EXHIBIT 33

AR 600-110
Identification, Surveillance, and Administration of Personnel Infected with Human Immunodeficiency Virus (current version)

Army Regulation 600–110

Personnel-General

Identification, Surveillance, and Administration of Personnel Infected with Human Immunodeficiency Virus

Headquarters
Department of the Army
Washington, DC
22 April 2014

UNCLASSIFIED

SUMMARY of CHANGE

AR 600-110
Identification, Surveillance, and Administration of Personnel Infected with Human Immunodeficiency Virus

This administrative revision, dated 27 June 2014--

- Modifies copy of DA Form 5669 (fig 4-1).
- Makes an administrative change to include this administrative revision (title page).

This rapid action revision, dated 22 April 2014--

- Changes Human Immunodeficiency Virus testing time requirements for Reserve Component Selected Reserve personnel from every 5 years to every 2 years (paras 3-2*k*(1), 3-2*k*(2), 7-4*a*(3), 7-4*a*(5), 7-4*b*(1), and 7-4*b*(2).
- Makes administrative changes (throughout).

Headquarters
Department of the Army
Washington, DC
22 April 2014

*Army Regulation 600–110

Effective 22 May 2014

Personnel-General

Identification, Surveillance, and Administration of Personnel Infected with Human Immunodeficiency Virus

By Order of the Secretary of the Army:

RAYMOND T. ODIERNO
General, United States Army
Chief of Staff

Official:

GERALD B. O'KEEFE
Administrative Assistant to the Secretary of the Army

History. This publication is a administrative revision. The portions affected by this administrative revision are listed in the summary of change.

Summary. This regulation implements the Office of the Assistant Secretary of Defense, Health Affairs Policy Memorandum-Human Immunodeficiency Virus Interval Testing, dated March 29, 2004 and Department of Defense Instructions 6485. 01 and prescribes Army policy and responsibilities on human immunodeficiency virus testing and surveillance requirements; procedures for identification, surveillance, and administration of personnel infected with human immunodeficiency virus; testing and counseling procedures for Soldiers and other military health care beneficiaries for human immunodeficiency virus infection; requirements for testing military applicants; conditions under which civilian employees may be tested; procedures for administration of human immunodeficiency virus infected Active Army, Army National Guard/Army National Guard of the United States, and U.S. Army Reserve Soldiers; guidance on the limitations on the use of testing information; information and education requirements of the human immunodeficiency virus testing program; and guidance to law enforcement and corrections personnel in handling known or suspected human immunodeficiency virus infected personnel.

Applicability. This regulation applies to the Active Army, the Army National Guard/the Army National Guard of the United States, and the U.S. Army Reserve, unless otherwise stated. It also applies to candidates and applicants for accession; Department of the Army civilian employees; nonappropriated fund employees; and military health care beneficiaries. If the provisions of this regulation conflict with existing negotiated labor agreements, the terms of those agreements will be controlling until renegotiated. In any activity where a union has been granted exclusive recognition to represent civilian employees, no new conditions of employment should be implemented without prior discussion with the servicing civilian personnel officer regarding the obligation to negotiate. During mobilization, the proponent may modify chapters and policies contained in this regulation.

Proponent and exception authority. The proponent of this regulation is the Deputy Chief of Staff, G–1. The proponent has the authority to approve exceptions or waivers to this regulation that are consistent with controlling law and regulations. The proponent may delegate this approval authority, in writing, to a division chief within the proponent agency or its direct reporting unit or field operating agency, in the grade of colonel or the civilian equivalent. Activities may request a waiver to this regulation by providing justification that includes a full analysis of the expected benefits and must include formal review by the activity's senior legal officer. All waiver requests will be endorsed by the commander or senior leader of the requesting activity and forwarded through their higher headquarters to the policy proponent. Refer to AR 25–30 for specific guidance.

Army internal control process. This regulation contains internal control provisions in accordance with AR 11–2 and identifies key internal controls that must be evaluated (see appendix B).

Supplementation. Supplementation of this regulation and establishment of command and local forms are prohibited without prior approval from Deputy Chief of Staff, G–1 (DAPE–HR–PR), 300 Army Pentagon, Washington, DC 20310–0300.

Suggested improvements. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) directly to Deputy Chief of Staff, G–1 (DAPE–HR–PR), 300 Army Pentagon, Washington, DC 20310–0300.

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

*This regulation supersedes AR 600–110, dated 17 August 2012.

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Chapter 1
Introduction

Section I
General

1–1. Purpose
This regulation prescribes policy, procedures, responsibilities, and standards concerning identification, surveillance, and administration of personnel infected with human immunodeficiency virus (HIV).

1–2. References
Required and related publications and prescribed and referenced forms are listed in appendix A.

1–3. Explanation of abbreviations and terms
Abbreviations and special terms used in this regulation are explained in the glossary.

Section II
Responsibilities

1–4. Deputy Chief of Staff, G–1
The DCS, G–1 will—

a. Serve as lead agent for all HIV policies.

b. Provide Army staff supervision for the HIV program.

c. Coordinate with U.S. Military Entrance Processing Command policies pertaining to preaccession HIV testing conducted at military entrance processing stations (MEPSs).

d. Ensure that HIV policies and programs are effectively implemented consistent with Department of Defense (DOD) guidance and current medical knowledge.

1–5. The Surgeon General
The Surgeon General will—

a. Program and manage funds and resources for the support of laboratory, research, education, prevention strategies, and contractor activities for medical aspects of the overall HIV program.

b. Provide up-to-date clinical and epidemiological information to the Army staff and Secretariat on HIV and Acquired Immune Deficiency Syndrome (AIDS).

c. Develop procedures for notification and counseling of HIV infected Soldiers and other health care beneficiaries (HCBs).

d. Through the proponency office for preventive medicine, provide oversight for the identification, surveillance, and management of HIV infected Soldiers.

e. Ensure responsive laboratory support to the Active Army and reserve components (RC) and to other testing programs for authorized HCBs.

f. Advise the Office of the DCS, G–1 and the Office of the Assistant Secretary of the Army (Manpower and Reserve Affairs) of Department of the Army (DA) and DOD epidemiological information and trends.

g. Through the U.S. Army Medical Research and Materiel Command—

(1) Provide input concerning the medical administration of the HIV testing program for publication in this regulation.

(2) Provide technical oversight in support of the Army's HIV testing program, to include guidance on the most current and appropriate laboratory tests to be used for screening and confirmation.

(3) Prescribe the methodology to be used by the laboratories supporting HIV testing.

(4) Provide technical guidance for the collection and shipment of specimens.

(5) Plan, program, and manage epidemiology and research initiatives.

h. Release HIV testing statistics only in response to specific queries. Such inquiries must be processed under the provisions of the Privacy Act (Title 5, United States Code, Section 552a (5 USC 552a)) and the Freedom of Information Act (FOIA) (5 USC 552) and should be handled in accordance with the procedures of AR 25–55 and AR 340–21. Generally, HIV information about specific individuals will not be released under the FOIA, but may be released under limited circumstances pursuant to the Privacy Act or DOD 6025.18–R, Chapter 7.

i. Through the U.S. Army Public Health Command (USAPHC) formerly known as U.S. Army Center for Health Promotion and Preventive Medicine—

(1) Serve as the technical lead for the public health aspects of installation HIV programs. The USAPHC functions include program development, written program guidance, automated tools, technical assistance, local HIV program

capacity building and maintenance, and continuing education for HIV program directors/coordinators (Public Health Nurses (PHNs)).

(2) Provide central tracking for HIV infected Soldiers in order to ensure timely notification, medical evaluation, and verification.

(3) Develop commander's guidance to assist the commanders of Soldiers infected with HIV.

(4) Develop programs for health education and primary and secondary HIV prevention education for individual HCBs, especially those who are HIV infected, or at high risk.

(5) Develop community health education materials in collaboration with the Chief Nurse, USAPHC, and the public affairs community (see chap 10).

(6) Assist Army commands (ACOMs), Army service component commands (ASCCs), or direct reporting units (DRUs) in the development and implementation of community health education programs regarding HIV infection and AIDS.

1–6. Chief of Chaplains

The Chief of Chaplains will provide pastoral care by ensuring that chaplain counseling and religious support is available to Soldiers and Family members who are infected with HIV and the uninfected members of those Families.

1–7. Chief of Public Affairs

The Chief of Public Affairs will—

a. In coordination with The Surgeon General and DCS, G–1, support a command information program that informs audiences about current information pertaining to HIV infection and the AIDS epidemic.

b. Help publicize the Army's testing, research, and education efforts for prevention strategies related to HIV and AIDS.

1–8. Chief, National Guard Bureau

The Chief, NGB will—

a. Budget money and resources to provide administrative support for oversight of the HIV testing program in the Army National Guard (ARNG).

b. Provide and coordinate medical support for the notification and counseling of HIV infected ARNG Soldiers and their spouses.

c. Provide oversight and quality assurance for managing and centrally tracking HIV infected ARNG Soldiers.

d. Ensure ARNG units comply with the Army's HIV policy.

e. Advise the DCS, G–1 regarding the impact of HIV programs on ARNG personnel and units.

1–9. Commanding General, U.S. Army Human Resources Command

The CG, HRC will—

a. Function as liaison between testing sites.

b. Provide timely notification of initial HIV positive test results to the U.S. Army Reserve (USAR).

c. Provide and coordinate administrative support for the notification and counseling which is inclusive of verification blood tests and completion of annual medical evaluation which determines fitness for duty.

d. Serve as the technical lead for transfer of all confirmed HIV infected individual ready reserve (IRR) Soldiers to the USAR Standby Reserve Active.

e. Develop and implement education program for USAR Soldiers.

f. Provide oversight and quality assurance for centrally tracking career management activities of HIV infected Soldiers including nondeployable assignments, long-term schooling, request for reassignment orders, and exception to policy.

g. Serve as primary point of contact (POC) for active component (AC) issues and inquiries.

h. Code administrative records to restrict permanent change of station (PCS) movement of enrollees.

i. Coordinate and advise command, assignment, and branch management staff on program provisions.

j. Maintain data on current enrollees and reconcile data furnished by medical lab processing element.

1–10. Commanding General, U.S. Army Reserve Command

The CG, USARC will—

a. Submit to HRC money and other resource requirements to provide administrative support for oversight of the HIV testing program in the USAR.

b. Provide and coordinate medical support for the notification and counseling of HIV infected USAR Soldiers and their spouses.

c. Provide oversight and quality assurance for managing and centrally tracking HIV infected USAR Soldiers.

d. Develop and coordinate USAR HIV policy for specified and unified commands, ACOMs, ASCCs, and DRUs.

e. Advise the DCS, G–1 regarding the impact of HIV programs on USAR personnel and units.

1–11. U.S. Army Medical Command commanders

The USAMEDCOM commanders will—

a. Identify appropriate resources and locations to collect and ship specimens to the servicing laboratories.

b. Ensure that information regarding HIV test results is appropriately safeguarded according to the policies in this regulation.

c. Coordinate testing, notification, counseling, and education procedures with Office of the Surgeon General (OTSG). Provide medical support for these functions per guidance from OTSG.

d. Ensure that epidemiologic assessment interviews and counseling are performed and that all medical requirements are accomplished according to the policies in this regulation, or request exceptions to policy when appropriate.

e. Ensure that guidance published by OTSG regarding the Blood Donor and Transfusion Recipient Look Back Program is followed within their command. For more guidance see Policy on the Use of Non-U.S. Food and Drug Administration Compliant Blood Products, March 19, 2010; Blood Program Letters (BPL) 09-01, DOD Policy on Blood Donor Screening, Donor Deferral, Notification and Lookback to Include Using Licensed Nucleic Acid Tests (NAT) With Approved Mini-Pool Strategies; and BPL 10-01, Department of Defense (DOD) Policy on Blood Donor Screening, Donor Deferral, Notification and Lookback to Include Updated Multiplex HIV/HCV/HBV Nucleic Acid Testing Algorithm.

f. Designate the medical positions outlined in chapter 2.

1–12. Army command, Army service component command, or direct reporting unit commanders

The ACOM, ASCC, or DRU commanders will—

a. Budget money and resources to provide administrative support for oversight of the HIV testing program in their command.

b. Designate a centralized POC in their headquarters to coordinate all administrative and medical aspects and educational preventive strategies, of the HIV testing program.

c. Ensure compliance with all aspects of the HIV testing program outlined in this regulation at their various installations and activities.

d. Ensure that information regarding HIV testing results is appropriately safeguarded per the policies in this regulation.

e. Ensure that their Public Affairs Office conducts an aggressive command information program per chapter 10.

1–13. Installation and community commanders

These commanders will—

a. Coordinate with the servicing medical department activity (MEDDAC) or medical center (MEDCEN) to accomplish scheduling, education, prevention strategies, and testing of personnel assigned to or supported by their installation or community.

b. Assist servicing MEDDAC or MEDCEN in implementing HIV education programs for Soldiers, commanders, health care workers, civilian employees, and other HCBs, as needed.

c. Establish a support network of professional personnel (chaplain, psychologist, psychiatrist, social worker, and a PHN) trained to provide assistance to HIV infected Soldiers and their uninfected Family members in such areas as Family support and suicide prevention.

d. Use local assets to support command and public information efforts.

e. Consult, as appropriate, with the servicing staff judge advocate on the limited use provisions of this policy and other restrictions on the use of HIV information.

f. Ensure that military and civilian personnel receive training and education on HIV and Army policies. Soldier and health care worker HIV prevention training is coordinated by a PHN. Commanders should ensure that all nonsupervisory civilian employees are given sufficient training regarding HIV and/or AIDS in the workplace so that employees understand—

(1) The medical ramifications of HIV and/or AIDS as they relate to communicability, and as they affect an employee's ability to perform official duties; and workplace rights of employees who are HIV positive or have AIDS.

(2) Civilian employees may be excused from HIV or AIDS training in the workplace if they believe the training is offensive or may be emotionally or psychologically stressful to them. Managers and supervisors who excuse civilian employees from scheduled training will offer those employees an appropriate alternative to the training, such as written materials on HIV and/or AIDS in the workplace.

g. Ensure that information regarding HIV testing results is appropriately safeguarded per the policies in this regulation.

