC

BREAKING BARRIERS...SINCE 1947

DEPARTMENT OF THE AIR FORCE
WASHINGTON DC

OFFICE OF THE ASSISTANT SECRETARY

JUN 0 6 2018

MEMORANDUM FOR AIR FORCE PERSONNEL CENTER/CC
AIR FORCE MEDICAL STANDARDS BRANCH
AIR FORCE MEDICAL OPERATIONS AGENCY/CC

FROM: Assistant Secretary of the Air Force (Manpower and Reserve Affairs)

SUBJECT: Appropriate Evaluation of Fitness for Continued Service for Airmen with Asymptomatic Human Immunodeficiency Virus (HIV)

This memo will provide guidance for the Air Force Personnel Center (AFPC) Medical Standards Branch in the Medical Service Officer Management Division (DP2NP) for the evaluation for fitness for Airmen with asymptomatic HIV.

In order to treat every Airman equitably and with dignity and respect, the appropriate treatment and medical evaluation of fitness for continued service for asymptomatic HIV Airmen will be accomplished in the same manner as any Airman with a chronic and/or progressive disease, and IAW with DoDI 6485.01, *Human Immunodeficiency Virus (HIV) in Military Service Members,* dated 7 June 2013. Asymptomatic HIV alone is not unfitting for continued service. Airmen will not be referred into IDES unless the criteria for referral, in accordance with DoDI 1332.18, *Disability Evaluation System*, Enclosure 3, Appendix 1, paragraph 2, are met.

Our point of contact is Col Karen Downes at karen.m.downes2.mil@mail.mil or 703-697-8822.

Shon J. Manasco
Assistant Secretary
(Manpower and Reserve Affairs)

DEPARTMENT OF THE AIR FORCE
WASHINGTON, D.C. 20330-1000

SEP 26 2018

OFFICE OF THE ASSISTANT SECRETARY

MEMORANDUM FOR AIR FORCE REVIEW BOARDS AGENCY
AIR FORCE PERSONNEL CENTER
AIR FORCE MEDICAL STANDARDS BRANCH
AIR FORCE MEDICAL OPERATIONS AGENCY

FROM: Assistant Secretary of the Air Force (Manpower and Reserve Affairs)

SUBJECT: Airmen with Asymptomatic Human Immunodeficiency Virus (HIV) Disposition

References: (a) Department of Defense Instruction 1332.18 *Disability Evaluation System,* dated 5 Aug 2014, Incorporating Change 1, 17 May 2018
(b) Department of Defense Instruction 6490.07, *Deployment –Limiting Medical Conditions for Service Members and DoD Civilian Employees,* dated 5 Feb 2010
(c) Department of Defense Instruction 6485.1 *Human Immunodeficiency Virus (HIV) in Military Service Members,* dated 7 June 2013
(d) *Appropriate Evaluation of Fitness for Continued Service for Airman with Asymptomatic Human Immunodeficiency Virus (HIV) Memorandum,* dated 6 June 2018

1. This memo provides additional guidance for the evaluation of fitness for duty for Airman with asymptomatic HIV.

2. Airmen identified with asymptomatic HIV will be evaluated through the Medical Retention Standards office (AFPC/DP2NP) and, based on the determination of DP2NP, will either be referred to the Integrated Disability Evaluation System (IDES) or returned to duty with an assignment limitation code.

3. When evaluating Airman with any chronic and/or progressive condition (to include HIV), the decision authority or boards will use the criteria in DoDI 1332.18, Enclosure 3, Appendix 1 and 2 as well as an assessment of the current career point of the Airman. Additionally, further evaluate the disability to see if it (1) represents a decided medical risk to the health of the member or to the welfare or safety of other members; or (2) the Airman's disability imposes unreasonable requirements on the military to maintain or protect the Service member.

4. Airmen with Asymptomatic HIV may be retained or separated on a case by case basis in accordance with DoDI 1332.18, *Disability Evaluation System* and DoDI 6485.1 *Human Immunodeficiency Virus.*

5. The phrase "asymptomatic HIV alone is not unfitting for continued Service" in Reference (d), is not a policy statement that asymptomatic HIV Airman are not to be referred into DES.

Referral into the DES system requires a further determination that the member is unfit for continued Service under the criteria in DoDI 1332.18.

6. Our point of contact is Col Karen Downes at 703-697-8822 or via email at karen.m.downes2.mil@mail.mil.

Shon J. Manasco
Assistant Secretary
(Manpower and Reserve Affairs)

Report to Congressional Defense Committees on Department of Defense Personnel Policies Regarding Members of the Armed Forces with HIV or Hepatitis B

2014

The estimated cost of report for the
Department of Defense is approximately
$5100.00
This includes $4,500.00 in expenses and
$600.00 in DoD labor.
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EXECUTIVE SUMMARY

INTRODUCTION: This report responds to section 572 the National Defense Authorization Act (NDAA) for Fiscal Year 2014 (Public Law 113-66), which requires the Secretary of Defense to submit a report on Department of Defense (DoD) personnel policies regarding members of the Armed Forces infected with human immunodeficiency virus (HIV) and hepatitis B (HBV).

DATA COLLECTION: DoD and Service policies were reviewed to develop this report.

POLICIES PERTAINING to HIV and HBV:

1. Individuals under consideration for appointment, enlistment, or induction into the Military Services with evidence of HIV or HBV infection do not meet accession standards, which require healthy recruits free of communicable diseases or medical conditions that may require excessive time lost for treatment or probably will result in separation for medical unfitness. Recruits must also be capable of functioning in the demanding military environment without aggravation of existing medical conditions.

2. Service members already serving who have laboratory evidence of HIV or HBV infection:
   - Are referred for appropriate treatment and managed in the same manner as a Service member with other chronic or progressive illnesses. If determined to be unfit for duty, the Service member will be separated or retired.
   - May not deploy without a waiver and the approval of the Combatant Commander. The factors considered ensure the Service member will be able to perform duties.
   - May not be subjected to adverse personnel action solely due to infection status. However, a Service member with laboratory evidence of HIV infection who disobeys an order to inform current or potential sexual partners of their infected status or to engage in safe sex practices may be subject to disciplinary action.

DISCUSSION: This review found that current DoD HIV and HBV policies are:

1. Established to maintain military readiness and based on international, national and federal guidelines, and professional organization recommendations for prevention, identification and treatment of HIV and HBV.

2. Evidence-based, medically accurate and reviewed regularly by subject matter experts.

3. Established to ensure applicants can complete rigorous military training and deploy to austere environments to accomplish the demanding missions of the military without jeopardizing their health, the health of their unit, or the health of the inhabitants of the lands where our forces are deployed.

4. In support of retention of DoD personnel already serving unless there is evidence of deteriorating health or other factors that make the individual unable or unfit to perform their duties.

5. Implemented to ensure that infection with HIV or HBV will not be the basis for adverse personnel actions.

CONCLUSION: The policies for management of DoD personnel with HIV or HBV are evidence-based, medically accurate, and are reviewed regularly and updated as practices, guidelines, and standards of care evolve.

INTRODUCTION:

Section 572 of NDAA for FY 2014, which was signed into law on December 26, 2013, required the Secretary of Defense to submit a report on DoD personnel policies regarding members of the Armed Forces infected with HIV or HBV to the congressional defense committees not later than 180 days after enactment of the act. The statute states: "The report shall include the following:

(1) A description of policies addressing the enlistment or commissioning of individuals with these conditions and retention policies, deployment policies, discharge policies, and disciplinary policies regarding individuals with these conditions.

(2) An assessment of these policies, including an assessment of whether the policies reflect an evidence-based, medically accurate understanding of how these conditions are contracted, how these conditions can be transmitted to other individuals, and the risk of transmission."

An interim report dated April 30, 2014 was sent to the chairpersons of the defense committees.

DATA COLLECTION:

The Assistant Secretary of Defense for Health Affairs (ASD(HA)) requested each of the Military Departments to provide a summary addressing the requirements in section 572 of the NDAA for FY 2014. The ASD(HA) reviewed DoD-level policies for enlistment or commissioning, retention, deployment, discharge and discipline of individuals infected with HIV or HBV. This report combines the Service data with the DoD assessment to provide a summary addressing the two requirements in the NDAA language.

POLICIES PERTAINING TO HIV AND HBV:

1. Enlistment or Commissioning

Standards for enlistment or commissioning of individuals into the Armed Services are stated in DoDI 6130.03, "Medical Standards for Appointment, Enlistment, or Induction in The Military Services." Paragraph 4 states "It is DoD policy to ensure that individuals under consideration for appointment, enlistment, or induction into the Military Services are:

(1) Free of contagious diseases that probably will endanger the health of other personnel.
(2) Free of medical conditions or physical defects that may require excessive time lost from duty for necessary treatment or hospitalization, or probably will result in separation from the Service for medical unfitness.
(3) Medically capable of satisfactorily completing required training.
(4) Medically adaptable to the military environment without the necessity of geographical area limitations.
(5) Medically capable of performing duties without aggravation of existing physical defects or medical conditions."

Applicants with the following specific medical conditions do not meet accession standards:

- Presence of HIV or serologic evidence of infection or false-positive screening test(s) with ambiguous results on confirmatory immunologic testing, or
- Current acute or chronic hepatitis carrier state, hepatitis in the preceding 6 months or persistence of symptoms after 6 months, or objective evidence of impairment of liver function

In accordance with DoDI 6485.01, "Human Immunodeficiency Virus (HIV) in Military Service Members," applicants to the U.S. Service Academies, the Uniformed Services University of the Health Sciences, and other officer candidate programs will be tested for laboratory evidence of HIV within 72 hours of arrival to the program and denied entry to the program if such test is positive. Reserve Officer Training Corps program cadets and midshipmen must be tested for laboratory evidence of HIV not later than during their commissioning physical examination, and denied a commission if they test positive.

Service accession policies are in compliance with DoDI 6130.03 and DoDI 6485.01.

2. Retention

Once a Service member has been trained, the goal is to retain members who acquire HIV or HBV who are still capable of performing their duties in the rigorous military environment and to deploy wherever the military serves. If any member incurs a medical condition that limits their ability to continue performing their military occupation, the Department's Disability Evaluation System (DES) provides for the member to have a fair and full review to determine fitness for duty (see paragraph 4 below for a discussion of DES).

The screening policies for HIV and HBV identify Service members who have been infected since accession into the military. In the Army and Air Force, HBV screening for Service members is performed if clinically indicated. SECNAVINST 5300.30E currently requires all AD personnel to receive, in addition to accession testing, an HBV test every 25 months. However, since it has been determined that there is no medical or force readiness indication for such frequent testing, the Secretary of the Navy has issued a temporary deferral from this requirement. Navy is currently revising SECNAVINST 5300.30E to remove this needlessly stringent requirement. Additional screening will be in accordance with the US Preventive Task Force Recommendation Statement, "Screening for Hepatitis B Virus Infection in Non-pregnant Adolescents and Adults," and as medically indicated.

DoDI 6485.01 requires all Service members to be screened periodically for laboratory evidence of HIV infection.

- AD and Reserve Component (RC) Selected Reserve (SELRES) personnel are screened every 2 years unless more frequent screenings are clinically indicated.

- Members of the SELRES are screened at least once every 2 years. RC personnel are screened when called to a period of AD greater than 30 days if they have not received an HIV test within the last 2 years.[1]

Testing for laboratory evidence of HIV for pre- and post-deployment is conducted in accordance with DoDI 6025.19, "Individual Medical Readiness" and DoDI 6490.03, "Deployment Health." (The requirements for screening in DoDI 6025.19 and DoDI 6490.03 are listed under the deployments section.)

The U.S. Preventive Services Task Force (USPSTF) makes recommendations for screening for HIV that are patient specific. In addition, the 2013 recommendations noted that there are no definitive data supporting specific screening intervals. These recommendations are reviewed by the subject matter experts when reviewing DoD policy for currency. It is important to note that DoD policy is population based screening based upon unique operational military requirements. For example, the safety of the U.S. military blood supply is a primary factor in determining the policy for screening. The DoD screening policy supports early detection and treatment. The USPSTF 2013 recommendations also noted that there is direct evidence of the benefits of early antiretroviral therapy for HIV infected persons and its effectiveness in preventing HIV transmission.

An AD Service member with laboratory evidence of HIV or HBV infection is evaluated and managed in the same manner as a Service member with other chronic or progressive illnesses. A treatment plan is established, any indicated treatment is initiated. The member may be allowed to continue to serve in a manner that ensures ongoing access to appropriate medical care provided that she or he is fit for duty Infected RC members who are fit for duty are also managed in the same manner as those with chronic or progressive illnesses and their medical condition is monitored periodically.

3. Deployment

DoDI 6025.19 requires that an HIV test result, completed within the last 24 months, be on file prior to deployment.

DoDI 6490.03 requires pre-deployment serum specimens and HIV testing (or as required by HIV threat or country requirements) for all deployments greater than 30 days to areas outside the contiguous United States (OCONUS) with non-fixed Military Treatment Facilities (MTFs). The combatant command (COCOM) Commander, Service component commander, or commander exercising operational control determines requirements for serum testing and HIV testing for all OCONUS deployments less than 30 days; OCONUS deployments to areas with fixed U.S. MTFs; and deployments within the contiguous United States (CONUS). When required, pre-deployment HIV tests must have been collected within 2 years of deployment (or more recently, based on country entry requirements). HIV serum samples that are not more than 12 months old

[1] "RC personnel" includes all members of the RC not in the SELRES. For example, a member in the Individual Ready Reserve is not routinely screened; however, the member is screened when ordered to AD for more than 30 days.

stored in the DoD Serum Repository may satisfy the pre-deployment specimen requirement. DoDI 6490.03 requires notification of Service members if a pre- or post-deployment serum sample will be tested for HIV.

In accordance with DoDI 6490.07, "Deployment-Limiting Medical Conditions for Service Members and DoD Civilian Employees," Service members with the following medical conditions may not deploy unless a waiver is granted:

- Known blood-borne diseases that may be transmitted to others in a deployed environment.
- Presence of HIV seropositivity with the presence of progressive clinical illness or immunological deficiency.

The Combatant Command surgeon must be consulted in all instances of HIV seropositivity and active HBV infection for consideration of a medical clearance for deployment. The Combatant Commander is the final approval authority for waivers.

AR 40-501, "Standards of Medical Fitness," directs that HIV infected members will not be deployed to a combat theater of operations. However, waivers may be granted to HIV infected individuals to serve in OCONUS duty assignments. AR 40-501 is currently under revision and will address the availability of medical care in OCONUS for members with HIV or HBV who are granted a waiver. The revised policy will direct that medical services available in the assignment area must provide the same standard of care as in CONUS.

In 2012, based on advances in medical treatment which have significantly simplified the disease management of individuals with HIV, the Navy updated its policies to allow individuals with HIV, who have had appropriate evaluation and medical clearance, to operationally deploy aboard select naval vessels. These personnel are considered to have controlled HIV infection as manifested by an unimpaired immune system, no current viremia, an established history of compliance with medical treatment, and a history of professional attitude. This policy is based on the following considerations:

- There is no demonstrated risk of transmission of infection in normal daily activities.
- An investment in training of these individuals has been made.
- The previous policy of denying deployments was making this subset of personnel less competitive in achieving career milestones or warrior qualifications.

The Air Force (AF) policy states that HIV-infected Service members cannot deploy or be stationed OCONUS without a waiver. The AF is continuing to develop guidance for non-permanent change of station (PCS) extended duty tours and/or travel to areas with increasing military operations tempo (such as United States Africa Command or United States Pacific Command).

4. Discharge From Duty or Retirement

A Service member infected with HIV or HBV is not retired or separated solely on the basis of being infected. However, an infected member whose condition deteriorates and interferes with the successful performance of their military occupation may be referred to the Disability Evaluation System (DES) for a physical disability evaluation, which provides for a fair and full review to determine fitness for duty.

DoDI 1332.18, "Physical Disability Evaluation," DoD Manual 1332.18, Vol 1, "Disability Evaluation System Manual: General Information and Legacy DES (LDES) Time Standards," and DoD Manual 1332.18, Vol 2: Disability Evaluation System Manual: Integrated Disability Evaluation System (IDES)" establish policy for determining fitness for duty and for retiring or separating Service members due to physical disability. A medical evaluation is the first step in the disability evaluation process. A Medical Evaluation Board (MEB) documents a Service member's medical conditions and full clinical information. A summary of clinical information includes a medical history, appropriate physical examination, indicated medical tests and their results, medical and surgical consultations as necessary, diagnoses, ongoing or recommended treatment, and prognosis. The medical evaluation documents the medical status and duty limitations of Service members (subject to Service departmental regulations).

If the Service member cannot perform the duties of her or his military occupational specialty, the MEB refers the case to the DES. Criteria for referral of Service members into the DES include:

- Have one or more medical conditions that may, individually or collectively, prevent the Service member from reasonably performing the duties of their office, grade, rank, or rating including those duties remaining on a Reserve obligation for more than 1 year after diagnosis;

- Have a medical condition that represents an obvious medical risk to the health of the member or to the health or safety of other members; or

- Have a medical condition that imposes unreasonable requirements on the military to maintain or protect the Service member.

In all cases, competent medical authorities will refer into the DES eligible Service members who meet the criteria within 1 year of diagnosis.

A Service member is considered unfit when the evidence establishes that the member, due to physical disability, is unable to reasonably perform the duties of her or his office, grade, rank, or rating to include duties during a remaining period of Reserve obligation. For members determined unfit due to duty-related medical impairments, the PEB determines their entitlement to benefits under Chapter 61 of 10 U.S.C. Members found unfit are separated or retired in accordance with the guidance in DoDI 1332.18.

A revision of DoDI 1332.18 and the supporting Manuals were published on 5 August 2014. As a result, the Military Services will need to review Service policies for disability evaluation to ensure compliance with the revised DoD policy.

5. Adverse Personnel Action

HIV or HBV infection may not be the sole cause for adverse personnel actions. DoDI 6485.01 directs that information obtained as a result of an epidemiologic assessment interview will not be used to support any adverse personnel action against the Service member.

The Services use a strategy of aggressive disease surveillance and health education programs to help control the transmission of HIV or HBV. An infected Service member receives training on the prevention of further transmission of HIV or HBV infection to others and the potential legal consequences of exposing others to HIV infection. All Services hold HIV infected members accountable under the Uniform Code of Military Justice (UCMJ) if they ignore orders to warn and protect others whose health might be jeopardized by sexual contact or other types of high risk exposures. Commanders may recommend that personnel who violate such guidance be considered for involuntary discharge or separation.

DISCUSSION:

International, national and federal guidelines and professional organization recommendations are considered in the development of DoD and Service policies and during the periodic reviews and updates. These guidelines and recommendations are evidence-based, and take into consideration the epidemiology and pathophysiology of how HIV and HBV are contracted and transmitted. DoD policies for HIV and HBV are consistent with the current guidelines and recommendations of the Centers for Disease Control and Prevention. Service policies are in compliance with the DoD policies. The health information and privacy of infected Service members are protected by DoD privacy policies and programs, with which the Services are also in compliance.

The Heads of the DoD Components must ensure that each issuance for which they are the office of primary responsibility is reviewed annually. The policy must be certified as current or revised, changed, or cancelled as appropriate. The DoD policy on HIV in military Service members was revised most recently on June 7, 2013 and was reviewed in June 2014 for currency.

All Department of the Army (DA) administrative publications must be no more than 5 years old. All DA Publications more than 5 years old must be updated to reflect current policies and procedures. The Army reported that their personnel policies are reviewed every 5 years at a minimum to ensure currency and that they reflect standard of care practices. AR40-501 is being revised in light of the advances in care and treatment for HIV, and normal life expectancy for those with adequate access to care and compliance with treatment recommendations. Army reports, for example, that a current policy that prevents the assignment of HIV infected soldiers to military-sponsored educational programs that would result in an additional service obligation is being reconsidered.

The Navy reported that its guidance for evaluation, diagnosis, and management options for HIV and HBV undergoes frequent and significant updates as medical capabilities, technologies, and evidence based practices evolve. Navy policy incorporates best practices to maintain a fit and ready force capable of carrying out the Navy's mission in its unique operational milieu.

Therefore, policies undergo review and revision to ensure maximum readiness at least every five years. When specific issues arise, policies are amended as needed on a case by case basis.

Recognizing the similarities in the transmission of, and risk factors for HIV and HBV infection, Department of the Navy medical, manpower and personnel policies reflect current knowledge of the natural history of these infections, the risks to the infected individual incident to continued military service, the risk of transmission of these viruses to non-infected personnel, the effect of infected personnel on commands and the mission, and the safety of military blood supplies.

The AF Medical Service reported that their HIV and HBV policies are assessed every two years to ensure they accurately reflect current evidence-based practice. Air Force Instruction 48-135, "Human Immunodeficiency Virus Program," was rewritten in 2014 in consultation with the Air Force Medical Service Infectious Disease physician and HIV point of contact at San Antonio Military Medical Center to ensure clinical accuracy. Similarly, HBV policies are reviewed by both Infectious Disease and Gastroenterology subject matter experts to ensure accuracy and adherence to up to date evidence-based practices.

To prevent hepatitis B, DoD began vaccinating all new recruits in 2002. Tri-service vaccination policy is contained in Army Regulation 40-562, *BUMEDINST 6230.15B, AFI 48–110, "Immunizations and Chemoprophylaxis for the Prevention of Infectious Diseases." Current policy continues vaccination of basic trainees and other accessions (unless sero-immune) during initial entry training. The hepatitis B vaccine is also provided for susceptible personnel who are at risk of potential exposure to blood-borne pathogens. For military purposes, this includes occupational specialties involving health care workers, emergency medical technicians, mortuary affairs personnel, search and rescue specialists, correctional facility staff, and designated special operations forces. Members deploying for more than 30 days to areas of high hepatitis B Service members who may have been exposed to Hepatitis B are evaluated and receive post-exposure prophylaxis, if appropriate.

There is no vaccine currently available to prevent HIV infection, but the Army is engaged in clinical research. Post-exposure prophylaxis is available and is provided for Service members, as appropriate, based upon the nature and timing of the exposure.

In summary, this review found that current DoD and Service policies for accession, retention, deployment, discharge, and discipline of DoD personnel with HIV or HBV:

- are based on international, national and federal guidelines, and professional organization recommendations for prevention, identification, and treatment of HIV and HBV;
- are evidence based and medically accurate in accordance with how HIV and HBV are contracted and transmitted;
- are reviewed regularly by subject matter experts at the DoD and Service level, and are updated as guidelines and recommendations evolve or new medical information becomes available;
- are consistent with national guidelines, consistently implemented across DoD, and that Service policies are in compliance with DoD-level policies;

- support retention of DoD personnel unless there is evidence of deteriorating health or other factors that make the individual unable or unfit to perform their duties;
- direct that infection with HIV or HBV will not be the sole basis for adverse actions; and
- protect the privacy of an infected individual.

Service policies reflect frequent changes and updates as medical capabilities, technologies, and evidence-based practices have evolved. The AF, which has the most recently revised policies for HIV and HBV, believes its current policies are appropriate, reflect the most current evidence-based practice, and are medically accurate based on how these conditions are contracted and transmitted. The Army and the Navy are currently revising the policies governing the management of Service members infected with HIV or HBV.

CONCLUSIONS:

DoD accession policies are consistent with the need of the military Services to recruit healthy personnel who are able to participate in demanding military training and capable of deploying to harsh and austere environments without deterioration in their health.

For those who become infected with HIV or HBV after accession, DoD policy is evidence-based and in accordance with state-of-the-art clinical guidelines. The emphasis is upon retention if the medical condition is stable with appropriate treatment.

A waiver is required for Service members with HIV or HBV infection to deploy. As with other medical conditions requiring a waiver, many factors that the Service member will encounter during the deployment are considered to determine whether it is likely the medical condition will limit the Service member's performance or cause the medical condition to deteriorate.

Service members with medical illnesses or conditions that might limit their ability to perform military duties (including HIV or HBV infection) may be evaluated for either duty limitations or medical discharge.

Adverse personnel actions based solely on HIV or other infection are precluded by DoD and Service policy. However, as with any direct order, a Service member, who violates the order to inform sexual partners of their HIV or HBV status or fails to use safe sexual practices, may be subject to disciplinary action.

The policies for management of DoD personnel with HIV or HBV are evidence-based, medically accurate, reflect standard of care medical practices, and have been reviewed regularly and updated as practices, guidelines, and standard of care have evolved.

Department of Defense Personnel Policies Regarding Members of the Armed Forces Infected with Human Immunodeficiency Virus:

Report to the Committees on the Armed Services of the Senate and House of Representatives

August 2018

The estimated cost of this report or study for the Department of Defense is approximately $18,000 for the 2018 Fiscal Year.
This includes $100 in expenses and $18,000 in DoD labor.
Generated on 2018Apr27 RefID: D-13AF836

EXECUTIVE SUMMARY

INTRODUCTION: House Report 115-200, pages 148-149, accompanying H.R. 2810, the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2018, requested that the Department of Defense (DoD) submit a report to the Committees on Armed Services of the Senate and House of Representatives on its personnel policies regarding members of the Armed Forces infected with human immunodeficiency virus (HIV). Specifically, the Committee requested DoD provide the following in its report:

(1) A description of policies addressing the enlistment or commissioning, retention, deployment, discharge, and disciplinary policies regarding individuals with this condition.

(2) An update on the status of the Department of the Army's HIV policy, which was under review during the issuance of a 2014 report.

(3) An assessment of these policies, with reference to medical experts and literature, which includes how the policies reflect an evidence-based, medically accurate understanding of how this condition is contracted; how this condition can be transmitted to other individuals; the risk of transmission; and treatment regimens available.

(4) The feasibility of allowing an individual who is currently serving as an enlisted member of the Armed Forces to become a commissioned officer of the Armed Forces, and what restrictions are different for an officer.

DATA COLLECTION: This report follows the Department's interim response submitted to the Committees on Armed Services of the Senate and House of Representatives on March 19, 2018, and includes DoD- and Service-level policies and assessments addressing the requirements specified in House Report 115-200. Service-level information was obtained from each of the Military Departments at the request of the Office of the Assistant Secretary of Defense for Health Affairs (OASD(HA)).

PERSONNEL POLICIES PERTAINING TO HIV:

1. Enlistment and Commissioning (i.e., Accession): Grounded in statutory requirements for accessions of able-bodied and physically qualified individuals, recently reissued Department of Defense Instruction (DoDI) 6130.03, "Medical Standards for Appointment, Enlistment, or Induction into the Military Services," May 6, 2018, establishes DoD policy to ensure that individuals considered for appointment, enlistment, or induction into the Military Services are:

- Free of contagious diseases that may endanger the health of other personnel.
- Free of medical conditions or physical defects that may reasonably be expected to require excessive time lost from duty for necessary treatment or hospitalization, or may result in separation from the Military Service for medical unfitness.
- Medically capable of satisfactorily completing required training and initial period of contracted service.

- Medically adaptable to the military environment without geographical area limitations.
- Medically capable of performing duties without aggravating existing physical defects or medical conditions.

That instruction also establishes a specific policy to allow applicants who do not meet the specified physical and medical standards to be considered for a medical waiver. The instruction addresses 29 body systems, and lists for each of those a number of conditions that do not meet medical accession standards. Under the heading "Systemic Conditions," there are 19 such conditions, including presence of HIV infection. Thus, HIV infection is a disqualifying medical condition for entry into the military service. Both prior service and non-prior service applicants undergo screening for HIV prior to entrance. As with all other disqualifying medical conditions, applicants may be considered for a medical waiver.

2. Retention and Discharge: DoD and Service policies restrict involuntary separation of a Service member solely due to being HIV positive. Service members who acquire HIV after joining the military are ensured access to appropriate medical care: DoD policy requires they receive counseling and treatment consistent with the standard of care, evidence-based HIV clinical practice standards, and medical management guidelines. HIV positive Service members receive a referral for medical evaluation of fitness for continued service in the same manner as a Service member with other chronic or progressive illnesses. Service members with HIV may continue their service as long as they are able to perform their military duties, taking into account the nature of their position. If they develop a disability, HIV-positive Service members undergo evaluation of fitness for continued service by the same process as those who are HIV-negative. Active duty (AD) and Reserve Component (RC) Service members with laboratory evidence of HIV infection who are determined to be unfit for further duty undergo separation or retirement. Military Departments and Combatant Commands (CCMD) limit assignments of HIV-infected individuals based on expert medical review, determination regarding the individual's fitness for duty, and the nature and location of the duties performed, in accordance with operational requirements.

3. Deployment: DoD policy establishing deployment-limiting medical conditions sets the minimum standard for all deploying and deployed DoD personnel. Military Department policy guidance, Service-specific readiness requirements, or Combatant Commander needs may involve additional restrictions. HIV antibody positive status is a deployment-limiting medical condition precluding contingency deployment.

DoDI 6490.07, "Deployment-Limiting Medical Conditions for Service Members and DoD Civilian Employees," Enclosure 3, dated February 5, 2010, provides that individuals with a diagnosis of "human immunodeficiency virus (HIV) antibody positive with the presence of progressive [HIV related] clinical illness or immunological deficiency" shall not deploy unless a waiver is granted. All Service policies preclude HIV positive Service members from deploying to combat areas or in support of contingency operations due to the potential lack of access to needed medical care or medications in austere environments, as well as the military risks inherent in the mission assigned that could lead to illness exacerbation and compromise unit readiness and mission completion. For purposes of this report, a contingency deployment is one that is outside the continental United States (OCONUS), more than 30 days in duration, and in a

location with medical support from only non-fixed (temporary) military medical treatment facilities. A contingency deployment also includes the relocation of forces and materiel to an operational area in a situation requiring military operations in response to natural disasters, terrorists, or as otherwise directed.

All Services currently permit HIV positive Service members to deploy for purposes other than combat or a contingency operation, or to be assigned for duty in certain overseas locations, subject to receipt of a waiver. In view of this, members with HIV infection may be considered deployable with limitations. A waiver may be recommended on a case-by-case basis after review of the individual Service member's health and consideration of factors including the climate, altitude, rations, housing, nature of the duty assignment proposed, and medical services available in the location to which deployment or assignment is proposed. Further, the condition must not pose a significant risk of substantial harm to the individual or others, taking into account the condition of the deployed environment. The following table outlines the Service-specific policies for grant of a waiver to permit an HIV positive Service member to deploy for other than combat or a contingency, or to be assigned for duty in an overseas location:

Army	Waivable?	Yes
	By Whom?	Combatant Commander
	Under what conditions?	Soldier is determined to be fit and free of HIV-related illness.
	Host nation rules apply?	Yes, but deployments may be permitted ***only*** to Europe and Korea.
Navy/ Marine Corps	Waivable?	Yes
	By Whom?	Sailors: Treating HIV Evaluation and Treatment Unit (HETU), Navy Bloodborne Infection Management Center, PERS-82, and receiving command. Marines: Deputy Commandant. Manpower & Reserve Affairs and receiving command.
	Under what conditions?	Agreement by all organizations/officials listed above and receiving command (including the CCMD, as appropriate). Sailors/Marines who have no viremia (i.e., there is no virus present in the bloodstream), do have an established history of medical compliance, and possess a professional attitude, may be considered on a case-by-case basis for large ship platform tours and OCONUS deployment/assignment.
	Host nation rules apply?	Yes
Air Force	Waivable?	Yes
	By Whom?	Air Force Medical Support Agency, with favorable coordination from receiving commander and CCMD approval.
	Under what conditions?	No HIV-related illness.
	Host nation rules apply?	Yes

DoD has recently issued a new policy, DoDI 1332.45, "Retention Determinations for Non-Deployable Service Members," July 30, 2018, for implementation October 1, 2018. The overarching policy is that to maximize the lethality and readiness of the Joint Force, all Service members are expected to be deployable. Service members who are considered non-deployable for more than 12 consecutive months will be evaluated for a retention determination by their respective Military Department, and, as appropriate, referral into the Disability Evaluation System (DES) or initiation of processing for administration separation, with the normal policies and procedures, including due process procedures, of those systems continuing to apply. The Military Departments will determine the deployability status of Service members and will make retention determinations for Service members who have been non-deployable for more than 12 consecutive months. They may retain such members if determined to be in the best interest of the Military Service. Under this DoDI, "non-deployable" and "deployable with limitations" are two separate categories; the retention determination process applying to the former but not the latter. The Military Departments have authority to determine the specific dividing line between the two categories most appropriate for the operational circumstances applicable to their respective Services.

4. Disciplinary: DoD policy provides that a HIV positive status is not a punishable offense and cannot be used as a sole basis for disciplinary action against an individual. DoD policy also prohibits the use of information obtained as a result of an epidemiologic assessment interview to support any adverse personnel action against a Service member. However, Service members with laboratory evidence of HIV infection may be subject to disciplinary action if they disobey an order to inform current or potential sexual partners of their infected status or do not engage in safe sex practices.

ARMY POLICY STATUS UPDATE: Initiated in 2015, a working group has reviewed Army Regulation (AR) 600-110, last updated in April 2014, to assess any need for changes to reflect an evidence-based, medically accurate understanding of HIV infectivity, transmission, and treatment. This process is expected to be completed in the near future.

MEDICAL ASSESSMENT OF PERSONNEL POLICIES: Currently, no vaccine exists to prevent HIV infection, and no treatment exists to cure it. Broad consensus regarding published medical evidence supports the notion that people living with HIV on antiretroviral therapy (ART) who have an undetectable viral load in their blood, have a "negligible risk" of sexually transmitting HIV. Depending on the ART drugs used, it may take as long as six months for an individual's viral load to reach an undetectable level. Thus, with the advent of ART, HIV infection has evolved from a once terminal condition to a chronic illness requiring regular management and strict adherence to treatment protocol. As a result, the Department's policies have evolved over time. They currently focus not only on minimizing risks of HIV exposure, but also on providing evidence-based care and support for Service members living with HIV, with the goal to maintain a Service member's fitness for duty, optimize retention and quality of life, and help avoid disease progression of HIV-positive Service members into potential disability. Recognizing the risk factors for HIV infection and transmission, DoD- and Service-level personnel policies intend to reflect current knowledge of: how HIV is contracted and transmitted to HIV-naïve individuals; the ability of an HIV-positive individual to continue service without exacerbating his or her condition or risking the military mission; the effect of

infected personnel on commands; and the safety of military blood supplies. Medical literature pertaining to HIV medicine rapidly evolves. Subject matter experts across the Military Services are aware of and have access to all available contemporary medical literature, practice guidelines, medications, and treatment modalities based on emerging and published evidence-based studies or expert opinion.

FEASIBILITY OF ALLOWING ENLISTED SERVICE MEMBERS TO BECOME COMMISSIONED OFFICERS AND RESTRICTIONS DIFFERENT FOR OFFICERS: DoD policy has long maintained a difference between accession medical standards and retention medical standards. The rationale for this difference is that once a member has been fully trained and has experience in performing the duties of his or her position, whether as an enlisted member or officer, the needs of the Service incline decidedly toward allowing the member to continue to perform those duties and return the investment the Service has made in the member. At the accession stage, the needs of the Service incline toward selecting members in whom to make the training and mentoring investment who minimize any risk of inability due to medical conditions to complete an initial period of service and potentially a longer military commitment. Longstanding DoD policy under DoDI 6130.03 has also held that in the case of an enlisted member seeking appointment as a commissioned officer, the accession standards are the appropriate ones to apply because it is a new position, involving a whole new set of duties and responsibilities and new training and mentorship. The needs of the Service do not necessarily favor an officer applicant with prior enlisted service compared to one without such service, in minimizing any risk of inability to perform satisfactorily in the commissioned officer position due to medical conditions. Yet, it is appropriate to note that a review of two individual officer candidates, one with and one without prior enlisted service, requesting a medical waiver for the same condition, the candidate with prior service may well have the advantage of a record of successful military service in the enlisted ranks. However, regarding which set of standards to apply to the initial medical screening, the accession medical standards are the more appropriate standards for all applicants, including applicants for enlistment or commissioning. This is long-established DoD policy for all medical conditions; there is no special or different rule for individuals with HIV infection.

DISCUSSION: The Department has a responsibility to ensure the health and well-being of Service members, and through its policies, aims to minimize the risk of Service members' exposure to HIV, while ensuring that those infected with HIV have access to appropriate care and management of their illness and are able to continue service. Military unique considerations; the rapidly evolving nature of medical evidence and understanding pertaining to the nature of HIV transmission, infectivity, associated risks, and treatment; evolving mission requirements; and Service member needs pertaining to health information privacy protections, as well as opportunities for career advancement, are key factors that influence personnel policy pertaining to HIV-infected members of the Armed Forces. Current DoD- and Service-level personnel policies pertaining to HIV-infected members of the Armed Forces:

- Are established to maintain military readiness and optimize lethality of the Armed Forces.

- Are instituted to ensure military applicants can successfully complete rigorous military training and deploy to austere environments to accomplish the demanding missions of the military, including combat against enemy forces, without jeopardizing their health, the health of their unit, or the military mission, as well as to respect host Nation laws where our forces are deployed.

- Support retention of Service members infected with HIV, unless there is evidence of deteriorating health or other factors that render the individuals unable or unfit to perform their duties.

- Require the same procedures for medically evaluating Service members who develop disability due to chronic illness to determine fitness for continued service, regardless of whether the Service member is HIV-positive.

- Aim to ensure that, except for assignment limitations, HIV-infected personnel are treated no differently than other Service members.

- Ensure that a Service member infected with HIV but able to fully perform duties is not retired or involuntarily separated solely based on being infected.

- Direct the protection of health information and privacy of HIV-infected personnel.

- Reflect existing evidence and adhere to current nationally-accepted, evidence-based guidelines, and assess evolving medical evidence and scientific understanding of the nature and risk of HIV transmission, available treatment regimens, and the latest HIV management approaches and practices.

- Stipulate clinical management to be consistent with standard of care, evidence-based HIV clinical practice standards, and medical management guidelines.

CONCLUSIONS: DoD- and Service-level personnel policies pertaining to members of the Armed Forces infected with HIV are evidence-based in accordance with current clinical guidelines and are reviewed and updated to align with evolving medical capabilities, technologies, evidence-based practices, and current scientific understanding of the nature of HIV infection, transmission, and management. Maintaining the health of military personnel is essential for force readiness. It is a strategic objective of the Military Health System (MHS) to sustain the health of Service members and restore the health and return to duty of Service members who become ill or injured, whenever possible. Once a Service member completes training, the goal is to retain members who acquire HIV and who are still capable of performing their duties in the rigorous military environment. Personnel policies aim to balance the need of the Services (e.g., readiness, resilience, deployability, mission accomplishment, retention) with the needs of Service members infected with HIV (e.g., access to quality care, counseling, support and educational services, privacy protections, option to continue service, if desired). As such, existing DoD- and Service-level personnel policies intend to maximize the lethality, readiness, and operational effectiveness of the Armed Forces, as well as help ensure the health and well-being of Service members, while mitigating the risk of HIV transmission.