1–14. Unit commanders

The unit commanders will—

a. Be knowledgeable of the provisions of this regulation.

b. Ensure that HIV information and education is included in unit training programs, with emphasis on the prevention of infection. See chapter 7 for RC personnel policy.

c. Ensure that their assigned or attached personnel comply with the HIV testing requirements.

d. Accompany Soldiers identified as HIV infected to the medical treatment facility (MTF) for notification of the (first) initial positive test as soon as possible after contact by preventive medicine, and no later than 4 days after contact by preventive medicine for Soldiers on leave or not on active duty (AD) status. (Unit commanders who are general officers may designate a subordinate officer to perform this function.) Upon learning of the Soldier's HIV status, commanders will not inform the Soldier nor be present in the room during the notification or the epidemiological assessment interview.

e. Provide support and facilitate the support network for the HIV infected Soldier from the point of initial notification.

f. Protect the confidentiality of HIV infected Soldiers from unwarranted invasions of their privacy. This responsibility includes strictly limiting knowledge of a Soldier's HIV status to individuals who have a "need to know" about the medical condition in the performance of their duties as defined by the Uniform Code of Military Justice (UCMJ). Commanders and legitimate administrative, legal, and medical authorities must ensure that the recipient of the information understands his or her obligation to protect the confidentiality of that information (see para 5–4).

g. Consult, as appropriate, with the servicing staff judge advocate on the limited use provisions of this policy and other restrictions on the use of HIV test results and epidemiological information.

h. Counsel HIV infected Soldiers per the policies in section III (DA Form 4856 (Developmental Counseling Form)) following formal counseling by the installation HIV program director (DA Form 5669 (Preventive Medicine Counseling Record)), with every change of command, and within 30 days of PCS and provide a copy to the HIV program coordinator (PHN).

i. Ensure that HIV infected AD Soldiers (including Active Guard Reserve (AGR)) report, at a minimum, every 6 months for their infectious disease medical evaluation visit and comply with medical management as directed by their infectious disease physician at military MTFs that have infectious disease providers.

j. Ensure that copies of HIV infected Soldier's PCS orders are provided to the HIV PHN to communicate to the gaining HIV PHN.

Section III
Policies

1–15. General

Headquarters, Department of the Army (HQDA) 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.

1–16. Human immunodeficiency virus policies

The following are established policies on HIV:

a. HIV infected personnel are not eligible for appointment or enlistment into the Active Army, the ARNG, or the USAR (see chap 5).

b. All AD and RC personnel designated in chapters 3, 6, and 7 will be tested periodically for evidence of HIV infection. Frequency of testing will be jointly determined by the DCS, G–1 and OTSG based on available medical and epidemiological evidence.

c. All procedures involving HIV testing results will comply with Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Public Law (PL) 104–191) regulations and will be handled in a confidential manner to prevent unauthorized access to the information. Access will be strictly limited to individuals who have a legitimate medical, administrative, or legal need to know that information in the performance of their duties. Current HIPAA privacy and security training is required.

d. Medical follow-up and evaluation will be conducted every 6 months and as directed by the infectious disease physician for all HIV infected Soldiers (see chaps 4 and 8).

e. Except for those identified during the accession testing program (chap 5), HIV infected AD Soldiers who do not demonstrate progressive clinical illness or immunological deficiency during periodic evaluations will not be involuntarily separated solely because they are HIV infected (see chaps 3, 6, and 9).

f. HIV infected AD Soldiers, including AGR, will be limited to duty within the United States (including Alaska, Guam, Hawaii, Puerto Rico, and the U.S. Virgin Islands). Soldiers identified as HIV positive while assigned outside the continental United States (OCONUS) will be reassigned to the United States per AR 614–30, and this regulation.

Direct coordination with Commander, U.S. Army Human Resources Command, Human Resource Center of Excellence (AHRC–SGD–H), Department 140, 1600 Spearhead Division Avenue, Fort Knox, KY 40122–5303; Commander, National Guard Personnel Center (NGB–ARP–CT), 4501 Ford Avenue, Alexandria, VA 22302–1450 (for ARNG AGR Title 10 personnel); or Commander, U.S. Army Human Resources Command, Human Resource Center of Excellence (AHRC–SGD–H), Department 140, 1600 Spearhead Division Avenue, Fort Knox, KY 40122–5303 (for USAR AGR personnel), will be made to ensure expeditious reassignment of HIV infected Soldiers (see chap 6).

(1) The duty limitation discussed above does not apply to RC personnel who reside overseas, or to AD Soldiers who are permanent residents of, and are currently stationed in Guam, the Virgin Islands, or American Samoa. It does, however, apply to all AD Soldiers not currently assigned to these locations, regardless of permanent residence.

(2) HIV infected Soldiers outside these areas who desire compassionate reassignment to these areas may apply per existing policy for compassionate reassignments. Requests will be considered on a case-by-case basis.

g. Conditions of national emergency and/or mobilization and deployment overseas may require reordering of priorities for screening and assignment of HIV infected Soldiers, but will not affect overseas assignment limitations. The Personnel Policy Guidance will contain HIV policy for particular wars, conflicts, or mobilization situations.

h. Unless modified by a combatant command (COCOM), AD Soldiers are considered available for deployment if they have a negative serum screening collected within 1 year of deployment.

i. RC Soldiers are considered deployable if they have a negative HIV test recorded within 5 years of scheduled deployment (or date of unit status report). However, upon mobilization, all Soldiers being ordered or called to AD will be tested for HIV within 24 hours of reporting to their mobilization station if there is no record of a negative HIV test within the previous 24 months.

j. Initial screening HIV test results will normally be available within 48 hours, but may be delayed due to logistical limitations. Soldiers will not be deployed until test results are known. If the test results are negative, the Soldier is considered available for deployment. If the initial test results are positive, the Soldier will be removed from further processing until independent verification tests are conducted and results are known.

k. HIV infected Soldiers who demonstrate rapidly progressive clinical illness or immunological deficiency may not meet medical retention standards under AR 40–501, and will be evaluated for physical disability processing under AR 635–40. (See paras 6–13 for officers and 6–14 for enlisted personnel.)

l. It is essential that HIV infected Soldiers provide accurate information during the epidemiological assessment process conducted confidentially by the HIV program director or coordinator (PHN). Accordingly, the mere presence of the HIV antibody or other medical evidence of HIV infection alone will not be used as the basis for adverse action against a Soldier (see chap 9).

m. Soldiers found to be HIV infected will have HIV listed on the medical problem list. As part of the commander's counseling, they will be counseled and ordered not to donate blood/blood products, sperm/semen or eggs, breast milk, tissues, or organs due to the risk of HIV transmission to recipients (see chap 4).

n. Mandatory testing of civilians (to include Family members) is not authorized, with the exception of those specific situations that may be defined and approved by DOD. Those situations will be published by HQDA (DAPE–CP or DAPE–HR) as they occur. Voluntary testing will be made available to all HCBs and civilian health care providers per chapter 8.

o. Except as stated below, civilian employees who have been diagnosed with HIV or AIDS must be permitted to continue to work so long as their performance is acceptable and they do not pose a significant risk of substantial harm to the health or safety of themselves or others that cannot be eliminated or reduced by reasonable accommodation. If serious performance or safety problems arise, managers and supervisors should address them by applying existing Federal and Army civilian personnel policies and practices. Further guidance is available in chapter 8.

p. There is no basis for civilian employees to refuse to work with fellow employees, Soldiers, or agency clients who have, or are suspected of having HIV or AIDS. The concerns of such employees will be addressed with education and counseling as appropriate. If an employee's continued refusal to work with a person with HIV or AIDS results in disruption in the workplace, appropriate disciplinary action may be taken against the employee. Further guidance is available in chapter 8.

q. Civilian employees with HIV or AIDS usually are considered "individuals with disabilities" within the meaning of the Rehabilitation Act of 1973, as amended (29 USC 701), the Americans with Disabilities Act (ADA) of 1990, as amended (42 USC 12101), and the Americans with Disabilities Act Amendments Act (ADAAA) PL 110–325), and, if otherwise qualified, are entitled to reasonable accommodation.

r. News media inquiries concerning HIV and/or AIDS policies, testing, or issues will be handled as follows:

(1) Routine news media queries on a local level will be directed to the appropriate Public Affairs Office. Media queries concerning Army HIV and/or AIDS policies should be referred to the Office of the Chief of Public Affairs, Media Relations Division.

(2) HIV testing statistics will be released only in response to specific queries. Such inquiries must be processed under the provisions of the Privacy Act (5 USC 552a) and the FOIA (5 USC 552) and should be handled in accordance with the procedures of AR 25–55 and AR 340–21. Generally, HIV information about specific individuals will not be released under the FOIA, but may be released under limited circumstances pursuant to the Privacy Act and DOD 6025.

18–R. In order to prevent accidental disclosure of HIV information that may be attributable to specific individuals, statistics may only be released for major installations or major commands.

s. Policies contained in this regulation will be reviewed as developments occur in scientific and/or medical knowledge, or issuances of revised DOD policies dictates.

Chapter 2
Installation Level Human Immunodeficiency Virus Program Management

2–1. General

a. The HIV program elements include the following:

(1) Prevention and education.
(2) Initial and verification HIV testing.
(3) Patient notification.
(4) Counseling.
(5) Contact tracing.
(6) Reporting.
(7) Medical evaluation and management.
(8) Profiling, fitness for duty evaluations, and medical boards.
(9) Medical record keeping.
(10) Personnel actions.
(11) Case management.
(12) Program oversight and quality assurance.
(13) Training and education.

b. The MTF commanders will assign appropriately trained individuals to the roles outlined in paragraph 2–2. Because of variations in medical staffing levels and expertise at different installations, MTF commanders may organize the local program as appropriate and within the general guidelines.

2–2. Human immunodeficiency virus program medical personnel

The functions delineated below may be reallocated with concurrence of USAMEDCOM commanders specified in paragraph 1–11.

a. Installation human immunodeficiency virus program director. This is a preventive medicine physician or other physician designated by the deputy commander for clinical services. The installation HIV program director—

(1) Monitors and ensures implementation of the program as outlined in this regulation.

(2) Supervises the installation HIV PHN.

(3) Serves as POC to the MTF laboratory for HIV testing and shall be the ordering provider for the routine HIV tests (medical readiness force testing, physical exams).

(4) Notifies the Soldier, in a face-to-face encounter, of a positive HIV test result in the absence of the provider ordering the test for clinical reasons, obtains a (second) verification test, and initiates referral to the servicing MEDCEN infectious disease service.

(5) Completes the initial DA Form 5669.

b. Installation human immunodeficiency virus program coordinator (PHN or designee). The PHN—

(1) Receives results from the clinical laboratory manager identifying new HIV infections.

(a) AD Soldiers are managed by the HIV program coordinator (PHN).

(b) Reserve and Guard Soldiers are referred to the appropriate Reserve or Guard HIV POC.

(c) AGR Soldiers are referred to the appropriate Reserve or Guard HIV POC and jointly managed with active HIV PHN.

(d) AD Navy, Marine Corps, Coast Guard, and Air Force Servicemembers are referred to the appropriate Service HIV POC.

(e) Retirees and Family members are referred to the servicing MEDCEN infectious disease service after a face-to-face notification of the initial and verification HIV positive test results. The notification procedures are the same as an AD Servicemember except commanders are not informed. The confidential epidemiological assessment is completed by the HIV PHN or referred to local public health officials.

(2) Informs the ordering provider of a new positive HIV test result if performed for clinical reasons, and the need for a face-to-face notification, second verification test, and referral to the servicing MEDCEN infectious disease service. If the test was performed for routine screening (medical readiness force testing, physical exam), inform the HIV program director.

(3) Confirms the identities of the commander and the Soldier with two unique identifiers before the commander is notified of the positive test result.

(4) Provides training on this regulation for the commander before initial commander's counseling.

(5) Coordinates notification of the Soldier, in a face-to-face encounter, of new positive HIV test result by the ordering provider or HIV program director, and obtains a second verification test.

(6) Coordinates the DA Form 5669 after notification of the (first) positive HIV test.

(7) Coordinates completion of the commander's counseling (DA Form 4856) on the same day and immediately following the DA Form 5669 counseling.

(8) Contacts installation HRC HIV POC and central AC or RC HRC HIV POC for assignment-limiting actions.

Note. For Reserve and Guard assignment-limiting actions see chap 7.

Sends memorandum with following information to central AC or RC HRC HIV POC by encrypted email or confidential fax:

(a) Subject: Medically Nondeployable.

(b) Reference: AR 40–501, Standards of Medical Fitness.

(c) Statement: For Official Use Only (FOUO) in accordance with the above reference, (person's rank, name, and last four digits of the social security number) is assessed as medically nondeployable effective (date of the first positive HIV test).

(d) Statement: Further information is available upon request. POC is (name, phone, and DOD email address of the HIV PHN).

(e) Signature block: HIV program director.

(9) Coordinates appointments for the initial medical evaluation with the servicing MEDCEN infectious disease service after notification of the (first) positive test.

(10) Coordinates a psychosocial evaluation and behavioral health appointment(s) following the initial notification or during the first infectious disease clinic medical evaluation visit and, as needed, for depression screening and suicide prevention.

(11) Provides HIV counseling and education, including community resources.

(12) Assesses for latent tuberculosis infection and counsels those who have opted out of latent tuberculosis infection treatment in the past to reconsider given their increased risk of active disease.

(13) Conducts initial confidential epidemiological assessment for the period from 3 months prior to last negative HIV test or 12 months in absence of a prior test to notification of the first positive test, and completes contact interview(s) in accordance with the Centers for Disease Control and Prevention (CDC) guidelines. Additional epidemiology assessment may be needed for public health purposes.

(14) Completes Federal, State, local, or host nation public health reporting.

(15) Locates, notifies, and counsels all military HCBs named as contacts of the HIV infected Soldier. If named contacts reside outside the catchment area, contacts the appropriate military HIV program coordinator (PHN) or other appropriate public health officials for notification and testing of contacts.

(16) Reviews Soldier responsibilities as reflected in the preventive medicine counseling (DA Form 5669) and commander's counseling (DA Form 4856) statements.

(17) Completes DA Form 7303 (Donor/Recipient History Interview) during the contact interview and submits to the local Army Blood Donor Center or, if there is no donor center on the installation, submits the completed form to the MTF's laboratory manager who, in turn, will submit it to the Army Blood Program Office (see fig 2–1 for a sample of completed DA Form 7303).

(18) Assures HIV infected Soldier's Medical Protection System (MEDPROS) documentation reflects a profile deployment restriction code (V) and medical nondeployment module "Yes" following notification of the confirmatory test from the first specimen. Coordinates periodic health assessment (PHA) at diagnosis and annually for AC, as required.

(19) Maintains, in a locked cabinet, a registry of all known HIV infected Soldiers within the catchment area per OTSG preventive medicine policy and in accordance with HIPAA, and maintains a duplicate file that includes DA Forms 5669, 4856, and 7303, public health forms, and demographic data. DA Forms 5669 and 4856 will not be scanned into the electronic medical record. Upon PCS the duplicate file contents are sent to the gaining HIV program coordinator (PHN). Upon the expiration term of service or retirement, the duplicate file will be destroyed.

(20) Meets with the HIV infected Soldier annually to complete a new DA Form 5669, update demographics, review safer sex counseling, and coordinate medical readiness. If the Soldier has not completed a medical evaluation every 6 months with the infectious disease physician he or she is out of compliance with this regulation, prompting commander notification.

(21) Coordinates Soldier transfer out of catchment area within 30 days of PCS to a new duty station and sends preventive medicine and commander's counseling statements encrypted or by confidential fax to gaining HIV program coordinator (PHN).

(22) Receives Soldier transfer into catchment area within 30 days of Soldier PCS, reviews Soldier responsibilities,

updates the preventive medicine counseling, coordinates commander's counseling, provides infectious disease clinic appointment information, coordinates medical readiness PHA, completes local health department reporting, and provides community resources.

(23) Coordinates HIV education programs for health care workers and unit-level training, as requested.

(24) Reviews HIV test results with MTF or MEDCEN laboratory HIV POC daily to weekly if not performed by the HIV program director.

c. Notifying individual. This is the ordering provider in a face-to-face appointment. For all other situations, this is a preventive medicine physician or other trained health care provider (skill level 2 or licensed independent provider). The notifying individual—

(1) Completes a psychosocial assessment and, as needed, referral to behavioral health.

(2) For Army medical and infectious disease staff, informs the MTF preventive medicine HIV director or coordinator (PHN) of AD Navy, Marine Corps, Coast Guard, and Air Force Servicemembers with a suspected or confirmed HIV infection.

d. Medical evaluation. This is completed by the regional MEDCEN infectious disease clinic after positive HIV verification. Initial appointments are scheduled by the HIV PHN. This includes—

(1) Conduction a medical reevaluation every 6 months and as directed by the infectious disease physician.

(2) Documenting safer sex education and nondeployable status in medical assessments.

(3) Ensuring HIV PHN is aware of known HIV positive Soldiers and beneficiaries, to include knowledge of impending PCS.

(4) Advising UCMJ commander of noncompliance with medical management of HIV infection pursuant to involuntary separation (see paras 6–13 and 6–14).

e. Psychosocial evaluation. This is completed by behavioral health or infectious disease clinic social work or psychiatry staff. This includes—

(1) Documenting evaluation in the electronic medical record.

(2) For communities with limited resources, pastoral care and chaplains providing support until medical evaluation appointments at the regional MEDCEN.

f. Clinical laboratory manager or blood bank officer. This function will—

(1) Coordinate obtaining unit-level and individual blood specimens for testing required by this regulation and other references.

(2) Maintain data concerning force testing and clinical screening, including the number of specimens drawn, the number submitted, results of initial testing, and results of confirmatory testing.

(3) Ensure compliance with guidelines for obtaining, processing, labeling, packaging, shipping, and storing specimens.

(4) Serve as local POC for matters pertaining to contracted laboratory support.

(5) Initiate look back investigation on any previous blood donations.

DONOR/RECIPIENT HISTORY INTERVIEW

For use of this form, see AR 600-110; the proponent agency is the DCS, G-1.

DATA REQUIRED BY THE PRIVACY ACT OF 1974.

AUTHORITY:	Title 5, United States Code *(USC)*, Section 301; Title 44, USC, Section 3101; and Title 10 USC. Section 1071.
PRINCIPAL PURPOSE:	To collect information from confirmed HIV infected individuals who indicate a past history of donating or receiving blood, blood products, organ *(s)*, tissue or sperm since 1977.
ROUTINE USES:	Information collected may be released to appropriate medical authorities in order to properly investigate the final disposition of any donations or recipient events recorded on this form.
DISCLOSURE:	Disclosure of information requested is voluntary. However, failure to provide the required information may hinder lookback procedures.

1. NAME OF INDIVIDUAL *(Last, First, Middle Initial)*: Doe, John Q.

2. CURRENT ADDRESS *(Number, Street, City, State)*: 111 First Street, Ft. Knox, KY 40121

3. SOCIAL SECURITY NUMBER: 000-00-0000

4. TELEPHONE NUMBER *(Include area code)*: WORK: (111) 000-0000 HOME: (000) 111-1111

5. DATE OF BIRTH (Mo. Day, Yr): 19890101

6. SEX: ☐ Male ☒ Female

7. I acknowledge that it may be necessary to release information to my confirmed HIV status by representatives of the Medical Advisory Committee of Any Army Community Hospital *(Medical Treatment Facility)* to the appropriate medical authorities in order to properly investigate the final disposition of any donations or recipient events recorded below. I hereby give permission for the release of this information.

John Q. Doe (signed) *(Signature)* — 20120505 *(Date)*

Jane Smith *WITNESS (Print/Type Name)* — Jane Smith (signed) *(Signature)* — 20120505 *(Date)*

COL John Q. Smith *Medical Advisory, Point of Contact: (Name)* — (111) 111-0000 *Telephone Number (DSN)* — (111) 111-0000 *(Commercial)*

8. Military Beneficiary Status *(Please Check appropriate category)*:

Active ☒ Dependent of Active Duty ☐ Sponsor's Name ____

Retired ☐ Dependent of Retired ☐ Sponsor's SSAN ____

Civilian ☐ Service Army ☐ Navy ☐

Air Force ☐ Marine ☐ Other ☐ *(Identify)* ____

9. Have you donated any blood, blood product, organ *(s)*, tissue or sperm since 1977? *(Please check appropriate response.)* YES ☒ NO ☐

10. If the answer to question #9 is YES, please indicate below the type and number of times you have donated. *(Please circle appropriate response and indicate the number of times below.)*

Blood / Blood Products Number Blood/2

Organ (s) / Tissues Number ____

Sperm Number ____

11. For each donation indicated above please provide that date and location below. Please note that any and all documentation pertaining to the donation events indicated above should be utilized to ensure that accurate information is provided. If exact information concerning the locations or dates is not available,then please provide the information that is available.

Donation #1 Type Blood *Date (Month, Day, Yr)* 20070110

Name or Organization Any Army Community Hospital

Location Ft. Knox, KY 40121 *(Street Address, City, State, Zip Code)*

Donation #2 Type Blood Date *(Month, Day, Yr)* 20101022

Name or Organization Any Army Community Hospital

Location Ft. Knox, KY 40121 *(Street Address, City, State, Zip Code)*

DA FORM 7303, JAN 1994 APD LF v1.01

Figure 2–1. Sample of completed DA Form 7303

Donation date and location continues. *(Please use additional sheets, if necessary.)*

Donation #3 Type _____ Date *(Month, Day, Yr)* _____

Name or Organization _____

Location _____
(Street Address, City, State, Zip Code)

12. Have you been the recipient of any blood, blood product, organ *(s)* , tissue or sperm since 1977? *(Please check appropriate response.)*

YES ☒ NO ☐

13. If the answer to question #12 is YES, please indicate below the type and number of times you have been a recipient. *(Please circle appropriate response and indicate the number of times below.)*

Blood / Blood Products Products Number I

Organ (s) / Tissues Number _____

Sperm Number _____

14. For each receipt indicated above please provide that date and location below. Please note that any and all documentation pertaining to the donation events indicated above should be utilized to ensure that accurate information is provided. If exact information concerning the locations or dates is not available, then please provide the information that is available. *(Please use additional sheets, if necessary.)*

Receipt #1 Type Blood Date *(Month, Day, Yr)* June 9, 1977

Name or Organization Ft. Knox, KY 40121

Location Any Army Community Hospital
(Street Address, City, State, Zip Code)

Receipt #2 Type _____ Date *(Month, Day, Yr)* _____

Name or Organization _____

Location _____
(Street Address, City, State, Zip Code)

Receipt #3 Type _____ Date *(Month, Day, Yr)* _____

Name or Organization _____

Location _____
(Street Address, City, State, Zip Code)

15. REMARKS

REVERSE OF DA FORM 7303, JAN 1994 APD LF v1.01

Figure 2–1. Sample of completed DA Form 7303–Continued

Chapter 3
Human Immunodeficiency Virus Testing

Section I
Introduction

3–1. General

a. Soldiers may not refuse mandatory HIV testing of the force, and will be informed of the pending procedure and referred to the HIV PHN for current CDC written patient education and counseling, as needed.

b. A testing, counseling, and surveillance program for HIV infection is necessary to—

(1) Assist in ensuring the continued readiness and deployability of the total force.

(2) Preserve the health of DA personnel and their Families by identifying HIV infected HCBs and providing appropriate counseling and medical treatment.

(3) Determine fitness for military duty.

(4) Permit commanders to assess the readiness, security, military fitness, good order, and discipline of their commands, and to take appropriate action based upon such assessment.

(5) Avoid potential complications of, and adverse reactions to, immunizations among HIV infected individuals, particularly new accessions to AD Army.

(6) Develop scientifically based information on the natural history and transmission pattern of HIV.

3–2. Testing categories

HIV testing will be performed in the following situations:

a. Accessions testing. See chapter 5.

b. Active force surveillance testing. See chapter 6.

c. Army National Guard and United States Army Reserve surveillance testing. See chapter 7.

d. Blood donor testing. All military blood donors will be screened for HIV using industry standards, ensuring compliance with Food and Drug Administration (FDA) requirements. AD HIV infected Soldiers will be referred to the HIV PHN. HIV infected Soldiers (both AD and RC) identified during civilian blood drives on military installations will be reported to the HIV PHN.

e. Clinical indications. All AD Soldiers with signs and/or symptoms compatible with or suggesting HIV infection, such as lymphadenopathy (enlarged lymph nodes), unexplained lymphopenia or leukopenia (depressed white cell count), thrombocytopenia (depressed platelet count), neurological disease, adult oral candidiasis (thrush), or evidence of opportunistic infections (such as pneumocystis pneumonia, candida esophagitis, or mononucleosis syndrome), will be tested in either the outpatient or inpatient setting as part of the medical evaluation.

f. Patients with sexually transmitted infections. These patients are seen mainly in primary care, sexually transmitted disease (STD), obstetrics and gynecology, urology, or dermatology clinics, but also may be seen in any MTF clinic or ward. Per CDC STD treatment guidelines, HIV testing is indicated with each new infection to include chlamydia, gonorrhea, nonspecific urethritis, syphilis, chancroid, lymphogranuloma venereum, granuloma inguinale, genital herpes, hepatitis, or other sexually transmitted infections (STIs). Such procedures are necessary to detect seroconversion in latent infections. HIV testing of AD Soldiers with a new STI is mandatory, and is the responsibility of the provider who ordered the initial test or made the clinical diagnosis. Patients found to be HIV infected will be evaluated per paragraph 4–11.

g. Blood transfusion or blood product recipients. The policies of the Armed Services Blood Program and guidelines of the FDA will be followed in the DA Blood Program and by civilian blood agencies collecting blood on Army installations.

(1) Blood or blood product donors whose donation tests positive for HIV will be notified, counseled, and evaluated, as required by this regulation.

(2) Recipients of blood products obtained from donors who are later determined to be HIV infected will be located, notified of the potential risk, and tested and evaluated.

(3) Donors of blood or blood products whose donations were transfused to recipients who were later determined to be HIV infected will be located, notified of their potential infection, and tested.

h. Sexual partners.

(1) Soldiers and other HCBs who are, or have been, sexual partners of HIV infected individuals will be tested. Although there are no documented cases of casual nonsexual transmission of infection, Soldiers who are household members with HIV infected individuals and are not sexual partners will be offered testing if there is any anxiety over the potential for household or casual nonsexual transmission.

(2) RC medical authorities will report information pertaining to HIV infected RC Soldiers and their identified sexual partners, including spouses, through designated channels to the RC HIV PHN or designee. That information will, in turn, be provided to State or local jurisdiction public health authorities in accordance with laws or reporting requirements. Specific guidance for reporting is included in detailed implementing instructions published by the NGB or Office of the Chief, Army Reserve (OCAR).

i. Intravenous drug use. Soldiers known to have used drugs intravenously will be routinely screened for HIV.

j. Voluntary screening. Individuals who engage in high risk behavior, such as having sex with known HIV infected persons or having multiple sexual partners, will be encouraged to be tested. HIV counseling and testing is available from the preventive medicine department PHN for any Servicemember or eligible beneficiary. See chapter 7 for Army RC personnel policies and procedures.

k. Overseas assignments. Unless modified by a COCOM, host nation, or other policy that requires earlier testing, personnel who are awaiting a PCS overseas or are scheduled for overseas deployments or temporary duty (TDY) must be screened and receive a negative HIV test result if they have not been tested within the 6 months preceding their departure. Individuals alerted for overseas assignments will be instructed, as part of their Soldier reassignment processing requirements, to report to the appropriate physical examination clinic or laboratory for a blood sample. For routine HIV testing requirements see paragraph 6–2 for Active Army and paragraphs 7–2 and 7–5 for ARNG and USAR. The following policy applies unless COCOM or host nation's policies require earlier testing:

(1) RC Personnel called to AD or scheduled for overseas deployments or TDY assignment require a negative HIV test within 2 years of the date they are called to AD regardless of whether the duty is overseas or in the United States (unless the host nation's policies require testing closer in time to arrival in the host nation).

(2) RC personnel located outside the United States scheduled for training either in the United States or overseas who do not meet the testing windows stated above will be tested immediately upon arrival at the training duty station when testing prior to departure is impractical.

l. Restricted assignments. Soldiers on orders for assignment to one of the units or programs identified in paragraph 6–3*b* must be screened and test negative for HIV infection if they have not been tested within the previous 6 months in accordance with AR 614–30. Individuals alerted for these assignments will be instructed to report to the appropriate physical examination clinic or laboratory for drawing of blood. Soldiers testing positive for HIV will not be assigned to a restricted unit or program.

Section II
Human Immunodeficiency Virus Testing Procedures

3–3. General human immunodeficiency virus testing procedures

HIV testing will include screening of all personnel designated in this regulation and verification of those who test positive by initial HIV screening tests.

a. The screening and verification for HIV will be an FDA-approved test and will be in accordance with Public Health Service or CDC guidelines.

b. Testing will be as follows, but may be modified by USAMEDCOM to reflect current best practice:

(1) Initial testing (first specimen).

(a) Personnel will receive an initial screening test performed by a designated facility in accordance with paragraphs 3–4 and 5–3.

(b) If the initial screen is HIV nonreactive, the Soldier is negative for HIV.

(c) If the initial screen is HIV reactive, the specimen will be retested in duplicate to ensure accuracy.

(d) If either of the duplicate tests is reactive, the specimen will be forwarded for confirmatory testing.

(2) Confirmatory testing (first specimen).

(a) If the specimen is repeatedly reactive (two of three tests are reactive), the specimen will reflex to supplemental confirmatory testing using a comparable FDA-approved antibody or nucleic acid test.

(b) If the confirmatory test fails to detect HIV antibody, antigen, and/or nucleic acid then the specimen is considered negative.