INTRODUCTION:

In House Report 115-200, page 148-149, to accompany H.R. 2810, NDAA for FY 2018 (Public Law 115-91), the Committee on Armed Services of the House of Representatives requested that the DoD submit a report to the Committees on the Armed Services of the Senate and House of Representatives on its personnel policies regarding members of the Armed Forces infected with HIV. Specifically, the Committee requested that DoD provide the following in its report:

(1) A description of policies addressing the enlistment or commissioning, retention, deployment, discharge, and disciplinary policies regarding individuals with this condition.

(2) An update on the status of the Department of the Army's HIV policy, which was under review during the issuance of a 2014 report.

(3) An assessment of these policies, with reference to medical experts and literature, which includes how the policies reflect an evidence-based, medically accurate understanding of how this condition is contracted; how this condition can be transmitted to other individuals; the risk of transmission; and treatment regimens available.

(4) The feasibility of allowing an individual who is currently serving as an enlisted member of the Armed Forces to become a commissioned officer of the Armed Forces, and what restrictions are different for an officer.

The Committee indicated that the Department's previous report, submitted to Congress in response to section 572 of the NDAA for FY 2014, did outline the current DoD policies; however, it failed to include how current policies reflect the evidence base and medical advances in the field of HIV. The Committee also stated the report fell short in describing the criteria guiding the implementation of these policies throughout different branches and among commanding officers.

DATA COLLECTION: This report follows the Department's interim response submitted to the Committees on Armed Services of the Senate and House of Representatives on March 19, 2018, and includes DoD- and Service-level policies and assessments addressing the requirements specified in House Report 115-200. Service-level information was obtained from each of the Military Departments at the request of the OASD(HA).

PERSONNEL POLICIES PERTAINING TO HIV:

1. Accession (Enlistment or Commissioning)

Accession standards require healthy recruits who are free of communicable diseases or medical conditions that will likely endanger the health of other personnel, require excessive time lost from duty for necessary treatment or hospitalization, or likely result in separation from service due to medical unfitness. DoDI 1304.26, "Qualification Standards for Enlistment, Appointment,

and Induction," provides basic entrance qualification standards "designed to ensure that individuals under consideration for enlistment, appointment, or induction are able to perform military duties successfully, and to select those who are the most trainable and adaptable to Service life." Recruits must also be capable of functioning in the demanding military environment without aggravation of existing medical conditions. DoDI 6130.03, "Medical Standards for Appointment, Enlistment, or Induction in the Military Services," states that individuals under consideration for appointment, enlistment, or induction into the Military Services must be:

- Free of contagious diseases that probably will endanger the health of other personnel.
- Free of medical conditions or physical defects that may require excessive time lost from duty for necessary treatment or hospitalization, or probably will result in separation from the Service for medical unfitness.
- Medically capable of satisfactorily completing required training.
- Medically adaptable to the military environment without the necessity of geographical limitations.
- Medically capable of performing duties without aggravation of existing physical defects or medical conditions.

DoDI 6130.03 also establishes a specific policy to allow applicants who do not meet the specified physical and medical standards to be considered for a medical waiver. This instruction addresses 29 body systems and lists for each a number of conditions that do not meet medical accession standards. Under the heading "Systemic Conditions," there are 19 such conditions, including presence of HIV infection. DoDI 6485.01, "Human Immunodeficiency Virus (HIV) in Military Service Members," June 7, 2013, reiterates that individuals with laboratory evidence of HIV infection are denied eligibility for appointment, enlistment, pre-appointment, or initial entry training for military service pursuant to DoDI 6130.03. All applicants for appointment, enlistment, or individuals being inducted into the Military Services are screened for laboratory evidence of HIV infection. Applicants do not meet accession standards if they present with HIV or serologic evidence of infection, or false-positive screening test(s) with ambiguous results on confirmatory immunologic testing. Thus, HIV infection is a disqualifying medical condition for military service, and persons infected with HIV are neither enlisted nor commissioned into military service. As with all other disqualifying medical conditions, applicants may be considered for a medical waiver pursuant to DoDI 6130.03.

Additionally, DoDI 6485.01 requires applicants to the U.S. Service Academies, the Uniformed Services University of the Health Sciences, and other officer candidate programs undergo testing for laboratory evidence of HIV within 72 hours of arrival to the program, and denies entry to the program if the test result is positive. Reserve Officer Training Corps program cadets and midshipmen must be tested for laboratory evidence of HIV no later than during their commissioning physical examination, and are denied a commission if they test positive.

Applicants for active and reserve enlisted service undergo HIV testing typically at U.S. Military Entrance Processing Command Military Entrance Processing Stations (MEPS) or other authorized locations. Applicants not tested at the MEPS undergo testing as part of the physical examination conducted prior to accession.

Service accession policies comply with DoDI 6130.03 and DoDI 6485.01. Applicable Service policies are set forth in the following: AR 600-110 and AR 40-501for the Army; Secretary of the Navy Instruction (SECNAVINST) 5300.30E for the Navy and Marine Corps; and Air Force Instruction (AFI) 48-123 for the Air Force.

DoD medical accession standards are reviewed periodically by the Accession Medical Standards Working Group (AMSWG), which evaluates and recommends updates to maintain the currency and validity of those standards. The AMSWG is co-chaired by representatives from the Office of the Assistant Secretary of Defense for Manpower and Reserve Affairs (M&RA) and OASD(HA). It includes a voting representative from each of the five Military Services, with additional support from the following DoD components/offices: Joint Staff Surgeon; Surgeons General of the Army, Navy, and Air Force; medical officers of the Coast Guard and National Guard Bureau; and personnel chiefs of the Army, Navy, Air Force, Marine Corps, Joint Staff, and National Guard Bureau. Among the functions of the AMSWG are to perform evidence-based assessments of the accession standards and provide direction in research initiatives for the Accession Medical Standards Research Activity, including evidence-based research in support of medical standards assessments.

Supported by the work of the medical and personnel experts of the AMSWG, the DoDI 6130.03 disqualification for accession for HIV infection does not reflect disagreement with the medical consensus that modern medication management of HIV infection produces very positive results. However, in the context of the extraordinary challenges of many aspects of military service, including potential mission needs under highly stressful combat conditions or in extremely austere and dangerous places worldwide, even well-managed HIV infection carries risks of complications and comorbidities, possibly with latent effects, immune system dysregulation, neurocognitive impairments (NCI) (discussed further below), disrupted medication maintenance and necessary monitoring for potential side-effects, possible military vaccination adverse effects, and potential communicability, including in circumstances of buddy-aid to a seriously injured member in combat and emergency whole blood battlefield transfusions. In view of these risks, the needs of the Service incline toward maintaining the longstanding medical standard disallowing accession of HIV infected individuals.

2. Retention/Discharge

Once a Service member completes initial training, the policy is to retain members who acquire HIV and are still capable of performing their duties in the rigorous military environment. Clinical management of an AD Service member and an RC Service member on AD for a period of more than 30 days with laboratory evidence of HIV infection is conducted consistent with standard of care, evidence-based HIV clinical practice standards, and medical management guidelines.

DoDI 6485.01 specifically addresses HIV in Service members, and prescribes procedures for the identification, surveillance, and management of members of the Military Services infected with HIV and for prevention activities to control transmission of HIV. An AD Service member with laboratory evidence of HIV infection is 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, in accordance with DoDI 1332.18, "Disability Evaluation System." AD Service members with laboratory evidence of HIV infection determined to be fit for duty are allowed to serve in a manner that ensures access to appropriate medical care.

A RC Service member with laboratory evidence of HIV infection is referred for a medical evaluation of fitness for continued service in accordance with Service regulations, and in the same manner as an RC Service member with other chronic or progressive illnesses. Eligibility for AD for a period of more than 30 days is denied to those RC Service members with laboratory evidence of HIV infection (except under conditions of mobilization and on the decision of the Secretary of the Military Department concerned). RC Service members, either who are not on AD for a period of more than 30 days or who are not on full-time National Guard duty, and who show laboratory evidence of HIV infection, are transferred involuntarily to the Standby Reserve only if they cannot be used in the Selected Reserve.

In accordance with DoDI 6485.01, the privacy of a Service member with laboratory evidence of HIV infection is protected consistent with DoD 5400.11-R, "Department of Defense Privacy Program" and DoD 6025.18-R, "DoD Health Information Privacy Regulation."

A Service member infected with HIV but able to fully perform their duties is not retired or separated solely based on being infected. However, Service members, including those infected with HIV, whose condition deteriorates or otherwise interferes with their ability to perform their military occupation successfully, may be referred to the DES. The DES provides for the member to have a fair and full review to determine fitness for duty. The following DoD issuances establish policy for determining fitness for duty, and for retiring or separating Service members due to physical disability: Department of Defense Manual (DoDM) 1332.18, Vol 1, "Disability Evaluation System (DES) Manual: General Information and Legacy DES (LDES) Time Standards;" DoDM 1332.18, Vol 2, "Disability Evaluation System (DES) Manual: Integrated Disability Evaluation System (IDES);" and DoDM 1332.18, Vol 3, "Disability Evaluation System (DES) Manual: Quality Assurance Program (QAP)."

A medical evaluation is the first step in the disability evaluation process. A Medical Evaluation Board (MEB) documents a Service member's medical conditions and full clinical information. A summary of clinical information includes a medical history; appropriate physical examination; indicated medical tests and their results; medical and surgical consultations as necessary; diagnoses; ongoing or recommended treatment; and prognosis. The medical evaluation documents the medical status and duty limitations of Service members (subject to Service departmental regulations).

If the Service member cannot perform the duties of her or his military occupational specialty (MOS), the MEB refers the case to the DES. Criteria for referral of Service members into the DES include:

- Having one or more medical conditions that may, individually or collectively, prevent the Service member from reasonably performing the duties of his or her office, grade, rank, or rating, including those duties remaining on a Reserve obligation for more than one year after diagnosis;

- Having a medical condition that represents an obvious medical risk to the health of the member or to the health or safety of other members; or

- Having a medical condition that imposes unreasonable requirements on the military to maintain or protect the Service member.

A Service member is considered unfit when the evidence establishes that the member, due to physical disability, is unable to perform the duties of her or his office, grade, rank, or rating reasonably, to include duties during a remaining period of Reserve obligation. AD and RC Service members with laboratory evidence of HIV infection who, because of their disease progression, are determined to be unfit for further duty are medically separated or retired pursuant to DoDI 1332.18.

Service retention and discharge policies comply with the retention and discharge DoD policies described above.

Retention/Discharge - Army:
AR 600-110 stipulates that individuals confirmed to be HIV infected will be treated with dignity and understanding. Guidance for dealing with the psychosocial aspects of the disease may be obtained from command medical authorities and chaplains. Every effort will be made to ensure that, except for their assignment limitations, HIV infected personnel are treated no differently than other Soldiers. Commanders must ensure that information about the HIV infected Soldier's medical condition is provided only to those whose duties require knowledge of that information.

In AR 600-110, there is no medical reason for HIV-infected Soldiers' duties to change solely because of their infection (except in certain instances for health care providers). In instances where a Soldier performs duties as a member of a flight crew, or other position requiring a high degree of alertness or stability (for example, explosive ordnance disposal), a case-by-case determination is made by a MEB as to the Soldier's fitness to perform his or her duties. In the case of HIV-infected health care providers, their duties may be restricted if they present a risk of transmitting HIV to their patients. An expert medical review committee designated by the deputy commander for clinical services makes this determination. This committee makes recommendations on a case-by-case basis to the Medical and Dental Activity/United States Army Medical Center (MEDCEN)/Dental Activity commander per AR 40–68, "Clinical Quality Management," regarding the restriction of duties of HIV infected health care providers. The restriction may only apply until the risk is eliminated. In all other instances, HIV infected

Soldiers are utilized in their primary MOS, per normal utilization criteria contained in Army personnel regulations and the assignment limitations specified in AR 600-110.

Infectious disease specialists medically evaluate HIV-infected Soldiers at a participating MEDCEN supporting the health service region to determine their infection status. HIV infected Soldiers who meet medical retention standards outlined in AR 40-501, and who do not demonstrate progressive clinical illness or immunological deficiency during periodic evaluations (every six months or as directed), are not involuntarily separated solely based on HIV status.

HIV-infected RC Soldiers who wish to continue to serve in the RC must prove fitness for duty per medical retention standards of AR 40–501 and be found fit for duty. RC Soldiers are required to obtain the fit for duty medical examination from the civilian medical community at no expense to the Government. The required medical procedures are provided to the Soldier to give to his or her physician. This examination must be repeated at least annually after the initial evaluation. Medical follow-up and evaluation are conducted every six months and as directed by the infectious disease physician for all HIV infected Soldiers.

Except for those identified during the accession testing program, HIV infected AD Soldiers able to perform duties fully who do not demonstrate progressive clinical illness or immunological deficiency during periodic evaluations are not involuntarily separated solely because they are HIV infected. HIV infected Soldiers who demonstrate rapidly progressive clinical illness or immunological deficiency may not meet medical retention standards under AR 40–501, and are evaluated for physical disability processing under AR 635–40, "Disability Evaluation for Retention, Retirement, or Separation." AR 600-110 specifies procedures for officers (paragraph 6-13) and for enlisted personnel (paragraph 6-14). In accordance with AR 40-501, HIV-infected Soldiers who demonstrate progressive clinical illness or immunological deficiency are referred to a MEB. For Active Army Soldiers and RC Soldiers on AD for more than 30 days (except for training under 10 U.S.C. § 10148), a MEB must be accomplished and, if appropriate, the Soldier must be referred to a Physical Evaluation Board (PEB) under AR 635–40. For RC Soldiers not on AD for more than 30 days or on AD for training under 10 U.S.C. § 10148, referral to a PEB will be determined under AR 635–40. Records of official medical diagnoses provided by civilian medical providers concerning the presence of progressive clinical illness or immunological deficiency in RC Soldiers may be used as a basis for administrative action under, for example, AR 135–133, "Ready Reserve Screening, Qualification Records System, and Change of Address Reporting," AR 135–175, "Separation of Officers," AR 135–178, "Enlisted Administrative Separations," or AR 140–10, "Assignments, Attachments, Details, and Transfers," as appropriate. Additionally:

- Soldiers identified as HIV infected within 180 days of initial entry on AD are separated under the provisions of AR 635–200 for failure to meet accession medical fitness standards.

- HIV infected Army National Guard (ARNG) Soldiers who demonstrate progressive clinical illness or immunological deficiency, as determined by medical authorities, and who do not meet medical retention standards are processed under AR 40–501 and

National Guard Regulation (NGR) 600–200, "Enlisted Personnel Management," or NGR 635–101, "Efficiency and Physical Fitness Boards," as appropriate.

- HIV infected United States Army Reserve Soldiers who demonstrate progressive clinical illness or immunological deficiency, as determined by medical authorities, and who do not meet medical retention standards under AR 40–501 are processed in accordance with AR 135–178 (enlisted) or AR 135–175 (officer).

The Army National Guard implements guidance as prescribed by the AR 600-110 and AR 40-501 with regard to HIV positive personnel. AR 600-110 is administered by the G1 (Army Personnel) section; however, Army National Guard – Office of the Chief Surgeon (ARNG-CSG) has oversight with regard to monitoring the implementation of laboratory testing and re-testing of HIV positive Soldiers). HIV positive Soldiers are retained in current MOS/Area of Concentration, as long as medical fitness standards are maintained in accordance with AR 40-501. ARNG-CSG relies highly on the input of Army Directives, the U.S. Army Public Health Center, and the Centers for Disease Control and Prevention (CDC) when considering medical retentions.

Retention/Discharge - Navy and Marine Corps:
If an AC Sailor or Marine tests HIV antibody positive during routine screening, he or she is directed by the Chief, Bureau of Medicine and Surgery to an appropriate medical facility for evaluation and determination of fitness for duty, like all Service members with a chronic medical condition, in accordance with SECNAVINST 1850.4E, "Navy Disability Evaluation Manual," and Chapter 18 of Naval Medical Command (NAVMED) P-117, "Manual of the Medical Department," which pertains to DES. Members with HIV undergo additional evaluation in accordance with DoDI 6485.01. If found fit for full duty (i.e., physically qualified to remain on AD), they are referred, evaluated, treated, and followed by an HETU, and are subsequently retained, deployed, and returned to their unit for duty. Further, they are eligible for reenlistment following normal reenlistment procedures. RC Sailors undergo evaluation by their civilian providers, and are also evaluated for fitness for duty in the same manner as all RC members with a chronic medical condition. Marine Corps Order (MCO) 1300.8, "Marine Corps Personnel Assignment Policy," is in accordance with SECNAVINST 5300.30E regarding the referral for medical evaluation for continued service, appropriate treatment, and determination of fitness for duty.

In SECNAVINST 5300.30E, if a Sailor or Marine is found unfit for continued service, he or she is processed for medical separation through the physical disability system and discharged. Sailors and Marines who have tested HIV positive also have the option to undergo voluntary separation, and are afforded the option of requesting a voluntary discharge under honorable conditions, unless there are other factors involved. Retention or discharge decisions are based on the determination of competent medical authority regarding fitness of service. SECNAVINST 5300.30E is currently under revision.

MCO 1900.16 Chapter 1, "Separation and Retirement Manual," refers to SECNAVINST 5300.30E for voluntary separation of Marines who have tested positive for HIV. In MCO 1001R.1L, "Reserve Administration Manual," Reserve Marines identified as HIV positive and

who, although deemed medically fit for duty, are unable to fill an appropriate billet within the Selected Reserve and are placed in the Standby Reserve-Inactive Status List. Under this status, such Marines are not eligible to participate, receive pay or retirement point credit, are not eligible for promotion consideration, and are not accountable for purposes of end strength or controlled grades.

SECNAVINST 5300.30E and DoDI 6485.01 permit members of the Marine Corps Ready Reserve who are HIV positive to continue to serve within the Marine Corps Reserve, barring any medically assessed unfitting conditions, such as immunologic deficiency, neurological deficiency, progressive clinical or laboratory abnormalities associated with HIV, or diagnosis of Acquired Immune Deficiency Syndrome (AIDS)-defining conditions.

Retention/Discharge - Air Force:
AFI 44-178, "Human Immunodeficiency Virus Program," instructs that "members with laboratory evidence of HIV infection who are able to perform the duties of their office, grade, rank and/or rating, may not be separated solely on the basis of laboratory evidence of HIV infection." AFI 48-123 stipulates that HIV is potentially a cause for denying continued service and requires a retention decision through a MEB or similar review."

AFI 44-178 guides the management of AD Service members with HIV and screening protocol routinely employed by the Air Force. In accordance with AFI 44-178, all AD Airmen with asymptomatic HIV are seen annually at the Air Force HIV Medical Evaluation Unit (MEU) in San Antonio. The MEU completes a narrative summary (NARSUM) for each Airman with HIV infection, which is forwarded to the Air Force Personnel Center (AFPC) for adjudication regarding retention.

In an effort to treat every Airman equitably and with dignity and respect, the Air Force refers Airmen with asymptomatic HIV infection into the DES in the same manner and process as any other Airman with a chronic medical condition. As outlined above, current Air Force policy requires that all Airmen with HIV have a NARSUM reviewed annually by AFPC. AFPC is the only entity that can assign Airmen an Assignment Limitation Code-C (ALC-C), which restricts permanent and temporary duty assignments to areas where appropriate medical care is available to the HIV-positive Service member. The intent of the ALC-C is to protect such members from being placed in environments where adequate medical care is not available. The benefit of assigning an ALC-C is that it ensures visibility at all levels that an Airman will require a waiver for OCONUS assignment or deployment.

3. Deployment
DoDI 6490.07, "Deployment-Limiting Medical Conditions for Service Members and DoD Civilian Employees," includes HIV antibody positive diagnosis with the presence of progressive clinical illness or immunological deficiency as a medical condition that usually precludes contingency deployment. In all instances of HIV seropositivity, the policy requires that the cognizant CCMD surgeon be consulted before medical clearance for deployment. The Combatant Commander is the final approval authority for waivers. The medical standards in DoDI 6490.07 are mandatory for contingency deployments, and permissible for any other deployment, based on the commander's decision.

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. DoD personnel with existing medical conditions may deploy based upon a medical assessment, if the following 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 MHS. 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.)

DoDI 6490.07 sets the minimum standard for all deploying and deployed DoD personnel. Military Department policy guidance, Service-specific readiness needs, or CCMD requirements may involve additional deployment restrictions. Additionally, DoDI 6485.01 instructs compliance with host-nation requirements for screening and related matters for Service members. As outlined below, all Services currently permit HIV positive Service members to deploy for purposes other than combat or a contingency operation, or be assigned for duty in certain overseas locations, subject to receipt of a waiver. In view of this, members with HIV infection may be considered deployable with limitations.

Deployment - Army:
AR 40-501, paragraph 5-14, "Medical fitness standards for deployment and certain geographical areas," states a general rule that "all Soldiers considered medically qualified for continued military status and medically qualified to serve in all or certain areas of the continental United States (CONUS) are medically qualified to serve in similar or corresponding areas outside the continental United States (OCONUS)." However, the policy acknowledges, "because of certain medical conditions, some Soldiers may require administrative consideration when assignment to combat areas or certain geographical areas is contemplated. Such consideration of their medical conditions would ensure these Soldiers are used within their functional capabilities without undue hazard to their health and well-being as well as ensure they do not produce a hazard to the health or well-being of other Soldiers."

AR 40-501, paragraph 5-14, lists medical conditions requiring careful review prior to recommending whether the Soldier can deploy to duty in a combat zone or austere isolated area

where medical treatment may not be readily available. In accordance with AR 40-501, HIV infected Soldiers are not permitted to deploy into the combat theater of operations. Additionally, in accordance with AR 600-110 and AR 614-30, "Overseas Service," Soldiers confirmed to be HIV infected while stationed overseas are reassigned to the United States.

However, if found fit by a PEB, HIV infected Soldiers may be considered for overseas deployment to Europe or Korea (host Nation permitting), in accordance with AR 40-501. HIV infected AD Soldiers, including Active Guard and Reserve, are otherwise limited to duty within the United States (including Alaska, Guam, Hawaii, Puerto Rico, and the U.S. Virgin Islands). In the United States (including Alaska, Hawaii, Guam, Puerto Rico, and the U.S. Virgin Islands), HIV infected Soldiers are not assigned to:

- Any table of organization and equipment or modified table of organization and equipment unit. Installation commanders may reassign any HIV infected Soldier in such units to table of distribution and allowances (TDA) units on their installation, provided the Soldier has completed a normal tour in that unit (a normal tour for these purposes is three years from reporting date to the unit). After completion of a normal tour, reassignment to TDA units may be made, provided assignment can be made according to normal personnel management and assignment criteria in AR 614–100, "Officer Assignment Policies, Details, and Transfers," and AR 614–200, "Enlisted Assignments and Utilization Management." Reassignment must be to an authorized position for the Soldier's grade and primary or secondary MOS. Installation commanders unable to make appropriate reassignments report the names of HIV infected Soldiers to the Commander, Human Resource Command (HRC), Army Human Resource Command (AHRC)–EPD–I (enlisted), or Total Army Personnel Command (TAPC)–OPD–M (officer).

- Military-sponsored educational programs, regardless of length, but which would result in an additional service obligation. These programs include, but are not limited to, advanced civilian schooling, professional residency, fellowships, training with industry, and equivalent educational programs, regardless of whether the training is conducted in civilian or military organizations. HIV infected Soldiers assigned to these programs are disenrolled at the end of the academic term in which HIV infection is confirmed and may be reassigned without regard to Permanent Change of Station restrictions. Any financial support received by the Soldier may be retained through the end of the current term of enrollment and will not be subject to any recoupment. In addition, any additional service obligation incurred as a result of attendance at military sponsored educational programs is waived. Not included in this restriction are military schools required for career progression in a Soldier's MOS, branch, or functional area (such as, Noncommissioned Officer Education System schools, Captains Career Course, or intermediate level education).

- U.S. Army Recruiting Command, Cadet Command, MEPS, ARNG full time recruiting force, or ARNG full time attrition/retention force, if a Soldier's medical condition requires frequent medical follow-up (as determined by medical authorities), and if the Soldier's projected duty station is geographically isolated from an Army military treatment facility capable of providing that follow-up. These organizations report HIV-

infected Soldiers who cannot be assigned under this policy to the Commander, HRC, AHRC–EPD–I (enlisted) or TAPC–OPD–M (officer), for assignment instructions.

AR 600-110 stipulates that commanders may not change the assignment or use of HIV-infected Soldiers solely because of their infection, unless required by that regulation or the Soldier's medical condition. Grouping all HIV infected Soldiers within a command into the same subordinate unit, duty area, or living area is prohibited unless no other unrestricted units, positions, or accommodations are available.

HIV infected Service members may transfer to the Active Army from another Armed Force (inter-Service transfer), if they meet medical retention standards in AR 40–501. However, Service members who are HIV infected may not be transferred to the Army from another Armed Force, if they are required to meet accession medical standards in AR 40–501, except as specifically permitted in the Accession Testing Program, as described in AR 600-110.

Deployment - Navy/Marine Corps:
Deployment determinations for HIV-infected Service members are based on guidance articulated in DoDI 6490.07 and in CCMD Area of Responsibility specific Force Health Protection policies. SECNAVINST 5300.30E permits certain personnel on a case-by-case basis to be considered for OCONUS or large ship platform tours, in consultation with the treating HETU, Navy Bloodborne Infection Management Center, and PERS-82 (Temporary Disability Retirement List] (for Sailors), or the United States Marine Corps M&RA (for Marines). These cases apply to personnel with controlled HIV disease (as manifested by a reconstituted immune system, no viremia, an established history of medical compliance, and a history of professional attitude). This placement requires the receiving command's acceptance. These personnel are not considered for overseas individual augmentee tours, given the austere environments in which they potentially could be placed. This policy is based on the following considerations:

- There is no demonstrated risk of transmission of disease in normal daily activities.
- An investment in training of these members has been made.
- The previous policy of denying deployments has made this subset of personnel less competitive in achieving career milestones or warrior qualifications.

MCO 1300.8 is in accordance with SECNAVINST 5300.30E regarding assignment of HIV infected personnel.

Deployment - Air Force:
AFI 48-123 indicates, "conditions, which may seriously compromise the near-term well-being if an individual were to deploy, are disqualifying for mobility status or deployment duty." In accordance with DoDI 6490.07, AFI 48-123 also indicates, "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." However, AFI 48-123 also states, "in general, a member must be able to perform duty in austere environment with no special food, billeting, medical or equipment support for up to 179 days."

DoD has recently issued a new policy, DoDI 1332.45, "Retention Determinations for Non-Deployable Service Members," July 30, 2018, for implementation October 1, 2018. The overarching policy is that to maximize the lethality and readiness of the Joint Force, all Service members are expected to be deployable. Service members who are considered non-deployable for more than 12 consecutive months will be evaluated for a retention determination by their respective Military Department, and, as appropriate, referral into the DES or initiation of processing for administration separation, with the normal policies and procedures, including due process procedures, of those systems continuing to apply. The Military Departments will determine the deployability status of Service members and will make retention determinations for Service members who have been non-deployable for more than 12 consecutive months. They may retain such members if determined to be in the best interest of the Military Service. Under this DoDI, "non-deployable" and "deployable with limitations" are two separate categories; the retention determination process applying to the former but not the latter. The Military Departments have authority to determine the specific dividing line between the two categories most appropriate for the operational circumstances applicable to their respective Services.

4. Disciplinary

In and of itself, being HIV positive is not a punishable offense and cannot be used as a basis for disciplinary action against the individual. DoDI 6485.01 directs that information obtained during or primarily as a result of an epidemiologic assessment interview, (which is defined in DoDI 6485.01 as the "questioning of a Service member who has been confirmed by DoD to have laboratory evidence of HIV infection for purposes of medical treatment or counseling or for epidemiologic or statistical purposes"), cannot be used to support any adverse personnel action against the Service member, in accordance with section 705(c) of Public Law 99-661, "National Defense Authorization Act for Fiscal Year 1987," November 14, 1986. DoDI 6485.01 defines "adverse personnel action" as "a court-martial, non-judicial punishment, involuntary separation for other than medical reasons, administrative or punitive reduction in grade, denial of promotion, an unfavorable entry in a personnel record (other than an accurate entry concerning an action that is not an adverse personnel action), or a bar to reenlistment other than for medical reasons."

DoDI 6485.01 also requires aggressive disease surveillance and implementation of health education programs for Service members. A Service member with laboratory evidence of HIV infection receives training on how to prevent further transmission of HIV infection to others, and the legal consequences of exposing others to HIV infection. In compliance with this policy, the Services provide counseling and training to Service members with HIV infection regarding the prevention of disease transmission to others and the legal consequences of intentional exposure to others, or failure to disclose status to sexual partners or blood donation centers.

However, infected Service members retained on AD who fail to comply with the directives given during preventive medicine counseling are subject to appropriate disciplinary actions for their disregard or disobedience. All Services hold HIV infected members accountable under the Uniform Code of Military Justice if they ignore orders to warn and protect others whose health might be jeopardized by sexual contact or other types of high-risk exposures. Commanders may recommend that personnel who violate such guidance be considered for involuntary discharge or separation.

STATUS UPDATE ON THE DEPARTMENT OF THE ARMY'S HIV POLICY:
Initiated in 2015, a working group has reviewed AR 600-110, last updated in April 2014, to assess any need for changes to reflect an evidence-based, medically accurate understanding of HIV infectivity, transmission, and treatment. This process is expected to be completed in the near future.

MEDICAL ASSESSMENT OF POLICIES:
Currently, no vaccine exists to prevent HIV infection, and no treatment exists to cure it. As such, the Department takes every effort to protect the health and well-being of Service members to minimize the risk of exposure to HIV through regular HIV screening and surveillance efforts. DoDI 6485.01 requires that the Secretaries of the Military Departments report HIV test results to the Defense Medical Surveillance System, pursuant to Department of Defense Directive (DoDD) 6490.02E, "Comprehensive Health Surveillance," and directs health care personnel providing medical care to follow the recommendations issued by the CDC for preventing HIV transmission in health-care settings.

DoD health surveillance policy also requires that medical surveillance systems continuously capture data on occupational and environmental exposures to potential and actual health hazards, and link with medical surveillance data to monitor the health of DoD's population and identify potential risks to health. Thus, this policy enables timely implementation of interventions to prevent, treat, or control disease and injury, and reinforces the provision of optimal medical care.

Impact of Antiretroviral Therapy on Disease Management

Viral suppression and AIDS are two ends of the spectrum of HIV infection. Virally-suppressed HIV infection usually requires an individual to take ART, alternatively referred to as combination Antiretroviral Therapy, regularly and to see an infectious disease specialist annually. ART consists of a combination of antiretroviral (ARV) drugs to suppress the HIV virus to undetectable levels and stop HIV disease progression. AIDS is usually the result of long-term non-adherence with medications and can be associated with impairment and disability (e.g., opportunistic infections, cancer, weakness).

There is broad consensus on evidence published in the medical literature to support the notion that people living with HIV on ART with an undetectable viral load in their blood have a "negligible risk" of sexually transmitting HIV. Depending on the ART drugs used, it may take as long as six months for the viral load to become undetectable. "Continued and reliable HIV suppression requires selection of appropriate agents and excellent adherence to treatment. HIV viral suppression should be monitored to assure both personal health and public health benefits."[1]

However, it is important to emphasize that despite undetectable viral loads, HIV transmission still can occur. According to the U.S. Public Health Service Guidelines for the Management of Occupational Exposures to Human Immunodeficiency Virus and Recommendations for Postexposure Prophylaxis, "exposure to a source patient with an undetectable serum viral load does not eliminate the possibility of HIV transmission or the need for (post-exposure prophylaxis) PEP and follow-up testing. While the risk of transmission from an occupational exposure to a source patient with an undetectable serum viral load is thought to be very low, PEP

should still be offered. Plasma viral load (e.g., HIV RNA [ribonucleic acid]) reflects only the level of cell-free virus in the peripheral blood; persistence of HIV in latently infected cells, despite patient treatment with ARV drugs, has been demonstrated, and such cells might transmit infection even in the absence of viremia. HIV transmission from exposure to a source person who had an undetectable viral load has been described in cases of sexual and mother-to-child transmissions."[2] It is also important to underscore that an "undetectable" viral load that confers a "negligible risk" of HIV transmission has no application in the setting of blood transfusion or needlestick (occupational) exposures.

Thus, with the advent of ART, HIV infection has evolved from a once terminal condition to a chronic illness requiring regular management and strict adherence to treatment protocol. As a result, the Department's policies have evolved over time. They currently focus not only on minimizing risks of HIV exposure for HIV-naïve individuals, but also on providing evidence-based care and support for Service members living with HIV, with the goal to retain and maintain a Service member's fitness for duty, optimize quality of life, as well as avoid any disability that might arise as a result of HIV infectivity.

Recent Findings Signifying Impairments Despite Viral Suppression and Asymptomatic HIV: Potential Impact on Future Policy

Despite virological suppression, long-term treated patients may experience memory difficulties, mental slowing, attention deficits, and other neurological impairment symptoms. Moreover, neurocognitive damage can occur without HIV-infected individuals experiencing related symptoms or interference in their daily functioning. The impact of HIV-associated neurocognitive disorder and asymptomatic NCI on fitness for duty, including resilience and readiness, is currently unknown.

According to a Department of Defense Infectious Disease Clinical Research Program cross-sectional study of 200 HIV-infected and 50 HIV-uninfected military beneficiaries including AD members, retirees, or dependents, HIV positive patients diagnosed and managed early during the course of HIV infection had a low prevalence of NCI. This is comparable to matched HIV-uninfected persons.[3] Based on these data, the early recognition and management of HIV infection may be important in limiting NCI.

Yet effective ART resulting in viral suppression and asymptomatic infection does not imply absence of HIV-associated injury or impairment. Some HIV-infected, virally suppressed patients on ART will develop illnesses associated with premature aging (e.g., cardiovascular disease, osteoporosis). As the HIV-positive population ages, there is greater recognition that cerebrovascular disease risk factors such as hypertension, diabetes, and hypercholesterolemia are becoming risk factors for cognitive impairment in HIV-positive patients on ART.[4]

Common neurocognitive symptoms experienced by HIV-infected patients potentially include changes in memory, concentration, attention, and motor skills, may present challenges for accurate diagnoses and assessments of functional capacity, and often require prolonged observation or reporting.[5,6] Some patients may experience a fluctuating course of NCI over time, including symptom normalization; however, it is unknown whether these changes reflect

biologic alterations induced by responses to (or failures) of ART, or occur independently of viral load and changes to ART regimens.[7] Despite effective systemic viral suppression among HIV-positive individuals on ART, scientific studies have indicated that a small subset of individuals show neurocognitive deterioration with evidence of persistent laboratory and neuroimaging abnormalities in the central nervous system.[8] A longitudinal cohort observation study found that numerous patients with asymptomatic NCI, even with a suppressed plasma viral load, eventually developed symptomatic NCI.[9] The impact of these potential NCIs on a Service member's readiness, resilience, and/or retention is currently unknown.

As the HIV-positive population on ART ages, there is greater recognition that cerebrovascular disease risk factors such as hypertension, diabetes, and hypercholesterolemia may become risk factors for cognitive impairment.[10] The future impact of HIV as a chronic disease on readiness, resiliency, and retention, as well as treatment and management approaches, are a part of ongoing DoD health surveillance efforts.

As stipulated in DoDD 6490.02E, DoD requires comprehensive, continuous and consistent health surveillance to enable continuous capture of individual and population data, including health status, occupational exposures, disease, and medical interventions (such as immunizations, treatments and medications), in order to implement early intervention and disease control strategies and reinforce provision of optimal medical care. As such, the policy enables DoD to be well-positioned to update policies and practices to appropriately identify and manage HIV infection among Service members as the HIV-positive population on ART ages.

Military-Unique Considerations

According to the Military Infectious Diseases Research Program (MIDRP), HIV "remains a significant threat to Service members deployed overseas, and is a major source of regional instability in areas of US force protection."[11] Additionally, the MIDRP also recognized that infectious diseases can also impose "a significant burden on the medical logistical system for people requiring treatment" and "loss of personnel to infectious diseases reduces operational readiness and effectiveness by requiring replacement troops." Therefore, the MIDRP indicates, preventing disease is "a force multiplier by keeping people healthy and by enhancing readiness," and DoD must protect its forces from diseases that may compromise its ability to complete missions and to prevent troops from acquiring illnesses. As such, preventing disease through limiting risk of exposure to infectious disease is a key component to enhance military readiness and effectiveness.

It is important to note that DoD HIV screening policy is population-based, and accounts for unique operational military requirements. For example, protecting the safety of the U.S. military blood supply or health of potential donors and recipients (i.e., Service members) is of critical importance to DoD and therefore a central issue. Combat-related injuries, especially during mass casualty situations, require large supplies of blood for transfusions. The need for screening the blood supply is therefore critical. In certain cases, "battlefield transfusions" may be required to resuscitate casualties in life-threatening situations when the inventory of U.S. Food and Drug Administration (FDA)-compliant blood products is depleted in combat zones due to austere operating conditions and irregular resupply. In these cases, the U.S. Army Institute of Surgical

Research Joint Trauma System Clinical Practice Guideline on Fresh Whole Blood indicates that Service members may receive an emergency transfusion of fresh whole blood in life-saving or limb-sparing situations.[12] This Joint Trauma System Clinical Practice Guideline also indicates that even though fresh whole blood undergoes rapid testing for HIV to the greatest extent possible prior to transfusion, the potential risk for HIV transmission remains in battlefield circumstances. HIV infection is among a number of medical conditions that preclude blood donation. Early CDC data demonstrate that the highest risk of transmission of HIV infection is via blood transfusion (92.50 percent transmission rate, or 9250/10000 exposures).[13] Even though this data included cases involving transmission of very high viral loads as well as lower levels of viremia, it is conceivable that a unit of whole blood (as utilized used in a "walking blood bank" scenario) would pose a very high risk of transmission of HIV infection, even if from an HIV-infected Service member with an undetectable viral load.[14] To the extent possible, DoD adheres to FDA blood-borne pathogen screening guidelines requiring all donated blood products be tested for HIV types I and II.[15] DoD ensures the safety of the blood supply through policies of the Armed Services Blood Program Office and the accreditation requirements of the American Association of Blood Banks. However, in emergency battlefield circumstances it is impossible to eliminate all risk of communicability through blood transfusion.