(c) If the confirmatory test detects either HIV antibody, antigen, and/or nucleic acid, then a second independent verification specimen will be collected from the individual as soon as possible and sent for identical testing.

(d) If the confirmatory test is indeterminate (detection of antibodies significant in the detection of HIV, but not confirmatory), the sample will be reflexed to qualitative nucleic acid testing for resolution of infection status.

(3) Second independent verification specimen (second specimen).

(a) If the second independent verification specimen result is concordant with the initial positive result, the individual will be medically evaluated for HIV infection at a designated Army MEDCEN.

(b) If the second independent verification specimen result is discordant with the initial positive, then a third specimen will be collected for definitive HIV testing and coordinated through the USAMEDCOM designated laboratory.

(4) Definitive HIV testing (third specimen).

(a) The USAMEDCOM designated laboratory will use the most current, FDA-approved laboratory techniques available for detection of HIV antibody and viral nucleic acid.

(b) If positive, the individual will be medically evaluated for HIV infection at a designated Army MEDCEN.

(c) If negative, the individual is not infected.

3–4. Medical and laboratory support for testing

a. Blood drawing and initial processing of samples from AD Soldiers being tested under the force surveillance program, RC personnel upon prior arrangement, or patients participating in routine adjunct testing will be accomplished by existing medical resources, under the direction of the clinical laboratory manager or other qualified official.

(1) USAMEDCOM will provide and/or coordinate necessary resources for testing support in the United States (including Alaska and Hawaii).

(2) In Europe, the Landstuhl Army Regional Medical Center, under guidance of USAMEDCOM and OTSG, will support all Army personnel in the European Command and Central Command by coordinating collection, processing, and shipment of specimens to USAMEDCOM identified testing facilities.

(3) Army personnel stationed in Korea, Japan, and the Pacific area will be supported as in paragraph (2), above by Tripler Army Medical Center, under guidance of USAMEDCOM and OTSG.

(4) Army personnel in Central and South America will be supported by the Southern Regional Medical Command, under guidance of USAMEDCOM and OTSG.

b. Civilian contract support will be used as discussed below.

(1) Central contracting for HIV screening and verification is the responsibility of OTSG, with support from USAMEDCOM and the U.S. Army Medical Research and Materiel Command.

(2) Contract testing may be used for accession, force surveillance, and routine adjunct testing.

(3) For RC surveillance testing, contracts will require the contractor to perform transportation and testing of blood.

(4) HIV screening capability may be maintained at MTFs to meet in-house requirements for patient HIV testing in time-sensitive patient care activities. These in-house testing procedures may be used to establish suspicion of infection, but screening, verification, and follow-up testing will be performed at USAMEDCOM designated laboratories.

(5) HIV screening or verification tests by other than USAMEDCOM designated laboratory or contract sources are not acceptable to meet any testing requirement established in this regulation.

Chapter 4
Notification, Counseling, Clinical Care, and Medical Records

Section I
Introduction

4–1. General

a. Patient notification, counseling, verification, contact tracing, clinical evaluations, and personnel actions will be completed as rapidly and professionally as possible. HIV PHN will be integral to the coordination and tracking of all aspects of this process.

b. Directors of health services, MEDDAC/MEDCEN commanders, command surgeons, unit surgeons, and clinic commanders will coordinate efforts in notifying individuals, commanders, and units.

4–2. Sensitive information

Information on HIV infected Soldiers will be handled in a sensitive manner and will comply with HIPAA standards.

Section II
Notification Procedures

4–3. Laboratory and provider notification

a. At USAMEDCOM, the HIV testing contractor or USAMEDCOM designated laboratory will notify the laboratory officer or POC designated at each MTF of the identity (by two unique identifiers, one of which must be the assigned laboratory specimen number) of specimens that test positive or negative for HIV by FDA-approved test (see chap 7 for USAR policy).

b. As an adjunct to routine laboratory notification of the ordering physician, the installation HIV PHN will regularly review new HIV test results with the MTF laboratory, preferably each work day. The HIV PHN will contact the ordering provider as soon as a positive test is identified.

4–4. Notification of the Soldier's Uniform Code of Military Justice commander

a. The HIV PHN will contact the commander in person or by telephone. The identities of the commander and the Soldier will be confirmed with two unique identifiers before the commander is notified of the positive test result. This should occur as soon as possible after receiving the results from the first positive sample, but no longer than 4 days after receipt of results for Soldiers on leave or not on AD status.

b. The HIV PHN will instruct the commander not to notify the Soldier about the test result. The HIV PHN will review commander's responsibilities in paragraph 1–14.

c. The commander will accompany the Soldier to the MTF, but will not be present in the room when the Soldier is notified about the (first) initial positive test by the medical provider.

d. The commander will accompany the Soldier to the MTF, but will not be present in the room when the Soldier is notified about the (second) positive verification test by the medical provider.

e. The commander will complete DA Form 4856 immediately after completion of DA Form 5669 (fig 4–1) (completed by the HIV program director) and provide a copy to the HIV PHN and Soldier. The HIV PHN will serve as a resource for the commander.

4–5. Soldier notification

a. All Soldiers will be individually and privately notified of all positive HIV test results in a face-to-face interview with the ordering provider or HIV program director.

b. After the first positive sample—

(1) The face-to-face notification must occur as soon as possible after the commander is contacted by preventive medicine and no later than 4 days after contact by preventive medicine for Soldiers on leave or not on AD status.

(2) The Soldier will be informed that he or she has a positive western blot or other FDA-approved test, which indicates HIV infection, and that a second blood sample will be drawn and sent for second independent verification.

(3) The Soldier will be advised not to donate blood/blood products, sperm/semen or eggs, breast milk, tissues, or organs and to refrain from sex until evaluated by the MEDCEN infectious disease service. The ordering provider will ensure the Soldier is informed that continuing to have sex without CDC recommended condoms or barriers may place sexual partners at risk of infection.

(4) The Soldier will be advised to immediately notify his or her spouse and/or sexual partner(s) of his or her infection. The Soldier will be advised that the HIV program director or coordinator (PHN) will verify that the spouse was informed and offer counseling and testing services.

(5) The Soldier will be asked if he or she has ever donated blood, and a DA Form 7303 (fig 2–1) will be completed on every Soldier, regardless of donation history, by the HIV PHN and forwarded to the Army Blood Program.

(6) The Solder will be assessed for the need of an immediate evaluation by behavioral health.

(7) The Soldier will be referred to the regional MEDCEN infectious disease service after the first positive western blot or other FDA-approved test which indicates HIV infection.

(8) The HIV program director will complete DA Form 5669 (fig 4–1) after notification of the first positive test and provide the original to the commander and copies to the Soldier and the HIV PHN.

(9) The UCMJ commander will complete DA Form 4856 after completion of DA Form 5669 and provide copies to the Soldier and the HIV PHN.

4–6. Notification of contacts of human immunodeficiency virus infected personnel

a. The HIV PHN will locate, notify, and counsel all military HCBs named as contacts to the HIV infected Soldier. The HIV PHN will verify the spouse of the newly infected Soldier was informed. If named contacts reside outside the catchment area, contact the appropriate military HIV PHN or other appropriate public health officials for notification and testing of contacts.

b. Information should be reported to civilian public health authorities, per local jurisdiction reporting requirements, when information is obtained through the epidemiological assessment interview indicating individuals who—

(1) Are not military personnel or military HCBs who are/were sexual partners of known HIV infected individuals.

(2) Were transfusion or blood product recipients from HIV infected donors.

4–7. Notification of the U.S. Army Human Resources Command

a. The Armed Forces Health Surveillance Center, designated central HIV program official, and the local HIV PHN will notify the officer and enlisted HIV POCs at HRC (AC or USAR HIV POC, as appropriate) after the first positive sample (see para 2–2*b*(8)).

b. HRC will place a formal nondeployable flag on the Soldier's record after the first positive sample. This will help ensure completion of the second independent verification test and will help prevent HIV infected Soldiers from deploying. The flag will be removed if the second and/or third independent verification tests are negative.

Section III
Counseling Procedures

4–8. Preventive medicine counseling

After the Soldier is notified about the first HIV positive test result (see para 4–5), the HIV program director will verbally counsel the Soldier on the relationship between HIV, the blood tests, and AIDS; the risks of disease transmission to close personal contacts and Family members; methods of prevention; and the fact that HIV infected individuals are not eligible to donate blood/blood products, sperm/semen or eggs, breast milk, tissues, and organs. Verbal preventive medicine counseling will occur after the first positive HIV test. The initial counseling will be recorded using DA Form 5669 (fig 4–1). Copies will be given to the Soldier and his or her commander.

4–9. Commander's counseling

a. Commanders will formally counsel Soldiers face-to-face after notification of their (first) positive HIV test and completion of the DA Form 5669. For AD and RC personnel, command counseling will be performed after the preventive medicine counseling. Commanders will use DA Form 4856, maintain the completed counseling forms in a locked filing cabinet or other storage unit to protect the confidentiality of the information, and provide a copy to the HIV PHN.

(1) When the commander counsels the HIV exposed Soldier, the following should be entered verbatim on DA Form 4856 in part III—Summary of Counseling (see http://www.armyg1.army.mil/hr/hivdna/ref_hiv.asp for a word document of the content):

I have been advised that you were counseled by the preventive medicine personnel concerning your positive HIV test, the risk HIV infection poses to your health, and the potential for transmitting HIV to others. You were advised by the preventive medicine personnel of the necessary precautions you must take to minimize the health risk to others as a result of your HIV infection. While I have great concern for your situation, in my capacity as your commander I must also be concerned with, and ensure the health, welfare, and morale of the other Soldiers in my command. Therefore, I am imposing the following restrictions:

(a) You will verbally advise all prospective sexual partners of your HIV infection prior to engaging in any sexual activity. You are ordered to use condoms should you engage in oral, vaginal, penile, or anal sexual activity with a partner.

(b) You will not donate blood/blood products, sperm/semen or eggs, breast milk, tissues, and organs, and will report previous donations to the HIV PHN.

(c) You will notify medical, dental, and emergency health care workers of your HIV infection.

(d) You will comply with the medical management of HIV infection directed by your infectious disease physician, to include medical evaluations every 6 months and as needed.

(e) You are nondeployable and may not go TDY OCONUS.

(f) You will obtain a PHA facilitated by the HIV PHN as soon as possible and annually.

(g) You will out-process and in-process with your preventive medicine HIV PHN as part of every PCS move.

(2) The following should be entered verbatim on DA Form 4856 in part III—Plan of Action (see http://www.armyg1.army.mil/hr/hivdna/ref_hiv.asp for a word document of the content):

(a) Cooperate fully with my HIV program coordinator to confidentially reveal the identity of all persons with whom I have had sex or shared needles for the period starting 3 months prior to my last negative HIV test so contacts may receive counseling and testing to break the chain of transmission. In addition to revealing their identities, I will personally inform my contacts, including my spouse, and recommend they seek medical consultation.

(b) Understand my status is nondeployable and I may not go TDY OCONUS.

(c) Do not donate blood/blood products, sperm/semen or eggs, breast milk, tissues, or organs.

(d) Follow my UCMJ commander's order by informing all potential sexual partners of my HIV positive status before engaging in intimate sexual contact. My partner will not be under the influence of alcohol, drugs, or prescription medications that could potentially alter his or her judgment during this discussion.

(e) Practice safer sex using a condom or other barrier method recommended by the CDC with every vaginal, penile, anal, and oral sexual encounter. Safer sex practice will not only protect my partners but will also protect me from exposure to other drug-resistant HIV strains.

(f) Notify medical, dental, and emergency health care workers of my HIV infection by stating, " I am blood donor ineligible" or "I have HIV."

(g) Schedule and attend infectious disease clinic appointments every 6 months and more often, as directed by my infectious disease clinic physician.

Note.
ARNG and Reserve Soldiers, unless activated, will have annual fit for duty (FFD) medical evaluations.

(h) Complete DA Form 5669 at diagnosis and annually with my HIV PHN.

(i) Complete the DA Form 4856 at diagnosis, within 30 days of a unit change of command, and within 30 days of every PCS move.

(j) Complete a PHA at diagnosis and annually as coordinated by my HIV PHN.

(k) Contact my current HIV PHN 1 month before PCS for coordination of medical appointments and command requirements with the gaining HIV PHN and in-process with my new HIV PHN at expiration term of service or retirement.

(l) Report all previous donations of blood/blood products, sperm/semen or eggs, breast milk, tissues, or organs to my HIV Program coordinator (PHN).

(m) Understand the health risk and will avoid live attenuated viral immunizations such as intranasal influenza, chicken pox, smallpox, measles, mumps, rubella, yellow fever, and oral typhoid.

b. The commander's copies of the DA Form 5669 and the DA Form 4856 will be maintained in a locked cabinet or storage unit and designated as "Eyes Only" for the commanding officer as long as the Soldier is assigned to that unit. The commanding officer, in situations of Soldier noncompliance, may disclose this information to designated unit senior leadership on a case-by-case basis to support the Soldier toward compliance. For Soldiers PCSing, the HIV PHN will transfer DA Form 5669 and DA Form 4856 by confidential mail or scanned encrypted email to the gaining HIV PHN. The new HIV PHN will complete a new DA Form 5669 and coordinate with the new unit commander to complete DA Form 4856. For unit commanders PCSing, a commander's copy of DA Form 5669 and DA Form 4856 will be provided to the new unit commander and a new DA Form 4856 will be completed.

4–10. Psychosocial counseling

a. HIV infected Soldiers will be referred for a psychosocial assessment and counseling as part of their initial medical evaluation. The purpose of this counseling is to provide an initial assessment of the Soldier's mental state and coping skills.

b. Behavioral health resources may include MTF behavioral health department, pastoral chaplain services, Family life chaplain, Military OneSource, MEDCEN infectious disease social work, and psychiatry.

c. The behavioral health provider and/or Family life chaplain should be skilled at counseling personnel dealing with trauma, depression, and rejection. They should be specifically trained in identifying and dealing with potential suicides and personal grief.

d. HIV infected Soldiers may be referred to psychosocial counseling, as needed.

Section IV
Clinical Evaluations and Recording of Medical Information

4–11. Clinical evaluation, medical profiles, and medical readiness

a. HIV infected Soldiers will be medically evaluated by infectious disease specialists at a participating MEDCEN supporting the health service region to determine the status of their infection.

b. 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 FFD. RC Soldiers are required to obtain the FFD medical examination from the civilian medical community at no expense to the Government. The required medical procedures will be provided to the Soldier to give to his or her physician. This examination must be repeated at least annually after the initial evaluation (see chap 7 for additional guidance regarding HIV infected RC Soldiers).

c. The CDC classification system for HIV infection will be used for medical classification purposes.

d. Soldiers determined HIV positive by confirmatory test on the first specimen will be noted in MEDPROS as follows: initial physical, upper, lower, hearing, eyes, psychiatric (PULHES) will remain the same, the V code for deployment restrictions will be added to the profile, and medical nondeployment module changed to "YES" by the HIV program coordinator (PHN).

e. Soldiers who are confirmed as HIV infected do not require a change in the PULHES on their physical profile solely because they are HIV infected. If the Soldier's physical or medical condition warrants a change in physical profile, a DA Form 3349 (Physical Profile) will be issued by the MEDDAC/MEDCEN commander or other profiling authority. Copies of the DA Form 3349 will be sent to the unit commander and the servicing personnel service center. Documents will be sealed in an envelope marked "To Be Opened By Addressee Only" and addressed, by name, to the appropriate unit commander and adjutant general or personnel officer. Procedures will be established by the appropriate medical authority to confirm that unit commanders and adjutants general or personnel officers have received proper notification of HIV infected Soldiers. If a change in physical profile is warranted, the following minimum entries will be made on the DA Form 3349:

(1) Item 1 of the DA Form 3349 will indicate the specific medical condition causing the change in physical profile. The profiling authority should avoid referring to HIV infection or retrovirus infection since these terms describe the disease process rather than the specific medical condition resulting in the profile.

(2) Item 2 will contain a V code denoting deployment restrictions and additional codes may be entered as necessary.

(3) Item 3 PULHES, will be adjusted per AR 40–501.

4–12. Blood donation

a. Preventive medicine will report confirmed HIV infected Soldiers to the Army Blood Program look back coordinator, USAMEDCOM for entry into the donor deferral registry.

b. Army blood donor centers will notify local preventive medicine officials about Soldiers who have positive HIV test results identified during blood donation. Test results will include initial reactive or repeat reactive and confirmatory test results.

4–13. Medical records and databases

Information on, and results of, HIV testing will be entered in individual medical records as follows:

a. HIV test dates from the DOD lab contractor go directly to the Armed Forces Health Surveillance Center and are then forwarded to the MEDPROS individual medical readiness.

b. Soldiers with a confirmed positive HIV test (first specimen) will be entered by the installation HIV program coordinator (PHN) until such time that a direct electronic feed is available from the confirmatory lab to MEDPROS. The entry is "initial PULHES will remain the same, the V code will be added to the profile, and medical nondeployment module changed to YES." In the case of a verification test revealing previous erroneous positive result, the HIV coordinator (PHN) will directly coordinate with the regional medical readiness coordinator to correct the MEDPROS database. This allows commanders and medical personnel to track these individuals over time and ensure their continental United States (CONUS) only duty status is not violated.

c. Records pertaining to evaluation and reevaluation of HIV infected Soldiers will be filed per AR 40–66.

d. Soldiers with confirmed positive HIV test (first specimen) will be entered by the installation HIV program coordinator (PHN) in the Armed Services Blood Program Blood Establishment Computer System, a DOD blood management system for tracking donations, testing, and shipping of products and transfusion of blood products.

PREVENTIVE MEDICINE COUNSELING RECORD

For use of this form, see AR 600-110; the proponent agency is DCS, G-1.

DATA REQUIRED BY THE PRIVACY ACT OF 1974

Authority:	5 USC 301, 10 USC 3012(G).
Principal Purpose:	To record preventive medicine counseling of Servicemembers testing positive for exposure to HIV.
Routine uses:	Prerequisite counseling under AR 600-110, paragraph 2-16.
Disclosure:	Disclosure is voluntary. However, failure to provide the information may result in incorrect identification.

INSTRUCTIONS

The counselor will obtain and record the administrative information required in Part I from official military records or from the Soldier's identification card. The HIV program coordinator public health nurse (PHN) will maintain this document in accordance with AR 600-110 in a locked cabinet. Upon PCS, this form will be sent to the gaining HIV program coordinator (PHN). Upon ETS or retirement, this form will be destroyed.

PART I - PATIENT INFORMATION

A. NAME OF PATIENT (Last, First, MI)	B. DOB	C. GRADE	D. NAME OF SPONSOR
Smith, John Q.	19880101	E6	Same
E. UNIT	**F. LOCATION**		
HHQ, 1st Training BDE	Ft. Knox, KY		
G. DATE OF DIAGNOSIS (YYYYMMDD)	**H. DATE AND TIME OF COUNSELING**		**I. LOCATION OF COUNSELING**
20120501	20120503/1330hrs		Ireland ACH, Ft. Knox, KY

J. Counselor:

1. NAME	2. GRADE/CORPS	4. UNIT
Doe, Jane A.	04/MC	A Company 1ACR Ft. Knox, KY
3. TITLE		
Chief, Preventive Medicine		

PART II - PATIENT COUNSELING ACKNOWLEDGMENT

I have been informed of my positive HIV test result. I understand as a member of the Active Army, Reserve, or Army National Guard, I have specific responsibilities to prevent transmission of the infection to others, specifically:

A. My confirmed positive HIV test means I have been infected with HIV.

B. I understand my UCMJ commander is informed of this positive result and is my advocate in accordance with AR 600-110. I have reviewed and understand my Soldier responsibilities.

C. There is no cure for HIV infection. My blood, semen, vaginal fluids, and breast milk may potentially transmit HIV infections to others. Even if my viral load is undetectable, my blood, semen, vaginal fluids, and breast milk may transmit HIV infection to others.

D. I will not donate blood/blood products, sperm/semen or eggs, breast milk, tissues, or organs.

E. I am nondeployable, may not go TDY OCONUS, and my career occupational specialty may be affected. My UCMJ commander will contact the HRC HIV POC for guidance.

F. I realize I may have infected others with HIV before I knew I was infected. For this reason, I am obliged to confidentially reveal the identity of all persons with whom I have had sex or shared needles for the period starting 3 months prior to my last negative HIV test, so that contacts may receive counseling and testing to break the chain of transmission. In addition to revealing their identities, I will personally inform my contacts, including my spouse, and recommend they seek medical consultation.

G. Intimate sexual contact includes oral, vaginal, penile, and anal sex with any partner potentially at risk of HIV transmission and infection. The use of condoms may reduce but does not eliminate the risk of HIV infection. I must follow safer sex practices using barriers such as condoms with every sexual act or insist my partners use condoms. Other barriers include female condoms and dental dams. I will not share razors or toothbrushes, and will cover wounds to prevent transmission.

H. Condom use does not remove my obligation to inform partners of my HIV infection before engaging in intimate sexual contact. When discussing this, my partner must not be under the influence of any potentially mind-altering substances (alcohol, illegal drugs, prescription medications, and so forth) that could potentially impair his or her judgment.

I. I understand I must notify medical, dental, and emergency health care workers potentially exposed to HIV infection through contact with my blood and/or body fluids. I understand the need to clarify which vaccines I am receiving and will avoid live attenuated viral immunizations such as intranasal flu, chicken pox, smallpox, measles, mumps, rubella, yellow fever, and oral typhoid vaccines.

J. HIV can be transmitted from an HIV positive mother to her baby; therefore, Family planning issues will be discussed with my infectious disease physician.

K. I will comply with the medical management of HIV infection directed by the infectious disease physician, to include attend medical evaluations every 6 months and as needed (active duty HIV-infected Soldiers only). Note: Army National Guard and Reserve Soldiers, unless activated will have annual fit for duty medical evaluations.

L. I must complete a DA Form 5669 (Preventive Medicine Counseling Record) and DA Form 4856 (Developmental Counseling Form) at diagnosis and as directed by my HIV program director/coordinator (PHN).

M. As a member of the Active Army, Reserve, or Army National Guard, I must complete a periodic health assessment (PHA) at diagnosis, and then annually.

N. To maintain my confidentiality and military requirements, I will contact my HIV program coordinator (PHN) 1 month before PCS, planned expiration term of service, or retirement.

I acknowledge that I, John A. Smith, have been counseled and understand that the preventive medicine measures listed in paragraphs A through N, above, which were explained to me, are necessary to preclude transmission of HIV infections.

O. SIGNATURE OF PATIENT	DATE (YYYYMMDD)	P. SIGNATURE OF COUNSELOR	DATE (YYYYMMDD)
DIGITAL SIGNATURE 12345678	20120503	DIGITAL SIGNATURE 12345678	20120503

DA FORM 5669, JUL 2012 PREVIOUS EDITIONS ARE OBSOLETE. APD LF v1.02ES

Figure 4–1. Sample for DA Form 5669

Chapter 5
Accession Testing Program

5–1. General
This chapter prescribes the DA policy for accession testing and nonaccession of individuals who are confirmed HIV positive by appropriate confirmatory test.

5–2. Accessions and probationary officers
a. For purposes of this chapter, accessions are—

(1) First enlistments in the AC or RC.

(2) Subsequent enlistments in the AC or RC other than immediate reenlistments in the same component.

(3) Original appointments as a commissioned or warrant officers in the AC (except for officer appointments in the AC under the provisions of AR 601–100, chap 2).

(4) Appointments as cadets at the United States Military Academy (USMA).

(5) First original appointments as commissioned or warrant officers in a RC (to include both qualifications for Federal recognition and for original appointment as a Reserve of the Army in the ARNG following Federal recognition).

(6) Original appointments as warrant officers in the Army of the United States.

(7) Peacetime orders of a member of a RC to AD, active duty for training (ADT), or full-time National Guard duty (FTNGD) for the purpose of attending initial entry training, regardless of whether the RC member is programmed at the conclusion of training for release from active duty (REFRAD), or is programmed to continue on active duty for operational support (ADOS) or FTNGD. This specifically includes the order to ADOS of Reserve commissioned officers commissioned through the Reserve Officers' Training Corps (ROTC) program where the officer's initial duty assignment is to an officer basic course.

(8) Enrollments as an ROTC scholarship cadet or as a nonscholarship cadet in military science III.

(9) Enrollments as an officer candidate (Active Army, ARNG, or USAR) in Officer Candidate School (OCS).

b. Probationary officers are—

(1) AC commissioned officers on the AD list with less than 5 years active commissioned service.

(2) RC commissioned officers who have less than 5 years commissioned service. Both AD and non-AD commissioned service counts.

(3) Warrant officers who have less than 3 years service (AD or non-AD) since original appointment in their present component.

(4) Officers who have less than 3 years service in the Army of the United States without component.

5–3. Human immunodeficiency virus testing policies
a. All applicants for accession (officer, warrant officer, and enlisted for AC and RC) will be screened for HIV using FDA-approved tests.

b. HIV testing of applicants for enlistment will be accomplished during the initial physical examination at the MEPS. Blood samples will be drawn by medical personnel at the MEPS. Testing from any source except MEPS, other DOD military treatment facilities, or DOD contract facilities is not acceptable for accession testing requirements (see AR 601–270).

c. Applicants for accession who have no military status of any kind at the time of testing and who are confirmed HIV infected will not be enlisted or appointed in any component of the Army.

d. Individuals who test HIV positive will be provided a list of civilian treatment facilities by the chief medical officer at the MEPS. The chief medical officer will recommend the individual seek further medical evaluation at one of the listed facilities and complete local health department reporting requirements.

e. Accession testing will be conducted within the first 29 days of AD at training centers, schools, or units (whichever provides the earliest opportunity) for all personnel who have not been previously screened at a MEPS or other authorized location, or for whom 6 months have elapsed from the initial pre-accession screening (such as personnel entering from the delayed entry program or a pre-commissioning program). For accession purposes, the pre-accession HIV test is valid until the Soldier is ordered to AD. Upon order to AD, if the pre-accession test is more than 6 months old, the Soldier will be retested within the first 29 days at the initial AD installation. Those confirmed to be HIV infected will be processed for separation for failure to meet procurement medical fitness standards.

f. Accessions processed by other than MEPS or an initial training center will follow a similar process as outlined above at the military point of entry. Vaccination with live virus vaccines may be administered provided there is a record of a previous negative HIV test no older than 24 months.

g. Prior service personnel required to meet accession medical fitness standards (AR 40–501) must be tested and found to be HIV negative no more than 6 months before enlistment in the Selected Reserve. Prior service applicants, who are not processed through MEPS, may conditionally enlist without an HIV test, or with a test result older than 6

months. Testing is required within the first 30 days after enlistment through the force surveillance testing program. A one-time 30-day extension may be granted by the State Adjutant General or by a commander of one of the numbered armies in CONUS. Soldiers testing HIV positive will be discharged for an existed prior to service medical condition. AD Soldiers transferring to or enlisting in a Selected Reserve unit at the end of their current contractual or statutory obligation without a break in service are required to meet retention medical fitness standards (AR 40–501). These Soldiers must have a negative HIV test no older than 24 months prior to the date of transfer or enlistment.

h. Candidates for active or reserve officer service will be tested during the pre-appointment physical examinations. This applies to any individual pending appointment as an officer in any officer procurement program, to include ROTC, direct commissioning, and OCS (ARNG, Reserve, or Active Army) programs. For accession purposes, the pre-accession HIV test is valid until the Soldier is ordered to AD. Upon order to AD, if the pre-accession test is more than 6 months old, the Soldier will be retested within the first 29 days at the initial AD installation. USMA cadets will be tested within 72 hours of reporting to the USMA on reception day.

(1) USMA cadets who are confirmed HIV positive will be separated from the academy and discharged under USMA regulations. The Superintendent, USMA, may delay separation until the end of the current academic year. If the cadet is in his or her final academic year and is otherwise qualified, the cadet may be graduated without commission and discharged. An honorable discharge will be issued if HIV infection is the sole basis for discharge.

(2) ROTC cadets who are confirmed HIV infected will be disenrolled from the program at the end of the current academic term (semester, quarter, or similar period). Cadets who are disenrolled due to HIV infection will be permitted to retain any financial support received through the end of the current academic term and such support is not subject to recoupment.

(3) Enlisted Soldiers who are officer candidates through OCS and are confirmed HIV infected will be immediately disenrolled from the program. If OCS is the Soldier's initial entry training, the Soldier will be discharged under the provisions of AR 635–200. If OCS is not the Soldier's initial entry training, the Soldier will be removed from the program under the provisions of AR 350–51, AR 140–50, or NGR 351–5, as appropriate, and will be reassigned in his or her original military occupational specialty (MOS) in accordance with assignment policies of chapters 6 or 7. Reassignment will be without regard to PCS restrictions.

5–4. Confidentiality

The provisions of chapters 3, 4, and 9, with regard to confidentiality and use of information, apply to this chapter, except that HIV infection may be used as the basis for separation under the accession testing program. Care will be taken that no one without a "need to know" in the performance of his or her duties is given any information about an applicant's HIV status. "Need to know" individuals are defined as the Soldier's commanding officer, designated laboratory, preventive medicine, behavioral health, pastoral care, pharmacy, wellness, primary care, and specialty medical personnel, Reserve and Guard HIV program directors or coordinators, and designated HRC personnel. In situations of Soldier noncompliance, the commanding officer may disclose this information to the designated unit senior leadership on a case-by-case basis to support the Soldier toward compliance. Current HIPAA privacy and security training is required for all "need to know" individuals.