Service Policies

Service policies accurately reflect current medical literature and expert opinion (consensus standards) regarding transmission and treatment of HIV. The U.S. Air Force (USAF) management of Airmen with HIV is highly structured and achieves viral load suppression in over 90 percent of patients. AFI 44-178 is the underpinning of the USAF's HIV management success. AR 600-110, "Identification, Surveillance, and Administration of Personnel Infected with Human Immunodeficiency Virus," and Headquarters, Department of the Army medical and personnel policies on HIV reflect current knowledge of the natural progression of HIV infection; the risks to the infected individual incident to military service; the risk of transmission of the disease to non-infected personnel; the overall impact of infected personnel in Army units and on readiness posture; and the safety of military blood supplies. The Assistant Secretary of the Navy (M&RA) established SECNAVINST 5300.30E to reflect current knowledge of the natural history of HIV; the risks to the infected individual incident to military service; the risk of transmission of HIV to non-infected personnel; the effect of infected personnel on commands; and the safety of military blood supplies. The Services are currently reviewing and updating several policies, to include SECNAVINST 5300.30E, AFI 44-178, AR 600-110, to reflect changes as medical capabilities, technologies, and evidence-based practices have evolved.

Medical literature pertaining to HIV medicine rapidly evolves. MHS subject matter experts are aware of and have access to all available contemporary medical literature, practice guidelines, medications, and treatment modalities based on emerging and published evidence-based studies or expert opinion, referenced in, but not limited to the following:

- "National HIV/AIDS Strategy for the United States." U.S. Department of Health & Human Services. Available at: https://www.hiv.gov.
- Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents Living with HIV. Department of Health

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- Primary Care Guidelines for the Management of Persons Infected with HIV, issued by expert panel of the HIV Medicine Association of the Infectious Diseases Society of America. Update issued in: Aberg JA, Gallant JE, Ghanem KG, et al. Primary care guidelines for the management of persons infected with HIV: 2013 update by the HIV medicine association of the Infectious Diseases Society of America. Clin Infect Dis. 2014;58(1):e1-34. Available at: https://www.ncbi.nlm.nih.gov/pubmed/24235263/.

- CDC. "Integrated prevention services for HIV infection, viral hepatitis, sexually transmitted diseases, and tuberculosis for persons who use drugs illicitly: summary guidance from CDC and the U.S. Department of Health and Human Services." MMWR Recomm Rep. 2012;61(RR-5):1-40. Available at: https://www.cdc.gov/mmwr/preview/mmwrhtml/rr6105a1.htm.

FEASIBILITY OF ALLOWING ENLISTED MEMBERS TO BECOME COMMISSIONED OFFICERS OF THE ARMED FORCES AND RESTRICTIONS DIFFERENT FOR OFFICERS:

DoD policy has long maintained a difference between accession medical standards and retention medical standards. The rationale for the difference is that once a member has been fully trained to perform, and has experience in performing the duties of his or her position, whether as an enlisted member or officer, the needs of the Service incline decidedly toward allowing the member to continue to perform those duties and return the investment the Service has made in the member. At the accession stage, the needs of the Service incline toward selecting members in whom to make the training and mentoring investment, who minimize any risk of inability due to medical conditions to complete an initial period of service and potentially a longer military commitment. Longstanding DoD policy under DoDI 6130.03 has also held that in the case of an enlisted member seeking appointment as a commissioned officer, the accession standards are the appropriate ones to apply because it is a new position, involving a whole new set of duties and responsibilities and new training and mentorship. The needs of the Service do not necessarily favor an officer applicant with prior enlisted service, compared to one without such service, when it comes to minimizing any risk of inability due to medical conditions to perform satisfactorily in the commissioned officer position. However, it is appropriate to note that a review of two individual officer candidates, one with and one without prior enlisted service, requesting a medical waiver for the same condition, the candidate with prior service may well have the advantage of a record of successful military service in the enlisted ranks. However, regarding which set of standards to apply to the initial medical screening, the accession medical standards are the more appropriate standards for all applicants, including applicants for enlistment or commissioning. This is long-established DoD policy for all medical conditions; there is no special or different rule for individuals with HIV infection.

DISCUSSION:

The Department has a responsibility to ensure the health and well-being of Service members, and through its policies, aims to minimize the risk of Service members' exposure to HIV, while ensuring that those infected with HIV have access to appropriate care and management of their illness and are able to continue service. Military unique considerations; the rapidly evolving

nature of medical evidence and understanding pertaining to the nature of HIV transmission, infectivity, associated risks, and treatment; evolving mission requirements; and Service member needs pertaining to health information privacy protections, as well as opportunities for career advancement, are key factors that influence personnel policy pertaining to HIV-infected members of the Armed Forces.

Current DoD- and Service-level personnel policies pertaining to HIV-infected members of the Armed Forces:

- Are established to maintain military readiness and optimize lethality of the Armed Forces.
- Are instituted to ensure military applicants can successfully complete rigorous military training and deploy to austere environments to accomplish the demanding missions of the military, without jeopardizing their health, the health of their unit, or the military mission, as well as to respect host Nation laws where our forces are deployed.
- Support retention of Service members infected with HIV, unless there is evidence of deteriorating health or other factors that render the individuals unable or unfit to perform their duties.
- Require the same procedures for medically evaluating Service members who develop disability due to chronic illness to determine fitness for continued service, regardless of whether the Service member is HIV-positive.
- Aim to ensure that, except for assignment limitations, HIV-infected personnel are treated no differently than other Service members.
- Ensure that a Service member infected with HIV is not retired or involuntarily separated solely based on being infected.
- Recognize that in the unique circumstances of military combat operations, there remain significant risks that individuals with even well-controlled HIV infection may suffer adverse health effects and create additional mission risks for the military command.
- Direct the protection of health information and privacy of HIV-infected personnel.
- Reflect existing evidence and adhere to current nationally accepted, evidence-based guidelines, and assess evolving medical evidence and scientific understanding of the nature and risk of HIV transmission, available treatment regimens, and the latest HIV management approaches and practices.
- Stipulate clinical management to be consistent with standard of care, evidence-based HIV clinical practice standards, and medical management guidelines.

CONCLUSIONS:

DoD personnel policy for HIV-positive Service members is evidence-based, in accordance with state-of-the-art clinical guidelines, reviewed for currency, and updated accordingly as medical capabilities, technologies, and evidence-based practices evolve.

DoD accession policies align with the military's requirements to recruit healthy personnel who are able to complete demanding military training and to deploy to austere environments without exacerbating their health or compromising operational effectiveness and mission accomplishment.

For those who acquire HIV after accession, DoD policy emphasizes retention if the medical condition is stable with appropriate treatment and the Service member is found fit for duty. Service members with laboratory evidence of HIV infection who are able to perform the duties of their office, grade, rank and/or rating, cannot be separated solely based on laboratory evidence of HIV infection. Service members with medical illnesses or conditions that might limit their ability to perform military duties (including HIV infection) may undergo evaluation for either duty limitations or medical discharge.

A waiver is required for HIV-positive Service members to deploy; medical evaluators must consider climate, altitude, rations, housing, duty assignment, and available medical services in theater when deciding whether an individual is deployable. However, current Service policies do not permit HIV-infected Service members to deploy to combat theaters of operation or in support of other contingency operations, given the austere environment, potential exacerbation of illness and lack of access to needed medical care, as well as risk of compromising unit readiness and successful mission completion. Army policy currently allows deployment to Europe and Korea for HIV-infected soldiers found fit by a PEB (host Nation permitting). Navy policy currently permits case-by-case consideration for non-combat OCONUS or large ship platform tours for HIV-infected personnel with controlled HIV disease (as manifested by a reconstituted immune system, no viremia, an established history of medical compliance).

DoD policy prohibits adverse personnel actions based solely on HIV status, assuming ability to perform duties fully. However, as with any direct order, a Service member who violates the order to inform sexual partners of their HIV status or fails to use safe sexual practices, as instructed during face-to-face consultation, may be subject to disciplinary action.

Maintaining the health of military personnel is essential for force readiness. It is a strategic objective of the MHS to sustain the health of Service members, restore the health, and return to duty of Service members who become ill or injured, if possible. Once Service members complete training, the goal is to retain members who acquire HIV who are still capable of performing their duties in the rigorous military environment. Personnel policies aim to balance the need of the Services (e.g., readiness, resilience, deployability, mission accomplishment, retention) with the needs of Service members infected with HIV (access to quality care, counseling, support and educational services, privacy protections, and option to continue service, if desired). Existing personnel policies intend to maximize the lethality, readiness, and operational effectiveness of the Armed Forces, as well as to help ensure the health and well-being of Service members, while mitigating the risk of HIV transmission.

ACRONYMS:	
AD	active duty
AFI	Air Force Instruction
AFPC	Air Force Personnel Center
AHRC	Army Human Resource Command
AIDS	Acquired Immune Deficiency Syndrome
ALC-C	Assignment Limitation Code-C
AMSWG	Accession Medical Standards Working Group
AR	Army Regulation
ARNG	Army National Guard
ARNG-CSG	Army National Guard – Office of the Chief Surgeon
ART	antiretroviral therapy
ARV	antiretroviral
CCMD	Combatant Command
CDC	Centers for Disease Control and Prevention
CONUS	continental United States
DES	Disability Evaluation System
DoD	Department of Defense
DoDD	Department of Defense Directive
DoDI	Department of Defense Instruction
DoDM	Department of Defense Manual
FDA	U.S. Food and Drug Administration
FY	Fiscal Year
HETU	HIV Evaluation and Treatment
HIV	human immunodeficiency virus
HRC	Human Resource Command
IDES	Integrated Disability Evaluation System
IMR	individual medical readiness
LDES	Legacy Disability Evaluation System
M&RA	Manpower and Reserve Affairs
MCO	Marine Corps Order

MEB	Medical Evaluation Board
MEDCEN	United States Army Medical Center
MEPS	Military Entrance Processing Stations
MEU	Medical Evaluation Unit
MHS	Military Health System
MIDRP	Military Infectious Diseases Research Program
MOS	military occupational specialty
MQA	medical quality assurance
NARSUM	narrative summary
NAVMED	Naval Medical Command
NCI	neurocognitive impairment
NDAA	National Defense Authorization Act
NGR	National Guard Regulation
OASD(HA)	Office of the Assistant Secretary of Defense for Health Affairs
OCONUS	outside the continental United States
PEB	Physical Evaluation Board
QAP	Quality Assurance Program
RC	Reserve Component
SECNAVINST	Secretary of the Navy Instruction
TAPC	Total Army Personnel Command
TDA	table of distribution and allowances
USAF	U.S. Air Force

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   - DoDI 1332.18, "Disability Evaluation System (DES)," August 5, 2014
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   - AR 135-175, "Separation of Officers," November 29, 2017
   - AR 135-178, "Enlisted Administrative Separations," November 7, 2017
   - AR 140-10, "Assignments, Attachments, Details, and Transfers," August 15, 2005
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   - AR 350-51, "United States Army Officer Candidate School," June 11, 2001
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IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
Alexandria Division

RICHARD ROE; VICTOR VOE; and OUTSERVE-SDLN, INC., Plaintiffs, v. PATRICK M. SHANAHAN, in his official capacity as Acting Secretary of Defense; HEATHER A. WILSON, in her official capacity as Secretary of the Air Force; and the UNITED STATES DEPARTMENT OF DEFENSE, Defendants.	)	No. 1:18-cv-1565-LMB-IDD

DECLARATION OF MS. MARTHA P. SOPER

I, Ms. Martha P. Soper, hereby declare as follows:

1. I work for the Assistant Secretary of the Air Force for Manpower and Reserve Affairs. My office is located within the Deputy Assistant Secretary's office, which is responsible for readiness issues. My specific duties within the office deal with health policy, which includes oversight of the Disability Evaluation System ("DES") within the United States Air Force.

2. DES cases involving airmen with HIV are processed in the same manner as any other case involving an airman with a chronic and progressive medical condition. This is required by DoD Instruction 6485.01, paragraph 2c, and a clarifying memorandum issued by the Assistant Secretary of the Air Force for Manpower and Reserve Affairs on September 26, 2018. Under DoDI 1332.18, airmen are "referred" for evaluation by the DES when one or more of the following conditions are met: 1) the member has one or more medical conditions that may, individually or collectively, prevent the Service member from reasonably performing the duties

of their office, grade, rank, or rating; 2) has a medical condition that represents an obvious medical risk to the health of the member or to the health and safety of other members; or 3) has a medical condition that imposes unreasonable requirements on the military to maintain or protect the Service member. Practically speaking, airmen are typically identified for referral to the DES by medical providers at their local medical treatment facility. Members with HIV are fully evaluated and treated by infectious disease specialists at the San Antonio Military Medical Center, where the Air Force's HIV program is located. After evaluation and treatment these specialists contact the Air Force Personnel Center to begin the process of determining whether the particular case will be referred into the DES.

3. The mere diagnosis of a medical condition does not mean that airmen will necessarily be evaluated through the DES. Before airmen are officially referred into the system the case is evaluated by the Air Force Personnel Center's Medical Retention Standards Office. This office reviews every case in which a potentially unfitting medical condition has been identified and determines whether the condition warrants referral to the DES by applying the standards for referral listed above. If the particular member being evaluated does not have significant limits on his ability to deploy, or is in a career field that does not require deployment and is otherwise reasonably performing the duties of his position, he may be returned to duty via a process called an Initial Review in Lieu of DES processing or "IRILO". The Medical Retention Standards Office, thus, can either return the member to duty or refer him or her for entrance into the DES. The Medical Retention Standards Office reviewed the cases of 31 airmen who were newly diagnosed with HIV in 2018. 10 of these individuals were returned to duty by the IRILO process and 21 were referred into the Disability Evaluation System.

4. Since 2016, the Air Force has reviewed and revised its evaluation of HIV cases through the DES. Prior to 2016, nearly all cases of asymptomatic HIV resulted in a return to duty via the IRILO process administered by the Air Force Personnel Center's Medical Retention Standards Office. Beginning in 2016 the Medical Retention Standards Office began referring certain cases of asymptomatic HIV into the DES in order to treat HIV in the same manner in which it treats all other chronic, progressive illnesses. While our review of DES policies relating specifically to the evaluation of members with asymptomatic HIV was underway, three policy guidance memos were issued. The first was issued by AF/A1 in October 2017. The second and third were issued by the Secretary of the Air Force for Manpower and Reserve Affairs in June 2018, and September 2018, respectively.

5. Most members who are referred for evaluation in the DES, including most members with HIV who are ultimately evaluated by the DES, are referred because they may be unable to reasonably perform the duties of their office, grade, rank or rating. As required by DoDI 1332.18, the Medical Retention Standards Office's determination of whether an airman's medical condition may cause him to be unable to reasonably perform his duties includes a consideration of the following criteria: 1) the member's ability to perform the common military tasks for his office, grade, rank, or rating, such as firing a weapon, performing field duty, or wearing load-bearing or protective gear; 2) whether the member is medically prohibited from taking the service's required physical fitness test; 3) whether the service member is deployable individually or as part of a unit, with or without prior notification to any location specified by the Air Force; and 4) if the medical condition disqualifies the airman for specialized duties whether the specialized duties constitute the member's current duty assignment; if the member has an alternate specialty; or whether reclassification or reassignment is feasible.

6. Asymptomatic HIV has not been found to interfere with airmen's ability to perform the fitness test, or to perform the day to day tasks of most Air Force career fields as long as they are located within the United States. However, asymptomatic HIV does place significant limits on where an airman could be deployed, and may disqualify airmen for some specialized duties.

7. Assuming that the Medical Retention Standards Office finds that the member has a condition that meets one of the criteria for referral into the DES, the next step in the process is for the member to undergo a Medical Evaluation Board ("MEB"). The MEB is a board consisting of two or more physicians who have state licensure and have met criteria to be credentialed to practice medicine at a military treatment facility, and one of the physicians must have detailed knowledge of the medical retention standards. The Air Force physicians review all available medical evidence, to include any examinations completed as part of the DES processing, and document the medical status and duty limitations of airmen who meet the referral criteria. After the MEB makes its recommendation, the airman has an opportunity to make a written rebuttal and to elect to have an impartial medical review of the case performed by a physician who was not involved in the MEB. Prior to the MEB's review, a medical provider prepares a Narrative Summary of the Airman's medical condition which contains a summary of the Airman's medical history and its impact upon the standards for fitness and the considerations involved in the reasonable performance of duties analysis.

8. The Physical Evaluation Board determines the whether airmen with medical conditions are fit to perform their duties, and for members determined to be unfit as a result of a duty related condition, will determine eligibility for benefits. The PEB process includes the Informal Physical Evaluation Board ("IPEB") and the Formal Physical Evaluation Board ("FPEB"). The IPEB reviews every case in which a member is not returned to duty by either the IRILO process

or by a MEB. The IPEB consists of at least two military members (one of whom must be a physician) and reviews all of the information available to the MEB and the Medical Retention Standards office. Specifically, this means that the IPEB reviews the Narrative Summary prepared for the MEB, any rebuttal matters submitted by the Airman, the Airman's complete medical record, and the recommendation of the Airman's immediate commander in determining whether the Airman's condition meets the criteria for unfitness under Appendix 2 to Enclosure 3 of DoDI 1332.18. These standards are: 1) that the evidence establishes that the member, due to disability, is unable to reasonably perform duties of his or her office, grade, rank, or rating; 2) that the evidence establishes that the service member's disability represents a decided medical risk to the health of the member or to the welfare or safety of other members; or 3) that the evidence establishes that the service member's disability imposes unreasonable requirements on the military to maintain or protect the service member. When considering whether an Airman is able to reasonably perform duties of his or her office, grade, rank, or rating the IPEB considers the same factors (common military tasks, physical fitness test, deployability, and special qualifications) that are considered by the Medical Retention Standards office and the MEB.

9. Once the IPEB has reached its decision, it makes a written recommendation as to whether the Airman should be discharged, retired, or retained with a succinct explanation of its reasoning on an Air Force Form 356 which is then provided to the Airman. At that point, the Airman may either accept the results or can elect to appeal to the Formal Physical Evaluation Board (FPEB).

10. All DES adjudicators are required by DoDI 1332.18 to uniformly consider deployability as a factor in making a fitness determination. The IPEB typically finds that members who are unable to deploy without waivers (and for whom waivers are unlikely to be approved) unfit, regardless of the condition which causes the deployment restriction. The IPEB and all subsequent levels of

review do, however, consider mitigating factors such as whether the Airman's career field is required to deploy infrequently, if the airman is likely to deploy, whether the airman is likely to deploy to locations that do not require a medical waiver for the condition at issue, and the airman's career point as more junior airmen generally deploy at higher rates than more senior airmen. Adjudicators at all levels consider deployment rates in each individual airman's career that is obtained from the Military Personnel Data System in making fitness determinations.

11. For the past two decades 80% of the Air Force's deployment taskings have been to the United States Central Command's Area of Responsibility. While CENTCOM's current guidance allows for the theoretical possibility of a waiver for an individual with asymptomatic HIV to deploy there, the considerations noted in CENTCOM's policy make it extremely unlikely that such a waiver would ever be granted. In fact, CENTCOM has never granted a waiver for an HIV positive service member to enter the AOR. The inability to deploy to CENTCOM, while extremely important, is not always outcome determinative when mitigating factors such as a low likelihood of deployment, specialized skillsets, or length of service weigh in the airman's favor. Adjudicators at all levels must weigh these factors when considering the specific merits of each case.

12. Airmen who do not accept the results of the IPEB and elect to appeal their cases to the FPEB are afforded an in person hearing before the FPEB at Joint Base San Antonio – Randolph, TX. Airmen who appear before the FPEB are entitled to representation, free of charge, by military attorneys assigned to the Office of Airmen's Counsel. Airmen can also be represented by civilian counsel of their own choice, at their own expense. The FPEB is comprised of 3 members, one physician and two line of the Air Force officers or civilian equivalent. The FPEB review includes the material submitted to the IPEB. At the hearing, the airman is entitled to

testify under oath or by unsworn statement, present any relevant witnesses, and any documentary evidence relevant to the case. After the hearing the FPEB deliberates and issues a written recommendation with a succinct explanation of its reasoning on an Air Force Form 356. The FPEB is required to provide the Air Force Form 356 to the member. Airmen who are unsatisfied with the recommendations of the FPEB are able to appeal to the Air Force Personnel Board ("AFPB") of the Secretary of the Air Force Personnel Council ("SAFPC").

13. The SAFPC serves as the decision authority for a wide array of personnel decisions made by the Air Force. One of the SAFPC's responsibilities is to serve as, effectively, the final appeal authority for Airmen evaluated by the DES prior to their separation from Active Duty. Airmen are entitled to review the SAFPC's decisions in DES cases by the Air Force Board for Correction of Military Records ("AFBCMR"). However, the SAFPC's decisions are not stayed pending the AFBCMR's review of the case, and case processing times at the AFBCMR make it virtually impossible that the AFBCMR would be able to review an SAFPC decision prior to an airman's disability separation or retirement. Airmen who receive relief from the AFBCMR may correct the airman's record to reflect reinstatement depending upon the circumstances of their individual case. The plaintiffs in this case have not appealed their cases to the AFBCMR.

14. Airmen are not entitled to an in person hearing before the SAFPC. Rather, in DES cases, the SAFPC reviews all information that was submitted to the MEB, IPEB, and FPEB, the airmen's current medical records, and any additional submissions or arguments made by the airmen or their counsel. The SAFPC applies the same DoDI 1332.18 standards for unfitness that are applied by the IPEB and FPEB. The SAFPC also analyzes the four criteria that are required to be considered by DoDI 1332.18 in determining whether an individual can reasonably perform the duties of his or her rank grade and position (common military tasks, fitness tests,

deployability, and specialized duties) in addition to other factors such as career field specific deployment rates, time in service, and critical skillsets.

15. The SAFPC decided ten cases of members with asymptomatic HIV during the month of October 2018, after the September 26, 2018 memorandum was issued by the Assistant Secretary of the Air Force for Manpower and Reserve Affairs. These cases included the cases of the two plaintiffs in this lawsuit. Of these cases, six individuals, including the plaintiffs, were found unfit and four were returned to duty. Each member was asymptomatic and had support from their command for retention. Of those who were found unfit all belonged to career fields in which a given individual had a greater than 20% chance of deployment in FY 18, and had at least a 20% likelihood of deployment between FY 15 and FY 17. Additionally, two of the Airmen found unfit were unable to be medically cleared for special flight duties, and one was found to have an unstable condition. Those who were retained, however, had a much lower likelihood of deployment as the highest likelihood of deployment in this cohort was only 12.8% in FY 18 and between 17.1% FYs 15 and 17. Moreover, each of the individuals who were retained were able to perform all of their regular duties without restrictions.

16. There have been eighteen DES cases involving airmen with HIV that have reached a final decision since the last policy guidance was issued in September 2018. Of these eighteen cases, one resulted in a return to duty finding by the FPEB and four resulted in return to duty findings from SAFPC. There were five cases in which the member was found unfit by the IPEB and elected to accept the IPEB's recommendation. There have been six cases, including plaintiffs' in which the member was found unfit by the SAFPC. Of the six members who received unfit findings, four were discharged with disability severance pay, one was medically retired, and one member was administratively separated due to misconduct unrelated to his medical condition.

In accordance with 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct. Executed this __25th_ of January 2019.

Martha P. Soper

Assistant Deputy, Health Policy

UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA

RICHARD ROE, *et al.*, Plaintiffs, v. PATRICK M. SHANAHAN, *et al.*, Defendants.	No. 1:18-cv-641-LMD-IDD

DECLARATION OF KEVIN CRON IN SUPPORT OF DEFENDANTS' OPPOSITION TO PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

I, Kevin Cron, do hereby declare as follows:

1. I currently serve as the Preventive Medicine Officer and primary Waiver Action Officer for U.S. Central Command ("CENTCOM"), a theater-level Unified Combatant Command with responsibility for military operations across North Africa, Central Asia, and the Middle East, including Iraq and Afghanistan, within the Department of Defense ("DoD"). I have held this position since 2015. I act on behalf of the CENTCOM Surgeon to develop and interpret CENTCOM medical readiness standards and advise commanders and units on deployment issues, and have issued determinations for over 14,000 medical waiver applications, including applicants from all branches of the U.S. Armed Forces, as well as a variety of governmental, non-governmental, and contracting agencies. I am responsible for assessing wartime medical and environmental threats, integrating threat analyses into operational and strategic plans, and developing programs to minimize medically-related threats to USCENTCOM personnel, forces, and missions.

2. In the exercise of my duties, I have been made aware of this lawsuit by counsel from the DOD Office of the General Counsel.

3. I submit this declaration in support of the Defendant's Response to the Plaintiffs' January 11, 2018 Motion for a Preliminary Injunction. I base this declaration on my personal knowledge and on information made available to me in the performance of my duties. Unless specifically noted, the opinions in this declaration are my own and relate to my assigned duties within the CENTCOM Surgeon's office.

Purpose of this Declaration

4. This declaration is submitted in support of Defendant's Reply to Plaintiffs' Motion for a Preliminary Injunction. In their November January 11, 2019 Memorandum in Support of Plaintiff's Motion for a Preliminary Injunction, Plaintiffs state "'the military's restrictions on deployability are not rationally related to military effectiveness or readiness, because a person's physical capabilities are not generally affected by an HIV diagnosis."

Deployment Restrictions to the CENTCOM AOR

5. Deployment to the CENTCOM area of responsibility ("AOR") is governed by a variety of regulations, including Department of Defense Instruction ("DoDI") 6490.07 and Modification Thirteen to USCENTCOM Individual Protection and Individual-Unit Deployment Policy ("MOD 13").

6. DoDI 6490.07 (Deployment Limiting Medical Conditions for Service Members and DoD Civilian Employees) puts forth baseline guidance on medical deployability for the DoD. Enclosure 3 states, "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." Paragraph (e) (2) then states, "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." Enclosure 4 additionally specifies Combatant Commanders shall "Serve as the final approval authority for exceptions to the medical standards (waivers) made pursuant to the procedures in this Instruction.", and serves as the basis for MOD 13.

8. MOD 13 is a CENTCOM policy, and provides guidance on medical readiness for deployment to the AOR. Paragraph 15.G.1 reiterates that, "the cognizant Combatant Command surgeon shall be directly consulted in all instances of HIV seropositivity before medical clearance for deployment." Tab A, Paragraph 7.C.2. clearly states that "Confirmed HIV infection is disqualifying for deployment". Paragraph 15.C of MOD 13 also notes that "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) traveling to the CENTCOM AOR must be medically, dentally and psychologically fit." This is an important caveat that is considered in every waiver decision. MOD 13 also makes clear that "the final authority of who may deploy to the CENTCOM AOR rests with the CENTCOM Surgeon and/or the Service Component Surgeon's waiver authority, not the individual's medical evaluating entity or deploying platform."

9. The CENTCOM AOR presents many medical care challenges. The AOR covers 20 countries and covers more than 4 million square miles. Operations in the AOR are expeditionary in nature, and health service support plans are designed to meet the reasonably anticipated needs of a pre-screened warfighting population without complex medical needs. Conditions requiring highly specialized medical personnel, treatments, or medications cannot be reliably supported. Moreover, contingency deployments and deployment to austere conditions

may place Service members with mandatory medication or treatment regimens at risk because these regimens may be disrupted and may be difficult to replace in a timely manner. In the case of HIV treatment, such a disruption could result in the reactivation of the virus, with acquired resistance to the medication. This situation would place not only the individual Service member at risk, but also medical providers at all levels, including Host Nation and Coalition personnel, who may have to treat the Service member for battlefield injuries. The remaining force must also be considered, due to potential exposure to blood from treating, or being treated for, battlefield trauma, or for those individuals requiring battlefield blood transfusions.

10. In considering a medical waiver, I conduct an individual assessment of the risk each applicant poses to themselves, the deployed force, and, most importantly, the military mission in the CENTCOM AOR. The decision to grant a deployment waiver is a risk calculation that accounts for the applicant's condition, occupation, and time/location of deployment. We consider not only their current condition and stability, but also how they will be impacted by reasonably anticipated contingencies, such as loss, theft, or destruction of medication, how their condition will impact the evaluation of routine medical issues, what secondary effects their treatment may have, and how their condition will influence, and be influenced by, operational activities within active combat zones. It is a necessarily complex process. For a waiver to be granted, the needs of the Service to have the specific Service member or civilian in theater must be great enough to validate taking on this additional risk.

11. In my tenure as the wavier authority for CENTCOM, I have reviewed waiver requests from HIV-positive service members. I have not granted a deployment waiver for a HIV-positive Service member. After conducting a thorough risk assessment for each waiver request and consulting with the CENTCOM Surgeon and Component Surgeons, we determined

in each case that the risks of deploying a HIV-positive Service member were too great to justify waiver approval. It is highly unlikely that either Service member Roe or Voe would be granted a waiver to deploy to the CENTCOM AOR.

12. There are features of HIV which make it difficult to compare to other conditions. Treatment medications are highly specialized, and require constant, diligent compliance to be effective. A resurgent infection may go unnoticed, and must be considered as a possibility when other medical complaints arise. Currently, there is no cure for the disease. Medical conditions all have their own challenges, and must be considered in that context.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge and belief.

EXECUTED this 25th day of January 2019, Tampa, Florida.

LTC KEVIN CRON, MD, MPH
Preventive Medicine Officer
USCENTCOM/CCSG

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Short Communication
Investigation of Incident HIV Infections Among U.S. Army Soldiers Deployed to Afghanistan and Iraq, 2001–2007

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Abstract

The U.S. Army initiated an investigation in response to observations of a possible increase in HIV incidence among soldiers deployed to combat. Human immunodeficiency virus (HIV)-infected U.S. Army soldiers are not eligible to deploy. Combat presents a health hazard to HIV-infected soldiers and they pose a threat to the safety of the battlefield blood supply and their contacts. All soldiers are routinely screened for HIV every 2 years and those who deploy are also screened both prior to and after deployment. Seroconversion rates were estimated for all soldiers who deployed to Afghanistan or Iraq in the period 2001–2007 and all active duty soldiers who did not. Seroconverters with an estimated date of infection, based on calculation of the midpoint between the last seronegative and first seropositive test date, that was either before or during deployment were eligible for inclusion. Confidential interviews and medical record reviews were conducted to determine the most likely time, geographic location, and mode of infection. Reposed predeployment samples were tested for HIV ribonucleic acid. The HIV seroconversion rate among all soldiers who deployed was less than the rate among those who did not deploy: 1.04 and 1.42 per 10,000 person-years, respectively. Among 48 cases, most were determined to have been infected in the United States or Germany and prior to deployment ($n=20$, 42%) or during rest and relaxation leave ($n=13$, 27%). Seven seronegative acute infections were identified in the predeployment period. Subtype was determined for 40 individuals; all were subtype B infections. All were acquired through sexual contact. These findings can inform development of preventive interventions and refinement of existing screening policy to further reduce HIV-infected deployed soldier person time.

The prevalence of HIV infection in the U.S. Army population remains at approximately 0.02%,[1] and is significantly lower than that of the general U.S. population. The epidemic in the Army is similar to that in the U.S. general population; HIV infection disproportionately affects blacks and males and also disproportionately affects certain regions of the country including the South and Northeast.[2–4] By regulation, all U.S. soldiers are subject to periodic serologic screening for HIV every 2 years. In addition, soldiers who deploy to combat are also screened both prior to and after returning from deployments. HIV-infected soldiers are excluded from overseas missions.[5,6] Requirements for U.S. Army soldiers who deployed to Afghanistan or Iraq from October 2001 to December 2007 were for serologic screening for HIV infection within 365 days before deployment and within 30 days after the end of deployment. HIV force screening began in 1986 with the purpose of enhancing the safety of blood products obtained in urgent donation settings, such as a battlefield, preventing potentially fatal complications from administration of military-required, live vaccines, and monitoring HIV-infected troops for continuing physical qualification for duty.[7]

Approximately 5 years ago observations by Army investigators suggested that there may be an increase in HIV incidence among soldiers associated with combat deployments.[8–10] On July 14, 2007, the U.S. Army Surgeon General ordered an

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[4]Armed Forces Health Surveillance Center, Silver Spring, Maryland.
[5]U.S. Army Public Health Command, formerly the U.S. Army Center for Health Promotion and Preventive Medicine (USACHPPM), Aberdeen Proving Ground, Maryland.

investigation to describe the location, time, and mode of transmission of HIV infections among U.S. Army soldiers who had deployed to Afghanistan and Iraq after October 1, 2001.

Soldiers with HIV seroconversions were identified using archived personnel, deployment, and HIV screening surveillance data from the Defense Medical Surveillance System (DMSS).[11] The rate of HIV seroconversion among soldiers who deployed to Afghanistan or Iraq was compared to the rate among active duty soldiers who did not deploy to Afghanistan or Iraq at any time during the study period. The midpoint between the last seronegative and first seropositive test date was estimated to be the date of HIV infection. Soldiers with an HIV-positive test who had deployed to Iraq or Afghanistan at any time during the study period were eligible for inclusion. Those who had a midpoint date either prior to or during deployment were included in this investigation. Soldiers were confirmed as cases after they individually verified their deployment dates.

All confirmed cases were invited to participate in a detailed epidemiologic interview and to permit a review of existing personnel and medical records. Soldiers were reminded of the protections from adverse action and confidentiality of the information obtained as part of epidemiologic interviews required by Army regulation.[5] To avoid the potential for favorable reporting, soldiers were not required to participate. Veterans who had separated from the Army were asked to provide informed consent and permission to release existing medical records. A single military infectious disease physician, who conducted interviews at U.S. Military Treatment Facilities, administered a questionnaire that guided the interviews and elicited individual health, social, and military occupational history including medical encounters and potential exposures to HIV.

For each case, archived serum remaining from the last seronegative HIV test performed prior to deployment was obtained from the Department of Defense Serum Repository (DoDSR)[11] and subjected to confirmatory HIV serologic testing[2,12] and nucleic acid amplification testing (NAAT, Amplicor HIV-1 Monitor v 1.5, Roche). Acute HIV infection (AHI) in an individual was identified by an HIV-seronegative sample that was NAAT positive. Whole blood specimens were collected at the time of epidemiologic interview for genotyping. Nucleic acid was extracted from plasma and serum using the QiAamp Viral RNA mini kit (QIAGEN Inc., Valencia, CA). HIV genotyping and sequence analysis were performed, as previously described, using a multiregion hybridization assay (MHA) for subtype B/non-B (MHAbnb) and partial length sequencing.[2,13]

The most likely time, geographic location, and mode of acquisition of HIV infection were determined using all available data. A timeline of events in the period of risk prior to HIV infection was generated for each participant and included self-assessment of the most likely time, location, and mode of infection; self-reported behavioral and occupational exposures; medical encounter and laboratory test records; and the dates and locations of all deployments, rest and relaxation (R&R) activities, and military assignments. Cases of probable, acute retroviral syndrome were identified using clinical histories and compatible medical encounter data. Where possible, administrative and medical records data were used to validate participant self-reports.

Approval of this investigation was obtained from the Division of Human Subjects Protections and Institutional Review Board of the Walter Reed Army Institute of Research (WRAIR #1678).

Among the 1,134,001 soldiers who deployed to Afghanistan or Iraq during the study period, 131 seroconverted (1.04/10,000 person years). By comparison, 258 of the 1,816,901 soldiers who did not deploy to Afghanistan or Iraq during the study period seroconverted (1.42/10,000 person-years).

Of the 131 seroconverters who deployed, 67 were not included because their midpoint date did not meet the inclusion criteria or due to misclassification of infection status or history of deployment. Of the 64 who were eligible for inclusion, nine declined participation, one was deceased, and one did not respond. Five others were excluded because the actual deployment dates individually verified by the soldier were different from those obtained from archived surveillance data such that their midpoint date was not prior to or during deployment. Thus, 48 confirmed cases participated. Compared to the overall deploying Army, cases were older, of higher rank, and were more frequently black and unmarried (Table 1).

Of the 48 confirmed cases, 20 (42%) were determined to have been infected before deployment, 13 (27%) during leave for R&R, and one (2%) while deployed. Determination of the most likely time of infection for four of the soldiers could be narrowed to only two time periods because exposure histories spanned more than one period. Five (10%) were determined to have been infected in the period between their deployment end date and postdeployment HIV serologic screening. For five other soldiers, there were insufficient existing data or exposure histories obtained in the interview to narrow the most likely time of infection down to even two periods (Fig. 1).

Most were determined to have been infected in the continental United States or Germany. Most (13/20) of the soldiers who were determined to have acquired their HIV-1 infection prior to deployment were infected in the last 6 months prior to departing for Afghanistan or Iraq (Fig. 2). Seven soldiers' predeployment samples were HIV seronegative and NAAT positive. These samples were collected between 290 and 41 days (median 76) prior to deployment. HIV subtype was determined by MHA or partial length sequencing for 40 of 48 participants and all were subtype B. For eight participants, samples were either not available or nontypeable.

High-risk exposures in the period at risk included unprotected sex with opposite and same sex partners; unprotected sex with strangers and other high-risk partners including commercial sex workers, injection drug users, and persons subsequently identified as HIV-infected; unprotected sex with multiple partners; and unprotected sex after alcohol use. None were emergency blood transfusion donors or recipients. One individual refused to provide a history of exposures.

Twenty-three individuals (48%) had a clinically apparent illness consistent with acute retroviral syndrome (ARS). Five were medically evacuated for evaluation of lymphadenopathy and one for evaluation of a febrile illness. Two soldiers contracted a sexually transmitted infection in addition to HIV during the period between when they were determined to have been infected and the end of their deployment. No participant experienced any vaccine adverse events.

This is the first report of HIV infections among U.S. Army soldiers deployed in support of combat operations. Overall, the rate of new HIV infections among those who deployed did

Table 1. Characteristics of HIV-Infected Cases (n=48) Compared to All HIV-Uninfected Active Army Personnel Who Deployed in the Period 2001–2007

Variable	*All deploying active Army personnel* n (%)	*Investigation participants* n (%)
Year of operation		
2002	56,226 (5)	2 (4)
2003	276,178 (24)	16 (33)
2004	230,695 (20)	14 (29)
2005	215,326 (19)	9 (19)
2006	162,507 (14)	6 (13)
2007	186,181 (16)	1 (2)
Age group[a,b]		
20–24	390,256 (34)	8 (17)
25–29	236,806 (21)	14 (29)
30–39	303,381 (27)	16 (33)
40+	138,370 (12)	10 (21)
Sex		
Male	1,019,894 (90)	47 (98)
Female	114,107 (10)	1 (2)
Race[b]		
Black	209,168 (18)	32 (67)
Other	924,869 (82)	16 (33)
Component		
Active	Not applicable	33 (69)
Reserve	Not applicable	15 (31)
Grade[b]		
E1–E4	537,927 (47)	18 (38)
E5+	596,090 (53)	30 (62)
Marital status[b,c]		
Married	590,549 (52)	22 (46)
Single	486,144 (43)	21 (44)
Other	57,344 (5)	5 (10)
Education		
Master degree	Not available	4 (8)
Associate/Bachelor degree		11 (23)
Some College		22 (46)
<High School		11 (23)
Occupation		
Combat arms	Not available	14 (29)
Combat support		23 (48)
Medical		4 (8)
Other support		7 (15)

[a]<20 age group (6% of deploying Army personnel) not shown.
[b]Differences were statistically significant ($p<0.05$, χ^2/Fisher's exact tests).
[c]Other includes divorced, separated, widowed, unknown.