Chapter 6
Active Duty Personnel Policies and Procedures

Section I
Assignment Policies and Procedures

6–1. General

a. The policies and procedures in this chapter apply to all AD Soldiers, including AGR personnel.

b. Individuals who are 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.

c. 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 (see para 5–4).

6–2. Active force surveillance testing

a. All Soldiers are required to be tested for HIV at least biennially (once every 2 years). Upon confirmation of a positive HIV infection status (after verification specimen) Soldiers are exempt from this requirement.

b. Unit commanders are notified of all personnel requiring biennial HIV testing via MEDPROS.

c. Unless modified by a COCOM, host nation, or other policy that requires earlier testing, personnel who are awaiting a PCS overseas or are scheduled for overseas deployments or TDY must be screened and receive a negative HIV test result if they have not been tested within the 6 months preceding their departure date. Individuals alerted for

overseas assignments will be instructed, as part of their Soldier reassignment processing requirements, to report to the appropriate physical examination clinic or laboratory for a blood sample. For routine HIV testing requirements for RC personnel, see paragraphs 7–2 through 7–6. The following policy applies unless COCOM or host nation's policies require earlier testing (see AR 614–30).

d. In the event that prioritization of testing is required due to resource constraints, screening will be accomplished in the following priority:

(1) Soldiers and military units assigned or pending assignment to areas of the world where a moderate to high risk exists of contracting serious tropical infections, such as yellow fever, malaria, and dengue. Such areas include Central America, South America, the Caribbean, the Philippines, Southeast Asia, Thailand, Malaysia, Central Africa, East Africa, and Southwest Asia.

(2) Soldiers or units pending assignment or deployment to areas of the world where medical support will be limited. Included are assignments to remote areas where periodic evaluation of personnel and monitoring of health will be difficult, such as Korea and the Far East.

(3) Units with contingency plans to deploy on short notice to areas of the world described in paragraphs (1) and (2), above. Included are alerted forces who must be deployed in 30 days or less and all personnel scheduled to participate in overseas exercises that have not been screened within 24 months of the projected deployment date.

(4) Other military units that could be deployed overseas and OCONUS Army Forces in Europe, Korea, and Japan.

(5) All other units.

(6) All Soldiers in conjunction with routine, periodic physical examinations for any purpose, or any other scheduled medical examinations.

6–3. Assignment limitations

a. HIV infected Soldiers will not be deployed or assigned overseas. HIV infected Soldiers will not perform official duties overseas for any duration of time. Soldiers confirmed to be HIV infected while stationed overseas will be reassigned to the United States per paragraph 6–8.

b. In the United States (including Alaska, Hawaii, Guam, Puerto Rico and the U.S. Virgin Islands), HIV infected Soldiers will not be assigned to—

(1) 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 3 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 and AR 614–200. Reassignment must be to an authorized position for the Soldier's grade and primary MOS or secondary MOS. Installation commanders unable to make appropriate reassignments will report the names of HIV infected Soldiers to the Commander, HRC, AHRC–EPD–I (enlisted) or TAPC–OPD–M (officer).

(2) 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 will be disenrolled at the end of the academic term in which HIV infection is confirmed and may be reassigned without regard to PCS 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 will be 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).

(3) U.S. Army Recruiting Command, Cadet Command, U.S. Military Entrance Processing Command, ARNG full time recruiting force, or ARNG full time attrition/retention force if a Soldier's medical condition requires frequent medical follow-up (medical authorities will determine if follow-up is frequent) and the Soldier's projected duty station is geographically isolated from an Army MTF capable of providing that follow-up. These organizations will report HIV infected Soldiers who cannot be assigned per this policy to the Commander, HRC, AHRC–EPD–I (enlisted) or TAPC–OPD–M (officer), for assignment instructions (AI). For special branch officers, forward assignment requests to HQDA (DAJA–PT) for Judge Advocate General's Corps (JAGC) officers or HQDA (DACH–PEA) for chaplains. For ARNG AGR Title 10 personnel, all requests should be sent to Commander, National Guard Personnel Center (NGB–ARP–CT), 4501 Ford Avenue, Alexandria, VA 22302–1450; for ARNG FTNGD Title 32 personnel, requests should be sent to the applicable State Adjutant General. Requests for AI for USAR AGR personnel should be sent to Commander, U.S. Army Human Resources Command, Human Resource Center of Excellence (AHRC–SGD–H), Department 140, 1600 Spearhead Division Avenue, Fort Knox, KY 40122–5303.

c. Assignment preclusion from units, organizations, schools, or programs other than those listed above must be approved by HQDA (DAPE–HR).

d. Commanders may not change the assignment or utilization of HIV infected Soldiers solely because of their

infection unless required by this regulation or the Soldier's medical condition (as reflected on DA Form 3349 or other pertinent medical records). 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.

e. HIV infected Servicemembers may transfer to the Active Army from another Armed Force (inter-Service transfer) if they meet medical retention standards (AR 40–501). However, Servicemembers who are HIV infected may not be transferred to the Army from another Armed Force if they are required to meet accession medical standards (AR 40–501), except as specifically permitted in chapter 5.

f. HIV infected Soldiers who demonstrate progressive clinical illness or immunological deficiency will be processed per section III of this chapter. (See the glossary for definitions of progressive clinical illness and immunological deficiency.)

6–4. Accompanied tours

a. Family members who are HIV infected may accompany their sponsor overseas. Paragraph 8–6 provides guidance for processing HIV infected Family members.

b. When a Family member is HIV infected, the sponsor may request deletion from an overseas assignment alert based on compassionate reasons, or request an "all others" tour. Deletion of the sponsor from overseas AI is not mandated solely based on a Family member's HIV status. If assigned overseas at the time the Family member is diagnosed as HIV infected, the sponsor may apply for a curtailment of foreign service tour (FST) for compassionate reasons per AR 614–30. A mandatory PCS or curtailment of FST of the sponsor will not occur solely because a Family member is determined to be HIV infected.

6–5. Military schooling

Soldiers who are HIV infected and are determined to meet retention standards are eligible for all military professional development schools (such as Noncommissioned Officer Education System, Captains Career Course, and intermediate level education). HIV infected Soldiers may also attend formal military training required to qualify them for reclassification to a new MOS or award a skill qualification identifier, additional skill identifier, or functional area.

6–6. Reenlistment

a. HIV infected enlisted Soldiers who meet medical retention standards of AR 40–501, chapter 3 are eligible to reenlist, if otherwise qualified.

b. There is no requirement to have an HIV test as part of reenlistment qualification unless the Soldier desires to reenlist for an overseas duty assignment or for an organization cited in paragraph 6–3*b*. Soldiers will not be permitted to reenlist for an overseas duty assignment or an organization cited in paragraph 6–3*b*, unless they have tested negative for HIV within the 6–month period preceding the desired date of reenlistment. If HIV infected, they may reenlist for any option in AR 601–280 except overseas or restricted units.

c. Enlisted Soldiers who enlisted or reenlisted for a unit or organization cited in paragraph 6–3*b* and who subsequently are confirmed as HIV infected will be processed as follows:

(1) If otherwise eligible, Soldiers will be advised of the procedures of AR 635–200, concerning requests for separation due to unfulfilled enlistment commitments.

(2) Soldiers who are not eligible for separation due to unfulfilled enlistment commitments under AR 635–200 and who are not under a suspension of favorable personnel actions may request separation for the convenience of the Government under AR 635–200, secretarial plenary authority. These procedures are outlined in paragraph 6–14.

(3) Enlistment contracts may be renegotiated where appropriate and Soldiers, if otherwise eligible, may be given other options commensurate with the established assignment limitations for HIV infected Soldiers.

6–7. Utilization

a. There is no medical reason for HIV infected Soldiers' duties to be changed 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 will be made by a medical evaluation board as to the Soldier's fitness to perform his or her duties.

b. In the case of HIV infected health care providers, their duties may be restricted when performing those duties that present a risk of transmitting HIV to their patient. This determination will be made by an expert medical review committee as designated by the deputy commander for clinical services. This committee will make recommendations on a case-by-case basis to the MEDDAC/MEDCEN/Dental Activity commander per AR 40–68 as to the restriction of duties of HIV infected health care providers. The restriction may only be to the extent that the risk is eliminated. In all other instances, HIV infected Soldiers will be utilized in their primary MOS per normal utilization criteria contained in Army personnel regulations and the assignment limitations in paragraphs 6–3*b* and 6–3*d*.

6–8. Assignment/reassignment policies and procedures

a. Overseas policies.

(1) Soldiers serving overseas who are identified as HIV infected will have their FSTs curtailed and will be expeditiously reassigned to the United States. This paragraph does not apply to Soldiers who are permanent residents of and are currently stationed in Guam, the Virgin Islands, or American Samoa. HIV infected Soldiers who are assigned outside these areas and who desire compassionate reassignment to these areas may apply per existing policies for compassionate reassignments. Requests will be considered on a case-by-case basis.

(2) Soldiers who are returned to the United States will have their FST curtailed and will be given credit for a completed tour as prescribed in AR 614–30.

(3) Overseas ACOM, ASCC, or DRU commanders are authorized to approve a second PCS in the same fiscal year for HIV infected Soldiers returning to the United States under this program. AR 614–30 prescribes authorities for approval of PCS and time on station waivers and tour curtailments.

b. Overseas procedures.

(1) Overseas adjutants general or personnel officers will, upon receipt of formal notification of Soldiers who are HIV infected, request immediate FST curtailment per AR 614–30. Curtailments of FST will be coordinated by priority message, "FOR OFFICIAL USE ONLY" with Commander, HRC, AHRC–EPD–I (enlisted) or TAPC–OPD–M (officer) for AI. For special branch-managed officers, forward assignment requests to HQDA (DAJA–PT) for JAGC officers or HQDA (DACH–PEA) for chaplains. (For ARNG AGR Title 10 personnel, all requests should be sent to Commander, National Guard Personnel Center (NGB–ARP–CT), 4501 Ford Avenue, Alexandria, VA 22302–1450; for USAR AGR personnel, all requests should be sent to Commander, U.S. Army Human Resources Command (AHRC–SG), Building 6434–6, 1600 Spearhead Division Avenue, Fort Knox, KY 40122–5303). Requests will include the following:

(a) Name, grade, social security number, primary MOS or control branch, and unit of assignment.

(b) Include the statement: "This curtailment request is submitted per AR 600–110, paragraph 6–8*b*."

(c) Desired report date.

(d) Three assignment preferences in the United States (including Alaska, Hawaii, Guam, Puerto Rico and the U.S. Virgin Islands) with rationale from the Soldier as to the three choices (for example, to be near Family).

(e) Known assignment limitations or special considerations that should be considered in making the assignment.

(f) Tour type: accompanied, unaccompanied (Family members in the United States), unaccompanied (Family members in-country at sponsor's personal expense).

(2) The Commander, HRC (Commander, National Guard Personnel Center (NGB–ARP–CT), for ARNG Title 10 AGR personnel, or Commander, HRC (AHRC–SGD–H), for USAR AGR personnel) will issue AI expeditiously.

(3) Soldiers overseas identified for referral into the physical disability system will be expeditiously processed per AR 635–40.

(4) Nothing in the procedures discussed above should be interpreted as prohibiting a Soldier from taking leave overseas solely because of HIV infection. Current Army and DOD policy does not restrict a Soldier from any travel in a leave status based on the results of an HIV test. However, HIV infected Soldiers must meet entrance requirements for countries they intend to visit. Countries may require evidence of HIV testing and may require negative test results as part of those entrance requirements.

c. Continental United States policies.

(1) Soldiers identified as HIV infected and who are assigned to organizations cited in paragraph 6–3*b* will be transferred within their current installations. If local reassignment is not possible, HIV infected Soldiers will be reported to the Commander, HRC for AI. These Soldiers are eligible for other assignments in the United States (including Alaska, Hawaii, Guam, Puerto Rico, and the U.S. Virgin Islands) according to the needs of the Army and existing PCS policies.

(2) Soldiers who receive overseas AI will require an HIV test as part of their Soldier reassignment processing requirements if they have not been tested in the 6 months prior to their port calls. Those who are HIV infected will be deleted from AI. Soldiers with Family members who are HIV infected will follow the policies and procedures in paragraphs 6–4*b* and 8–6.

d. Continental United States procedures. Adjutants general/personnel officers in the United States will, upon receipt of formal notification from the commander of the local MTF of Soldiers who are HIV infected, take the following actions:

(1) Soldiers who are HIV infected will be deleted from overseas AI. For enlisted personnel, requests for deletions will be submitted to the Commander, HRC (AHRC–EPD–I). Approval will be automatic and confirmed through the Enlisted Distribution and Assignment System by HRC. For officer personnel, requests for deletions will be forwarded to the Commander, HRC (TAPC–OPD–M) for officers managed by Officer Personnel Management Directorate; HQDA (DAJA–PT) for JAGC officers; or HQDA (DACH–PEA) for chaplains. For ARNG Title 10 AGR personnel, all requests for deletion will be forwarded to Commander, National Guard Personnel Center (NGB–ARP–CT), 4501 Ford Avenue, Alexandria, VA 22302–1450; for ARNG Title 32 AGR personnel, all requests for deletion will be forwarded to the State Adjutant General, Support Personnel Management Office, of the particular State/territory to which the

AGR Soldier is assigned for duty. For USAR AGR personnel, all requests for deletion will be forwarded to the Commander, U.S. Army Human Resources Command, Human Resource Center of Excellence (AHRC-SGD-H), Department 140, 1600 Spearhead Division Avenue, Fort Knox, KY 40122-5303.

(2) Other than accession testing per chapter 5, enlisted Soldiers undergoing initial entry training (to include prior service Soldiers) with AI to an overseas location and who are confirmed as HIV infected will be reported to the Commander, HRC (AHRC–EPD–I) under provisions of AR 635–200 (see separation for convenience of the Government) for separation if less than 180 days of service or for issuance of AI to an installation in the United States or Puerto Rico if over 180 days of service.

6–9. Transfer of personnel and medical records

The procedures below apply to the transfer of personnel and medical records of all Soldiers identified as HIV infected. These procedures apply to moves within the United States as well as from overseas locations to the United States, excluding those conducted through medical evacuation channels.

a. When AI on an HIV infected Soldier are received, the HIV infected Soldier will inform his or her HIV program coordinator (PHN) and out-process within 30 days of PCS. The losing HIV program coordinator (PHN) will contact the gaining HIV program coordinator (PHN) and provide the expected date of departure, the new assignment location or unit (if known), and the anticipated arrival date, and send the contents of the duplicate file, including all preventive medicine and commander's counseling statements encrypted or by confidential fax to the gaining HIV program coordinator (PHN).

b. The Soldier will in-process with the gaining HIV program coordinator (PHN) immediately upon arrival.

c. The gaining HIV program coordinator (PHN) will ensure that any immediately necessary medical care, to include medical evaluation and reevaluation, is fully coordinated.

d. The HIV program coordinator (PHN) will notify the gaining unit commander of the Soldier's medical condition as soon after his or her arrival as possible.

e. HIV infected Soldiers transferred into a unit will be provided preventive medicine counseling and commander's counseling in the same manner as that prescribed for newly identified HIV infected Soldiers (see paras 4–8 and 4–9).

f. Soldiers who are returning to the United States from overseas for initial medical evaluation at the regional infectious disease service will be ordered, as part of HRC (AHRC–SG) for USAR AGR Soldiers' AI, to report TDY en route to the regional Army MEDCEN for the new assignment location for a period not to exceed 10 days. HRC will ensure that the AI includes instructions to provide a copy of the PCS orders to the designated MEDCEN. Soldiers who will be accompanied by Family members will be counseled that housing for the Family at the TDY location will be at the Soldier's own expense and that Government transient quarters may not be available. Soldiers referred to medical or physical evaluation boards immediately following medical evaluation will be handled per normal medical or physical evaluation boards procedures and will be deleted from their original orders. The MEDCEN HIV program coordinator (PHN) will notify the gaining installation HIV program coordinator (PHN) of pertinent medical information telephonically or by encrypted email.

6–10. Monitoring patient health

a. Long-term monitoring of the HIV infected individual's health is essential. Clinical evaluation will be accomplished at least twice a year by an infectious disease specialist at a participating MEDCEN. Commanders should be advised if AD Soldiers fail to comply with treatment instructions, preventive medicine counseling, or orders given during the commander's counseling.

b. The attending physicians or medical POCs must inform the Soldier's commander when a significant change in immunological status or clinical disease status is identified. Likewise, commanders must consult the attending physician or medical POC if the Soldier's FFD becomes suspect. Soldiers thought to be unfit for duty will be processed through normal medical or physical evaluation boards for determinations.

c. When HIV infected Soldiers are attached to another unit for a period in excess of 15 days, their commanders will personally notify the gaining unit commander of the Soldier's medical condition. The gaining commander will maintain this information confidentially and will release that information only to those with an established "need to know" of the medical condition.

Section II
Procedures

6–11. Overseas

a. The medical activity commander and/or division surgeon—

(1) Provides formal notification to the unit commander and the adjutant general or personnel officer having custody of an HIV infected Soldier's Army Military Human Resource Record (AMHRR).

(2) Expeditiously schedules HIV infected Soldier for a second verification HIV test, medical evaluation at the designated regional MEDCEN, and referral to the HIV program coordinator (PHN) at the gaining CONUS installation.

b. The adjutant general or personnel officer having custody of the AMHRR of HIV infected Soldiers—

(1) Requests FST curtailment per AR 614–30.

(2) Expeditiously processes AI issued by HRC (National Guard Personnel Center for ARNG personnel or HRC for USAR AGR personnel) and issues necessary orders.

(3) Follows procedures prescribed in paragraph 6–8*b*.

c. The CG, HRC—

(1) Issues AI for Soldiers identified as HIV infected.

(2) Directs award of tour credit in the special instructions of the AI.

d. For ARNG AGR personnel, the Commander, National Guard Personnel Center, will use the procedures described for CG, HRC, in paragraph *c*, above.

6–12. Continental United States

a. The HIV program director—

(1) Provides formal notification to the unit commander and the adjutant general or personnel officer having custody of the AMHRR of HIV infected Soldiers.

(2) Ensures that Soldiers are referred into the physical disability system in coordination with the infectious disease physician, as appropriate.

b. Adjutants general or personnel officers having custody of the AMHRR of HIV infected Soldiers—

(1) Request deletion of those Soldiers who are on overseas AI.

(2) Reassign locally those Soldiers who are infected and are assigned to organizations cited in paragraph 6–3*b*. Request AI in those cases where on-post transfer cannot be accomplished to satisfy assignment policy limitations.

(3) Follow the procedures described in paragraph 6–8*d*.

c. The CG, HRC—

(1) Approves deletion requests for HIV infected Soldiers who are on overseas AI.

(2) Upon request, issues AI for those Soldiers in organizations cited in paragraph 6–3*b* who cannot be reassigned locally.

d. For AGR personnel, the following individuals will perform those procedures described for the CG, HRC, in paragraph *c*, above.

(1) The Commander, National Guard Personnel Center for ARNG personnel on NGB-controlled Title 10 tours.

(2) The State Adjutants General for ARNG personnel on Title 32 tours.

(3) The Commander, HRC (AHRC–SGD–H) for all USAR personnel.

Section III
Administrative Separations

6–13. Administrative separation of officers

a. Officers who are HIV infected and no longer desire to remain on AD may submit an unqualified resignation under the provisions of AR 600–8–24 or request voluntary REFRAD under the provisions of AR 600–8–24, as appropriate. Probationary officers (as defined in AR 600–8–24) who have tested positive for HIV infection and who were infected prior to acceptance of appointment may request resignation under the provisions of AR 600–8–24.

b. Officers submitting voluntary applications for resignation or REFRAD should use the formats indicated in AR 600–8–24, as appropriate. The officer will execute the following statement and include it in his or her application: "I have been counseled by a member of The Judge Advocate General's Corps regarding the consequences of my request and I certify that this request is voluntary. I understand that if my request is accepted, I will be granted an honorable discharge (if requesting resignation) or honorable characterization of service (if requesting REFRAD)." Officers who are HIV infected but still meet medical retention standards and desire to be discharged must be counseled by a member of The Judge Advocate General's Corps, who will explain the impact of the officer's request. As a minimum, specific information regarding the officer's post-discharge eligibility for medical care will be provided. A copy of the counseling statement will accompany the request for separation. The counseling statement will contain the following statement, as a minimum: "Officer was advised that disability benefits under provisions of 10 USC 61 may be available in the event that he or she remains in the Army until the U.S. Army Physical Disability Agency determines the officer is no longer fit to perform assigned military duties."

c. Requests for resignation or REFRAD will be submitted through command channels to the appropriate career manager indicated below:

(1) Maneuver, fires, and effects (formerly combat arms)—Commander, U.S. Army Human Resources Command (HRC–OPA), Department 140, 1600 Spearhead Division Avenue, Fort Knox, KY 40122–5500.

(2) Operation support division (formerly combat support arms)—Commander, U.S. Army Human Resources Command (HRC–OPB), Department 140, 1600 Spearhead Division Avenue, Fort Knox, KY 40122–5500.

(3) Field services division (formerly combat service support)—Commander, U.S. Army Human Resources Command (HRC–OPC), Department 140, 1600 Spearhead Division Avenue, Fort Knox, KY 40122–5500.

(4) Health services to health services division—Commander, U.S. Army Human Resources Command (HRC–OPH), Department 140, 1600 Spearhead Division Avenue, Fort Knox, KY 40122–5500.

(5) Colonels to senior leader division—Commander, Headquarters, Department of the Army (DACS–CMO), 200 Army Pentagon, Washington, DC VA 20310–0200.

(6) Chaplains—Headquarters, Department of the Army (DACH–PER), 2700 Army Pentagon, Washington, DC 20310–2700.

(7) JAGC officers—Headquarters, Department of the Army (DAJA–PT), 200 Army Pentagon, Washington, DC 20310–2200.

(8) AGR Officers—For ARNG Title 10 AGR officers, Commander, National Guard Personnel Center (NGB–ARP–CT), 4501 Ford Avenue, Alexandria, VA 22302–1450; for ARNG Title 32 AGR officers, State Adjutant General, Support Personnel Management Office; and for USAR AGR officers, Commander, U.S. Army Human Resources Command, Human Resource Center of Excellence (AHRC–SGD–H), Department 140, 1600 Spearhead Division Avenue, Fort Knox, KY 40122–5303.

d. AC commissioned and warrant probationary officers entering AD who are identified as HIV infected within 180 days of their original appointment, or USAR and ARNG commissioned and warrant probationary officers who report for initial entry training in an AD (other than ADT) status and are identified as HIV infected within 180 days of reporting to AD, will be processed for discharge under the provisions of AR 600–8–24.

e. Officers who are HIV infected and have been found not to have complied with preventive medicine counseling prescribed in paragraph 4–8 may be involuntarily discharged. Commanders may recommend that such officers be eliminated under the provisions of AR 600–8–24. Recommendations for separation must be based upon information obtained independently from interviews or surveys conducted in conjunction with the epidemiologic assessment process. Other than the fact that an officer is HIV infected and has been counseled regarding preventive medicine procedures, no other information related to the assessment process will be used to support involuntary separation. Evidence of unprotected intimate sexual behavior, drug abuse, or other violations of the preventive medicine procedures must be derived from sources not related to the assessment process.

f. Examples of independently derived evidence include, but are not limited to, urinalysis tests conducted under the Alcohol Substance Abuse Program (ASAP), noncompliance with the medical management of HIV infection as determined by an infectious disease physician, or the routine diagnosis of STIs other than HIV.

g. HIV infected officers remain subject to involuntary separation under any provision of AR 600–8–24, as appropriate. The policies described in chapter 9 apply. Officers who no longer meet medical retention standards will be processed per AR 635–40.

6–14. Administrative separation of enlisted personnel

a. Enlisted Soldiers who are HIV infected may submit a voluntary request for discharge under the provisions of AR 635–200, secretarial plenary authority. Voluntary requests for separation will be submitted through command channels to Commander, U.S. Army Human Resources Command (AHRC–EPF–M), Department 140, 1600 Spearhead Division Avenue, Fort Knox, KY 40122–5303. (For ARNG Title 10 enlisted AGR personnel, requests will be sent to Commander, National Guard Personnel Center (NGB–ARP–CT), 4501 Ford Avenue, Alexandria, VA 22302–1450. The National Guard Personnel Center will forward these requests to HRC for decision. Requests from ARNG Title 32 enlisted AGR personnel will be sent to the State Adjutant General, Support Personnel Management Office, of the particular State/territory in which the Soldier is assigned for duty. For USAR AGR enlisted personnel, requests will be sent to Commander, U.S. Army Human Resources Command, Human Resource Center of Excellence (AHRC–SGD–H), Department 140, 1600 Spearhead Division Avenue, Fort Knox, KY 40122–5303.) Requests for voluntary separation will not be accepted from Soldiers who no longer meet medical retention standards of AR 40–501. Such Soldiers will be processed for medical separation under the provisions of AR 635–40.

(1) HIV infected Soldiers who still meet medical retention standards and desire to be discharged must be counseled by a member of The Judge Advocate General's Corps, who will explain the impact of the Soldier's request. As a minimum, specific information regarding the Soldier's post-discharge eligibility for medical care will be provided. A copy of the counseling statement will accompany the request for separation. The counseling statement will contain the following statement, as a minimum: "Soldier was advised that disability benefits under provisions of 10 USC 61 may be available in the event that he or she remains in the Army until the U.S. Army Physical Disability Agency determines the Soldier is no longer fit to perform assigned military duties."

(2) Soldiers desiring discharge will complete a DA Form 4187 (Personnel Action) and execute the following statement: "I request discharge from the Army under the provisions of AR 635–200, secretarial plenary authority, for my own convenience. I have been counseled by a member of The Judge Advocate General's Corps regarding the consequences of my request, and I certify that this request is voluntary. I understand that, if my request is accepted, I will be granted an honorable discharge."

(3) Requests for separation must include certification that the Soldier is HIV infected but meets medical retention

standards. Commanders endorsing requests for separation under the provisions of paragraph *a*, above, will verify the Soldier's medical condition and that the Soldier still meets medical retention standards.

b. Soldiers identified as HIV infected within 180 days of initial entry on AD will be separated under the provisions of AR 635–200 for failure to meet procurement medical fitness standards.

c. HIV infected enlisted Soldiers found not to have complied with preventive medicine counseling prescribed in paragraph 4–8 may be involuntarily separated. Commanders may recommend that such enlisted Soldiers be separated under the provisions of AR 635–200, under either secretarial plenary authority, or for acts or patterns of misconduct, as the unit commander deems appropriate. The following procedures apply:

(1) If the Soldier is processed for separation under the provisions of AR 635–200, secretarial plenary authority, the notification procedure (AR 635–200) will be used to notify the Soldier that his or her discharge is being recommended. Soldiers processed for separation under the provisions of AR 635–200 for acts or patterns of misconduct, will be notified of the recommendation for discharge under administrative board procedures (AR 635–200) or the notification procedure (AR 635–200), as appropriate.

(2) Recommendations for involuntary separation must be based upon information that is not obtained through interviews or surveys conducted in conjunction with the epidemiologic assessment process. Other than the fact that a Soldier is HIV infected and has been counseled regarding preventive medicine procedures, no other information related to the assessment process will be used to support involuntary separation. Evidence of unprotected intimate sexual behavior, drug abuse, or other violations of the preventive medicine procedures must be derived from sources not related to the assessment process.

(3) Examples of independently derived evidence include, but are not limited to, urinalysis tests conducted under the ASAP, noncompliance with the medical management of HIV infection as determined by an infectious disease physician, or the routine diagnosis of STIs other than HIV.

(4) Recommendations for involuntary separation under the provisions of AR 635–200 and recommendations for involuntary separation of Soldiers with 18 or more years of service will be forwarded to Commander, HRC (AHRC–EPF–M), for processing. (For ARNG Title 10 enlisted AGR personnel, requests will be sent to Commander, National Guard Personnel Center (NGB–ARP–CT), 4501 Ford Avenue, Alexandria, VA 22302–1450; for ARNG Title 32 enlisted AGR personnel, requests will be sent to the State Adjutant General, Support Personnel Management Office, of the particular State/territory in which the Soldier is assigned for duty. For USAR enlisted AGR personnel, requests will be sent to Commander, U.S. Army Human Resources Command, Human Resource Center of Excellence (AHRC–SGD–H), Department 140, 1600 Spearhead Division Avenue, Fort Knox, KY 40122–5303.) As a minimum, recommendations for separation must include documentation of the notification process (to include the Soldier's acknowledgement of notification), statements submitted by the Soldier and/or his or her counsel, certification that the Soldier has been counseled regarding preventive medicine measures, and details/evidence of the Soldier's failure to comply with those measures.

d. HIV infected enlisted Soldiers remain subject to involuntary administrative separation under any provision of AR 635–200; however, Soldiers who no longer meet medical retention standards will not be involuntarily separated except under AR 635–200 (see misconduct; in lieu of trial by court-martial; dishonorable and bad conduct discharges; limitations on referral to the Physical Disability Evaluation System; and administrative separations).