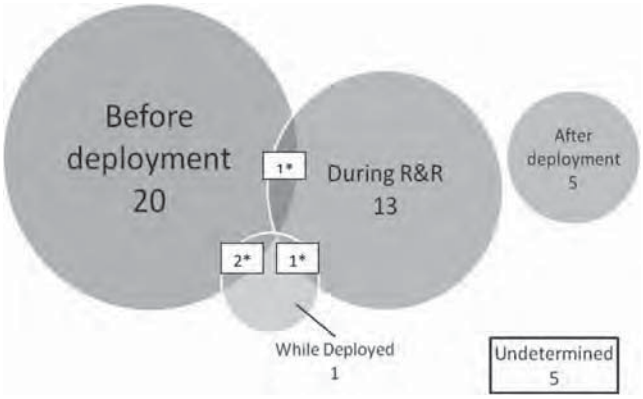

FIG. 1. Numbers of cases with determination of most likely time of infection occurring during particular periods in relation to deployment ($n=48$). R&R locations: 11 continental United States, 1 South America, 1 unknown. *The most likely time of infection could be narrowed to only one of two time periods because exposure histories spanned more than one period.

not exceed the rate among nondeploying soldiers and infection while deployed in Afghanistan and Iraq was extremely rare. Single, male, and black soldiers were overrepresented among the soldiers with new HIV infections who deployed. This was not unexpected as these findings are consistent with those in a previous report of the epidemic of HIV in the U.S. Army and Air Force.[2] However, these data demonstrate that HIV infection results in short-term morbidity and lost duty time in the combat environment. The realities of the current combat environment support the rationale that served as a basis for implementing force-wide screening policies 25 years ago.[7] Deployment and the battlefield present potential exposures to blood-borne pathogens including HIV. In addition to sexual transmission[14,15] there is potential contact with the battlefield supply of non-FDA-approved blood products,[16,17] occupational combat exposures, and casualty care with infection control measures limited by austere field conditions.[18,19] The probability of any transfusion-transmitted (TT) infection in combat settings is relatively low, while the potential impact is high. Underscoring this is a recent report of the first documented case of TT hepatitis C virus infection in a U.S. military recipient of a battlefield transfusion of non-FDA licensed, fresh whole blood,[16] as well as a recent report of TT HIV infection in the United States.[20]

Optimal HIV-related policy development and decision making rely on both knowledge of the current epidemiology and careful consideration of the technical, fiscal, and operational costs associated with each potential strategy. The observed, small number of HIV-infected soldiers in the combat theater of operations suggests that periodic force screening and perideployment screening using serological diagnostic algorithms to identify HIV infection are highly successful and effectively decrease HIV-infected deployed soldier person time. These findings contributed to an interim change in deployment screening policy that shortened the required HIV testing interval from 365 days to 90 prior to deployment in order to increase case finding, referral for clinical care, and exclusion from deployment eligibility. They may also inform further refinement of screening policy and laboratory methodology.

These data identify potential time period targets for the delivery of preventive interventions. As part of soldier readiness processing, soldiers preparing to deploy receive country-specific threat briefs that include information about potential disease, environmental, and occupational health hazards, and individual countermeasures available to stay healthy. These briefs include specific information and prevention messages about HIV/HIV-related infections. These data also reinforce the need to maintain a highly sensitive, readily adaptable, state-of-the-art capacity to determine HIV

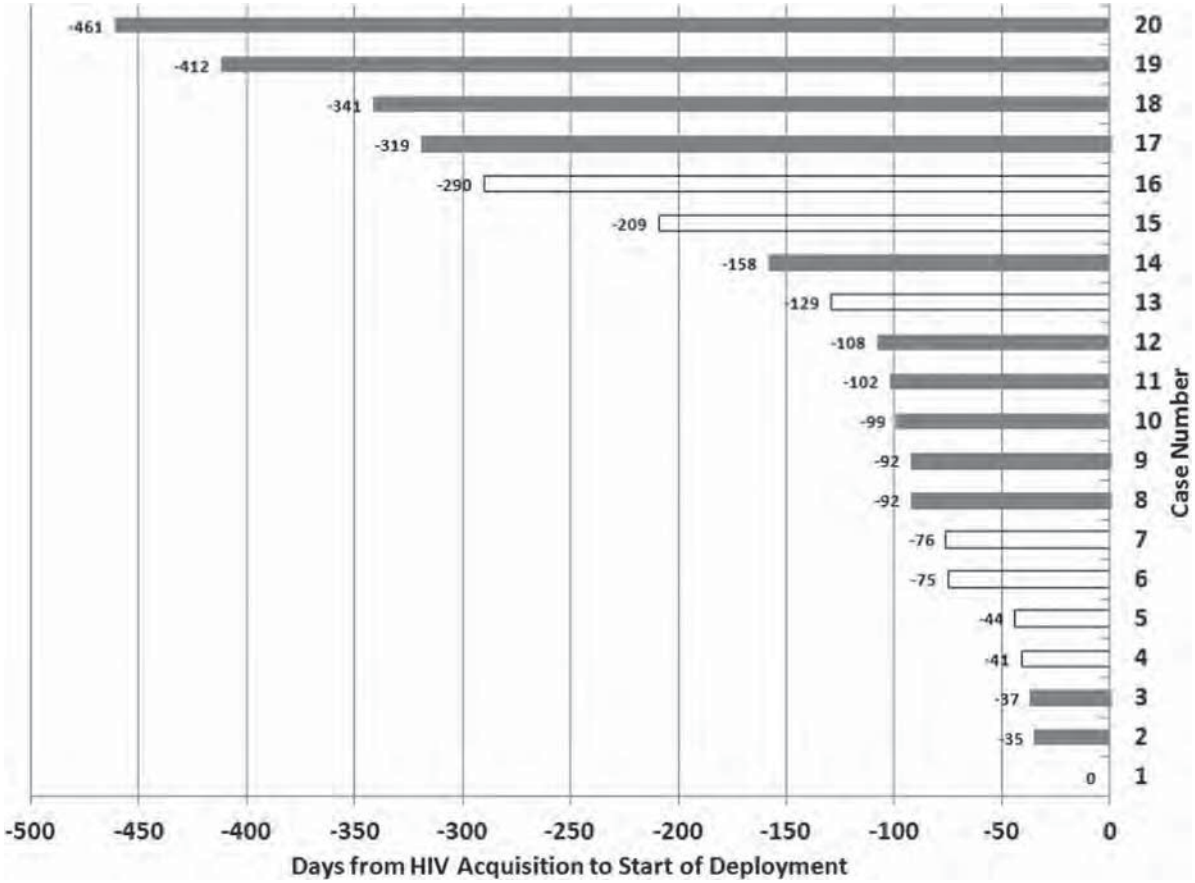

FIG. 2. Days from determination of most likely time of acquisition of HIV infection to start of deployment for soldiers infected prior to deployment ($n = 20$).

infection status when the tempo of military operations is high. Identification of acute HIV infection is a rare event.[21] By using an enhanced diagnostic algorithm that included HIV NAAT testing in this investigation that exceeded the sensitivity and time of earliest detection of the routine deployment serology-only screening diagnostic algorithm in place during the study period, we identified seven HIV infections that were RNA positive and serology negative. These results indicated that infection occurred as early as 5 22 days prior to sample collection.[22] The finding of acute infection occurring in close proximity to predeployment HIV screening suggests that there may be an association between mobilization for deployment and HIV infection acquisition.

Predeployment HIV testing is one part of the soldier readiness processing and training that occurs prior to deployment. This testing, performed in addition to the periodic HIV testing of the entire force, is conducted only among soldiers preparing to deploy. It is possible then that there is a relationship between incident HIV infection and deployment. There was no control group so additional study is warranted to investigate the possibility that deployment is associated with changes in behavior and exposures associated with HIV infection.

Future study is also warranted of soldiers who had incident HIV infections and deployed but were not compliant with deployment screening interval regulations and were not included in this investigation. A limitation of this study is that the inclusion criteria excluded those who have an estimated date of infection that was after the end of deployment. Due to the variability in compliance with predeployment and postdeployment and periodic HIV screening interval requirements, these inclusion criteria potentially excluded soldiers who may have contributed HIV infected person time while deployed and also eliminated description of the epidemiology of postdeployment incident HIV infection. Additional study of those soldiers with deployment exposure and postdeployment HIV infection is warranted. And on-going surveillance efforts of and reporting requirements for HIV screening compliance should continue. Findings from these studies would inform development and optimal timing for delivery of preventive interventions.

This study supports the utility of perideployment HIV screening. The findings of this investigation can advance the objectives of a force-wide HIV screening program to improve individual and force health, prevent the deployment of HIV-infected soldiers, and protect the safety of the battlefield blood supply.

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Author Disclosure Statement

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HIV Preexposure Prophylaxis in the U.S. Military Services — 2014–2016

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Human immunodeficiency virus (HIV) infection is a substantial health concern for the U.S. Department of Defense (DoD) and for service members stationed throughout the world. Each year, approximately 350 new HIV infections are diagnosed in members of the U.S. military services, with most infections acquired within the United States (*1*). The DoD populations most affected by HIV mirror those in the U.S. civilian population; the highest rates of new military diagnoses are in men and blacks or African Americans (blacks) (*1*). Blacks are disproportionally affected, and most new diagnoses occur among men who have sex with men (MSM). HIV preexposure prophylaxis (PrEP) is approximately 90% effective in preventing HIV infection when used properly (*2*), and an increasing number of active duty personnel have used HIV prevention services and PrEP in the military health system since the repeal of "Don't Ask, Don't Tell"* in 2011 (*3*). Military health system and service records were reviewed to describe HIV PrEP use among military personnel, and military health care providers were surveyed to assess HIV PrEP knowledge and attitudes. Among 769 service members prescribed PrEP during February 1, 2014–June 10, 2016, 60% received prescriptions from an infectious disease provider, 19% were black men, and 42% were aged >28 years. Half of surveyed military health care providers self-rated their PrEP knowledge as poor. DoD is developing new policy to address access to care challenges by defining requirements and establishing pathways for universal patient access to PrEP.

Charts were reviewed for service members without a diagnosis of HIV infection whose records indicated a prescription for emtricitabine/tenofovir disoproxil fumarate (Truvada, Gilead Sciences, Inc.) during February 1, 2014–June 10, 2016, and data were collected on demographic characteristics, service branch, risk behavior, and MSM risk index (*4*). The MSM risk index is a validated seven-item screening index used to prioritize patients for intensive HIV prevention efforts, including PrEP, with a score ≥10 having a sensitivity and specificity of 84% and 45%, respectively (*5*). Laboratory data were obtained from the Defense Medical Surveillance System (*6*). Infection status was ascertained by negative fourth generation HIV antigen/antibody testing and HIV viral load when clinically indicated. During 2015–2017, surveys were administered to 4,217 primary care and infectious disease providers in the Army, Navy, and Air Force to evaluate knowledge, attitudes, experience, and beliefs related to HIV PrEP.

Among 769 service members without HIV infection who were prescribed Truvada during February 1, 2014–June 10, 2016, 759 (99%) were men, and 320 (42%) were aged

* The 1993 Department of Defense policy that prohibited military personnel from discriminating against service members or applicants who did not disclose their homosexual or bisexual sexual orientation, while barring openly gay, lesbian, or bisexual persons from military service.

INSIDE

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>28 years, including 57 aged >40 years (Table) (Figure 1). Blacks accounted for 19% of those prescribed Truvada, compared with 47% who were white. Among the 769 Truvada recipients (including 33 whose education level was unknown), 285 (37%) had at least some college education. The indication for initiating PrEP was most commonly sexual contact with men (87%) and condomless sex (73%); 30% reported exposure to sexual partners with known HIV infection. The MSM risk index score was documented for 156 (20%) PrEP prescription recipients; among those for whom MSM risk index score was available, 72% had scores ≥10.

Service members who received PrEP were assigned to duty locations throughout the United States and several locations overseas; 315 (41%) of all PrEP recipients accessed services at one of three medical centers located in the Maryland/District of Columbia area; Portsmouth, Virginia; and San Diego, California (Figure 2). Of the 769 Truvada recipients, 464 (60%) accessed PrEP at infectious disease clinics. The majority had appropriate laboratory screening; however, 16% did not have an HIV test within 14 days of initiating PrEP, 13% were never evaluated for hepatitis B virus infection, and 20% and 30% did not have kidney function assessed at baseline or within 90 days of PrEP initiation, contrary to recommendations.

Among the 4,217 Army, Navy, and Air Force health care providers who were asked to respond to a web-based survey, 1,599 (38%) responded, including 1,190 (74% of respondents) primary care providers. Overall, 789 (49%) respondents rated their knowledge of PrEP as poor, and 470 (29%) reported ever having prescribed PrEP. Common health care provider concerns included medication adverse effects (915; 57%), compliance (817; 51%), and a need for more clear evidence

TABLE. Number of U.S. military service members (N = 769) without human immunodeficiency virus (HIV) infection who initiated preexposure prophylaxis, by selected characteristics — February 1, 2014–June 10, 2016

Characteristic	No. (%)
Total	**769 (100)**
Sex	
Men	759 (99)
Women	10 (1)
Age group (yrs)	
18–28	449 (58)
29–40	263 (34)
41–48	44 (6)
≥49	13 (2)
Race	
White	361 (47)
Black	149 (19)
Other*	259 (34)
Service branch	
Army	207 (27)
Navy	364 (47)
Air Force	158 (21)
Marine Corps	40 (5)
Education, highest level	
High school or less	451 (59)
Some college	84 (11)
Bachelor's degree	120 (16)
Higher than bachelor's degree	81 (11)
Unknown	33 (4)

* Includes American Indian/Alaska Native, Asian, Native Hawaiian/Pacific Islander, and unknown.

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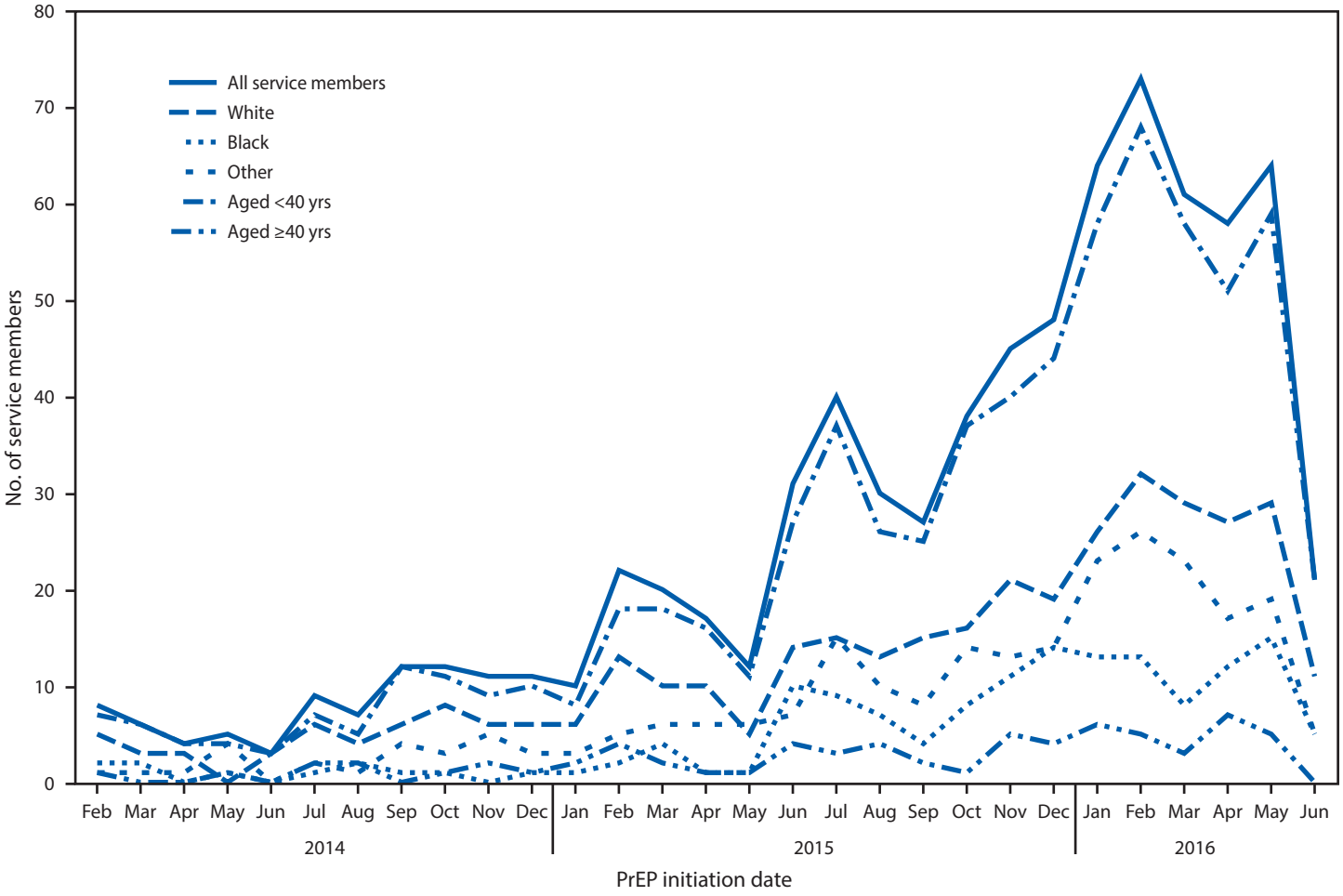
FIGURE 1. Number of military service members who initiated human immunodeficiency virus (HIV) preexposure prophylaxis (PrEP) among U.S. military personnel on active service who did not have HIV infection, by month — 2014–2016*



* Any patient without HIV infection who received an initial prescription for Truvada paid for by the U.S. Department of Defense during February 1, 2014–June 10, 2016, was considered to have received HIV PrEP.

of safety or efficacy (812; 51%). Despite these limitations and concerns, 1,082 (68%) of the responding health care providers endorsed provision of PrEP in the military health care system.

Discussion

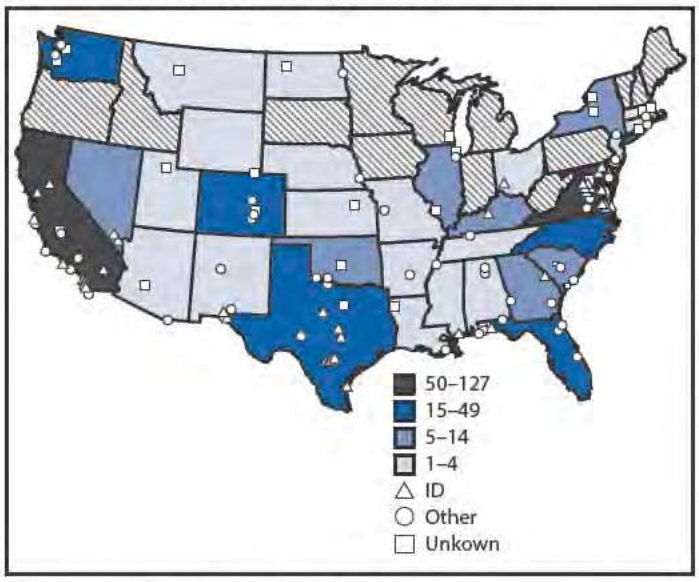
A key goal of the national HIV prevention strategy is effective use of HIV prevention services, including PrEP.† As in the U.S. civilian population, in the military, HIV disproportionately affects blacks, who represent 17% of the military force§ but account for approximately half of all military HIV diagnoses (*7*); during the 2014–2016 study period, only 19% of service members who used PrEP services were black. Further studies are required to learn whether this represents a true disparity and whether improving culturally appropriate efforts will increase PrEP use among black service members who are at increased risk for acquiring HIV infection.

Based on the assumptions that 1) men constitute 85% of the 1.3 million active duty service members, 2) an estimated 4.23% of these men are MSM (including those who self-reported as gay [0.78%], bisexual [2.15%], or other MSM [1.30%]) (*8*), and 3) 25% of MSM have substantially increased risk for HIV (i.e., are candidates for PrEP) (*9*), an estimated 12,000 service members would be eligible for PrEP. However, as of February 2017, approximately 2,000 service members and their beneficiaries had accessed PrEP (Pharmacy Operations Division, Defense Health Agency, unpublished data, 2018). Most patients currently using PrEP are receiving Truvada from major military medical centers after referral to infectious disease specialists. Although a majority of surveyed military

† White House Office of National AIDS Policy. National HIV/AIDS strategy for the United States: Updated to 2020; 2016 progress report. December 2016. https://www.whitehouse.gov/sites/whitehouse gov/files/images/nhas-2016-progress-report.pdf.

§ Office of the Deputy Assistant Secretary of Defense for Military Community and Family Policy, Department of Defense. 2015 demographics: profile of the military community. http://download.militaryonesource.mil/12038/MOS/Reports/2015-Demographics-Report.pdf.

FIGURE 2. Number of military service members who initiated human immunodeficiency virus (HIV) preexposure prophylaxis (PrEP) among U.S. military personnel on active service who did not have HIV infection, by location of duty and prescribing clinic type — 2014–2016*



Abbreviation: ID = infectious disease.
* Any patient without HIV infection who received an initial prescription for Truvada paid for by the U.S. Department of Defense during February 1, 2014–June 10, 2016, was considered to have received HIV PrEP.

health care providers support the use of PrEP for military beneficiaries, increased capacity through provider education and expanded access to the requisite pharmacy and laboratory support services are necessary to meet the anticipated future demand for PrEP and ensure effective delivery of these services in the primary care setting. The transition to use of a fourth-generation HIV immunoassay for HIV screening throughout the DoD has substantially reduced the failure to diagnose acute HIV infection during the "window period" (i.e., the time between exposure to HIV infection and appearance of the first detectable HIV RNA). However, because of variable access to diagnostic tests, some health care providers expressed concern that patients with acute HIV infection might inappropriately be prescribed PrEP instead of antiretroviral treatment because of unrecognized HIV infection.

The maximum estimated annual cost of PrEP to the military health care system is substantial, and new prescriptions for PrEP are expected to continue to rise. Based on the estimate that approximately 12,000 service members would be eligible for PrEP and the current annual cost of Truvada is $12,000 per user,[¶] the potential maximum annual cost to the military health care system in drug costs alone would exceed $140 million. However, these cost estimates are largely based on assumptions using data from civilian populations and do not account for the lower costs of potential generic prescriptions; further evaluation is needed. In addition, the cost of PrEP services in the DoD can be weighed against the cost savings of preventing HIV infection in the service member; the average lifetime cost of medical care for a person with HIV infection is estimated to be nearly $450,000 (*10*). In addition, indirect costs associated with HIV-infected personnel who are prohibited from combat deployment might have substantial impact on military unit readiness and ability to accomplish specific missions.

Considerations unique to DoD are associated with initiation and maintenance of PrEP services among service members subject to worldwide assignment and deployment. Clinical, pharmacy, and laboratory services are limited in some deployment settings; moreover, access to expedited laboratory testing for HIV infection and the three-site (throat, rectum, and urine) gonorrhea and chlamydia nucleic acid amplification testing (NAAT) recommended by CDC's 2017 PrEP guidelines for MSM is either unavailable or not easily accessible at many smaller military medical treatment facilities in the United States. In addition, because some pharmacies have insufficient stock of medication for use for PrEP, not every service member or family member who needs Truvada can obtain it. Occupational considerations also exist. Historically, pilots and air crew members on flight status were prohibited from using Truvada and all other antiretrovirals.** To date, only Navy aviation has formally amended its aeromedical waiver guide to allow PrEP use among pilots and air crew.†† In addition, adherence to the recommended 3-month follow-up evaluations can be difficult in light of the often unpredictable training and mission schedules. These differences between military policy and clinical practice have the potential to create confusion for both patients and health care providers with regard to implementation of standard PrEP management.

Approximately 28% of PrEP users with documented MSM risk indices had scores <10. The DoD legacy "Don't Ask, Don't Tell" policy and reluctance of service members to disclose MSM status might in part explain why only 20% of PrEP users had a documented MSM risk index score and why 28% of those had scores <10. As a result, in the military setting, the risk index alone might not be a reliable discriminator of candidacy for PrEP services. In addition, sexual relations and physical intimacy between unmarried service members,

¶ National Acquisition Center and U.S. Department of Veteran Affairs. Pharmaceutical Catalog; 2017 https://www.va.gov/nac/Pharma/List?cboContractNumbers=&cboContractorNames=&txtCriteria1=truvada&TxtNDC=&txtPackage=&cboVAClass=&Sort=1&search=Search.

** Official Air Force Aerospace Medicine approved medications. https://www.315aw.afrc.af.mil/Portals/13/Users/096/96/96/Aircrew%20Medication%20List%20June%202017.pdf?ver=2017-07-13-121648-710. Army Regulation 40-501: Standards of Medical Fitness. Updated June 14, 2017. https://armypubs.army.mil/epubs/DR_pubs/DR_a/pdf/web/ARN3801_AR40-501_Web_FINAL.pdf.

†† U.S. Navy Aeromedical Reference and Waiver Guide. http://www.med.navy.mil/sites/nmotc/nami/arwg/Documents/WaiverGuide/18_Medications.pdf.

Summary

What is already known about this topic?

Each year, approximately 350 new human immunodeficiency virus (HIV) infections are diagnosed in U.S. military service members, with most diagnoses occurring among men who have sex with men (MSM).

What is added by this report?

Among 769 service members prescribed preexposure prophylaxis (PrEP) during February 1, 2014–June 10, 2016, 87% were MSM. In a survey of health care providers, 49% rated their knowledge of PrEP as poor, and 29% reported ever having prescribed PrEP.

What are the implications for public health practice?

Strategies for reducing barriers to receipt of HIV prevention and care services include patient self-referrals for PrEP evaluations and development of new health policy to provide universal access to the provider, laboratory, and pharmacy services required for an effective PrEP program.

regardless of sex, in the deployed setting has been historically regarded as unprofessional behavior in a combat environment. The currently accepted practice is to discontinue PrEP because Truvada is considered a nondeployable medication in current combat environments.[§§]

The findings in this report are subject to at least three limitations. First, MSM risk index scores were infrequently documented by health care providers, which might have led to candidacy for PrEP services being misclassified. Second, the reported locations of PrEP initiation were based on uneven availability of PrEP services throughout the military health system, which limits generalizability. Finally, the percentage of survey responses from military health care providers was low, which might have led to misrepresentation of provider knowledge of PrEP.

Despite the universal access to care afforded to service members by the military health care system, there is a recognized need to improve and expand access to PrEP for those patients at highest risk for HIV infection. Currently, the availability of PrEP services is heterogeneous, based on the individual patient's geographic location. If located close to a tertiary care medical center, a patient typically is referred by a primary care provider to an infectious disease specialist to receive PrEP services. To reduce the barrier of requiring a consult to a subspecialty provider, several locations with infectious disease specialists are now allowing patients to self-refer for PrEP evaluations. Patients located closer to smaller military treatment facilities might find it difficult to access PrEP because resources required for PrEP services might be lacking, including three-site gonorrhea and chlamydia NAAT testing and adequate supplies of Truvada at the military pharmacy. In addition, primary care providers with limited knowledge and experience might lack confidence to provide PrEP services. New DoD policy is being developed to address identified gaps through initiatives to improve health care provider education and so ensure universal access to PrEP at the primary care level, and to standardize pharmacy and laboratory service delivery at all military treatment facilities.

[§§] Department of Defense. PPG-Tab A: Amplification of the minimal standards of fitness for deployment to the CENTCOM AOR; to accompany MOD thirteen to USCENTCOM individual protection and individual/unit deployment policy. July 12, 2017. https://health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Access-to-Healthcare/Pharmacy-Program/Deployment-Prescription-Program.

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Conflict of Interest

Jason Okulicz reports personal fees from Gilead Sciences, outside the submitted work. No other conflicts of interest were reported.

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Transfusion-transmitted human T-lymphotropic virus Type I infection in a United States military emergency whole blood transfusion recipient in Afghanistan, 2010

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BACKGROUND: The United States introduced human T-lymphotropic virus Type I (HTLV-I) screening of blood donors in 1988. The US military uses freshly collected blood products for life-threatening injuries when available stored blood components in theater have been exhausted or when these components are unsuccessful for resuscitation. These donors are screened after donation by the Department of Defense (DoD) retrospective testing program. All recipients of blood collected in combat are tested according to policy soon after and at 3, 6, and 12 months after transfusion.

CASE REPORT: A 31-year-old US Army soldier tested positive for HTLV-I 44 days after receipt of emergency blood transfusions for severe improvised explosive device blast injuries. One donor's unit tested HTLV-I positive on the DoD-mandated retrospective testing. Both the donor and the recipient tested reactive with enzyme immunoassay and supplemental confirmation by HTLV-I Western blot. The donor and recipient reported no major risk factors for HTLV-I. Phylogenetic analysis of HTLV-I sequences indicated Cosmopolitan subtype, Subgroup B infections. Comparison of long terminal repeat and *env* sequences revealed molecular genetic linkage of the viruses from the donor and recipient.

CONCLUSION: This case is the first report of transfusion transmission of HTLV-I in the US military during combat operations. The emergency fresh whole blood policy enabled both the donor and the recipient to be notified of their HTLV-I infection. While difficult in combat, predonation screening of potential emergency blood donors with Food and Drug Administration–mandated infectious disease testing as stated by the DoD Health Affairs policy should be the goal of every facility engaged with emergency blood collection in theater.

Human T-lymphotropic virus Type I (HTLV-I) is an intracellular human RNA retrovirus that is associated primarily with adult T-cell leukemia in 2% to 5% and HTLV-I–associated myelopathy or tropical spastic paraparesis in 1% to 2% of infected carriers.[1-3] Six subtypes have been identified: a (Cosmopolitan)—Japan; b to f—Central Africa; c—Melanesia; and e—South and Central Africa.[4-9] Isolates from West African countries are almost identical to those from the French West Indies, Haiti, French Guyana, and Peru.[8] While the genetic variability of the HTLV-I proviral sequence is relatively low when compared to other viruses such as human immunodeficiency virus (HIV) and hepatitis C virus (HCV), epidemiologically linked infections

ABBREVIATIONS: ASBPO = Armed Services Blood Program Office; DoD = Department of Defense; FOB = forward operating base; IED = improvised explosive device; LTR = long terminal repeat; MTF(s) = military treatment facility(-ies).

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The views expressed are those of the authors and should not be construed to represent the positions of the US Department of Defense.

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TABLE 1. Countermeasures employed to reduce the risk of transfusion-transmitted viral infection from freshly collected blood products in the combat theater of operations

Countermeasure	HIV	HCV	HBV	HTLV-I/II
Periodic screening of the force	Every 2 years*			
Theater entrance screening	Within 120 days†			
Vaccination	NA*	NA*	Required‡	NA
Volunteer donor screening questionnaire	Yes	Yes	Yes	No§
Volunteer donor pools‖	Yes	Yes	Yes	Yes
Rapid test	Yes	Yes	Yes	NA

* Force screen policy 2001—current by service and component for active component; every 5 years for reserve component.
† Central Command (CENTCOM) theater entrance requirement for predeployment HIV testing within 120 days of deployment, as of December 2011 (MOD 11).
‡ Universal vaccination during initial entry training since 2001. Required to initiate vaccination prior to entry in to the CENTCOM combat theater of operations.
§ Not currently utilized; recommendation has been made to consider modification of the DoD donor screening questionnaire (DD572) and include questions pertaining to risk for HTLV-I/II infection.
‖ Volunteers at facilities with blood donation capacity are screened for HIV, HBV, HCV, HTLV-I/II, West Nile virus, and syphilis. Donors are admitted to the donor pool upon receipt of negative test results and rescreened every 90 days after readmission. At the time of donation, donated units are tested for HIV, HBV, and HCV with rapid diagnostic tests.

have been identified.[10-12] In HTLV-I–endemic areas such as southwestern Japan, the Caribbean, sub-Saharan Africa, South America, and parts of Iran, seroprevalence rates range from less than 5% to 10%.[13]Infection is lifelong with transmission of the virus primarily through breast milk, sexual contact, blood transfusion, or from sharing needles in intravenous drug use.

Reports of transfusion-transmitted HTLV-I in the United States have been infrequent with the last such report in 1989.[14] The United States initiated HTLV-I screening of blood donors in 1988[15] to prevent transmission of the virus from transfusion of blood products.[14,16] As a lifesaving measure when stored blood products have failed and when existing US Food and Drug Administration (FDA)-approved blood products have been exhausted or are unavailable, the US military uses freshly collected blood products during conflicts for combat casualty resuscitation.[17,18] Health Affairs policy guidelines for non–FDA-compliant emergency blood collection include, in order of preference, 1) blood donors screened for FDA-mandated transfusion-transmitted pathogens within 90 days by a Clinical Laboratory Improvement Amendments–certified laboratory; military treatment facilities (MTFs) and US Naval vessels conducting predonation screening are required to maintain up-to-date rosters of eligible blood donors; 2) donors who self-report to have been nondeferred repeat donors; and 3) donors who neither have been screened for FDA-mandated transfusion transmitted pathogens nor have a history of donation.[19] The US military utilizes several countermeasures to reduce the risk of transfusion-transmitted viral infections from battlefield transfusion of emergency blood products collected in the deployed setting. Any MTF in the combat theater of operations with blood donation capability may initiate a walking donor program, which includes screening volunteers for HIV, hepatitis B virus (HBV), HCV, HTLV, West Nile virus, and syphilis. MTFs send samples collected from volunteers to a commercial laboratory in the continental United States for testing. After being tested, volunteers who screened negative are eligible to donate for a period of 90 days and are retested at 90-day intervals and at each donation event. Other countermeasures include universal HBV immunization and, in accordance with Health Affairs policy, screening of blood products for HIV, HBV, and HCV with rapid diagnostic test devices at the time of collection from donors in emergency situations who have not been screened in the combat theater of operations (Table 1). We report here the results of an investigation conducted as a result of the Department of Defense (DoD) retrospective testing program of non–FDA-compliant fresh whole blood.

CASE REPORT

The recipient, a 31-year-old US Army soldier, received 13 units of fresh whole blood in Jalalabad, Afghanistan, on the day of his injury after an improvised explosive device (IED) blast (Table 2). The soldier had sustained multiple injuries to the head, chest, midsection, groin, and lower extremities requiring chest tubes, fasciotomies, and washouts. Before arrival at the forward operating base (FOB) he had received basic care in the field on the day of the blast (Day 0, Table 2). He was transferred to Bagram Airfield from the FOB for a laparoscopic splenectomy and follow-up care, which included more washouts, external fixation placements, and splinting for his groin and fracture injuries. He received 4 units of platelets (PLTs). He was evacuated subsequently to a military hospital in Germany on Day 3 where he remained for 2 days for stabilization due to his traumatic brain injury, which required bolts for subarachnoid injuries.

On Day 5 he was transferred by a Critical Care Air Transport Team to a tertiary care military hospital in Texas where he remained for approximately 3 months before

TABLE 2. Timeline of events and testing for a lookback investigation of a donated unit which tested positive for HTLV-I, Afghanistan, 2010

Donor	Day	Recipient
1 unit donated in theater	0	IED blast; field medical care; 13 units fresh whole blood transfused, FOB Fenty, Jalalabad, Afghanistan
	2	4 units PLTs, BAF, Bagram, Afghanistan
	3	Medical evacuation to Germany
	4	Germany
	5	Transfer to a military hospital in United States for definitive care
Donated unit tested HTLV+	12	
	15	Lookback Test 1 = HTLV-I indeterminate
Notified in theater of HTLV diagnosis	31	
	44	Lookback Test 2 = HTLV-I ; notification and counseling
	180	Lookback Test 3 = HTLV-I+
	234	Reposed sample collected 142 days before transfusion = HTLV–
Reposed sample collected 265 days before donation = HTLV+	279	
	293	Epidemiologic interview; sample collection for HTLV sequencing
Epidemiologic interview; sample collection for HTLV sequencing	309	

BAF = Bagram Airfield.

being released to the Veterans Administration health system for follow-up care. While in care at the military hospital in 2012, recurring fever and increasing white blood cell counts in the soldier 29 days into his admission led to an infectious disease work-up for malaria, brucellosis, cytomegalovirus, Epstein Barr virus, *Clostridium difficile*, and Q fever. These tests, along with routine evaluation for nosocomial and other trauma-related wound infections, were unrevealing. In the midst of his infectious disease work-up, his providers received notification that the soldier's posttransfusion surveillance sample, drawn 19 days after the IED blast as part of the DoD retrospective testing program, had tested HTLV-I indeterminate: rg46-1 and -2 reactive, p19 and GD21 nonreactive (Day 19, Table 3). The sample had tested negative for HIV, HBV, HCV, and other pathogens. Retrospective testing performed 44 days after transfusion (Quest Laboratories, Irving, TX) indicated that the recipient had seroconverted and was HTLV-I infected: rgp 46-1, p19, GD21 reactive (Day 44, Table 3).

The Armed Services Blood Program Office (ASBPO) initiated a lookback investigation for the donors of the recipient. Mandatory testing of donation aliquots shipped to the United States after fresh whole blood combat theater donations had revealed a blood unit, donated 12 days prior in Afghanistan (Day 0, Table 2), that was positive for HTLV but negative for HIV, HBV, HCV, and syphilis.[19,20] The other 12 of 13 fresh whole blood units the recipient had received at the FOB had tested negative for HTLV and other blood-borne pathogens.

The ASBPO initiated another investigation to determine the HTLV-I infection status of the recipient and donor before transfusion and donation, respectively. The method has been previously described.[21] Briefly, the recipient's pretransfusion and donor's predonation reposed sera, residual sample from mandatory HIV force

TABLE 3. Results for donor and recipient samples tested in the lookback investigation of an HTLV-I–positive donated unit in Afghanistan, 2010

	Days in relation to donation/transfusion					
	Donor		Recipient			
Assay	–265*	128	–142*	19	44	180
HTLV-I/II EIA	R	R	NR			R
Western blot†						
Band interpretation				Ind	P	
P19				NR	R	
P24				NR	R	
GP46				NR	NR	
P26				NR	R	
GD21				NR	R	
P28				NR	R	
P32				NR	R	
RG46-1				R	R	
RG46-2				R	NR	
P53				NR	NR	
P36				NR	R	
Line immunoassay						
Interpretation	P	P				P
Streptavidin	NR	NR				NR
P19 I/II	R	R				R
P24	R	R				R
GP46	R	R				R
GP21	R	R				R
P19	R	R				R
GP46 I	R	R				R
GP46 II	NR	NR				NR

* Predonation and pretransfusion testing for donor and recipient, respectively.
† Positive for HTLV-I if P19, GD21, and RG46-I are reactive; positive for HTLV-II if P24, GD21, and RG46-II are reactive; indeterminate if criteria for positivity are not met; negative if HTLV bands are not present.
Ind = indeterminate; NR = nonreactive; P = positive; R = reactive.

testing, were retrieved from the DoD Serum Repository and sent to Quest Laboratories for HTLV testing (Days –142 and –265, respectively; Table 3).[22] For the donor, both a predonation sample, drawn 265 days before donation, and a postdonation sample, drawn 128 days after donation, were HTLV enzyme immunoassay (EIA) reactive and HTLV line immunoassay positive. The recipient's pretransfusion sample, drawn 142 days previously, was HTLV EIA nonreactive (Table 3). Since all evidence pointed to a case of transfusion-transmitted HTLV-I infection, an epidemiologic investigation was launched.

An infectious disease clinician interviewed both the donor and the recipient for HTLV risk factors using a standardized case report form for transfusion-transmitted viral infections. The interview indicated that the recipient was white and US-born and had served 13 years in the US military at the time of his transfusion. At the time of the interview, he had no signs or symptoms of HTLV-I/II: skin lesions; numbness, stiffness, or weakness of the legs; difficulty walking; acute bronchitis; asthma; pneumonia; leukemia; arthritis; abscess; lymphadenopathy; bladder or kidney infection; and *Staphylococcus* or *Strongyloides* infections. There was no evidence of HTLV infection–related neurologic disease on physical examination. The only risk factors reported were blood transfusions received in theater reported here, ear piercings, and corrective surgeries as described above for injuries sustained in combat. The recipient revealed no history of: sexually transmitted diseases, sex with a commercial sex worker, or injection drug user; incarceration; residence in a group or halfway home; tattoos; rape; needlestick; blood splash to mucous membranes; organ, tissue, or marrow transplant; and sex or household contact with a person with hepatitis, HIV, or HTLV-I/II or a person who had received clotting factors. He recounted that he had traveled to Australia, France, and Germany.

The donor was a US-born 32-year-old white male from the Pacific Northwest region whose parents were white and not of mixed race. He was an Army Reservist who had been in service for 3 years at the time of his donation. He reported having no awareness of HTLV infection until he was informed of his donated unit's screening results (Table 2). At the time of his interview, he reported no signs or symptoms of his HTLV-I infection and revealed no risk factors other than acquiring a couple of tattoos at reputable facilities and having had surgery as a child. He indicated no history of blood transfusions and denied having sex or household contact with a person known to have HTLV-I/II infection and did not report having sex partners from HTLV-endemic regions of the world. His travel history included trips to Germany, Prague, Poland, Spain, and Amsterdam.

Molecular characterization of HTLV-I from both the donor and the recipient was initiated to determine whether HTLV-I infection in the recipient was transfusion

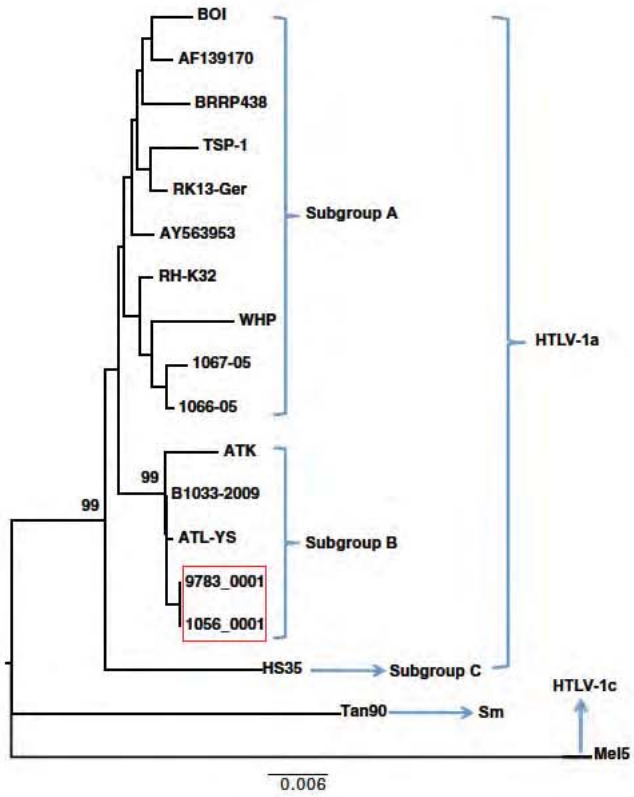

Fig. 1. A phylogenetic tree of HTLV-1 sequences from the donor (9783) and recipient (1056), as highlighted by the red box, and 16 HTLV-I subtype reference sequences was constructed by the maximum likelihood method using MEGA 5.05 software. The sequences were concatenated from 1353 nucleotides in envelope gene corresponding to ATK1 numbering Positions 5217 to 6569 and 433 nucleotides in LTR region corresponding to ATK1 numbering positions 8269 to 8700. The scale bar indicates the number of nucleotide substitutions per site estimated by general time reversible model with number of bootstrap replications at 1000.

transmitted. Blood samples provided at the time of interviews were sent to the US Military HIV Research Program for sequencing. DNA extracted from peripheral blood mononuclear cells was used for partial genome sequencing: 433 nucleotides of the long terminal repeat (LTR) region (ATK1 reference positions, 8269 to 8700) and 1353 nucleotides from the envelope (*env*) region (ATK1, 5217-6569). Phylogenetic analysis was performed using computer software (MEGA 5.05, http://www.megasoftware.net/). Due to the very low evolutionary rate of HTLV-1, a maximum likelihood approach with the number of nucleotide substitutions per site estimated by general time reversible model and number of bootstrap replications at 1000 was chosen for the analysis.

Maximum likelihood trees generated from LTR and *env* concatenated sequences (Fig. 1) showed that the virus sequences from the pair, 1056_001 (recipient) and

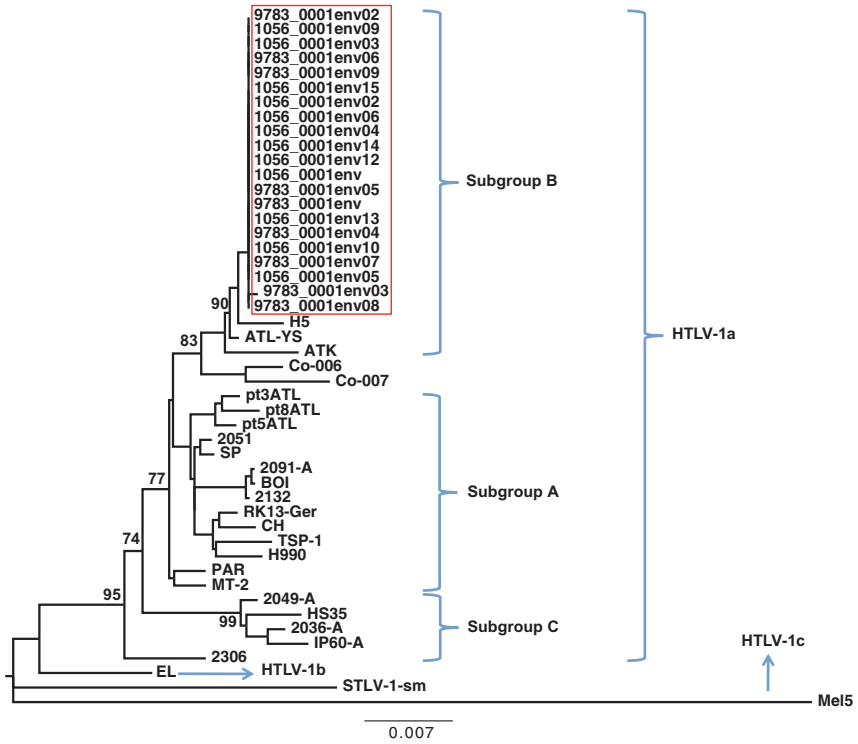

Fig. 2. A phylogenetic tree of HTLV-1 envelope genes corresponding to ATK Positions 5217 to 6569 was constructed by the maximum likelihood method using MEGA 5.05 software. There are 27 HTLV-1 subtype references and 21 envelope sequences from the donor (9783) and recipient (1056), as highlighted by the red box. The scale bar indicates the number of nucleotide substitutions per site estimated by general time reversible model with number of bootstrap replications at 1000.

9783_0001 (donor) clustered together with HTLV-I reference strains: Cosmopolitan subtype or Subtype a, Subgroup B (Japanese). To further confirm molecular genetic linkages between HTLV-I viruses from the donor and recipient, an independent polymerase chain reaction amplification reaction strategy was utilized. A DNA template at near endpoint dilution was used to generate an additional eight and 11 *env* gene sequences from the donor (9783) and recipient (1056), respectively. Comparison of these *env* sequences revealed nearly 100% sequence identity, except for a single-base pair (9783-0001*env*03) G-to-A transition. A maximum likelihood tree of the *env* sequences provided further evidence of a molecular genetic linkage between the viruses from these two individuals (Fig. 2).

DISCUSSION

We present a case report wherein evidence indicates that a service member was infected with HTLV-I after transfusion of non–FDA-licensed fresh whole blood. This transfusion-transmitted HTLV case is the first such report in the US military and a rarely reported occurrence in the United States; the last documented transmission in the United States occurred more than a decade ago but not since universal donor screening.[14,23] Transfusion-transmitted HTLV is strongly suggested for several reasons: 1) The recipient's pretransfusion reposed sample indicated no evidence of HTLV-I, whereas the donor's predonation reposed sample demonstrated HTLV-I infection; 2) the timing of the recipient's anti-HTLV status was consistent with a new infection: EIA positivity and indeterminate Western blot profile on Day 19 after transfusion, but full complement of HTLV-I bands by Day 44; 3) both the donor and the recipient were infected with HTLV-I Subtype a, Subgroup B; 4) viral sequences from the donor and recipient were nearly 100% homologous, indicating molecular genetic linkage; 5) the recipient had no major risk factors for HTLV-I; 6) clinical presentation of the recipient 29 days after transfusion fits the 30- to 90-day incubation period reported for HTLV before seroconversion.[24] The lookback investigation identified the donor who was unaware of his HTLV-I infection until notification of his test results in theater.

Prevention of transfusion transmission of HTLV in combat settings is challenging. While a voluntary HTLV screened donor pool is available near combat support hospitals and MTFs, in mass casualty scenarios, where prepositioned FDA-approved blood component supplies have been exhausted, or at smaller outposts, limited screening of emergency blood donors is possible. In the 2010 incident described herein, although 13 screened blood donors of

groups O and A were standing by at the FOB, the IED blast injuries necessitated additional donors since 54 fresh whole blood units were required for the ensuing mass casualties. Emergency donors are called from among volunteers who might be members of the receiving in-theater MTF, the recipient's military unit, or other civilian workers on the base and are referred to as the "walking blood bank." Theater infrastructure precludes donor screening with a FDA-approved screening assay and a Western blot investigational assay. Furthermore, a HTLV rapid kit has not been licensed for point-of-care use and questionnaires used in theater to screen emergency blood donors do not inquire about HTLV-I/II infection.

Since the issuance of the FDA guidance in November 1988 to screen blood donors for HTLV antibodies, transmission of HTLV-I/II has decreased in the United States.[25] A prevalence of 0.11 per 10,000 donations was found among first-time and repeat male US donors at the American Red Cross in 2009.[25] HTLV-I seroprevalence among US blood donors has been associated with older age, female sex, black race, birthplace outside the United States, and positive HCV serology.[26] US military blood donation centers in the continental United States, Hawaii, Germany, and Japan have routinely screened donors for HTLV-I/II since universal donor screening began in the United States (ASBPO). In 2011, of 91,656 donated units, 81 were repeat reactive by EIA of which 1 unit was confirmed positive by Western blot for a seroprevalence rate of 0.001% (0.11 per 10,000 units), which is consistent with that seen in US first-time donors (ASBPO). Donor screening and deferral in the US military for HTLV are based on FDA's 1997 guidance.[27] Donors repeatedly reactive for licensed HTLV screening tests are deferred from donation and placed under surveillance; in the combat theater, any donor testing HLTV positive on an initial screen is deferred indefinitely from theater donations. These donors are indefinitely deferred if repeatedly reactive a second time using screening assays. Although military health care providers may at their discretion request supplemental Western blot confirmatory testing for repeat-reactive donors, this information is not relayed systematically to the deployed environment. Screened donor pools at FOBs would be the best course of action to prevent future cases of transfusion-transmitted HTLV.

While the HTLV seroprevalence among blood donors in the US military and the general US population is low, and HTLV survival in stored red blood cells is limited,[16] the threat of transfusion transmission of HTLV-I/II among fresh whole blood recipients in the combat theater remains. Additionally, the seroprevalence of HTLV-I among US military personnel is unknown. Whereas modification of the predonation screening questionnaire administered to emergency blood donors to include questions regarding HTLV-I/II infection may be helpful, this would not have deferred donation in this instance. However, the utility of modifying the DoD donor screening questionnaire (DD572) to include questions pertaining to risk for HTLV-I/II infection should be considered. Since no licensed confirmatory assay is currently available for blood establishments, the use of HTLV Western blot assays should be employed to confirm any EIA HTLV reactive or repeat-reactive donor samples. Rapid detection of HTLV-I/II for emergency blood donations would be beneficial to prevent transfusion transmissions.

SEQUENCE DATA

Sequences described here were submitted to GenBank and are available under Accession Numbers JX984801-JX984802 and JX885208-JX885228.

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CONFLICT OF INTEREST

The authors declare that they have no conflicts of interest relevant to the manuscript submitted to **TRANSFUSION**.

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FRESH WHOLE BLOOD (FWB) TRANSFUSION

Original Release/Approval		Oct 2006	Note: This CPG requires an annual review.
Reviewed:	Oct 2012	Approved:	24 Oct 2012
Supersedes:	Fresh Whole Blood (FWB) Transfusion, updated 17 Jul 2012		
☐ Minor Changes (or)		☒ ***Changes are substantial and require a thorough reading of this CPG (or)***	
☐ Significant Changes			

1. **Goal.** Provide the rationale and guidelines for FWB transfusion, including but not limited to indications, collection, testing, transfusion, and documentation.

2. **Background.** Whole blood has been used extensively to resuscitate casualties in military conflicts since World War I. Its use in civilian settings is limited due to the wide availability of fractionated components derived from whole blood and provided for specific deficits (e.g., packed red blood cells (RBCs) for anemia, fresh frozen plasma (FFP) to replace lost/consumed clotting factors, apheresis platelets (PLTs) for thrombocytopenia, cryoprecipitate (Cryo) for hypofibrinoginemia.) However, in austere conditions, fractionated blood products may be in limited supply or unavailable. In these settings, FWB may be the only source of blood components available for the management of hemorrhagic shock and its associated coagulopathy in casualties. (Appendix A, Blood Donor Pre-Screening SOP).

   Massively transfused casualties (≥ 10 units RBCs in 24 hours) have a high mortality rate (33%) and have the greatest potential to benefit from appropriate transfusion strategies.[1] Large retrospective cohort studies of casualties requiring massive transfusions during Operations IRAQI FREEDOM (OIF) and ENDURING FREEDOM (OEF) demonstrate a significant survival benefit for the massively transfused casualty when RBCs, fresh frozen plasma, and platelets are transfused at a 1:1:1 ratio. Two retrospective analyses in combat casualties comparing FWB to component therapy (which included platelets) have been published. One study showed a potential survival benefit to the use of FWB during resuscitation of severe combat injuries, and the other showed FWB to be equivalent to component therapy.[2, 3]

   Advantages to FWB: FWB provides FFP:RBC:PLTs in a 1:1:1 ratio. For US casualties presenting in hemorrhagic shock, a transfusion strategy that included FWB with RBCs and plasma has an improved survival compared to the use of stored components only (FFP, RBCs, and PLTs). Additionally, FWB is available in austere conditions, has no loss of clotting factor or platelet activity that is often associated with cold storage, and has no red blood cell "storage lesion".

   Disadvantages to FWB: Since FWB has both RBCs and plasma, it must be ABO type-specific. There are risks associated with the use of FWB, including but not limited to increased risk of transfusion-transmitted infections (e.g., HIV, hepatitis B/C, syphilis), a period of decreased exercise tolerance in donors (who are often members in the casualty's unit), and an increased risk of clerical errors (e.g., ABO typing) due to the potentially chaotic activity during which FWB is requested. Additionally, field conditions are inherently unsanitary and are presumed to increase the risk of bacterial contamination of the blood. Recent history with approximately 10,000 FWB transfusions to U.S. personnel during

OIF/OEF have resulted in one Hepatitis C (HCV), one Human T-Lymphocyte Virus (HTLV) seroconversion, and one fatal case of transfusion-associated graft-versus host disease.[4]. Fresh WB is not FDA-approved and is not intended or indicated for routine use. **It is NOT appropriate, as a matter of convenience, to use FWB as an alternative to more stringently controlled blood products for patients who do not have severe, immediately life-threatening injuries. FWB is to be used only when other blood products are unable to be delivered at an acceptable rate to sustain the resuscitation of an actively bleeding patient, when specific stored components are not available (e.g., pRBCs, PLTs, Cryo, FFP), or when stored components are not adequately resuscitating a patient with an immediately life-threatening injury.**

3. **Recommendations**. The use of FWB should be reserved for casualties who are anticipated to require massive transfusion (10 or more units pRBCs in 24 hours), for those with ***clinically significant shock or coagulopathy (e.g. bleeding with associated metabolic acidosis, thrombocytopenia or INR>1.5) when optimal component therapy (e.g. apheresis platelets and FFP) are unavailable or stored component therapy is not adequately resuscitating a patient with immediately life-threatening injuries.***

   a. *Facilities where full component therapy is available:* Due to infectious concerns, the risk:benefit ratio does not justify the routine use of FWB over banked blood products in non life-threatening severe trauma. Conversely, when platelets and FFP inventories are depleted, or in contingencies such as mass casualty (MASCAL) situation where the blood inventory may be exhausted, the use of FWB remains an appropriate life-saving option.

   b. Surgical Facilities where component therapy is limited (e.g. no availability of apheresis platelets): Due to risks inherent with the use of FWB it should only be used for patients *with immediate life-threatening injuries.*

   c. *Facilities where full component therapy is not available:* FWB should only be used when there is a threat to loss of life, limb or eye-sight.

4. **Guidelines**. The decision to use FWB is a medical decision that must be made by a physician who has full knowledge of both the clinical situation and the availability of compatible blood components. A Walking Blood Bank (WBB) Program will be established based on a risk assessment and the potential for casualties. Coordination with the Area Joint Blood Program Officer (AJBPO) is required to establish a WBB Program. (Appendix A, Blood Donor Pre-screening SOP). FWB should be collection for transfusion as outlined in Appendix B, Emergency Whole Blood Drive SOP.

   a. In general, the use of FWB should be limited to casualties who are anticipated to require a massive transfusion when the physician determines that optimal component therapy is unavailable or in limited supply, or in patients that are not responding to stored component therapy.

   b. The decision to initiate a FWB drive should be made in consultation with the appropriate MTF medical authority (e.g., DCCS, Trauma Director) and Laboratory/Blood Bank OIC.

   c. Pre-screened donors registered into the WBB Program are preferably composed of active duty, active reserve, active National Guard, and other DoD beneficiaries. Coalition Forces will not be utilized routinely as donors, only by exception. Foreign Nationals should be used as a last resort.

d. Donor FWB must be an ABO type-specific match to the casualty. If not matched, a fatal hemolytic reaction may occur. **TYPE O whole blood is NOT universal.**

e. **The decision to use FWB that has not been completely screened for infectious agents is a medical decision that must be made after thorough consideration of risks and benefits. Decision-making should be adequately documented in the casualty record**.

f. Prior to issuing FWB for transfusion, the ABO and Rh type should be verified and approved rapid infection disease tests (e.g., HIV, HCV, and HBV) should be performed as outlined in Appendix B, Emergency Whole Blood Drive SOP to the greatest extent possible.

g. Theater Medical Data Stores (TMDS), Blood Portal, shall be utilized to record FWB donations and infectious disease testing results.

5. Precautions. Transfusion of FWB in the field may be dangerous for several reasons:

a. There is no universally compatible FWB type. Transfusions of FWB must be an ABO match. For female casualties of child-bearing potential, there must also be an Rh match. Service members' blood types are not always known with certainty. The blood type on identification tags is occasionally incorrect (last correlated data equated to about 4%) and must not be relied upon routinely to determine blood type for either donors or recipients. **Identification tags for ABO/Rh verification should be utilized as a last resort only.**

b. Because it is not subject to the same infectious disease testing and strict quality controls as banked blood, FWB does not meet FDA standards and has an increased risk of transfusion-transmitted infections (e.g., HIV, hepatitis B/C, syphilis).

c. In MASCAL situations, particularly when more than one blood type is being collected, there is an increased risk of a clerical error leading to a life-threatening transfusion reaction.

d. Field conditions are inherently unsanitary and increase the risk of bacterial contamination of the blood.

e. Use of non-standard blood donation material and equipment may lead to coagulation during the collection process potentially causing an adversely transfusion reaction; therefore, only authorized equipment will be utilized (Appendix B enclosure 6, WBB Supply List (with NSNs)).

6. Planning. Since the need for FWB cannot be predicted, a robust contingency operational plan should be developed by the MTF staff to include the Laboratory/Blood Bank and surgical and anesthesia providers in coordination with the Area Joint Blood Program Officer. The plan should be reviewed and rehearsed regularly.

The key elements for planning and readiness to administer FWB are knowledge and rehearsal of two SOPs: Appendix A, Blood Donor Pre-Screening SOP and Appendix B, Emergency Whole Blood Drive SOP.

a. A contingency plan should be developed for collecting, storing, and transfusing FWB in MASCAL situations or when it may be deemed the current blood inventory will be exhausted prior to re-supply (e.g., when multiple type-O trauma casualties are exhausting the type-O RBC inventory).

b. The physical donation site should be organized in such a way as to maintain the integrity of the screening and donation process, and to minimize the possibility of clerical errors. This is especially important in emergency situations involving more than one casualty.

c. Every effort should be made to adhere to the same screening, drawing, labeling, and issuing standards required for U.S. FDA-approved blood products.

d. Pre-screened donors in the WBB Program determined to be suitable should be utilized before using personnel who: (1) are not fully suitable; (2) do not have a current screening and infectious disease testing history; (3) have no donation history, to the greatest extent possible.

e. Upon determining the ABO/Rh status of the casualty, activate the WBB Program re-calling pre-screened donors with the exact same ABO/Rh using the TMDS>Manage Donor>View Donor List, if available, or other communication networks.

f. Before any FWB is transfused, rapid infectious disease testing (i.e., HIV, HBV, HCV) of donor specimens shall be performed, to the greatest extent possible.

g. Retrospective samples must be sent to a state-side laboratory for FDA-approved testing, regardless whether the rapid infectious disease testing is performed pre- or post-transfusion, as these tests are not licensed for donor testing.

h. Upon the notification of confirmed positive infectious disease results, a medical provider or preventive medicine personnel should be notified to ensure the donor is notified and counseled.

i. If a patient receives a confirmed positive infectious disease unit, the AJBPO will notify the Armed Services Blood Program immediately to initiate patient notification and a respective evaluation of both the donor and patient.

j. In accordance with HA Policy 10-002, *Policy on the Use of Non-U.S. Food and Drug Administration*, recipients of FWB shall receive follow-up infectious disease testing as soon as possible, 3-, 6-, and 12-months post-transfusion.

k. A contingency plan should be developed for collecting, storing, and transfusing FWB in MASCAL situations or when it may be deemed the current blood inventory will be exhausted prior to re-supply (e.g., when multiple type-O trauma casualties are exhausting the type-O RBC inventory).

l. **Procedure**. See Appendix B for DD Form 572–Emergency Whole Blood Donation Record.

7. Performance Improvement (PI) Monitoring.

a. Intent (Expected Outcomes).

FWB is reserved for casualties who are anticipated to require massive transfusion (10 or more units of RBCs in 24 hours), for those with clinically significant shock or coagulopathy (e.g., bleeding with associated metabolic acidosis, thrombocytopenia or INR >1.5) when optimal component therapy (e.g., PLTs and FFP) are unavailable or stored component therapy is not adequately resuscitating a patient with immediately life-threatening injuries.

b. Performance/Adherence Measures.

1) FWB was used for casualties who were anticipated to require massive transfusion (10 or more units of RBCs in 24 hours), for those with clinically significant shock or coagulopathy (e.g., bleeding with associated metabolic acidosis, thrombocytopenia or INR >1.5) when optimal component therapy (e.g., PLTs and FFP) was unavailable or stored component therapy was not adequately resuscitating the patient with immediately life-threatening injuries.

c. Data Source

1) Patient Record

2) Joint Theater Trauma Registry (JTTR)

3) Blood transfusion databases

d. System Reporting & Frequency.

The above constitutes the minimum criteria for PI monitoring of this CPG. System reporting will be performed annually; additional PI monitoring and system reporting may be performed as needed.

The system review and data analysis will be performed by the Joint Theater Trauma System (JTTS) Director, JTTS Program Manager, and the Joint Trauma System (JTS) Performance Improvement Branch.

8. Responsibilities. It is the trauma team leader's responsibility to ensure familiarity, appropriate compliance and PI monitoring at the local level with this CPG.

9. References:

[1] Repine TB, Perkins JG, Kauvar DS, Blackborne L. The use of fresh whole blood in massive transfusion. *J Trauma.* 2006;60:S59-S69.

[2] Spinella PC, Perkins JG, Grathwohl JG, Beekley AC, Holcomb JG. Warm fresh whole blood is independently associated with improved survival for patients with combat-related traumatic injuries. *J Trauma.* 2009;66:S69-S76.

[3] Perkins JG, Cap AP, Spinella PC, Shorr AF, Beekley AC, Grathwohl KW, Rentas FJ, Wade CE, Holcomb JB; 31st Combat Support Hospital Research Group. Comparison of platelet transfusion as fresh whole blood versus apheresis platelets for massively transfused combat trauma patients (CME). *Transfusion*. 2011 Feb;51(2):242-52.

[4] Gilstad C, Roschewski M, Wells J, Delmas A, Lackey J, Uribe P, Popa C, Jardeleza T, Roop S. Fatal transfusion-associated graft-versus-host disease with concomitant immune hemolysis in a group A combat trauma patient resuscitated with group O fresh whole blood. *Transfusion*. 2012 May;52(5):930-5.

[5] CENTCOM FRAGO 09-1222: *Joint Theater Blood Program Update*: 4 May 2007.

[6] *Emergency War Surgery*, 2004, Third US Revision, Chap 7: Shock and Resuscitation.

[7] Theater MTF-specific Standard Operating Procedures (SOPs).

[8] *Technical Manual*, AABB, Bethesda Maryland, 16th Edition, 2008.

[9] *Standards for Blood Banks & Transfusion Services*, AABB, 25th Ed, February 2008.

[10] Theater Medical Data Stores (TMDS), Blood Portal, Standard Operating Procedures (http://militaryblood.dod.mil/Staff/eMOAS.aspx).

Approved by CENTCOM JTTS Director, JTS Director and CENTCOM SG

Opinions, interpretations, conclusions, and recommendations are those of the authors and are not necessarily endorsed by the Services or DoD.

APPENDIX A
Blood Donor Pre-Screening SOP

Materials and Equipment	Use the following materials and equipment as applicable. • Modified DD Form 572s • Clip Boards • Gloves • Testing Collection Set: premade bags with 2x2 gauze, 2 gold tops (SST), 2 pearl tops (PPT), 1 purple top tube (more tubes may be required if using short draw or small volume tubes) • Blood Collection Needles • BD Vacutainer Hubs • Coban • Assigned Pre Screen ISBT Labels (500 number series) • Sharps Containers • ABO/Rh Testing Card (e.g., Eldon Military Kit or other FDA-approved device) • Centrifuge • Disposable Pipettes • Plastic Aliquot tubes/lids 13X100mm (or 12X75mm) • Para-Film • Biohazard Bags • Trash Bags • Leak Resistant Chucks • Disposable Lab Coats • Cold Packs • Test Tube Racks
Records/Forms	• Modified **DD FORM 572**, Form 147, Form 148 (See Enclosures—Blood Donor Pre-Screening SOP.) • Theater Medial Data Store (TMDS), Blood Portal
Quality Control	Perform QC on ABO/Rh Testing Card (See instrument package inserts for procedures). Medical personnel should be trained by BSD or other qualified personnel.
Procedure	**Pre-screening of a prospective emergency whole blood donor pool is mandatory. Development of a pre-screened donor pool should be considered a commander's priority when a level II or III facility is established or replaced. It is imperative that a donor pool once established is maintained because of the frequent redeployment of units out of theatre. Due diligence in establishing a pre-screened whole blood donor pool will decrease the risk of transmitting infectious disease while simultaneously increasing the efficiency of the whole blood collection process.** Perform the following steps when Pre-screening Donors:
	Prepare for Donor Pre-Screening Event
	1. Coordinate with appropriate units/contacts for times and location of event. May need to conduct a site survey to ensure appropriate site, i.e., space, lighting, privacy for interview, etc. Samples need to be sent to the blood support detachment as soon as possible after collection, so prior coordination with transport assets is a must.

Blood Donor Pre-Screening SOP

	Conducting the Pre-Screening Event		
	1.	**Medical History**-Provide prospective donor a Modified DD Form 572 – ensure demographic info is legible and as complete as possible.	
	2.	**Interview**-Trained medical personnel will need to determine if the donor is eligible to donate based on the information collected –Donor eligibility requirements. can found on the Blood Portal at: http://rceast.afghan.swa.army.mil/sites/tfmeda/	
		If	**Then**
		There are all '**N**'o responses except for questions 22-24	Proceed to Step 3.
		There are any '**Y**'es responses except for questions 22-24	Document the reason for the 'Y'es response. Refer donor to a qualified provider (i.e., MD, DO, NP or PA) to determine the donor's eligibility. Defer the donor as required, if necessary document "Ineligible" status on **DD FORM 572** and in TMDS.
		NOTE: For Q: 39, use State Tattoo and Permanent Make-up Reference List. See Tattoo and Make-up Reference List to screen for acceptability.	
	3.	Using the Direct Oral Questions, ask the donor Group A, B, and C questions. Record name of interviewer on DD Form 572. See Enclosures—Blood Donor Pre-Screening SOP.	
		If	**Then**
		The donor answers '**N**'o to each group	Proceed to Step 4.
		The donor answers '**Y**'es to any group	Defer donor for designated period of time and stop the donation process. Document donor as "Ineligible".
	4	**Phlebotomy**- Collect 1 Purple Top, 2 Pearl Top (PPT), 2 Gold Top (SST) and label with small **Pre-Screen** (500 number series) ISBT labels (***without*** barcodes). Apply the same ISBT label number to the DD Form 572.	
	Register Donor in TMDS per Manage Donations/Donors SOP . See steps below.		
	Rapid Infectious Disease Testing. If performed, see Emergency Whole Blood Collection SOP for instructions**.**		
	Perform ABO/Rh Testing		
	1.	Utilizing blood from purple top tube, perform ABO/Rh confirmation using Eldon Card or other FDA-approved method to verify ABO listed on **DD FORM 572**. (Refer to package inserts and approved SOPs for further instructions).	
	2.	Record Lot # of reagents, EXP Date and Results on Form 147.	
	3.	Record blood type in TMDS.	
	See Enclosures—Blood Donor Pre-Screening SOP.		

Blood Donor Pre-Screening SOP

	Processing Samples for Shipment & Testing	
	1.	Centrifuge Gold Top and Pearl Top Tubes for 5 minutes at 4000 RPM.
	2.	Label aliquot (pour off) tubes with corresponding ISBT Labels ***with small*** **barcodes**. Position the ISBT label vertically toward top of tube as shown at left. **If ISBT labels are not available utilize the Donor SSN as the unit number.** 
	3.	Pour 1 Pearl Top into 1 aliquot tube and mark as **Plasma**. Repeat for each Pearl Top tube. ***3ml sample requirement per aliquot.**
	4.	Pour contents of 2 Gold Top tubes into 1 aliquot tube and mark as **Serum**. * Do not fill over ¾ full to allow for expansion from freezing
	5.	The seal of capped aliquot tubes should be reinforced with para-film wrap and placed into a biohazard shipping bag or rack. If a rack is not used, rubber-band tubes from the same donor together. Repeat for each series.
	6.	Record sample and donor demographic data on Form 148 (Shipping Manifest). Include a printed copy of manifest with shipment and e-mail to BSD or designated facility, if possible.
	7.	Maintain the (pre-screening) **DD FORM 572**s at your site until the potential donor redeploys. As soon as possible ship samples, and Form 148 in a blood box (Collins Blood Box) with ice bag(s) to your respective blood detachment. E-mail a copy of manifest to BSD or designated facility, if possible, or call to alert incoming shipment. **For Afghanistan**: Blood Support Detachment TF MED/Bagram Airfield APO AE 09354 (BAF) 431-5446/5536 Blood Support Detachment Kandahar Air Field APO AE 09355 (KAF) 421-6171 **For other deployed units**. Freeze samples until they can be shipped to a designated laboratory to perform FDA-approved testing.
	8.	The BSD or unit will send all samples for FDA-approved testing to designated laboratory for FDA-approved testing. Enter results in TMDS and forward to submitting Level II or Level III upon completion. **NOTE: The prospective donor is NOT considered pre-screened and fully qualified for FWB donation until negative or non-reactive testing results are received from a testing facility.**
	9.	Any positive testing that is received by BSD or unit will be forwarded to Preventive Medicine Consultant to ensure proper donor care and follow-up is initiated. At no time will laboratory staff notify donors directly regarding positive testing results.

Blood Donor Pre-Screening SOP

	Maintain Database (TMDS)	
	1.	Transfer demographic information from the **DD FORM 572** and Form 147 to Donor Management Database in TMDS. This will act as a deferral list or an eligible donor list when a whole blood drive is necessary. It is recommended that a hard copy of Donor Database and deferral list be printed monthly (or at some regular interval) for use during Emergency Whole Blood Collection when computer assets are unavailable. **Information in database should be kept confidential.**
	2.	To enter demographic data into TMDS, go to the **Manage Donation** tab and select **Donate Product**. Enter the Donor SSN, first name, last name in appropriate fields and click **NEXT**.
	3.	In product code field, enter **E9999V00** (pre-screen). In the expiration date field, enter date 90 days from today and click **Add Product**.
	4.	Verify donation ID, product code, ABO/Rh and expiration date are correct, then click **NEXT**.
	5.	Carefully Re-verify all demographic data that populates on the screen, then click **Confirm Donation**. Prospective donor is now entered in TMDS.
	6.	From **Manage Donation** tab, select **Update Donation.** Enter donation ID number and click **NEXT.**
	7.	Enter ABO/Rh test result and date tested from Form 147 under Rapid Testing Results. In "Samples sent to" field, select BSD or unit from pull down menu and enter date samples were sent out from your facility. Now click **Update Tests**.
	8.	To Register another donor, select **Donate Product** under **Manage Donation** tab and repeat process above.
	9.	Once pre-screen donations have been created utilizing the process above, a re-deployment date must be entered to ensure the active donor list will auto-update upon donor's exodus from theater. To accomplish this, select Manage Donor from beneath Manage Donor tab. Enter donor SSN and click Next. Select re-deployment date from the calendar tool in the "Update Re-deployment Date" field and click Update Donor. Once the displayed entry is confirmed to be correct, click Confirm Update. TMDS will now remove donor from active donor list on the re-deployment date that was entered.
	10.	BSD will populate FDA results and forward to submitting facility. Donor alerts will also be activated by BSD or unit, as necessary. This data once populated, will be the basis by which potential donors will be deemed fully qualified for Fresh Whole Blood (FWB) donations, should the need for a Walking Blood Bank (WBB) arise at your facility.
	NOTES: Investing time and care into building a donor pool will make performing whole blood drives easier and safer when the time comes. Your donor pool does not need to be enormous. 50 people covering most of the blood types (O, A, B) is ideal for most locations. **!!!REMEMBER WHOLE BLOOD MUST BE TRANSFUSED TYPE SPECIFIC!!!**	
References	[1] AABB *Technical Manual*, current edition [2] AABB *Standards for Blood Banks and Transfusion Services* [3] JTTS Clinical Practice Guideline: Fresh Whole Blood (FWB) Transfusion [4] Theater Medical Data Store (TMDS) Version 2.7.0.0 System User's Manual	

Blood Donor Pre-Screening SOP

Enclosures	DD Form 572-Emergency Whole Blood Donation Record Approved State Tattoo and Permanent and Make-up Reference List Direct Oral Questions Form 147–Eldon Card ABO/Rh Typing Record Form 148–Pre-Screen/Whole Blood Sample Shipping Manifest

DD FORM 572—EMERGENCY WHOLE BLOOD DONATION RECORD

Please circle as appropriate:
WHOLE BLOOD DONATION
PRE-SCREEN

EMERGENCY WHOLE BLOOD DONATION RECORD
(Modified Version of the DD Form 572)

Blood Unit Number
Use Donor SSN if ISBT # Not Available

MTF/Location: _____ Donation Date: _____

Donor's Full Name: _____ Rank: _____ Branch: USA USAF USN USMC CIV

SSN: _____ Date of Birth (DDMMMYYYY): _____ Sex: M / F Ht/Wt: _____ (> 110 lbs) ABO/Rh (Blood Type) :_____

Deployed Unit/Location: _____ Local DSN Phone: _____ Local Cell/ Evening Phone_____
Redeployment Date: _____
Current Residence: Bldg/Tent # _____ RM # _____
Home Address (Stateside) _____
Home Phone Number: (____) _____ Email: _____

Y 21. N	Female Donors: Are you pregnant now, or have you been Pregnant in the last 6 weeks?	Y 36. N	Have you ever had Chagas' disease, babesiosis, or Leishmaniasis?
Y 22. N	Are you feeling well and healthy today?	Y 37. N	In the past 12 months, have you been given a rabies shot?
Y 23. N	Have you read and do you understand all the donor information presented to you, and have all your questions been answered?	Y 38. N	In the past 12 months, have you had an accidental needle stick or come in contact with someone else's blood?
Y 24. N	Do you understand that if you are in a high risk group, you may have the AIDS virus and you can give it to someone else even though you may feel well and have a negative AIDS test?	Y 39. N	In the past 12 months, have you had a tattoo, ear or skin piercing, or acupuncture?
Y 25. N	Have you ever given blood under another name or Social Security Number?	Y 40. N	In the past 12 months, have you had close contact with a person with yellow jaundice or hepatitis or been given Hepatitis B Immune Globulin (HBIG)?
Y 26. N	In the past 8 weeks have you given blood, plasma or platelets?	Y 41. N	Have you ever had yellow jaundice, liver disease, hepatitis, or a positive test for hepatitis?
Y 27. N	Have you ever been refused as a blood donor or told not to donate blood?	Y 42. N	In the past 4 weeks, have you had any shots or vaccinations?
Y 28. N	In the past 12 months have you been under a doctor's care, had an illness, or surgery?	Y 43. N	In the past 8 weeks, have you received a smallpox vaccination or had close contact with the vaccination site of anyone else?
Y 29. N	In the past 12 months, have you received blood, blood products, or a tissue transplant including any you may have donated for yourself (autologous)?	Y 44. N	In the past month, have you taken Finasteride (Proscar, Propecia) or Isotretinoin (Accutane, Amnesteem, Claravis, Sotret) or in the past 6 months, have you taken Dutasteride (Avodart)
Y 30. N	In the past 3 years, have you had malaria?		
Y 31. N	In the past month, have you taken any pills or medications?		
Y 32. N	Have you ever been given growth hormone or received a dura mater (or brain covering) graft?		
Y 33. N	Have you ever taken Etretinate (Tegison) or Acitretin (Soriatane)?		
Y 34. N	Have you ever had cancer, a blood disease, or a bleeding problem?		
Y 35. N	Have you ever had chest pain, heart disease, or lung disease?		

(Use this section and reverse side of form to explain "Yes" answers above. With the exception of questions 22-24)

High Risk Oral Questions (10 Jan 2010) Asked By: _____ Donor: Temp: _____°F/°C (< 99.6°F/37.5°C) BP: _____/_____ (≤ 180/100) Pulse: _____ (< 100 bpm) HCT/Hgb: _____ (> 38% or 12.5 g/dL)

31. Medications: _____

Malaria Prophylaxis: Daily_____(Doxycycline) Weekly_____(Mefloquin) N/A _____

Your blood will **NOT** be tested for viral diseases prior to transfusion due to the emergency, if you any reason you feel your blood may not be safe or you could answer yes to the high risk questions, please do not donate today. I have read/ had explained to me the high risk questions and am not in a high risk category, and feel my blood is safe to donate at this time.

I verify that I have answered the questions honestly, and feel my blood is safe to be transfused. _____
Donor's Signature

Phlebotomist:_____ Start Time:_____ Stop Time:_____ (Should be < 15 minutes)
Bag Manufacturer _____Lot #:_____ Expiration date: _____ Segment Number: _____

The Modified DD Form 572 has been reviewed for completeness. If there are any risk factors that place the recipient at harm notify the ordering physician immediately for appropriate follow-up.

DD 572 (WB)
Version: 13 May 2010

APPROVED STATE TATTOO AND PERMANENT AND MAKE-UP REFERENCE LIST

Armed Services Blood Program
State Tattoo and Permanent Make-Up Reference List

NOTICE: The Department of Defense (DOD) assumes no risk for the use of this information by non-DoD personnel, blood programs, or individual medical institutions. The use of this information by DoD personnel is strictly for blood donor operations and must adhere to the current Service (Army, Navy and Air Force) specific Standard Operating Procedure dealing with the screening of blood donors.

NOTE: The following criteria provided by AABB Reference Standard 5.4.1A, Requirements for Allogeneic Donor Qualification, were used to determine acceptability of each state: (a) application by a state-regulated entity, (b) mandated use of sterile needles, (c) one-time use ink required.

If the state is acceptable, defer the donor for one week to ensure the site has properly healed. Although the state of application may be acceptable, prospective donors should be asked if the procedure was performed using sterile needles and single-use dye. If the donor answers no, or does not know, he/she should be deferred for 12 months. Prospective donors who had a procedure performed in a state listed as "No" must be deferred for 12 months from the time of application.

Armed Services Blood Program

State	Acceptable	Note
Alabama	YES	
Alaska	YES	
Arizona	YES	
Arkansas	YES	
California	NO	
Colorado	YES	
Connecticut	NO	
Delaware	YES	
District of Columbia	NO	
Florida	NO	

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Armed Services Blood Program

State	Acceptable	Note
Georgia	NO	
Hawaii	YES	
Idaho	NO	
Illinois	YES	
Indiana	YES	
Iowa	YES	
Kansas	YES	
Kentucky	YES	
Louisiana	YES	
Maine	YES	
Maryland	NO	
Massachusetts	NO	
Michigan	NO	
Minnesota	NO	
Mississippi	YES	
Missouri	YES	
Montana	YES	
Nebraska	YES	
Nevada	NO	
New Hampshire	NO	
New Jersey	YES	

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Armed Services Blood Program

State	Acceptable	Note
New Mexico	NO	
New York	NO	
North Carolina	YES	
North Dakota	NO	
Ohio	YES	
Oklahoma	NO	
Oregon	YES	
Pennsylvania	NO	
Rhode Island	YES	
South Carolina	YES	
South Dakota	YES	
Tennessee	YES	
Texas	YES	
Utah	NO	
Vermont	YES	
Virginia	YES	
Washington	YES	
West Virginia	YES	
Wisconsin	YES	
Wyoming	NO	

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DIRECT ORAL QUESTIONS

Preamble	I am required to ask you some questions. If you do not understand a question, please ask me to explain it before answering. The reason for asking these questions is to determine your suitability as a volunteer blood donor. Your answers to these questions will be kept strictly confidential, but may result in you being asked not to donate blood, either temporarily or permanently. Do not respond until I have asked you the entire group of questions, which at that time only give me one answer – Yes or No.	
Group A	1. Do you have AIDS or have you ever had a positive test for the AIDS virus (HIV)? 2. Have you ever taken illegal drugs with a needle, even one time (including steroids)? 3. Have you ever taken clotting factor concentrates for a bleeding disorder such as hemophilia? 4. At any time since 1977, have you taken money or drugs in exchange for sex? 5. ***Male donors only***: Have you had sex with another male, even one time since 1977? **A "Yes" answer to Group A is a PERMANENT DEFERRAL**	
Group B	1. Were you born in, have you lived in, or traveled to any African country since 1977?	
	If response is	**Then**
	No	Proceed to Group B, Question 3
	Yes	Was it any of these countries: Cameroon, Benin, Central African Republic, Chad, Congo, Equatorial Guinea, Kenya, Gabon, Niger, Nigeria, Senegal, Togo or Zambia?
	If No	Go to Group B, Question 3
	If Yes – Travel Only	Proceed to Group B Question 2
	If Yes – Born or Lived in	**Document when, DEFER INDEFINITELY**
	2. When you traveled to (name of country) did you receive a blood transfusion, or any other medical treatment with a product made from blood?	
	If response is	**Then**
	No	Proceed to Group B, Question 3
	Yes	**DEFER INDEFINITELY**
	3. Have you had sex with anyone who was born in, or has lived in any African Country since 1977?	
	If response is	**Then**
	No	Proceed to Group C
	Yes	Was it any of these countries: Cameroon, Benin, Central African Republic, Chad, Congo, Equatorial Guinea, Kenya, Gabon, Niger, Nigeria, Senegal, Togo or Zambia?
	If No to listed countries	Proceed to Group C
	Yes to listed countries	**Document when, DEFER INDEFINITELY**

Group C	1. Have you had sex in the last 12 months, even once, with anyone who has AIDS or has had a positive test for the AIDS virus? 2. Have you had sex in the last 12 months, even once, with anyone who has ever taken illegal drugs with a needle (including steroids)? 3. Have you had sex in the last 12 months, even once, with anyone who has taken clotting factor concentrates for a bleeding disorder such as hemophilia? 4. At any time in the last 12 months have you given money or drugs to someone to have sex with you? 5. At any time in the last 12 months, have you had sex with someone who has taken money or drugs in exchange for sex? 6. In the past 12 months, have you had a positive test for syphilis? 7. In the last 12 months have you had syphilis or gonorrhea or have you been treated for syphilis or gonorrhea? 8. In the last 12 months, have you received blood or blood products? 9. In the last 12 months, have you been incarcerated in a correctional institution (including jail or prison) for more than 72 consecutive hours? 10. In the last 12 months, have you taken (snorted) cocaine through your nose? 11. Female donors only: In the past 12 months, have you had sex with a man who had sex with another man, even one time since 1977? **A "Yes" answer to Group C is a TEMPORARY DEFERRAL for 12 months following the event**
Group D	1. Have you at any time since 1980 injected Bovine (Beef) Insulin? **A "Yes" answer to Group D is an INDEFINITE DEFERRAL**

FORM 147–ELDON CARD ABO/RH TYPING RECORD

Eldon Card ABO/Rh Typing

Date of Testing:__________.

	Eldon Card ABO/Rh Typing					
	Lot #					
	Exp:					
Assigned Unit #	Anti-A	Anti-B	Anti-D	Rh Control	Interpretation	Tech Initials
	+ =	+ =	+ =	+ =		
	+ =	+ =	+ =	+ =		
	+ =	+ =	+ =	+ =		
	+ =	+ =	+ =	+ =		
	+ =	+ =	+ =	+ =		
	+ =	+ =	+ =	+ =		
	+ =	+ =	+ =	+ =		
	+ =	+ =	+ =	+ =		
	+ =	+ =	+ =	+ =		
	+ =	+ =	+ =	+ =		
	+ =	+ =	+ =	+ =		
	+ =	+ =	+ =	+ =		
	+ =	+ =	+ =	+ =		
	+ =	+ =	+ =	+ =		
	+ =	+ =	+ =	+ =		
	+ =	+ =	+ =	+ =		
	+ =	+ =	+ =	+ =		
	+ =	+ =	+ =	+ =		
	+ =	+ =	+ =	+ =		
	+ =	+ =	+ =	+ =		
	+ =	+ =	+ =	+ =		
	+ =	+ =	+ =	+ =		
	+ =	+ =	+ =	+ =		
	+ =	+ =	+ =	+ =		
	+ =	+ =	+ =	+ =		
	+ =	+ =	+ =	+ =		
	+ =	+ =	+ =	+ =		
	+ =	+ =	+ =	+ =		
	+ =	+ =	+ =	+ =		
	+ =	+ =	+ =	+ =		
	+ =	+ =	+ =	+ =		

Form 147
V: 28 June 2010

Technical Review: __________ Date: __________
QA/QC Review: __________ Date: __________

Form 148–Pre-Screen/Whole Blood Sample Shipping Manifest

Prescreen/Whole Blood Sample Shipping Manifest

Blood Unit Number					Donor Name								
Facility ID (W0138)	YR	Unit Id #	ABO RH	Donation Date	Last	First	Branch of Service	Nationality	SSN or ID #	DOB	FOB/Base	Unit	Donation Type (PS or FWB)

rm 148

APPENDIX B
EMERGENCY WHOLE BLOOD COLLECTION SOP

Materials and Equipment	Use the following materials and equipment as applicable: • Vitals Machine • Blood Collection Beds • Stethoscope • Blood Pressure cuff • Digital Thermometer and/or Tempadots • Lancets • STAT Site M* (*or other POCT Hemaglobinometer) • STAT Site M test cards* • STAT Site M controls* • Coban • Alcohol Pads • Electronic table top scale (optional) • Blood Bags (Terumo- Single Blood Bags, preferred) **NOTE: If an additive solution (AS) bag is present with a multiple bag set-up, the AS SHALL NOT be added to the whole blood.** • Blood Trip Scale with 585±2g trip counter-weight and QC weights or HemoFlow. • Testing Collection Set: premade bags with sterile 4x4 gauze, Frepp Sepp, 2 gold tops (SST), 2 pearl tops (PPT), 1 purple top tubes, and tube collection device. • ChloraPrep, Iodine alternative • Adapter MS DIR 100S Luer 100S • ABO/Rh Testing Card (e.g., Eldon Military Kit or other FDA-approved device) • Rapid HIV, Malaria, HBsAg, and HCV test kits • Serological RPR kit • Clinical Rotator • Centrifuge • Disposable Pipettes • Adhesive Tape • Hemostats • Scissors • Strippers • Metal Clips • Gloves • Tourniquet • Biohazard Container/ Sharps Container • Whole Blood ISBT Labels (100 number series)
Records/Forms	Forms required: modified **DD FORM 572**, Form 145A, Form 147, Form 148, Form 150A, Form 150B, Form 151 and SF 518 (as applicable.) See Enclosures-Emergency Whole Blood Collection SOP. Theater Medical Data Store (TMDS), Blood Portal.

EMERGENCY WHOLE BLOOD COLLECTION SOP

Quality Control	Perform QC on STAT Site M (or equivalent POCT Hemaglobinometer) Perform QC on ABO/Rh Testing Card, RPR, HCV, HBsAg, HIV, and Malaria Kits (See instrument package inserts and local SOPs for procedures.) Medical personnel should be trained by BSD or other qualified personnel.	
Procedure	Perform the following steps when the physician request whole blood units:	
	Permission to conduct the blood drive	
	1.	Notify Level II/III Commander, DCCS and Laboratory OIC/NCOIC that a physician is requesting whole blood for transfusion.
	2.	Once the Commander/DCCS grants permission, initiate the emergency whole blood collection. Trained medical personnel should oversee the process.
	Donor Recruitment	
	1.	!!!REMEMBER WHOLE BLOOD MUST BE TRANSFUSED TYPE SPECIFIC!!! Announce the whole blood drive. -First, donors should be recruited from the pre-screened donor pool, who's infectious disease testing results are negative or non-reactive. -If insufficient pre-screened donors are available, determine acceptability based on prospective donors: (1) are not fully suitable; (2) do not have a current screening and infectious disease testing history; (3) have no donation history.
	2.	Pull a pre screened donor list from TMDS: **Manage Donor>View Donor List**.
	3.	Select filters for ABO/Rh of the potential whole blood recipient, Screened (select **ALL**), Alert (select **ALL),** Cocom (select **CENTCOM**). Highlight your facility in the Available Facilities tab and click **Add**. Once your facility appears in the Search Facility box, click **Display Donor List**. The potential donor list for the blood type required will now appear on the screen.
	Donor and Testing Area Preparation	
	1.	Set up blood donor beds.
	2.	Perform QC on weighing device, (i.e., HemoFlow or Trip Scale). **NOTE:** If no trip scale is available, see section below Whole Blood Collection, Step 6.
	3.	Ensure counterweight is set at **585**g One milliliter of blood equals 1.053g 450 mL of Whole Blood equals 474g The final container must weigh 425g to 520g (405 to 495 ml) plus the weight of the primary blood bag with its anticoagulant. The target weight for a 450mL bag is 585g. • Under fill is less than 555g total weight • Over fill is greater than 650g total weight
	4.	Perform QC on the STAT Site M*, ABO/Rh Cards, HIV, HCV, HBsAg, Malaria, and RPR Kits.
	5.	Ensure the necessary equipment to perform donor screening, testing and collection are available. (See WBB Supply List (with NSNs)).

EMERGENCY WHOLE BLOOD COLLECTION SOP

	Perform Donor Screening		
	1.	**To the greatest extent possible, potential whole blood donors should be selected from among the pre-tested and qualified population documented in TMDS. This is the best practice to mitigate the risk of Transfusion Transmitted Disease (TTD) to the recipient.**	
	2.	Give donor Emergency Donation Record (Modified DD Form 572) and instruct donor to complete demographic information and to answer questionnaire by circling '**Y**'es or '**N**'o. If donor already has a pre-completed DD Form 572 on file, have them review the form and verify information is correct and update as necessary. While donor is completing **DD FORM 572**, screen for donor alerts and completed FDA test results in TMDS (deferrals).	
	3.	Locate donor's name on the Donor List displayed in TMDS. To the left of their name, click **View**. If all TTD results are Negative (within last 90 days) and there are no Donor Alerts, then the Donor is deemed fully **Pre- Screened/Tested.** To minimize risk to the recipient, it is recommended that pre-tested population be exhausted prior to resorting to collections from the untested population.	
	4.	A qualified interviewer will review Modified DD Form 572 for completeness and Donor Suitability Criteria following Steps 5-11 below (See attached Enclosures).using standards available for reference and download through Blood Portal at http://rceast.afghan.swa.army.mil/sites/tfmeda/ or at http://www militaryblood.dod mil/.	
	5.	**If**	**Then**
		There are all '**N**'o responses except for questions 22-24	Proceed to Step 6.
		There are any '**Y**'es responses except for questions 22-24	Document the reason for the 'Y'es response. Refer donor to a qualified provider to determine the donor's eligibility. Defer the donor as required, if necessary document "Ineligible" status on **DD FORM 572** and in TMDS.
		NOTE: For Q: 39, use State Tattoo and Permanent Make-up. Reference List (See Enclosure.) to screen for acceptability.	
	6.	Using the Direct Oral Questions (See Enclosure), ask the donor Group A, B, and C questions. Record name of interviewer on Modified DD Form 572.	
		If	**Then**
		The donor answers '**N**'o to each group.	Proceed to Step 7.
		The donor answers '**Y**'es to any group.	Defer donor for designated period of time and stop the donation process. Document donor as "Ineligible".

EMERGENCY WHOLE BLOOD COLLECTION SOP

	7.	Perform and record temperature on Modified DD Form 572. (See DD Form 572– Emergency Whole Blood Donation Record.)	
		If	**Then**
		≤99.5 ºF or 37.5 ºC	Proceed to Step 8.
		>99.5 ºF or 37.5 ºC	Stop the donation process. The donor is "Ineligible" at this time.
	8.	Perform and record measurements of donor pulse and blood pressure.	
		If	**Then**
		BP ≤ 180/100 and Pulse is ≤ 100 bpm	Proceed to Step 9.
		BP >180/100 and Pulse is > 100 bpm	Stop the donation process. The donor is "Ineligible" at this time.
	9.	For female donors, perform and record hematocrit/hemoglobin results on Modified DD Form 572, if possible. Male donors do not require hematocrit/hemoglobin testing.	
		If	**Then**
		≥38% or 12.5 g/dL	Proceed to Step 10.
		<38% or 12.5 g/dL	Defer donor and stop the donation process. The donor is "Ineligible" at this time.
	10.	Donor is physiologically acceptable to donate, have the donor sign the Modified DD Form 572 and proceed to Step 11.	
	11.	A competent medical authority should review the Modified DD Form 572 to determine the eligibility of the donor.	
		If	**Then**
		Acceptable	Donor is "Eligible". Proceed to Step 12.
		Unacceptable	Donor is "Ineligible". Stop donation process and document deferral as appropriate in TMDS.
	12.	Issue blood bag and test collection set to donor. Label bag and **DD FORM 572** with Whole Blood ISBT labels. Blood collection tubes (2 gold tops (SST), 2 pearl tops (PPT), 1 purple top tube) should be labeled with the corresponding small ISBT labels (without barcode). See Illustration to the left. If no labels are available, bags and all samples should be labeled with donor's full name and SSN or Blood Bag Segment Number.	

EMERGENCY WHOLE BLOOD COLLECTION SOP

	Whole Blood Collection	
	1.	Seat donor in blood donor table or reclining chair. Ask the donor their name and verify donor demographic information is correct on the Modified DD Form 572. Verify also that the labels the blood bag, sample tubes, and Modified DD Form 572 correctly correspond to each other and the donor. **NOTE:** If a discrepancy is noted, STOP and correct before proceeding further.
	2.	Ask donor if they are allergic to iodine or shellfish.
		If / **Then** Yes / Skip Step 3 and proceed to Step 4. No / Proceed to Step 3.
	3.	Utilizing Frepp-Sepp, apply Povidone Iodine (Frepp), 2% Aqueous Solution. Scrub vigorously for at least 30 seconds. Within a 3" diameter area around venipuncture site. Then Apply 10% Iodine (Sepp) to venipuncture site starting at the center and moving outward in concentric circles at least 1½ inches in all directions
	4.	For donors allergic to iodine follow the same procedure outlined above, but substitute a chlorohexidene scrub (ChloraPrep). **NOTE:** If a disinfectant is not available, clean the site with alcohol or other solution, if possible.
	5.	Allow area to dry.
	6.	Set-up trip scale (Manual or Electronic). Perform quality control, if possible, to obtain a counter-weight of 585 grams. **NOTE:** If no trip scale is available, the Terumo Single Blood Bag can be filled with whole blood to the mark pictured below. It is however recommended that weight then be checked with table top scale (if available)  The target weight for 450 mL is 585 grams. **Do not use if overfilled as blood clots may develop from an incorrect ratio of whole blood to anti-coagulant causing potential harm to the patient.**
	7.	Using a hemostat, clamp tubing between the needle and the main bag. This will prevent air contamination of blood after the needle cover is removed. Place tape within reach for anchoring the needle during phlebotomy. **NOTE:** Place a loose knot in the tubing approximately 6 inches from the needle **prior** to uncapping needle, if metal seal clips and hand crimpers are not available.
	8.	Apply tourniquet with enough pressure. If using a blood pressure cuff adjust to approximately 40-60 mm Hg.
	9.	Twist off the needle cover and inspect the needle for barbs or other defects.
	10.	Pull the skin taut below the venipuncture site.
	11.	With the bevel up, hold the needle at the hub, at approximately a 30-45 degree angle and pierce the skin with a smooth, quick thrust at the selected point of entry.

EMERGENCY WHOLE BLOOD COLLECTION SOP

<table>
<tr><td></td><td>12.</td><td colspan="2">When the bevel is completely under the skin, lower the angle of the needle to approximately 10º or less and, with a steady push, advance needle to penetrate the vein wall. Thread needle approximately ½ inch inside the vein to maintain a secure position and to lessen the chance of a clot forming.</td></tr>
<tr><td></td><td>13.</td><td colspan="2">Release the hemostat clamp on the collection bag tubing and observe the blood flow through the tubing and into the collection bag.</td></tr>
<tr><td></td><td></td><td>If blood flow</td><td>Then</td></tr>
<tr><td></td><td></td><td>Is impeded</td><td>Try adjusting the needle with least discomfort without hurting the donor.</td></tr>
<tr><td></td><td></td><td>Is still impeded</td><td>Seek assistance from another phlebotomist before discontinuing the phlebotomy.</td></tr>
<tr><td></td><td>14.</td><td colspan="2">Fill sample tubes using the tube adaptor. After filling sample tubes, gently rock tubes to mix contents and verify once again that donation identification number on tubes corresponds to donation identification number on the collection bag and the DD FORM 572.</td></tr>
<tr><td></td><td>15.</td><td colspan="2">Instruct donor to relax their grip and to rhythmically squeeze every 5 to 10 seconds, relaxing between squeezes.</td></tr>
<tr><td></td><td>16.</td><td colspan="2">Secure the needle to the donor’s arm with tape, across the hub or on the tubing near the hub of the needle. This will optimize the positioning of the needle to prevent rotation of the needle or drag on the tubing, which may impede blood flow. An additional piece of tape may be placed across the tubing lower on the arm.</td></tr>
<tr><td></td><td>17.</td><td colspan="2">Partially reduce the pressure by loosening the tourniquet or blood pressure cuff to approximately 20-40 mm Hg. Mix blood bag several times during the collection to prevent clotting.</td></tr>
<tr><td></td><td>18.</td><td colspan="2">Cover the phlebotomy site with sterile gauze dressing, to keep the site clean and needle out of view. Lift the gauze occasionally to monitor for a hematoma.</td></tr>
<tr><td></td><td>19.</td><td colspan="2">If a hematoma is evident, remove tourniquet and needle from donor’s arm and place sterile gauze square over the hematoma and apply firm digital pressure while donor’s arm is held above the heart level.</td></tr>
<tr><td></td><td>20.</td><td colspan="2">Record the following in the appropriate blocks on the DD Form 572:
Time phlebotomy was started
Initials of the phlebotomist</td></tr>
<tr><td></td><td>21.</td><td colspan="2">Watch for the signal of a filled unit by monitoring for the completion indicator of the weighing device or visual reference point (see step 6), if not using a weighing device. Record stop time on the DD FORM 572.</td></tr>
<tr><td></td><td>22.</td><td colspan="2">Seal the tubing 1 to 2 inches below the “Y” segment of the tubing using a metal seal slip and a hand crimper (or pulling tight the loose knot in the tubing).</td></tr>
<tr><td></td><td>23.</td><td colspan="2">Grasp the tubing on the donor side of the seal and press to remove a portion of blood in the tubing. Crimp the tubing at this spot. Cut the tubing between the two seals.</td></tr>
<tr><td></td><td>24.</td><td colspan="2">Remove tourniquet or blood pressure cuff and tape strips from donor’s arm.</td></tr>
<tr><td></td><td>25.</td><td colspan="2">Place the fingers of one hand gently over the sterile gauze. DO NOT APPLY PRESSURE OVER THE NEEDLE. With the other hand, smoothly and quickly withdraw the needle. Apply firm pressure to the phlebotomy site.</td></tr>
</table>

EMERGENCY WHOLE BLOOD COLLECTION SOP

	26.	Instruct donor to apply firm pressure over the gauze. Encourage donor to maintain a relaxed elevated position, rather than tensing the muscle. This precaution will minimize the bleeding into the venipuncture area.
	27.	Discard the needle assembly into a sharps container.
	28.	Using a hand stripper/crimper, strip all blood from the tubing into the primary collection bag. This should be done ASAP after collection. (Stripping is pushing the blood in the tubing into the blood filled bag with the rollers on the stripper/crimper device)
	29.	Mix contents in the primary collection bag. DO NOT strip the tubing and allow tubing to refill without mixing. Release the stripper and allow the anti-coagulated blood to reenter the tubing. Perform this procedure three times.
	Processing Donor Units	
	1.	Take donor unit and donor sample tubes (2 gold tops (SST), 2 pearl tops (PPT), and 1 purple top tubes) to processing area.
	2.	Strip donor units segment tubing three times and mix, so as to avoid the development of clots.
	3.	Perform ABO, Rh type utilizing ABO/Rh Testing Card and purple top tube. Record results on Form 147.
	4.	Write the donor blood type **on the bag** (ABO/Rh Testing Card) along with date, time and phlebotomist initials of collection.
	5.	Write the expiration of the unit, which is 24 hours from collection if stored in a refrigerator (1 to 6 degrees Celsius) or 8 hours from collection if stored at room temperature (20 to 24 degrees Celsius).
	6.	Create product in TMDS while Rapid Testing is being performed. **NOTE: Rapid tests should be performed and found to be negative prior to transfusion, to the greatest extent possible. In situations requiring whole blood, available blood component inventory should continue to be transfused in lieu of whole blood until rapid testing has been performed and found to be negative.**
	Creating Whole Blood Units in TMDS	
	1.	From Manage Donation tab, select **Donate Product**.
	2.	Enter SSN of donor and click **Next**.
	3.	Verify demographic information for donor is correct, enter donation date and Donation ID number (from bar code label) and click **Add Products**.
	4.	Enter product code **E0009V00** for whole blood.
	5.	Enter expiration date (24 hours from collection if stored in a refrigerator (1 to 6 degrees Celsius) or 8 hours from collection if stored at room temperature (20 to 24 degrees Celsius).
	6.	Click **Add Product.**
	7.	Verify Donation ID/ ABO/Rh and expiration date then click **Next**.
	8.	Re-verify all demographic and unit data then click **Confirm Donation.**
	9.	Repeat steps 1-8 for each product collected.

EMERGENCY WHOLE BLOOD COLLECTION SOP

	Pre-Transfusion Rapid Testing	
	1.	**Rapid tests should be performed and found to be negative prior to transfusion, to the greatest extent possible. In situations requiring whole blood, available blood component inventory should continue to be transfused in lieu of whole blood until rapid testing has been performed and found to be negative.**
	2.	Spin down gold and pearl top tubes.
	3.	Perform rapid HBsAg, HCV, RPR using Serum/Plasma, and HIV, Malaria using whole blood. Testing should be performed IAW Test Kit package inserts and local SOP. Record reagent Name, Lot #, Exp Date, and Results on Form 145a.
	4.	Upon completion of rapid tests with negative results, whole blood unit may be issued for transfusion.
	5.	When time allows, rapid test results need to be entered into TMDS. To do this click on **Update Donation** under the Manage Donation tab.
	Issuing &Managing Whole Blood Inventory	
	1.	It is recommended that some sort of blood product issue document (ex., SF 518) be utilized to account for the issue of Whole Blood from the laboratory. WBB operations are at times chaotic and do not often allow for real-time updates of TMDS.
	2.	Provider requesting Fresh Whole Blood should sign Emergency Release Letter of understanding Form 150a or 150b as appropriate. Forms should be maintained in patient transfusion records.
	3.	Accurate dispositions of all Whole Blood units collected **MUST** be properly dispositioned in TMDS**.** Every unit must be created, transfused, expired or destroyed as appropriate.
	4.	**Fresh Whole Blood should be destroyed 24-hours post collection**. FWB can be stored at room temperature for 8-hours, and refrigerated thereafter.
	Processing Samples for Shipment & Testing	
	1.	Label aliquot (pour off) tubes with corresponding ISBT Labels ***with small*** **barcodes**. Position the ISBT label vertically toward top of tube as shown at left. **If ISBT labels are not available utilize the Donor SSN as the unit number.**
	2.	Pour 1 Pearl Top into 1 aliquot tube and mark as **Plasma**. Repeat for each Pearl Top tube. *3ml sample requirement per aliquot.
	3.	Pour contents of 2 Gold Top tubes into 1 aliquot tube and mark as **Serum**. * Do not fill over ¾ full to allow for expansion from freezing.
	4.	The seal of capped aliquot tubes should be reinforced with para-film wrap and placed into a biohazard shipping bag or rack. Repeat for each series.
	5.	Record sample and donor demographic data on Form 148 (Shipping Manifest). Include a printed copy of manifest with shipment and e-mail to BSD or designated facility, if possible.
	6.	Form 151- Whole Blood Transfusion Checklist must be submitted with shipment for **every unit of whole blood transfused.**
	7.	Copies of **DD FORM 572** and for all units of whole blood collected **MUST** be forwarded to BSD or designated facility with specimens and Form 145a.

EMERGENCY WHOLE BLOOD COLLECTION SOP

	8.	As soon as possible ship samples, Form 145a, Form 148, Form 151 and all **DD FORM 572**s in a blood box (Collins Blood Box) with ice bag(s) to your respective blood detachment. E-mail a copy of manifest to BSD or designated facility, if possible, or call to alert of incoming shipment. For Afghanistan: Blood Support Detachment TF MED/Bagram Airfield APO AE 09354 (BAF) 431-5446/5536 Blood Support Detachment Kandahar Air Field APO AE 09355 (KAF) 421-6171 Or **For other deployed units**, freeze samples until they can be shipped to a designated laboratory to perform FDA-approved testing.
	9.	The BSD or unit will send all samples for FDA approved testing in the rear enter results in TMDS and forward to submitting Role II or Role III upon completion. **NOTE: This results of this testing will be viewed as pre-screen for donors next donation.**
	10.	Any positive testing that is received will be forwarded to Preventive Medicine Consultant to ensure proper donor care and follow-up is initiated. At no time will laboratory staff notify donors directly regarding positive testing results.
References	AABB *Technical Manual*, current edition AABB *Standards for Blood Banks and Transfusion Services* JTTS Clinical Practice Guideline: Fresh Whole Blood (FWB) Transfusion Theater Medical Data Store (TMDS) Version 2.7.0.0 System User's Manual	
Enclosures	DD Form 572–Emergency Whole Blood Donation Record Direct Oral Questions Approved State Tattoo and Permanent Make-up List Acceptable Donor Worksheet Form 145A–Rapid Testing Worksheet Form 147–Eldon Card ABO/Rh Typing Record Form 148–Pre-Screen/Whole Blood Sample Shipping Manifest Form 150A–Emergency Release Letter of Understanding (tested) Form 150B–Emergency Release Letter of Understanding (un-tested) Form 151–Whole Blood Transfusion Checklist WBB Supply List (with NSNs)	

DD FORM 572–EMERGENCY WHOLE BLOOD DONATION RECORD

Please circle as appropriate:
WHOLE BLOOD DONATION
PRE-SCREEN

EMERGENCY WHOLE BLOOD DONATION RECORD
(Modified Version of the DD Form 572)

Blood Unit Number
Use Donor SSN if ISBT # Not Available

MTF/Location: _____ Donation Date: _____

Donor's Full Name: _____ Rank: _____ Branch: USA USAF USN USMC CIV

SSN: _____ Date of Birth (DDMMMYYYY): _____ Sex: M / F Ht/Wt: _____ (> 110 lbs) ABO/Rh (Blood Type) :_____

Deployed Unit/Location: _____ Local DSN Phone: _____ Local Cell/ Evening Phone_____

Redeployment Date: _____

Current Residence: Bldg/Tent # _____ RM # _____

Home Address (Stateside) _____

Home Phone Number: (_____) _____ Email: _____

Y	21. N	Female Donors: Are you pregnant now, or have you been Pregnant in the last 6 weeks?	Y	36. N	Have you ever had Chagas' disease, babesiosis, or Leishmaniasis?
Y	22. N	Are you feeling well and healthy today?	Y	37. N	In the past 12 months, have you been given a rabies shot?
Y	23. N	Have you read and do you understand all the donor information presented to you, and have all your questions been answered?	Y	38. N	In the past 12 months, have you had an accidental needle stick or come in contact with someone else's blood?
Y	24. N	Do you understand that if you are in a high risk group, you may have the AIDS virus and you can give it to someone else even though you may feel well and have a negative AIDS test?	Y	39. N	In the past 12 months, have you had a tattoo, ear or skin piercing, or acupuncture?
Y	25. N	Have you ever given blood under another name or Social Security Number?	Y	40. N	In the past 12 months, have you had close contact with a person with yellow jaundice or hepatitis or been given Hepatitis B Immune Globulin (HBIG)?
Y	26. N	In the past 8 weeks have you given blood, plasma or platelets?	Y	41. N	Have you ever had yellow jaundice, liver disease, hepatitis, or a positive test for hepatitis?
Y	27. N	Have you ever been refused as a blood donor or told not to donate blood?	Y	42. N	In the past 4 weeks, have you had any shots or vaccinations?
Y	28. N	In the past 12 months have you been under a doctor's care, had an illness, or surgery?	Y	43. N	In the past 8 weeks, have you received a smallpox vaccination or had close contact with the vaccination site of anyone else?
Y	29. N	In the past 12 months, have you received blood, blood products, or a tissue transplant including any you may have donated for yourself (autologous)?	Y	44. N	In the past month, have you taken Finasteride (Proscar, Propecia) or Isotretinoin (Accutane, Amnesteem, Claravis, Sotret) or in the past 6 months, have you taken Dutasteride (Avodart)
Y	30. N	In the past 3 years, have you had malaria?			
Y	31. N	In the past month, have you taken any pills or medications?			
Y	32. N	Have you ever been given growth hormone or received a dura mater (or brain covering) graft?			
Y	33. N	Have you ever taken Etretinate (Tegison) or Acitretin (Soriatane)?			
Y	34. N	Have you ever had cancer, a blood disease, or a bleeding problem?			
Y	35. N	Have you ever had chest pain, heart disease, or lung disease?			

(Use this section and reverse side of form to explain "Yes" answers above. With the exception of questions 22-24)

High Risk Oral Questions (10 Jan 2010) Asked By: _____ Donor: Temp: _____°F/°C (< 99.6°F/37.5°C) BP: _____/_____ (≤ 180/100) Pulse: _____ (< 100 bpm) HCT/Hgb: _____ (> 38% or 12.5 g/dL)

31. Medications: _____

Malaria Prophylaxis: Daily_____(Doxycycline) Weekly_____(Mefloquin) N/A _____

Your blood <u>will **NOT** be tested</u> for viral diseases prior to transfusion due to the emergency, if you any reason you feel your blood may not be safe or you could answer yes to the high risk questions, please do not donate today. I have read/ had explained to me the high risk questions and am not in a high risk category, and feel my blood is safe to donate at this time.

I verify that I have answered the questions honestly, and feel my blood is safe to be transfused. _____
Donor's Signature

Phlebotomist:_____ Start Time:_____ Stop Time:_____ (Should be < 15 minutes)

Bag Manufacturer _____Lot #:_____ Expiration date: _____ Segment Number: _____

The Modified DD Form 572 has been reviewed for completeness. If there are any risk factors that place the recipient at harm notify the ordering physician immediately for appropriate follow-up.

DD 572 (WB)
Version: 13 May 2010

DIRECT ORAL QUESTIONS

<table>
<tr><td>Preamble</td><td colspan="2">I am required to ask you some questions. If you do not understand a question, please ask me to explain it before answering. The reason for asking these questions is to determine your suitability as a volunteer blood donor. Your answers to these questions will be kept strictly confidential, but may result in you being asked not to donate blood, either temporarily or permanently. Do not respond until I have asked you the entire group of questions, which at that time only give me one answer – Yes or No.</td></tr>
<tr><td>Group A</td><td colspan="2">1. Do you have AIDS or have you ever had a positive test for the AIDS virus (HIV)?
2. Have you ever taken illegal drugs with a needle, even one time (including steroids)?
3. Have you ever taken clotting factor concentrates for a bleeding disorder such as hemophilia?
4. At any time since 1977, have you taken money or drugs in exchange for sex?
5. Male donors only: Have you had sex with another male, even one time since 1977?
A “Yes” answer to Group A is a PERMANENT DEFERRAL</td></tr>
<tr><td rowspan="11">Group B</td><td colspan="2">1. Were you born in, have you lived in, or traveled to any African country since 1977?</td></tr>
<tr><td>If response is</td><td>Then</td></tr>
<tr><td>No</td><td>Proceed to Group B, Question 3</td></tr>
<tr><td>Yes</td><td>Was it any of these countries: Cameroon, Benin, Central African Republic, Chad, Congo, Equatorial Guinea, Kenya, Gabon, Niger, Nigeria, Senegal, Togo or Zambia?</td></tr>
<tr><td>If No</td><td>Go to Group B, Question 3</td></tr>
<tr><td>If Yes – Travel Only</td><td>Proceed to Group B Question 2</td></tr>
<tr><td>If Yes – Born or Lived in</td><td>Document when, DEFER INDEFINITELY</td></tr>
<tr><td colspan="2">2. When you traveled to (name of country) did you receive a blood transfusion, or any other medical treatment with a product made from blood?</td></tr>
<tr><td>If response is</td><td>Then</td></tr>
<tr><td>No</td><td>Proceed to Group B, Question 3</td></tr>
<tr><td>Yes</td><td>DEFER INDEFINITELY</td></tr>
<tr><td colspan="2">3. Have you had sex with anyone who was born in, or has lived in any African Country since 1977?</td></tr>
<tr><td>If response is</td><td>Then</td></tr>
<tr><td>No</td><td>Proceed to Group C</td></tr>
<tr><td>Yes</td><td>Was it any of these countries: Cameroon, Benin, Central African Republic, Chad, Congo, Equatorial Guinea, Kenya, Gabon, Niger, Nigeria, Senegal, Togo or Zambia?</td></tr>
<tr><td>If No to listed countries</td><td>Proceed to Group C</td></tr>
<tr><td>Yes to listed countries</td><td>Document when, DEFER INDEFINITELY</td></tr>
</table>

Group C	1. Have you had sex in the last 12 months, even once, with anyone who has AIDS or has had a positive test for the AIDS virus? 2. Have you had sex in the last 12 months, even once, with anyone who has ever taken illegal drugs with a needle (including steroids)? 3. Have you had sex in the last 12 months, even once, with anyone who has taken clotting factor concentrates for a bleeding disorder such as hemophilia? 4. At any time in the last 12 months have you given money or drugs to someone to have sex with you? 5. At any time in the last 12 months, have you had sex with someone who has taken money or drugs in exchange for sex? 6. In the past 12 months, have you had a positive test for syphilis? 7. In the last 12 months have you had syphilis or gonorrhea or have you been treated for syphilis or gonorrhea? 8. In the last 12 months, have you received blood or blood products? 9. In the last 12 months, have you been incarcerated in a correctional institution (including jail or prison) for more than 72 consecutive hours? 10. In the last 12 months, have you taken (snorted) cocaine through your nose? 11. Female donors only: In the past 12 months, have you had sex with a man who had sex with another man, even one time since 1977? **A "Yes" answer to Group C is a TEMPORARY DEFERRAL for 12 months following the event**
Group D	1. Have you at any time since 1980 injected Bovine (Beef) Insulin? **A "Yes" answer to Group D is an INDEFINITE DEFERRAL**

APPROVED STATE TATTOO AND PERMANENT MAKE-UP LIST

Armed Services Blood Program
State Tattoo and Permanent Make-Up Reference List

NOTICE: The Department of Defense (DOD) assumes no risk for the use of this information by non-DoD personnel, blood programs, or individual medical institutions. The use of this information by DoD personnel is strictly for blood donor operations and must adhere to the current Service (Army, Navy and Air Force) specific Standard Operating Procedure dealing with the screening of blood donors.

NOTE: The following criteria provided by AABB Reference Standard 5.4.1A, Requirements for Allogeneic Donor Qualification, were used to determine acceptability of each state: (a) application by a state-regulated entity, (b) mandated use of sterile needles, (c) one-time use ink required.

If the state is acceptable, defer the donor for one week to ensure the site has properly healed. Although the state of application may be acceptable, prospective donors should be asked if the procedure was performed using sterile needles and single-use dye. If the donor answers no, or does not know, he/she should be deferred for 12 months. Prospective donors who had a procedure performed in a state listed as "No" must be deferred for 12 months from the time of application.

Armed Services Blood Program

State	Acceptable	Note
Alabama	YES	
Alaska	YES	
Arizona	YES	
Arkansas	YES	
California	NO	
Colorado	YES	
Connecticut	NO	
Delaware	YES	
District of Columbia	NO	
Florida	NO	

Revised Date: 14-Mar-12 BPL 12-01 BPL Date: 14-Mar-12 Page 1 of 3

Armed Services Blood Program

State	Acceptable	Note
Georgia	NO	
Hawaii	YES	
Idaho	NO	
Illinois	YES	
Indiana	YES	
Iowa	YES	
Kansas	YES	
Kentucky	YES	
Louisiana	YES	
Maine	YES	
Maryland	NO	
Massachusetts	NO	
Michigan	NO	
Minnesota	NO	
Mississippi	YES	
Missouri	YES	
Montana	YES	
Nebraska	YES	
Nevada	NO	
New Hampshire	NO	
New Jersey	YES	

Revised Date: 14-Mar-12 BPL 12-01 BPL Date: 14-Mar-12 Page 2 of 3

Armed Services Blood Program

State	Acceptable	Note
New Mexico	NO	
New York	NO	
North Carolina	YES	
North Dakota	NO	
Ohio	YES	
Oklahoma	NO	
Oregon	YES	
Pennsylvania	NO	
Rhode Island	YES	
South Carolina	YES	
South Dakota	YES	
Tennessee	YES	
Texas	YES	
Utah	NO	
Vermont	YES	
Virginia	YES	
Washington	YES	
West Virginia	YES	
Wisconsin	YES	
Wyoming	NO	

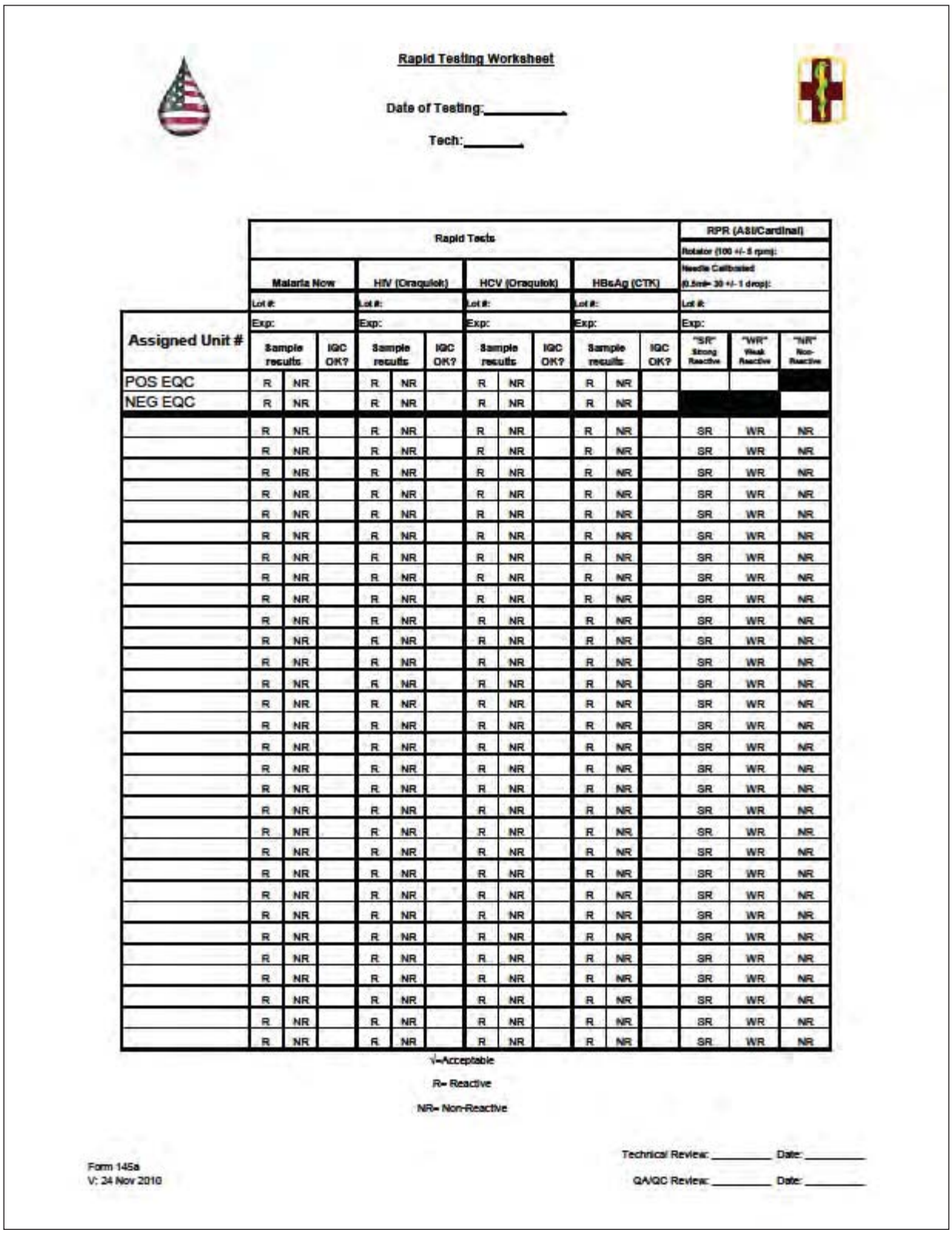
Revised Date: 14-Mar-12 BPL 12-01 BPL Date: 14-Mar-12 Page 3 of 3

ACCEPTABLE DONOR WORKSHEET

Document all results on **DD FORM 572**

Donor Weight	≥ 110 lbs
Donor Weight	≥ 110 lbs
Blood Pressure	≤ 180/100
Pulse	50-100 bpm (may be < 50 if donor is athletic)
Temperature	≤ 99.6°F
Hemoglobin	≥ 12.5 g/dL
Hematocrit	≥ 38 %
Medications	Do not collect from donors currently on antibiotics, to exclude anti-malarial prophylaxis. Donors taking medications that the competent medical authority deems may cause harm to the recipient must be deferred from donating. Be advised: If the purpose of the whole blood drive is derive a source of platelets for a patient then donors who have taken aspirin in the last 72 hours should be deferred.
Medical Conditions	Any donors with an underlying medical condition that could put them at risk if they were to donate should be deferred from donating i.e., heart and/or lung conditions.

FORM 145A–RAPID TESTING WORKSHEET



Rapid Testing Worksheet

Date of Testing:__________

Tech:_______

	Rapid Tests												RPR (ASI/Cardinal)		
													Rotator (100 +/- 5 rpm):		
	Malaria Now			HIV (Oraquick)			HCV (Oraquick)			HBsAg (CTK)			Needle Calibrated (0.5ml= 30 +/- 1 drop):		
	Lot #:			Lot #:			Lot #:			Lot #:			Lot #:		
	Exp:			Exp:			Exp:			Exp:			Exp:		
Assigned Unit #	Sample results		IQC OK?	Sample results		IQC OK?	Sample results		IQC OK?	Sample results		IQC OK?	"SR" Strong Reactive	"WR" Weak Reactive	"NR" Non-Reactive
POS EQC	R	NR		R	NR		R	NR		R	NR				■
NEG EQC	R	NR		R	NR		R	NR		R	NR		■	■	
	R	NR		R	NR		R	NR		R	NR		SR	WR	NR
	R	NR		R	NR		R	NR		R	NR		SR	WR	NR
	R	NR		R	NR		R	NR		R	NR		SR	WR	NR
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	R	NR		R	NR		R	NR		R	NR		SR	WR	NR
	R	NR		R	NR		R	NR		R	NR		SR	WR	NR
	R	NR		R	NR		R	NR		R	NR		SR	WR	NR

√=Acceptable

R= Reactive

NR= Non-Reactive

Form 145a
V: 24 Nov 2010

Technical Review: ________ Date: ________

QA/QC Review: ________ Date: ________

FORM 147–ELDON CARD ABO/RH TYPING RECORD

Eldon Card ABO/Rh Typing

Date of Testing:__________.

	Eldon Card ABO/Rh Typing					
	Lot #					
	Exp:					Tech
Assigned Unit #	Anti-A	Anti-B	Anti-D	Rh Control	Interpretation	Initials
	+ =	+ =	+ =	+ =		
	+ =	+ =	+ =	+ =		
	+ =	+ =	+ =	+ =		
	+ =	+ =	+ =	+ =		
	+ =	+ =	+ =	+ =		
	+ =	+ =	+ =	+ =		
	+ =	+ =	+ =	+ =		
	+ =	+ =	+ =	+ =		
	+ =	+ =	+ =	+ =		
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	+ =	+ =	+ =	+ =		
	+ =	+ =	+ =	+ =		
	+ =	+ =	+ =	+ =		
	+ =	+ =	+ =	+ =		
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	+ =	+ =	+ =	+ =		
	+ =	+ =	+ =	+ =		
	+ =	+ =	+ =	+ =		
	+ =	+ =	+ =	+ =		
	+ =	+ =	+ =	+ =		
	+ =	+ =	+ =	+ =		
	+ =	+ =	+ =	+ =		
	+ =	+ =	+ =	+ =		
	+ =	+ =	+ =	+ =		

Form 147
V: 28 June 2010

Technical Review: __________ Date: __________
QA/QC Review: __________ Date: __________

FORM 148–PRE-SCREEN/WHOLE BLOOD SAMPLE SHIPPING MANIFEST

Prescreen/Whole Blood Sample Shipping Manifest

Blood Unit Number				Donation Date	Donor Name		Branch of Service	Nationality	SSN or ID #	DOB	FOB/Base	Unit	Donation Type (PS or FWB)
Facility ID (W0138)	YR	Unit Id #	ABO RH		Last	First							

rm 148

FORM 150A–EMERGENCY RELEASE LETTER OF UNDERSTANDING (TESTED)

Provider Letter of Understanding for Emergency (Non-FDA) Whole Blood Units

I understand that Emergency Whole Blood Units are NOT FDA approved and transfusion of these units may result in unintended disease and/or transfusion reactions. I accept full responsibility for the units and the consequences that may follow transfusion.

Print	Sign	Date
_____	_____	_____
Provider		

Form 150a

FORM 150B–EMERGENCY RELEASE LETTER OF UNDERSTANDING (UN-TESTED)

Provider Letter of Understanding for Untested Emergency Whole Blood Units

I understand that these Emergency Whole Blood Units have not had complete Rapid Testing prior to transfusion and transfusion of these units may result in an increased risk of unintended disease and/or transfusion reactions. I accept full responsibility for the units and the consequences that may follow transfusion.

Print Sign Date

_____ _____ _____

Provider

Form 150b

STANDARD FORM 518–BLOOD OR BLOOD COMPONENT RELEASE

518–123 NSN 7540-00-634-4158

MEDICAL RECORD | BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*
- ☐ RED BLOOD CELLS
- ☐ FRESH FROZEN PLASMA
- ☐ PLATELETS *(Pool of _____ units)*
- ☐ CRYOPRECIPITATE *(Pool of _____ units)*
- ☐ Rh IMMUNE GLOBULIN
- ☐ OTHER *(Specify)* _____

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*
- ☐ TYPE AND SCREEN
- ☐ CROSSMATCH

DATE REQUESTED

DATE AND HOUR REQUIRED

REQUESTING PHYSICIAN *(Print)*

DIAGNOSIS OR OPERATIVE PROCEDURE

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

VOLUME REQUESTED *(If applicable)* _____ ML

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

SIGNATURE OF VERIFIER

REMARKS:

IF PATIENT IS FEMALE, IS THERE HISTORY OF:
RhIG TREATMENT? DATE GIVEN: _____
HEMOLYTIC DISEASE OF NEWBORN? _____

DATE VERIFIED

TIME VERIFIED

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.	TRANSFUSION NO. / PATIENT NO.	TEST INTERPRETATION: ANTIBODY SCREEN	TEST INTERPRETATION: CROSSMATCH
DONOR ABO Rh	RECIPIENT ABO Rh		

PREVIOUS RECORD CHECK: ☐ RECORD ☐ NO RECORD

SIGNATURE OF PERSON PERFORMING TEST

☐ CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED | DATE

REMARKS:

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)*

AT *(Hour)* | ON *(Date)*

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERIFIER *(Signature)*

2nd VERIFIER *(Signature)*

PRE-TRANSFUSION
TEMP. | PULSE | BP

DATE OF TRANSFUSION | TIME STARTED

POST-TRANSFUSION DATA

AMOUNT GIVEN ML

TIME/DATE COMPLETED/INTERRUPTED

REACTION ☐ NONE ☐ SUSPECTED | TEMPERATURE | PULSE | BLOOD PRESSURE

If reaction is suspected—IMMEDIATELY:
1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. Solutions to the Blood Bank.

DESCRIPTION OF REACTION
☐ URTICARIA ☐ CHILL ☐ FEVER ☐ PAIN
☐ OTHER *(Specify)*

OTHER DIFFICULTIES *(Equipment, clots, etc.)*
☐ NO ☐ YES *(Specify)*

SIGNATURE OF PERSON NOTING ABOVE

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, first, middle; grade; rank; rate; hospital or medical facility) | SEX | WARD

BLOOD OR BLOOD COMPONENT TRANSFUSION
Medical Record

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

FORM 151–WHOLE BLOOD TRANSFUSION CHECKLIST

WHOLE BLOOD TRANSFUSION CHECKLIST

COMPLETE THIS CHECKLIST FOR EACH UNIT TRANSFUSED POST EVENT

LOCATION OF TRANSFUSION:	DATE:
WHOLE BLOOD UNIT #	

1. DONOR PRESCREENED FOR TRANSFUSION TRANSMITTED DISEASE (TTD) MARKERS WITH FDA APPROVED TESTS WITHIN LAST 90 DAYS?

YES_____ NO_____

2. DONORS SCREENED AT TIME OF COLLECTION USING RAPID TESTS FOR:

MALARIA	YES_____ NO_____
HIV	YES_____ NO_____
HBV	YES_____ NO_____
HCV	YES_____ NO_____
RPR	YES_____ NO_____

3. RAPID TEST RESULTS AVAILABLE PRIOR TO PRODUCT RELEASE?

YES_____ NO_____

4. DONORS SCREENED USING **DD572** & CURRENT SOP ? YES_____ NO_____

5. BLOOD TUBES COLLECTED AT THE TIME OF COLLECTION FOR FOLLOW UP WITH FDA TTD TESTING YES_____ NO_____

6. INTERNATIONAL SOCIETY FOR BLOOD TRANSFUSION (ISBT) LABELS USED YES_____ NO_____

7. TUBES AND A COPY OF **DD572** FORWARDED TO BSD? YES_____ NO_____

8. UNIT ACCOUNTED FOR IN TMDS? YES_____ NO_____

9. WAS COMPONENT THERAPY AVAILABLE WHEN FWB WAS GIVEN YES_____NO_____

10. PLEASE PROVIDE ANY INFLUENCING FACTORS THAT PREVENTED YOU FROM FOLLOWING THE SOP FOR THIS TRANSFUSION EVENT (IF APPLICABLE):

_____

_____

_____

_____

INDIVIDUAL COMPLETING CHECKLIST

Print Name	Signature

This checklist is to be kept on file for a minimum of one (1) year. Forward a copy to BSD with corresponding samples for Every unit of Whole Blood transfused.

Form 151

WBB SUPPLY LIST (WITH NSNS)

Item Description	Stock# / NSN #
SHARPS Container	6515014922824
Biohazard Bags	0707A950012
Leak Resistant Chucks	3583001093
Gloves-SM	4352MG6001
-MED	4352484802
-LRG	4352MG6003
Surgical Tape	6510009268882
Sphygmomanometer	3596994215
Stethoscope	3596994510
Tempa Dots	4509005122
Lancet	F50924058510
Alcohol Pads	4725APP104
2x2 Gauze	3583001806
STAT SiteM	1750SB900900
STAT SiteM Test Cards	6550015096101
Blood Bag Scales-Hemo Flow	6515015137010
Blood Bag Stand	6515004114375
Terumo Single Blood Bags	6515014802307
Frepp/Sepp Kit	4335260288
4x4 Gauze	3583002634
Hand Stripper/Sealer/Cutter	6515011405267
Hand Sealer Clips	06814R4418
Scissors	6515003650640
Hemostats	5867097442
Adapter MS DIR 100S Luer 100S	723364902
Purple Top (EDTA Plasma)	0723367861
Pearl Top (PPT)	0723362788
Gold Top (SST)	723364902
Coban 5x1	4509001583
Eldon Card (Rapid ABO/Rh)	65500 8T003314
HIV 1/2 RA OraQuick	6550015267424
ORAQUIK HCV	6550015899845
ONSITE (CTK) HBSAG (Hep B)	6550008T000102
Malarial Rapid Test	6550081332341
RPR Test Kit	6550015110291

APPENDIX C

ADDITIONAL INFORMATION REGARDING OFF-LABEL USES IN CPGs

Purpose. The purpose of this Appendix is to ensure an understanding of DoD policy and practice regarding inclusion in CPGs of "off-label" uses of U.S. Food and Drug Administration (FDA)–approved products. This applies to off-label uses with patients who are armed forces members.

Background. Unapproved (i.e., "off-label") uses of FDA-approved products are extremely common in American medicine and are usually not subject to any special regulations. However, under Federal law, in some circumstances, unapproved uses of approved drugs are subject to FDA regulations governing "investigational new drugs." These circumstances include such uses as part of clinical trials, and in the military context, command required, unapproved uses. Some command requested unapproved uses may also be subject to special regulations.

Additional Information Regarding Off-Label Uses in CPGs. The inclusion in CPGs of off-label uses is not a clinical trial, nor is it a command request or requirement. Further, it does not imply that the Military Health System requires that use by DoD health care practitioners or considers it to be the "standard of care." Rather, the inclusion in CPGs of off-label uses is to inform the clinical judgment of the responsible health care practitioner by providing information regarding potential risks and benefits of treatment alternatives. The decision is for the clinical judgment of the responsible health care practitioner within the practitioner-patient relationship.

Additional Procedures.

1. Balanced Discussion. Consistent with this purpose, CPG discussions of off-label uses specifically state that they are uses not approved by the FDA. Further, such discussions are balanced in the presentation of appropriate clinical study data, including any such data that suggest caution in the use of the product and specifically including any FDA-issued warnings.
2. Quality Assurance Monitoring. With respect to such off-label uses, DoD procedure is to maintain a regular system of quality assurance monitoring of outcomes and known potential adverse events. For this reason, the importance of accurate clinical records is underscored.
3. Information to Patients. Good clinical practice includes the provision of appropriate information to patients. Each CPG discussing an unusual off-label use will address the issue of information to patients. When practicable, consideration will be given to including in an appendix an appropriate information sheet for distribution to patients, whether before or after use of the product. Information to patients should address in plain language: a) that the use is not approved by the FDA; b) the reasons why a DoD health care practitioner would decide to use the product for this purpose; and c) the potential risks associated with such use.

DEPARTMENT OF THE AIR FORCE
WASHINGTON, DC

Office of the Assistant Secretary

MEMORANDUM FOR AFPC/DPFDD

FROM: SAF/MRBP

SUBJECT: Physical Evaluation—[redacted]

On behalf of the Secretary of the Air Force, it is directed that [redacted] be discharged and receive severance pay with a disability rating of 10 percent under the provisions of Title 10, United States Code, Section 1203. This disability rating was determined based on the Veterans Affairs Schedule for Rating Disabilities (VASRD) in accordance with the National Defense Authorization Act of 2008.

[redacted] case was considered by the Air Force Personnel Board (AFPB), which made a recommendation regarding its disposition. The following rationale is provided for the final decision in this case. The Board considered the member's contention that he is fit and should be returned to duty. The Board noted the member has been compliant with all treatment, is currently asymptomatic, and has an undetectable human immunodeficiency virus (HIV) viral load. Additionally, he is able to perform all in garrison duties, has passed his most recent fitness assessment without any component exemptions, and his commander strongly supports his retention. However, the Board noted the member's condition precludes him from being able to deploy world-wide without a waiver and renders him ineligible for deployment to the Central Command (CENTCOM) Area of Responsibility (AOR), where the majority of Air Force members are expected to deploy. Deployability is a key factor in determining fitness for duty and the Board recognized the member belongs to a career field with a comparatively high deployment rate/tempo. Therefore, based on his inability to deploy and considering his current career point, the Board determined he is unfit for continued military service and shall be discharged with severance pay.

When addressing the applicant's disability rating award, the Board is required by law to rate a disability using criteria outlined in the VASRD. The AFPB typically applies the disability ratings proposed by the Department of Veterans Affairs (DVA) under the Integrated Disability Evaluation System (IDES), as these ratings should be in compliance with the VASRD. The Board therefore assigned a rating of [redacted] percent to the member's HIV infection. This rating warranted discharge with severance pay.

This action is taken under the authority delegated by the Secretary of the Air Force.

[redacted]

X John K. Vallario

JOHN K. VALLARIO
Deputy Director, SAF Personnel Council
Signed by: VALLARIO.JOHN.K.1069511070

Attachment:
Additional Information Sheet

Additional Information Sheet

Your case was reviewed by the Air Force Personnel Board (AFPB) of the Secretary of the Air Force Personnel Council (SAFPC) under authority delegated by the Secretary of the Air Force. The board reviewed all facts and evidence in the case, to include the testimony presented before the Formal Physical Evaluation Board (FPEB) and the remarks of the FPEB (if applicable), the remarks of the Informal Physical Evaluation Board (IPEB), the service medical record (including electronic entries contained in the Armed Forces Health Longitudinal Technology Application, or AHLTA), the Narrative Summary of the Medical Evaluation Board (MEB), the Department of Veterans Affairs (DVA) medical examination, information provided by you and your counsel, and any additional information that was provided.

If you are on extended active duty and have between 15 and 19+ years of active duty service (but less than 20 years), have an essentially stable condition, and wish to return to duty, you ***may*** be eligible to apply for the Limited Assignment Status (LAS) program. Please see Chapter 6 of AFI 36-3212 for more information or discuss your options with your Office of Airmen's Counsel (OAC) representative. Note: you are normally **not** eligible to apply for LAS if you are being placed on the Temporary Disability Retired List (TDRL).

The board is sensitive to your potential need for continuing medical care. Therefore, the board encourages you to utilize the resources of the DVA to the extent that you may be entitled. The DVA is the agency chartered by Congress to provide assistance to all eligible veterans. A full complement of medical services is available at any tertiary-level DVA health care facility. The DVA's Vocational Rehabilitation and Employment Program's mission is to assist veterans with a service-connected disability to prepare for and find suitable employment. Additional information regarding this program can be obtained at the following website: http://www.benefits.va.gov/vocrehab/index.asp. The Military Disability Evaluation System (MDES) is responsible for maintaining a fit and vital fighting force. While the MDES considers all of the service member's medical conditions, compensation can only be offered for those medical conditions that cut short a service member's career, and then only to the degree of severity present at the time of final disposition. However, the DVA, operating under a different set of laws (Title 38, United States Code), is empowered to periodically re-evaluate veterans for the purpose of adjusting their disability ratings should their degree of impairment vary over time.

You are also advised of your right to pursue further appeal through application to the Air Force Board for Correction of Military Records (AFBCMR) should you find reason that brings into question the decision of the board. The AFBCMR is an independent body chartered by Congress to redress any Air Force personnel action without influence of previous boards or their respective decisions. You may obtain information on appeal procedures from the AFBCMR website at: http://www.afpc.af.mil/Board-for-Correction-of-Military-Records.

FORMAL	FINDINGS AND RECOMMENDED DISPOSITION OF USAF PHYSICAL EVALUATION BOARD	DATE: [redacted]

PRIVACY ACT STATEMENT

AUTHORITY 10 U.S.C. 8013, Secretary of the Air Force (AF); as implemented by AF Instruction 36-2608 and Executive Orders 9397 (SSN) and 13478.
PRINCIPAL PURPOSE Military personnel records are used at all levels of AF personnel management for actions/processes related to disability evaluation for separation/retirement or retention.
ROUTINE USES Records may be disclosed to the Department of Veterans Affairs for research, processing, and adjudication of claims, and providing medical care.
DISCLOSURE Voluntary. SSN is necessary to ensure positive identification. Refusal to divulge information may delay or halt further processing and may jeopardize entitlement to disability benefits.

1. BOARD CONVENED AT JBSA Randolph AFB TX 78150-4708	2. EXHIBITS ATTACHED: A-C, G-Y

3. MEMBER'S NAME (Last, First, MI)	4. GRADE	5. SSN
[redacted]	[redacted]	[redacted]

6. COMPONENT:	7. 10 USC 1208 SERVICE	8. APPROVED RETIREMENT/HYT:
Regular AF	**05**	

9. FINDINGS CONCERNING INDIVIDUAL CONDITIONS DESCRIBED IN THE RECORDS

A. DIAGNOSIS
B. INCURRED WHILE ENTITLED TO RECEIVE BASIC PAY (Enter "Yes", "No", or "NA" for Not Applicable.)
C. LINE OF DUTY OR PROXIMATE RESULT OF PERFORMING DUTY (Enter "Yes" for in line of duty or proximate result, "No" for not proximate result of performing duty (ARC only), "M" for Not LOD - intentional misconduct, "N" for Not LOD - willful neglect, "A" for Not LOD - incurred during a period of unauthorized absence, or "NA" for not applicable)
D. DISABILITY COMPENSATION RATING
E. VETERANS ADMINISTRATION SCHEDULE FOR RATING DISABILITIES (VASRD) CODE
F. COMBAT RELATED DETERMINATION AS DEFINED IN 26 USC 104 (Enter "A" for direct result of armed conflict, "I" for direct result of instrumentality of war, "S" for duty under conditions simulating war, or "H" for while engaged in hazardous service, or "No" if not combat related.)

A. DIAGNOSIS	B.	C.	D.	E.	F.
CATEGORY I - UNFITTING CONDITIONS: Human Immunodeficiency Virus (HIV) w/ Pharyngitis	Yes	Yes	10	6351	No
CATEGORY II - CONDITIONS THAT CAN BE UNFITTING BUT ARE NOT CURRENTLY UNFITTING: See NOTE in Block 15					
CATEGORY III - CONDITIONS THAT ARE NOT UNFITTING AND NOT COMPENSABLE OR RATABLE: NONE					

10. ADDITIONAL FINDINGS

A. MEMBER IS UNFIT BECAUSE OF PHYSICAL DISABILITY	YES
B. OVERCOMES THE PRESUMPTION OF FITNESS	N/A
C. CONDITION IS PERMANENT/STABLE	YES
D DISABILITY WAS INCURRED IN LINE OF DUTY IN TIME OF WAR OR NATIONAL EMERGENCY OR AFTER 14 SEP 1978	YES
E. DISABILITY WAS INCURRED IN A COMBAT ZONE OR INCURRED DURING THE PERFORMANCE OF DUTY IN COMBAT-RELATED OPERATIONS AS DESIGNATED BY THE SECRETARY OF DEFENSE (NDAA 2008, Sec 1646)	NO

11. COMBINED COMPENSABLE PERCENTAGE	12. RECOMMENDED DISPOSITION
10	**Discharge With Severance Pay (DWSP)**
13. NAME OF PEB PRESIDENT OR REPRESENTATIVE **ADAM N. CARTER, Lt Col, USAF**	14. SIGNATURE 

CLINICS FOR TDRL EVALUATIONS

N/A	N/A	N/A	N/A

AF Form 356, Dec 14 PREVIOUS VERSION IS OBSOLETE

FINDINGS AND RECOMMENDED DISPOSITION OF USAF PHYSICAL EVALUATION BOARD

GRADE/NAME:	SSN:	DATE:
[redacted]	[redacted]	[redacted]

Continuation of Item 9, FINDINGS CONCERNING INDIVIDUAL CONDITIONS DESCRIBED IN THE RECORDS

A. DIAGNOSIS	B.	C.	D.	E.	F.

15. REMARKS:

Contention: [redacted] contends he is fit and should be returned to duty.

[redacted] is a [redacted] who was diagnosed with HIV, Stage 3, in [redacted] He reported a previous illness in [redacted] suggestive of acute retroviral syndrome. He is treated with antiretroviral therapy and is asymptomatic. His commander reports he is able to perform all in-garrison duties of his AFSC and recommends his retention. The most recent AF Form 469, Duty Limiting Condition Report, indicates he is not worldwide qualified. Confirmed HIV infection is disqualifying for deployment IAW CENTCOM MOD 13, Tab A paragraph 7C. The FPEB acknowledges [redacted] record of performance during his five years of military service and the numerous letters of support for his retention. Unfortunately, his condition significantly affects his ability to be assigned worldwide and deploy, which would have significant effect on his career progression and place increased burden on others within his career field. Therefore, the FPEB finds this condition is *unfitting* for continued military service.

The Formal Physical Evaluation Board (FPEB) finds [redacted] medical condition prevents him from reasonably performing the duties of his office, grade, rank or rating and recommends discharge with severance pay with a disability rating of 10% IAW the Veterans Administration Schedule for Rating Disabilities (VASRD) guidelines.

NOTE: The FPEB has considered all other medical conditions rated by the Department of Veterans Affairs related to [redacted] military service as required under the Integrated Disability Evaluation System. The Board finds these conditions are currently not unfitting for duty separately or collectively.

INFORMAL	FINDINGS AND RECOMMENDED DISPOSITION OF USAF PHYSICAL EVALUATION BOARD	DATE: [redacted]

PRIVACY ACT STATEMENT

AUTHORITY 10 U.S.C. 8013, Secretary of the Air Force (AF); as implemented by AF Instruction 36-2608 and Executive Orders 9397 (SSN) and 13478.
PRINCIPAL PURPOSE Military personnel records are used at all levels of AF personnel management for actions/processes related to disability evaluation for separation/retirement or retention.
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DISCLOSURE Voluntary. SSN is necessary to ensure positive identification. Refusal to divulge information may delay or halt further processing and may jeopardize entitlement to disability benefits.

1. BOARD CONVENED AT JBSA Randolph AFB TX 78150-4708	2. EXHIBITS ATTACHED: A	
3. MEMBER'S NAME (Last, First, MI) [redacted]	4. GRADE [redacted]	5. SSN [redacted]
6. COMPONENT: **Regular AF**	7. 10 USC 1208 SERVICE **05**	8. APPROVED RETIREMENT/HYT:

9. FINDINGS CONCERNING INDIVIDUAL CONDITIONS DESCRIBED IN THE RECORDS

A. DIAGNOSIS
B. INCURRED WHILE ENTITLED TO RECEIVE BASIC PAY (Enter "Yes", "No", or "NA" for Not Applicable.)
C. LINE OF DUTY OR PROXIMATE RESULT OF PERFORMING DUTY (Enter "Yes" for in line of duty or proximate result, "No" for not proximate result of performing duty (ARC only), "M" for Not LOD - intentional misconduct, "N" for Not LOD - willful neglect, "A" for Not LOD - incurred during a period of unauthorized absence, or "NA" for not applicable)
D. DISABILITY COMPENSATION RATING
E. VETERANS ADMINISTRATION SCHEDULE FOR RATING DISABILITIES (VASRD) CODE
F. COMBAT RELATED DETERMINATION AS DEFINED IN 26 USC 104 (Enter "A" for direct result of armed conflict, "I" for direct result of instrumentality of war, "S" for duty under conditions simulating war, or "H" for while engaged in hazardous service, or "No" if not combat related.)

A. DIAGNOSIS	B.	C.	D.	E.	F.
CATEGORY I - UNFITTING CONDITIONS: Human Immunodeficiency Virus (HIV) w/ Pharyngitis	Yes	Yes	10	6351	No
CATEGORY II - CONDITIONS THAT CAN BE UNFITTING BUT ARE NOT CURRENTLY UNFITTING: See NOTE in Block 15					
CATEGORY III - CONDITIONS THAT ARE NOT UNFITTING AND NOT COMPENSABLE OR RATABLE: NONE					

10. ADDITIONAL FINDINGS

A. MEMBER IS UNFIT BECAUSE OF PHYSICAL DISABILITY	YES
B. OVERCOMES THE PRESUMPTION OF FITNESS	N/A
C. CONDITION IS PERMANENT/STABLE	YES
D DISABILITY WAS INCURRED IN LINE OF DUTY IN TIME OF WAR OR NATIONAL EMERGENCY OR AFTER 14 SEP 1978	YES
E. DISABILITY WAS INCURRED IN A COMBAT ZONE OR INCURRED DURING THE PERFORMANCE OF DUTY IN COMBAT-RELATED OPERATIONS AS DESIGNATED BY THE SECRETARY OF DEFENSE (NDAA 2008, Sec 1646)	NO

11. COMBINED COMPENSABLE PERCENTAGE	12. RECOMMENDED DISPOSITION
10	**Discharge With Severance Pay (DWSP)**
13. NAME OF PEB PRESIDENT OR REPRESENTATIVE [redacted]	14. SIGNATURE [redacted]

CLINICS FOR TDRL EVALUATIONS

N/A	N/A	N/A	N/A

AF Form 356, Dec 14 PREVIOUS VERSION IS OBSOLETE

FINDINGS AND RECOMMENDED DISPOSITION OF USAF PHYSICAL EVALUATION BOARD

GRADE/NAME: [redacted]	SSN: [redacted]-0260	DATE: [redacted]

Continuation of Item 9, FINDINGS CONCERNING INDIVIDUAL CONDITIONS DESCRIBED IN THE RECORDS

A. DIAGNOSIS	B.	C.	D.	E.	F.

15. REMARKS: The Informal Physical Evaluation Board (IPEB) finds the service member's (SM) medical condition prevents him from reasonably performing the duties of his office, grade, rank or rating. Accordingly, the IPEB recommends the SM be discharged with severance pay with a disability rating of 10% IAW the Veterans Administration Schedule for Rating Disabilities (VASRD) guidelines. The SM is a [redacted] submitted for HIV, stage 3, diagnosed in [redacted] with last negative test in [redacted] He reports an illness suggestive of acute retroviral syndrome in [redacted] He was started on antiretroviral therapy in [redacted] The AF FORM 469, Duty Limiting Condition Report, indicated the SM has the following mobility/duty/fitness restrictions: no PCS/TDY/mobility. The IPEB reviewed and considered the SM's comments and multiple letters of support. The SM's commander has indicated the SM is able to function in his primary AFSC and recommends retention. The IPEB acknowledges the commander's recommendation for retention and statement that the SM is able to perform his daily in-garrison duties; however, the IPEB finds the SM's medical condition is subject to sudden and unpredictable progression and will result in deployment restrictions that prevent him from being fully worldwide qualified. Personnel with confirmed HIV infection are disqualified from deploying without a waiver. Additionally, some nations have legal prohibitions against entering their country with this diagnosis. Due to these restrictions, the SM's condition is not compatible with the fundamental expectations of military service. Thus, the IPEB finds the SM's HIV is incompatible with the rigors of military service and unfitting. NOTE: The IPEB has considered all other medical conditions rated by the Department of Veterans Affairs related to the SM's military service as required under the Integrated Disability Evaluation System. The Board finds these conditions are currently not unfitting for duty separately or collectively.

MEDICAL BOARD REPORT

(This form is subject to the Privacy Act of 1974 - Use Blanket PAS - DD Form 2005)

1. INSTALLATION AT WHICH CONVENED	2. DATE CONVENED
49 MDG, Holloman AFB	[redacted]

3. NAME (Last, First, Middle Initial)	4. GRADE	5. SSN	6. COMPONENT
[redacted]	[redacted]	[redacted]	[redacted]

7. DEPT OR SERVICE	8. ORGANIZATION	9. SEX	10. DATE OF BIRTH (Yr, Mo, day)	11. AGE
USAF	[redacted]	[redacted]	[redacted]	[redacted]

12. SEPARATION/ RETIREMENT DATE	13. HOSPITAL INITIALLY ADMITTED	14. TRANSFERRED FROM	15. HOME ADDRESS
[redacted]	N/A	N/A	[redacted]

16. MILITARY OCCUPATIONAL SPECIALTIES		17. TOTAL YEARS MILITARY SERVICE		18. DATE ENTERED AD CURRENT TOUR 4/26/12
TITLE	CODE	ACTIVE	INACTIVE	19. AERO RATING N/A
[redacted]		[redacted]		20. ON FLYING STATUS ON ADMISSION ☐ YES ☑ NO
				21. DATE RELIEVED FROM FLYING STATUS

22. BY DIRECTION OF THE APPOINTING AUTHORITY, THE BOARD CONVENED TO CONSIDER THE CASE OF THE ABOVE NAMED MEMBER.

A. UNDER PROVISIONS OF THE FOLLOWING DIRECTIVES:		B. FOR THE PURPOSE OF:	
☑ AFI 44-113 AND 48-123	☐ MANUAL FOR COURTS-MARTIAL	☐ CONTINUED ACTIVE DUTY	☐ EPTS DEFECTS
☐ OTHER (Specify)		☑ SEPARATION/RETIREMENT	☐ OTHER (Specify)

23. DIAGNOSIS AND FINDINGS

AFTER CONSIDERATION OF CLINICAL RECORDS, LABORATORY FINDINGS, AND PHYSICAL EXAMINATION, THE BOARD ESTABLISHES THE FOLLOWING DIAGNOSIS. *(List all diagnoses, in accordance with applicable directives, which contribute or may contribute to make the qualifications of the individual for worldwide duty questionable. Include any competency determinations (DFAS-DE MANUAL 177-173).* A	APPROXIMATE DATE OF ORIGIN B	INCURRED WHILE ENTITLED TO BASIC PAY		EXISTED PRIOR TO SERVICE		PERMANENTLY AGGRAVATED BY SERVICE	
		YES C	NO D	YES E	NO F	YES G	NO H
HIV Admin LOD: Yes	[redacted]	X			X	X	

24. SANITY DETERMINATION *(To be completed for sanity board cases only.) (Manual for Courts-Martial)*	YES	NO
A. IS THIS A DISEASE OR DEFECT OF THE MIND AS DISTINGUISHED FROM A CHARACTER DEFECT?	☐	☐
B. DID THE ACCUSED, AT THE TIME OF THE ALLEGED OFFENSE AND AS A RESULT OF MENTAL DISEASE OR DEFECT, LACK SUBSTANTIAL CAPACITY TO APPRECIATE THE CRIMINALITY OF THIS CONDUCT?	☐	☐
C. DID THE ACCUSED, AT THE TIME OF THE ALLEGED OFFENSE AND AS A RESULT OF MENTAL DISEASE OR DEFECT, LACK SUBSTANTIAL CAPACITY TO CONFORM HIS/HER CONDUCT TO THE REQUIREMENTS OF THE LAW?	☐	☐
D. DID THE ACCUSED HAVE THE MENTAL CAPACITY TO FORM THE SPECIFIC INTENT OR REQUIRED STATE OF MIND?	☐	☐

25. ACTION RECOMMENDED BY BOARD *(or directed by higher authority)*
Refer to Informal Physical Evaluation Board _X_ or Return to Duty ___

26. BOARD MEMBERS

TYPED NAME, GRADE, ARM OF SERVICE	SIGNATURE *(Please check after signature of psychiatrist)*	
PRESIDENT Joann B. Couch, LtCol, USAF, MC		
MEMBER Dorothy L. Saine, Maj, USAF		
MEMBER Franklin D Waddell, Lt Col, USAF		

27. MINORITY REPORT ON REVERSE ☐ YES ☑ NO

28. HOSPITAL COMMANDER OR DESIGNEE

A. DATE REVIEWED	B. BOARD RECOMMENDATION [1]	C. TYPED NAME, GRADE, SERVICE	D. SIGNATURE
	☐ APPROVED ☐ DISAPPROVED	Not required per AFI41-210	

29. I HAVE BEEN INFORMED OF THE FINDINGS AND RECOMMENDATIONS OF THE MEDICAL BOARD

A. DATE	B. SIGNATURE OF SERVICE MEMBER	C. LETTER OF EXCEPTION ATTACHED					
[redacted]	[redacted]	☒	YES	☐	NO	☐	N/A

[1] If applicable indicate reason for disapproval on reverse.

AF IMT 618, 19951001, V2 PREVIOUS EDITION IS OBSOLETE

DEPARTMENT OF THE AIR FORCE
WASHINGTON, DC

Office of the Assistant Secretary

MEMORANDUM FOR AFPC/DPFDD

FROM: SAF/MRBP

SUBJECT: Physical Evaluation—[redacted]

On behalf of the Secretary of the Air Force, it is directed that [redacted] be discharged and receive severance pay with a disability rating of 10 percent under the provisions of Title 10, United States Code, Section 1203. This disability rating was determined based on the Veterans Affairs Schedule for Rating Disabilities (VASRD) in accordance with the National Defense Authorization Act of 2008.

[redacted]s case was considered by the Air Force Personnel Board (AFPB), which made a recommendation regarding its disposition. The following rationale is provided for the final decision in this case. The Board considered the member's contention that he is fit and should be returned to duty. The Board noted the member has been compliant with all treatment, is currently asymptomatic, and has an undetectable human immunodeficiency virus (HIV) viral load. Additionally, he is able to perform all in garrison duties, has passed his most recent fitness assessment without any component exemptions, and his commander strongly supports his retention. However, the Board noted the member's condition precludes him from being able to deploy world-wide without a waiver and renders him ineligible for deployment to the Central Command (CENTCOM) Area of Responsibility (AOR), where the majority of Air Force members are expected to deploy. Deployability is a key factor in determining fitness for duty and the Board recognized the member belongs to a career field with a comparatively high deployment rate/tempo. Therefore, based on his inability to deploy and considering his current career point, the Board determined he is unfit for continued military service and shall be discharged with severance pay.

Addressing the applicant's disability rating award, the Board is required by law to rate a disability using criteria outlined in the VASRD. The AFPB typically applies the disability ratings proposed by the Department of Veterans Affairs (DVA) under the Integrated Disability Evaluation System (IDES), as these ratings should be in compliance with the VASRD. The Board therefore assigned a rating of 10 percent to the member's HIV infection. This rating warranted discharge with severance pay.

This action is taken under the authority delegated by the Secretary of the Air Force.

[redacted]

X John K. Vallario

JOHN K. VALLARIO
Deputy Director, SAF Personnel Council
Signed by: VALLARIO.JOHN.K.[redacted]

Attachment:
Additional Information Sheet

Additional Information Sheet

Your case was reviewed by the Air Force Personnel Board (AFPB) of the Secretary of the Air Force Personnel Council (SAFPC) under authority delegated by the Secretary of the Air Force. The board reviewed all facts and evidence in the case, to include the testimony presented before the Formal Physical Evaluation Board (FPEB) and the remarks of the FPEB (if applicable), the remarks of the Informal Physical Evaluation Board (IPEB), the service medical record (including electronic entries contained in the Armed Forces Health Longitudinal Technology Application, or AHLTA), the Narrative Summary of the Medical Evaluation Board (MEB), the Department of Veterans Affairs (DVA) medical examination, information provided by you and your counsel, and any additional information that was provided.

If you are on extended active duty and have between 15 and 19+ years of active duty service (but less than 20 years), have an essentially stable condition, and wish to return to duty, you ***may*** be eligible to apply for the Limited Assignment Status (LAS) program. Please see Chapter 6 of AFI 36-3212 for more information or discuss your options with your Office of Airmen's Counsel (OAC) representative. Note: you are normally **not** eligible to apply for LAS if you are being placed on the Temporary Disability Retired List (TDRL).

The board is sensitive to your potential need for continuing medical care. Therefore, the board encourages you to utilize the resources of the DVA to the extent that you may be entitled. The DVA is the agency chartered by Congress to provide assistance to all eligible veterans. A full complement of medical services is available at any tertiary-level DVA health care facility. The DVA's Vocational Rehabilitation and Employment Program's mission is to assist veterans with a service-connected disability to prepare for and find suitable employment. Additional information regarding this program can be obtained at the following website: http://www.benefits.va.gov/vocrehab/index.asp. The Military Disability Evaluation System (MDES) is responsible for maintaining a fit and vital fighting force. While the MDES considers all of the service member's medical conditions, compensation can only be offered for those medical conditions that cut short a service member's career, and then only to the degree of severity present at the time of final disposition. However, the DVA, operating under a different set of laws (Title 38, United States Code), is empowered to periodically re-evaluate veterans for the purpose of adjusting their disability ratings should their degree of impairment vary over time.

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FORMAL	FINDINGS AND RECOMMENDED DISPOSITION OF USAF PHYSICAL EVALUATION BOARD	DATE: [redacted]

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DISCLOSURE Voluntary. SSN is necessary to ensure positive identification. Refusal to divulge information may delay or halt further processing and may jeopardize entitlement to disability benefits.

1. BOARD CONVENED AT JBSA Randolph AFB TX 78150-4708	2. EXHIBITS ATTACHED: A-C; G-I	
3. MEMBER'S NAME (Last, First, MI) [redacted]	4. GRADE [redacted]	5. SSN [redacted]
6. COMPONENT: **Regular AF**	7. 10 USC 1208 SERVICE **05**	8. APPROVED RETIREMENT/HYT:

9. FINDINGS CONCERNING INDIVIDUAL CONDITIONS DESCRIBED IN THE RECORDS

A. DIAGNOSIS
B. INCURRED WHILE ENTITLED TO RECEIVE BASIC PAY (Enter "Yes", "No", or "NA" for Not Applicable.)
C. LINE OF DUTY OR PROXIMATE RESULT OF PERFORMING DUTY (Enter "Yes" for in line of duty or proximate result, "No" for not proximate result of performing duty (ARC only), "M" for Not LOD - intentional misconduct, "N" for Not LOD - willful neglect, "A" for Not LOD - incurred during a period of unauthorized absence, or "NA" for not applicable)
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A. DIAGNOSIS	B.	C.	D.	E.	F.
CATEGORY I - UNFITTING CONDITIONS: HIV	Yes	Yes	10	6351	No
CATEGORY II - CONDITIONS THAT CAN BE UNFITTING BUT ARE NOT CURRENTLY UNFITTING: See NOTE in Block 15					
CATEGORY III - CONDITIONS THAT ARE NOT UNFITTING AND NOT COMPENSABLE OR RATABLE: NONE					

10. ADDITIONAL FINDINGS	
A. MEMBER IS UNFIT BECAUSE OF PHYSICAL DISABILITY	YES
B. OVERCOMES THE PRESUMPTION OF FITNESS	N/A
C. CONDITION IS PERMANENT/STABLE	YES
D DISABILITY WAS INCURRED IN LINE OF DUTY IN TIME OF WAR OR NATIONAL EMERGENCY OR AFTER 14 SEP 1978	YES
E. DISABILITY WAS INCURRED IN A COMBAT ZONE OR INCURRED DURING THE PERFORMANCE OF DUTY IN COMBAT-RELATED OPERATIONS AS DESIGNATED BY THE SECRETARY OF DEFENSE (NDAA 2008, Sec 1646)	NO

11. COMBINED COMPENSABLE PERCENTAGE	12. RECOMMENDED DISPOSITION
10	**Discharge With Severance Pay (DWSP)**
13. NAME OF PEB PRESIDENT OR REPRESENTATIVE **JEFFERY A. TOWNS, Lt Col, USAF**	14. SIGNATURE Jeffery A. Towns

CLINICS FOR TDRL EVALUATIONS

N/A	N/A	N/A	N/A

AF Form 356, Dec 14 PREVIOUS VERSION IS OBSOLETE

FINDINGS AND RECOMMENDED DISPOSITION OF USAF PHYSICAL EVALUATION BOARD

GRADE/NAME:	SSN:	DATE:
[redacted] / [redacted]	[redacted]	[redacted]

Continuation of Item 9, FINDINGS CONCERNING INDIVIDUAL CONDITIONS DESCRIBED IN THE RECORDS

A. DIAGNOSIS	B.	C.	D.	E.	F.

15. REMARKS:

Contention: [redacted] contends he is fit for duty.

[redacted] His initial viral load was 14,000. After initiation of treatment which included daily Tivicay and Descovy, subsequent testing revealed a reduction in viral load and [redacted] testified his viral load is currently "0". [redacted] has undergone routine follow-up since his diagnosis and has exhibited no evidence of infection related to his HIV diagnosis. As of [redacted], [redacted] is considered to be stage 2 by CDC case definition and nadir values and he does not have evidence of immune compromise. [redacted] testified he is aware his condition is associated with deployment limitations, but he noted he is able to perform his in-garrison duties and he has no fitness restrictions. The AF FORM 469, *Duty Limiting Condition Report*, indicates [redacted] has the following mobility/duty/fitness restrictions: no PCS/TDY/mobility. [redacted] commander commented [redacted] is able to function in his primary AFSC garrison duties but is limited to deploy; however, she recommends retention. The Board acknowledges the commander's recommendation for retention. The Board also notes [redacted] HIV condition is welled controlled and he is currently asymptomatic. However, as a result of his chronic medical condition, [redacted] requires frequent follow-up with a specialist and he is a non-deployable asset in a high ops-tempo career field. For these reasons, the Board finds [redacted] HIV condition *unfitting* for continued military service

[redacted] HIV medical condition prevents him from reasonably performing the duties of his office, grade, rank, or rating. The Formal Physical Evaluation Board finds SrA [redacted] *unfit* and recommends discharge with severance pay with a disability rating of 10% IAW Veterans Administration Schedule for Rating Disabilities guidelines.

NOTE: The FPEB has considered all other medical conditions rated by the Department of Veterans Affairs related to SrA [redacted] military service as required under the Integrated Disability Evaluation System. The Board finds these conditions are currently not unfitting for duty separately or collectively.

INFORMAL	FINDINGS AND RECOMMENDED DISPOSITION OF USAF PHYSICAL EVALUATION BOARD	DATE: [redacted]

PRIVACY ACT STATEMENT

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1. BOARD CONVENED AT JBSA Randolph AFB TX 78150-4708	2. EXHIBITS ATTACHED: A	
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9. FINDINGS CONCERNING INDIVIDUAL CONDITIONS DESCRIBED IN THE RECORDS

A. DIAGNOSIS
B. INCURRED WHILE ENTITLED TO RECEIVE BASIC PAY (Enter "Yes", "No", or "NA" for Not Applicable.)
C. LINE OF DUTY OR PROXIMATE RESULT OF PERFORMING DUTY (Enter "Yes" for in line of duty or proximate result, "No" for not proximate result of performing duty (ARC only), "M" for Not LOD - intentional misconduct, "N" for Not LOD - willful neglect, "A" for Not LOD - incurred during a period of unauthorized absence, or "NA" for not applicable)
D. DISABILITY COMPENSATION RATING
E. VETERANS ADMINISTRATION SCHEDULE FOR RATING DISABILITIES (VASRD) CODE
F. COMBAT RELATED DETERMINATION AS DEFINED IN 26 USC 104 (Enter "A" for direct result of armed conflict, "I" for direct result of instrumentality of war, "S" for duty under conditions simulating war, or "H" for while engaged in hazardous service, or "No" if not combat related.)

A. DIAGNOSIS	B.	C.	D.	E.	F.
CATEGORY I - UNFITTING CONDITIONS: HIV	Yes	Yes	10	6351	No
CATEGORY II - CONDITIONS THAT CAN BE UNFITTING BUT ARE NOT CURRENTLY UNFITTING: See NOTE in Block 15					
CATEGORY III - CONDITIONS THAT ARE NOT UNFITTING AND NOT COMPENSABLE OR RATABLE: NONE					

10. ADDITIONAL FINDINGS

A. MEMBER IS UNFIT BECAUSE OF PHYSICAL DISABILITY	YES
B. OVERCOMES THE PRESUMPTION OF FITNESS	N/A
C. CONDITION IS PERMANENT/STABLE	YES
D DISABILITY WAS INCURRED IN LINE OF DUTY IN TIME OF WAR OR NATIONAL EMERGENCY OR AFTER 14 SEP 1978	YES
E. DISABILITY WAS INCURRED IN A COMBAT ZONE OR INCURRED DURING THE PERFORMANCE OF DUTY IN COMBAT-RELATED OPERATIONS AS DESIGNATED BY THE SECRETARY OF DEFENSE (NDAA 2008, Sec 1646)	NO

11. COMBINED COMPENSABLE PERCENTAGE	12. RECOMMENDED DISPOSITION
10	**Discharge With Severance Pay (DWSP)**
13. NAME OF PEB PRESIDENT OR REPRESENTATIVE **RICHARD S. BINGER, DAFC**	14. SIGNATURE [signature]

CLINICS FOR TDRL EVALUATIONS

N/A	N/A	N/A	N/A

AF Form 356, Dec 14 PREVIOUS VERSION IS OBSOLETE

FINDINGS AND RECOMMENDED DISPOSITION OF USAF PHYSICAL EVALUATION BOARD		
GRADE/NAME: [redacted]	SSN: [redacted]	DATE: [redacted]

Continuation of Item 9, FINDINGS CONCERNING INDIVIDUAL CONDITIONS DESCRIBED IN THE RECORDS

A. DIAGNOSIS	B.	C.	D.	E.	F.

15. REMARKS: The Informal Physical Evaluation Board (IPEB) has reviewed the available evidence and finds the service member's (SM) medical condition incompatible with continued military service; accordingly, the IPEB recommends the SM be discharged with severance pay with a disability rating of 10% IAW the Veterans Administration Schedule for Rating Disabilities (VASRD) guidelines. The SM is a [redacted] ([redacted] submitted for HIV. He has undergone HIV treatment protocols since [redacted] without any additional sequelae but due to this lifelong condition, he will require quarterly evaluations and restrictions for deploying. The AF FORM 469, Duty Limiting Condition Report, indicated the SM has the following mobility/duty/fitness restrictions: no PCS/TDY/mobility. The SM's commander has indicated the SM is able to function in his primary AFSC garrison duties but is limited to deploy; however, she recommends retention. The IPEB acknowledges the commander's recommendation for retention; however, the IPEB finds the SM's medical condition prevents him from reasonably performing the duties of his office, grade, rank or rating; represents a medical risk to the health of the SM or the health/safety of others with continued service; is subject to progression; requires frequent follow-up with a medical specialist; and limits the SM's ability to meet mobility requirements. Thus, the IPEB finds the SM's condition is incompatible with the rigors of military service and unfitting. NOTE: The IPEB has considered all other medical conditions rated by the Department of Veterans Affairs related to the SM's military service as required under the Integrated Disability Evaluation System. The Board finds these conditions are currently not unfitting for duty separately or collectively.

MEDICAL BOARD REPORT

(This form is subject to the Privacy Act of 1974 - Use Blanket PAS - DD Form 2005)

1. INSTALLATION AT WHICH CONVENED	2. DATE CONVENED
[redacted]	[redacted]

3. NAME (Last, First, Middle Initial)	4. GRADE	5. SSN	6. COMPONENT
[redacted]	[redacted]	[redacted]	Reg AF

7. DEPT OR SERVICE	8. ORGANIZATION	9. SEX	10. DATE OF BIRTH (Yr, Mo, day)	11. AGE
DOD/USAF	[redacted]	[redacted]	[redacted]	[redacted]

12. SEPARATION/ RETIREMENT DATE	13. HOSPITAL INITIALLY ADMITTED	14. TRANSFERRED FROM	15. HOME ADDRESS
[redacted]	N/A	N/A	[redacted]

16. MILITARY OCCUPATIONAL SPECIALTIES		17. TOTAL YEARS MILITARY SERVICE	18. DATE ENTERED AD CURRENT TOUR 20151229
TITLE	CODE		19. AERO RATING N/A
Training Instructor	2W0X1	ACTIVE [redacted] INACTIVE N/A	20. ON FLYING STATUS ON ADMISSION ☐ YES ☑ NO
			21. DATE RELIEVED FROM FLYING STATUS

22. BY DIRECTION OF THE APPOINTING AUTHORITY, THE BOARD CONVENED TO CONSIDER THE CASE OF THE ABOVE NAMED MEMBER.

A. UNDER PROVISIONS OF THE FOLLOWING DIRECTIVES:			B. FOR THE PURPOSE OF:		
☑	AFI 44-113 AND 48-123	☐	MANUAL FOR COURTS-MARTIAL	☑ CONTINUED ACTIVE DUTY	☐ EPTS DEFECTS
☑	OTHER *(Specify)* AFI 10-203, 36-3212, 41-210			☐ SEPARATION/RETIREMENT	☐ OTHER *(Specify)*

23. DIAGNOSIS AND FINDINGS

AFTER CONSIDERATION OF CLINICAL RECORDS, LABORATORY FINDINGS, AND PHYSICAL EXAMINATION, THE BOARD ESTABLISHES THE FOLLOWING DIAGNOSIS: *(List all diagnoses, in accordance with applicable directives, which contribute or may contribute to make the qualifications of the individual for worldwide duty questionable. Include any competency determinations. (DFAS-DE MANUAL 177-173).*	APPROXIMATE DATE OF ORIGIN	INCURRED WHILE ENTITLED TO BASIC PAY		EXISTED PRIOR TO SERVICE		PERMANENTLY AGGRAVATED BY SERVICE	
		YES C	NO D	YES E	NO F	YES G	NO H
A	B						
1. HIV	20170201	X			X		

ADMINISTRATIVE LOD: YES

24. SANITY DETERMINATION *(To be completed for sanity board cases only.) (Manual for Courts-Martial)*	YES	NO
A. IS THIS A DISEASE OR DEFECT OF THE MIND AS DISTINGUISHED FROM A CHARACTER DEFECT?	☐	☐
B. DID THE ACCUSED, AT THE TIME OF THE ALLEGED OFFENSE AND AS A RESULT OF MENTAL DISEASE OR DEFECT, LACK SUBSTANTIAL CAPACITY TO APPRECIATE THE CRIMINALITY OF THIS CONDUCT?	☐	☐
C. DID THE ACCUSED, AT THE TIME OF THE ALLEGED OFFENSE AND AS A RESULT OF MENTAL DISEASE OR DEFECT, LACK SUBSTANTIAL CAPACITY TO CONFORM HIS/HER CONDUCT TO THE REQUIREMENTS OF THE LAW?	☐	☐
D. DID THE ACCUSED HAVE THE MENTAL CAPACITY TO FORM THE SPECIFIC INTENT OR REQUIRED STATE OF MIND?	☐	☐

25. ACTION RECOMMENDED BY BOARD *(or directed by higher authority)*

Refer to Informal PEB

26. BOARD MEMBERS

TYPED NAME, GRADE, ARM OF SERVICE	SIGNATURE *(Place check after signature of psychiatrist)*	27. MINORITY REPORT ON REVERSE
PRESIDENT ~~TILTON, PAUL A., LT COL~~ USAF, MC, SFS	[signature]	
MEMBER OLSEN, LYNN A., CIV USAF, ~~MC, FS~~	[signature] MD	
MEMBER ~~MARTIN, BRYANT R., LT COL~~ USAF, MC, SFS	[signature]	☐ YES ☐ NO

28. HOSPITAL COMMANDER OR DESIGNEE

A. DATE REVIEWED	B. BOARD RECOMMENDATION [1]	C. TYPED NAME, GRADE, SERVICE	D. SIGNATURE
	☐ APPROVED ☐ DISAPPROVED	Not Required Per AFI 41-210	

29. I HAVE BEEN INFO[redacted]

A. DATE		C. LETTER OF EXCEPTION ATTACHED					
[redacted]	[redacted]	☐	YES	☒	NO	☐	N/A

[1] If applicable indicate reason for disapproval on reverse.

AF IMT 618, 19951001, V2 PREVIOUS EDITION IS OBSOLETE.

DEPARTMENT OF THE AIR FORCE
WASHINGTON DC

OFFICE OF THE ASSISTANT SECRETARY

The case was reviewed by the Personnel Board of the Secretary of the Air Force Personnel Council, under authority delegated by the SAF. The Board considered the member's contention to be returned to duty. Following a review of all facts and evidence in the case, to include the testimony presented before the Formal Physical Evaluation Board (FPEB), the remarks by the FPEB, the remarks by the Informal Physical Evaluation Board (IPEB), the service medical record (including electronic entries contained in the Armed Forces Health Longitudinal Technology Application, or AHLTA), the Narrative Summary of the Medical Evaluation Board (MEB), the Department of Veterans Affairs (DVA) medical examination, and additional information provided by the member; the Board directs that the member be returned to duty.

In keeping with the 11 October 2017 AF/A1P Policy, *Retention of Airmen with Asymptomatic HIV*, and in accordance with AFI 48-178, *Human Immunodeficiency Virus Program*, the Board offers the following rationale for its decision. Airman First Class was diagnosed with her condition in March 2016. On a standard regimen of Tivicam and Truvada as prescribed by her specialist at San Antonio Military Medical Center, she has remained symptom free and with an undetectable viral load. She has strong command support for retention. Given her current health status and no requirement for medications requiring special handling, the Board found returning her to duty constitutes a reasonable medical risk.

It is understood that the member may require an Assignment Limitation Code "C" and, if so, would require waivers to deploy. If it is found that the member's condition changes or that he requires additional duty restrictions, then a new MEB should be initiated. The member will be required to undergo an annual review in lieu of MEB at which time his case may be subjected to any updated policy changes.

BREAKING BARRIERS...SINCE 1947

This document contains information that must be protected IAW AFI 33-332 and DoD Regulation 5400.11 Privacy Act of 1974, as amended, applies. For Official Use Only (FOUO).

This action is taken under the authority delegated by the Secretary of the Air Force.

1/22/2018

X

LISA M. CRAIG, Colonel, USAF
Director, SAF Personnel Council
Signed by: CRAIG.LISA.M.1159521326

DEPARTMENT OF THE AIR FORCE
WASHINGTON, DC

Office of the Assistant Secretary

MEMORANDUM FOR AFPC/DPFDD

FROM: SAF/MRBP

SUBJECT: Physical Evaluation—Senior Airman [redacted]

On behalf of the Secretary of the Air Force, it is directed that Senior Airman [redacted] be discharged and receive severance pay with a disability rating of 10 percent under the provisions of Title 10, United States Code, Section 1203. This disability rating was determined based on the Veterans Affairs Schedule for Rating Disabilities (VASRD) in accordance with the National Defense Authorization Act of 2008.

Senior Airman [redacted]'s case was considered by the Air Force Personnel Board (AFPB), which made a recommendation regarding its disposition. The following rationale is provided for the final decision in this case. The Board considered the member's contention that he is fit and should be returned to duty. The Board noted the member has been compliant with all treatment, is currently asymptomatic, and has an undetectable human immunodeficiency virus (HIV) viral load. Additionally, he is able to perform all in garrison duties, has passed his most recent fitness assessment without any component exemptions, and his commander strongly supports his retention. However, the Board noted the member's condition precludes him from being able to deploy world-wide without a waiver and renders him ineligible for deployment to the Central Command (CENTCOM) Area of Responsibility (AOR), where the majority of Air Force members are expected to deploy. Deployability is a key factor in determining fitness for duty and the Board recognized the member belongs to a career field with a comparatively high deployment rate/tempo. Therefore, based on his inability to deploy and considering his current career point, the Board determined he is unfit for continued military service and shall be discharged with severance pay.

The applicant also contends that there are numerous Air Force instructions indicating he should not be discharged due to having this condition. In support of this assertion, he includes a copy of a HQ AF/A 1P memo, *Retention of Airmen with HIV*, dated 11 Oct 17, which indicates that asymptomatic HIV alone is not unfitting for continued service. However, this memo also indicates AFPC/DP2NP may return Airmen with asymptomatic HIV to duty, or refer them into the Integrated Disability Evaluation System (IDES). There is no evidence to indicate that AFPC/DP2NP's action to refer the member's case into the IDES was somehow inappropriate or contrary to governing instructions. After a thorough review of his case, both the Informal Physical Evaluation Board (IPEB) and Formal Physical Evaluation Board (FPEB) determined that Senior Airman [redacted]'s condition rendered him unfit. For the reasons indicated above, the

AFPB agrees that his condition precludes him from performing the full range of his military duties and he is therefore unfit for continued military service.

Addressing the applicant's disability rating award, the Board is required by law to rate a disability using criteria outlined in the VASRD. The AFPB typically applies the disability ratings proposed by the Department of Veterans Affairs (DVA) under the Integrated Disability Evaluation System (IDES), as these ratings should be in compliance with the VASRD. The Board therefore assigned a rating of 10 percent for the member's HIV infection. This rating warranted discharge with severance pay.

This action is taken under the authority delegated by the Secretary of the Air Force.

11/7/2018

X John K. Vallario

JOHN K. VALLARIO
Deputy Director, SAF Personnel Council
Signed by: VALLARIO.JOHN.K.1069511070

Attachment:
Additional Information Sheet

DEPARTMENT OF THE AIR FORCE
WASHINGTON, DC

Office of the Assistant Secretary

MEMORANDUM FOR AFPC/DPFDD

FROM: SAF/MRBP

SUBJECT: Physical Evaluation—Senior Airman [redacted]

On behalf of the Secretary of the Air Force, it is directed that Senior Airman [redacted] be placed on the Temporary Disability Retired List (TDRL) with a disability rating of 60 percent under the provisions of Title 10, United States Code, Section 1202. This disability rating was determined based on the Veterans Administration Schedule for Rating Disabilities (VASRD) in accordance with the National Defense Authorization Act of 2008.

Senior Airman [redacted]'s case was considered by the Air Force Personnel Board (AFPB), which made a recommendation regarding its disposition. The following rationale is provided for the final decision in this case. The Board considered the member's contention that he is fit and should be returned to duty. The Board noted the member has been compliant with all treatment, is currently asymptomatic and has a low human immunodeficiency virus (HIV) viral load. Additionally, he is able to perform all in garrison duties, has passed his most recent fitness assessment without any component exemptions, and his commander strongly supports his retention. However, the Board noted the member's condition precludes him from being able to deploy worldwide without a waiver and renders him ineligible for deployment to the Central Command (CENTCOM) Area of Responsibility (AOR), where the majority of Air Force members are expected to deploy. Deployability is a key factor in determining fitness for duty and the Board recognized the member belongs to a career field with a comparatively high deployment rate/tempo. Therefore, based on his inability to deploy and considering his current career point, the Board determined he is unfit for continued military service and shall be placed on the Temporary Disability Retired List (TDRL) with a disability rating of 60 percent.

The member should be reevaluated in 12 months, to consist of an evaluation by an Infectious Disease Specialist (to include comments on interim course/treatment, compliance, current HIV labs/virus status/ treatment, social/industrial impairment, functionality, employability, and prognosis). The member is reminded to bring all of his interim healthcare records to the TDRL reevaluation, to ensure that he receives the correct disability rating. Per DoDI 1332.18, Enclosure 3, Appendix 4, paragraph 2.h, the member shall provide to the examining physician, for submission to the Physical Evaluation Board, copies of all his medical records (civilian, DVA, and all military medical records) documenting treatment since the last disability evaluation.

Addressing the applicant's disability rating award, the Board is required by law to rate a disability using criteria outlined in the VASRD. It typically applies the disability ratings proposed by the DVA under the Integrated Disability Evaluation System (IDES), as these ratings should be in compliance with the VASRD. The AFPB therefore assigned a rating of 60 percent.

This action is taken under the authority delegated by the Secretary of the Air Force.

11/7/2018

X John K. Vallario

JOHN K. VALLARIO
Deputy Director, SAF Personnel Council
Signed by: VALLARIO.JOHN.K.1069511070

Attachment:
Additional Information Sheet

DEPARTMENT OF THE AIR FORCE
WASHINGTON, DC

Office of the Assistant Secretary

MEMORANDUM FOR AFPC/DPFDD

FROM: SAF/MRBP

SUBJECT: Physical Evaluation - Airman First Class [redacted] [redacted]

On behalf of the Secretary of the Air Force, it is directed that A1C [redacted] be discharged and receive severance pay with a disability rating of zero percent under the provisions of Title 10, United States Code, Section 1203. This disability rating was determined based on the Veterans Affairs Schedule for Rating Disabilities (VASRD) in accordance with the National Defense Authorization Act of 2008.

A1C [redacted]'s case was considered by the Air Force Personnel Board (AFPB), which made a recommendation regarding its disposition. The following rationale is provided for the final decision in this case. The AFPB considered the member's contention that he is fit and should be returned to duty. The AFPB noted the member has been compliant with all treatment, is currently asymptomatic, and has a nearly undetectable human immunodeficiency virus (HIV) viral load. Additionally, he is able to perform all in-garrison duties, passed his most recent fitness assessment without any component exemptions, and his commander supports his retention. However, the AFPB noted the member's condition precludes him from being able to deploy worldwide without a waiver and renders him ineligible for deployment to the Central Command (CENTCOM) Area of Responsibility (AOR), where the majority of Air Force members are expected to deploy. Deployability is a key factor in determining fitness for duty and the AFPB recognized the member belongs to a career field with a comparatively high deployment rate/tempo. Therefore, based on his inability to deploy and considering his current career point, the AFPB determined he is unfit for continued military service and shall be discharged with severance pay.

When addressing the applicant's disability rating award, the AFPB is required by law to rate a disability using criteria outlined in the VASRD. The AFPB typically applies the disability ratings proposed by the Department of Veterans Affairs (DVA) under the Integrated Disability Evaluation System (IDES), as these ratings should be in compliance with the VASRD. Therefore, the AFPB assigned a rating of zero percent to the member's HIV condition, VASRD Code 6351. This disability rating warranted discharge with severance pay.

This action is taken under the authority delegated by the Secretary of the Air Force.

12/4/2018

X Shane Prater

SHANE T PRATER, Colonel, USAF
Director, SAF Personnel Council
Signed by: PRATER SHANE T 1081079567

Attachment:
Additional Information Sheet

DEPARTMENT OF THE AIR FORCE
WASHINGTON, DC

Office of the Assistant Secretary

MEMORANDUM FOR AFPC/DPFDD

FROM: SAF/MRBP

SUBJECT: Physical Evaluation – Senior Airman [redacted]

On behalf of the Secretary of the Air Force, it is directed that SrA [redacted] be discharged and receive severance pay with a disability rating of 10 percent under the provisions of Title 10, United States Code, Section 1203. This disability rating was determined based on the Veterans Affairs Schedule for Rating Disabilities (VASRD) in accordance with the National Defense Authorization Act of 2008.

SrA [redacted]'s case was considered by the Air Force Personnel Board (AFPB), which made a recommendation regarding its disposition. The following rationale is provided for the final decision in this case. The AFPB considered the member's contention that he is fit and should be returned to duty. The AFPB noted the member has been compliant with all treatment, is currently asymptomatic, and has a nearly undetectable human immunodeficiency virus (HIV) viral load. Additionally, he is able to perform all in-garrison duties and his commander supports his retention. He passed his most recent fitness assessment with some component exemptions that were not related to his HIV. However, the AFPB noted the member's condition precludes him from being able to deploy worldwide without a waiver and renders him ineligible for deployment to the Central Command (CENTCOM) Area of Responsibility (AOR), where the majority of Air Force members are expected to deploy. Deployability is a key factor in determining fitness for duty and the AFPB recognized the member belongs to a career field with a comparatively high deployment rate/tempo. Therefore, based on his inability to deploy and considering his current career point, the AFPB determined he is unfit for continued military service and shall be discharged with severance pay.

When addressing the applicant's disability rating award, the AFPB is required by law to rate a disability using criteria outlined in the VASRD. The AFPB typically applies the disability ratings proposed by the Department of Veterans Affairs (DVA) under the Integrated Disability Evaluation System (IDES), as these ratings should be in compliance with the VASRD. Therefore, the AFPB assigned a rating of 10 percent to the member's HIV condition, VASRD Code 6351. This disability rating warranted discharge with severance pay.

This action is taken under the authority delegated by the Secretary of the Air Force.

12/5/2018

X Shane Prater

SHANE T. PRATER, Colonel, USAF
Director, SAF Personnel Council
Signed by: PRATER.SHANE.T.1081079567

Attachment:
Additional Information Sheet

Additional Information Sheet

Your case was reviewed by the Air Force Personnel Board (AFPB) of the Secretary of the Air Force Personnel Council (SAFPC) under authority delegated by the Secretary of the Air Force. The board reviewed all facts and evidence in the case, to include the testimony presented before the Formal Physical Evaluation Board (FPEB) and the remarks of the FPEB (if applicable), the remarks of the Informal Physical Evaluation Board (IPEB), the service medical record (including electronic entries contained in the Armed Forces Health Longitudinal Technology Application, or AHLTA), the Narrative Summary of the Medical Evaluation Board (MEB), the Department of Veterans Affairs (DVA) medical examination, information provided by you and your counsel, and any additional information that was provided.

If you are on extended active duty and have between 15 and 19+ years of active duty service (but less than 20 years), have an essentially stable condition, and wish to return to duty, you ***may*** be eligible to apply for the Limited Assignment Status (LAS) program. Please see Chapter 6 of AFI 36-3212 for more information or discuss your options with your Office of Airmen's Counsel (OAC) representative. Note: you are normally **not** eligible to apply for LAS if you are being placed on the Temporary Disability Retired List (TDRL).

The board is sensitive to your potential need for continuing medical care. Therefore, the board encourages you to utilize the resources of the DVA to the extent that you may be entitled. The DVA is the agency chartered by Congress to provide assistance to all eligible veterans. A full complement of medical services is available at any tertiary-level DVA health care facility. The DVA's Vocational Rehabilitation and Employment Program's mission is to assist veterans with a service-connected disability to prepare for and find suitable employment. Additional information regarding this program can be obtained at the following website: http://www.benefits.va.gov/vocrehab/index.asp. The Military Disability Evaluation System (MDES) is responsible for maintaining a fit and vital fighting force. While the MDES considers all of the service member's medical conditions, compensation can only be offered for those medical conditions that cut short a service member's career, and then only to the degree of severity present at the time of final disposition. However, the DVA, operating under a different set of laws (Title 38, United States Code), is empowered to periodically re-evaluate veterans for the purpose of adjusting their disability ratings should their degree of impairment vary over time.

You are also advised of your right to pursue further appeal through application to the Air Force Board for Correction of Military Records (AFBCMR) should you find reason that brings into question the decision of the board. The AFBCMR is an independent body chartered by Congress to redress any Air Force personnel action without influence of previous boards or their respective decisions. You may obtain information on appeal procedures from the AFBCMR website at: http://www.afpc.af.mil/Board-for-Correction-of-Military-Records.

CERTIFICATE OF SERVICE

I hereby certify that on May 28, 2019, I electronically filed this joint appendix with the Clerk of the Court for the United States Court of Appeals for the Fourth Circuit by using the appellate CM/ECF system. Participants in the case are registered CM/ECF users, and service will be accomplished by the appellate CM/ECF system, except for the following, who will be served (as agreed upon) via email:

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s/ James Y. Xi
James Y. Xi