6–15. Disability separation

a. HIV infected military personnel who demonstrate progressive clinical illness or immunological deficiency as determined by medical authorities, do not meet medical retention standards of AR 40–501 and may be processed for separation per AR 40–501 and AR 635–40.

b. While infectious disease medical evaluation will not serve as the sole criteria for determining medical fitness or a disability rating, the clinical manifestations that determine a stage of the disease's severity may, in fact, contribute to determining a Soldier's fitness for duty. All HIV infected Soldiers who show signs of immunological deficiency or a progressive illness must be referred to medical evaluation boards regardless of the clinical stage of the disease. This should result in a more expeditious status determination that will benefit both the Soldier and the Government.

Chapter 7
Reserve Components Personnel Policies and Procedures

Section I
Introduction

7–1. General

This chapter prescribes policies and procedures for HIV testing pertaining to ARNG and USAR personnel performing duty under USC Title 10 and USC Title 32, to include Active Guard and USAR (AGR refer to chap 6). These policies and procedures are intended primarily to apply to troop program units (TPUs); however, the policies and procedures

also pertain to the USAR Standby Reserve (active and inactive) and individual mobilization augmentee (IMA). Current HIPAA security and privacy training is required for "need to know" individuals (see para 5–4).

7–2. Testing requirement for National Guard and Reserve Soldiers applying for tours of active duty

a. Personnel ordered to AD for more than 30 days including travel time (for example, ADT, AGR, initial AD for training, and ADOS) must have been tested for HIV with negative results no more than 2 years prior to the report date and prior to issuance of orders. In rare situations where this requirement cannot be met, orders will include the following statement: "You will obtain a HIV test from a designated military facility en route to, or immediately upon, arrival at your duty station. If your HIV test status is not communicated through established medical channels to the orders issuing authority within the first 29 days including travel time, these orders will terminate."

b. Under mobilization conditions (as declared by Congress or executive order and implemented by DOD), the Assistant Secretary of the Army (Manpower and Reserve Affairs) may authorize HIV infected RC Soldiers to be ordered to ADOS. If ordered to ADOS, RC Soldiers known to be HIV infected will be assigned and utilized within the United States (including Alaska, Hawaii, Guam, Puerto Rico, and the U.S. Virgin Islands). RC Soldiers identified as HIV positive during mobilization station testing will be immediately REFRAD. Specific guidance will be provided in the Personnel Policy Guidance.

c. Personnel ordered to AD with duty oversees for more than 30 days including travel time (for example, ADT, AGR, initial AD for training, and AD for special work) must have been tested for HIV antibodies with negative results 180 days prior to the report date and prior to issuance of orders. In rare situations where this requirement cannot be met, orders will include the following statement: "You will obtain a HIV test from a designated military facility en route to, or immediately upon, arrival at your duty station. If your HIV test status is not communicated through established medical channels to the orders issuing authority within the first 29 days including travel time, these orders will terminate." Soldiers identified at power projection platform or during deployment and mobilization as HIV infected after verification test validates will be REFRAD.

Section II
Policies and Procedures

7–3. General

a. HIV testing and retention policies will be consistent with all DOD and DA policies and regulations.

b. HIV testing should remain available for all Soldiers upon their request without inquiring as to the reason for the test. However, testing for USAR Soldiers will be at no additional cost to the Government if not event driven. Reserve Soldiers can request HIV testing at an MTF by contacting the HIV program coordinator at HRC.

c. The HIV testing program is accomplished primarily during periodic physical examinations, physical health assessment, or periodic Soldier readiness processing.

7–4. Testing timeline requirements

a. General.

(1) Testing of all nonprior service Soldiers will be accomplished upon appointment, enlistment, or induction.

(2) Testing of all AD Title 10 and Title 32 USC Soldiers will be accomplished every 2 years. Upon confirmation of HIV infection status (after verification specimen) Soldiers are exempt from this requirement.

(3) RC personnel not on AD are required to have current HIV test every 2 years. Upon confirmation of HIV infection status (after verification specimen) Soldiers are exempt from this requirement.

(4) HIV testing for ARNG personnel during State emergency duty will be accomplished in conjunction with post deployment health assessment before ARNG personnel are de-mobilized from State emergency duty.

(5) RC personnel performing AD Title 10 or Title 32 USC for 30 days or less are required to have a current HIV test, unless HIV infection has previously been confirmed.

(6) RC personnel will be 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.

(7) HIV infected Soldiers will not be permitted to serve in the IRR. Those in the USAR, when so identified, will be processed per paragraph 7–12. HIV infected AD Soldiers leaving AD who have a contractual or statutory obligation remaining will be transferred to the USAR control group (Standby).

(8) Personnel located OCONUS scheduled for training either in the United States or overseas who do not meet the testing windows stated above will be tested immediately upon arrival at the training duty station when testing prior to departure is impractical.

b. Transferring components.

(1) HIV testing of all ARNG Soldiers transferring from one RC to another, or to the IRR, will have a HIV negative test within 2 years. This does not apply to HIV infected Soldiers exercising their option to voluntarily transfer to the Standby or Retired Reserve.

(2) HIV testing of all personnel who transfer from another Service or USAR control group into the ARNG, including members of the Inactive National Guard, will have a HIV negative test within 2 years.

7–5. Reserve component surveillance testing

a. ARNG and USAR Selected Reserve screening will be conducted every 2 years.

b. ARNG and USAR Soldiers will also undergo HIV screening as part of their periodic physical examinations or physical health assessment. AD Soldiers may not refuse screening, but should be informed of the pending procedure. Soldier privacy will be maintained in the same manner as required in AC MTF procedures.

c. If prioritization of testing is necessary, screening will be accomplished in the same order as in paragraph 6–2*d*. RC Soldiers ordered to AD for more than 30 days will be considered priority 4 if they do not meet the criteria of priorities 1 to 3.

d. ARNG and USAR TPU surveillance testing will normally be accomplished as part of the periodic physical examination or physical health assessment.

e. Soldiers assigned to the IRR and IMA programs will be tested during annual training (AT) or ADT if their last HIV test is older than 2 years, and during periodic physical examinations or physical health assessment, including flight physicals. IRR and IMA Soldiers' physical examinations or physical health assessments that are performed by civilian contract will be considered "interim complete" if the Soldier has a documented HIV test no older than 2 years. Under this circumstance, an HIV test will be required within 48 hours of reporting for any AD period to ensure the physical examination is updated.

f. IRR and IMA Soldiers not on AD who require testing or are participating in overseas deployment for training will be tested in MTF facilities or by the Reserve Health Readiness Program contracted authorized providers. Those IRR and IMA Soldiers who require periodic medical examinations or PHAs will be tested in MTF facilities or by authorized contract providers.

g. For USAR Soldiers, HIV test results will be annotated on DD Form 2808 (Report of Medical Examination), item 49, if testing occurred as part of a physical exam. If testing occurred separately from a physical exam, results will be annotated on Standard Form (SF) 600 (Medical Record - Chronological Record of Medical Care). DD Form 2808 and SF 600 will be posted in the Soldiers' medical records. Compliance with HIV testing is in the MEDPROS individual medical readiness record.

h. HIV test dates are electronically transferred into the MEDPROS individual medical readiness record.

7–6. Human immunodeficiency virus testing for reserve component on active duty

a. All RC personnel ordered to AD for more than 30 days under Title 10 or Title 32 USC programs, to include AGR, will be required to have a current HIV test with negative results. Testing will occur within 2 years of a CONUS assignment or within 180 days for an OCONUS assignment. Testing must occur prior to the report date and issuance of orders, including travel time. In rare situations where this requirement cannot be met, orders will include the following statement: "You will obtain a HIV test from a designated military facility en route to, or immediately upon, arrival at your duty station. If your HIV test status is not communicated through established medical channels to the orders issuing authority within the first 29 days including travel time, these orders will terminate."

b. According to Department of Defense Instruction (DODI) 6490.03, every deployed Soldier will have a baseline blood serum drawn and placed in the DOD Serum Repository, Armed Forces Health Surveillance Center, within 12 months before the Soldier actually deploys. The Soldier must be informed that this serum will be tested for HIV en route to the repository. This is a separate requirement from the HIV test required within 2 years before deployment (or closer to deployment if mandated by COCOM or other appropriate policies).

7–7. Priority for testing

a. Soldiers who are scheduled for overseas PCS will be tested prior to PCS.

b. Testing will be based on the priorities listed in paragraph 6–2*d*.

c. For RC Soldiers mobilized on short notice, the guidance in paragraph 7–6 will be followed. If a Soldier does not have a negative HIV test within the required period of time prior to mobilization, then an HIV specimen will be drawn immediately upon issuance of orders. Specimens should be processed and shipped to the DOD designated laboratory overnight by the collection site for processing. Routinely, the designated laboratory will process the specimens with 24 to 48 hours of receipt and results will return to the RC usually with 7 to 10 days. If a State is mobilizing troops and needs the results back immediately, the State HIV POC can mark the shipment "PROCESS IMMEDIATELY, need for MOBILIZATION." Screening HIV test results will normally be available within 48 hours, but may be delayed due to logistical limitations. Soldiers will not be mobilized until test results are known. If the test results are negative, the Soldier is considered available for mobilization. If the initial test results are positive, the Soldier will be removed from further processing until independent verification tests are conducted and results are known. HIV positive test results generally are available within 72 hours.

7–8. Roles and responsibilities

a. The Chief, NGB; CG, HRC; and CG, USARC are responsible for implementation of HIV testing of RC Soldiers in accordance with this regulation.

b. The State Adjutants General of each ARNG State and territory and USARC will—

(1) Appoint an HIV program director/manager to develop State (HRC) testing plans for notification and counseling procedures, reporting and recording of test data, and procedures for periodic follow-up.

(2) Ensure that medical patient confidentiality is maintained per laws and regulations and specifically ensure that there are no unwarranted disclosures of information concerning an individual's medical condition.

c. The ARNG and HRC HIV program director will—

(1) Perform the duties of a contract officer technical representative for the RC centrally funded HIV testing contract. Ensure that HIV testing services and funding are appropriated in accordance with the HIV contract.

(2) Produce and distribute specific HIV testing information to the HIV program manager or deputy State surgeon for State distribution.

(3) Track and report the number of HIV infected Soldiers in the ARNG to the Chief National Guard surgeon and in the USAR to the CG, USARC on a monthly basis.

(4) Serve as designated backup at the headquarters level for the NGB in the event the State POC cannot be reached during the notification phase of a positive HIV test result from the laboratory or AC HIV program director or coordinator.

d. The State (AHRC–SG) HIV program manager will—

(1) Be responsible for coordination and notification of Soldier HIV testing results with the individual, the unit commanders, the State surgeon, regional support command, operational and functional commands, the HIV program director, and the local health department.

(2) Coordinate to obtain the second independent verification specimen to be tested for HIV in a USAMEDCOM designated laboratory. A second specimen is required through the USAMEDCOM designated laboratory even if the Servicemember self identifies after testing positive in a civilian setting.

(3) Track, update, and protect the annual FFD status of all HIV infected Soldiers in the State and USAR on a monthly basis.

(4) Ensure that all HIV testing on Soldiers assigned to the State and USAR is conducted in accordance with this regulation.

(5) Ensure maximum participation with minimal interruption of mission training. The State HIV program manager will identify testing locations by month, date, and quantities of blood samples to be submitted according to the testing contract. The minimum number of testing sites necessary to accomplish the mission will be utilized in order to reduce the overall cost of the centrally funded contract. Order, maintain, and distribute HIV testing supplies for all HIV testing requirements, in accordance with this regulation, within the State and State emergency duty locations.

(6) Maintain transmittal sheets matching names, social security numbers, and units with laboratory numbers. Ensure that the transmittal sheets will be confidentially handled as medical records.

(7) Coordinate the notification of all State and USAR HIV infected personnel in accordance with this regulation and the positive HIV test notification checklist.

(8) Order, manage, and maintain HIV testing supplies for all Soldiers and State Home Land Defense and Home Land Security missions.

e. Unit commanders will—

(1) Ensure that all personnel in their units are tested in accordance with this policy.

(2) Ensure that the HIV infection and/or AIDS information and education requirements in chapter 10 are included in unit training programs. This training will be conducted annually and will be documented in command training records. Commanders are encouraged to use TDA Army Medical Department (AMEDD) officers, mission and funds permitting. If AMEDD officers cannot be used, trainers may be members of the chain of command, assigned officers or enlisted Soldiers, or nonmilitary personnel from outside sources.

7–9. Army National Guard notification and counseling procedures

a. The results from testing will be returned by the designated HIV testing laboratory to the State designated HIV program director and/or coordinator. All positive HIV tests will be verified by a second independent blood draw. However, the Soldiers must be notified and counseled in accordance with this regulation upon the first positive HIV test.

b. ARNG Soldiers who are HIV infected will be notified and counseled in accordance with chapter 4. All HIV infected ARNG Soldiers and their spouses will be individually and privately notified of all positive HIV test results in a face-to-face interview by a designated and qualified AMEDD officer within the State, in accordance with chapter 8. All HIV infected ARNG Soldiers and their spouses will be counseled regarding the significance of a positive HIV test, current medical knowledge on HIV infections, and ways to prevent transmission of the virus. HIV infected ARNG Soldiers will be referred to civilian physicians for medical care and further counseling. The telephone number of local

civilian health authorities will be given to Soldiers if information on local physicians or facilities is requested (for notification and testing of ARNG HIV infected Soldiers' spouses see chap 8).

c. Individuals tested at MEPS for accession purposes or component transfers will be notified of HIV positive test results by the examining physician or other appointed, qualified counselor. Soldiers tested at MEPSs as part of a periodic physical examination (space available basis) will be notified of HIV positive test results through the Soldier's unit physician or chain of command.

d. The Soldier, commander, and medical corps officer will be in official status (inactive duty training, Reserve special training, ADT, AT, or ADOS) at the time of notification(s), counseling, and blood drawing.

e. ARNG positive HIV test notification checklist must include the following:

(1) Has the State HIV program manager been notified?

(2) Has the State HIV program manager reviewed this regulation?

(3) Before the Soldier is contacted, has the Soldier's original HIV test sample been tested and clinically indicated using an approved FDA test?

(4) Has the Soldier been notified in a face-to-face interview, by a physician or designated health care provider, and counseled via the DA Form 5669 and DA Form 4856 and chapter 4?

(5) Once the Soldier has been notified about the clinical indication of a HIV positive test results, has the Soldier's blood been re-drawn for a second independent verification specimen, using an approved FDA test method?

(6) Was a copy of the test result given to the Soldier during the face-to-face notification?

(7) Has the State HIV program manager reported to the local public health authorities?

(8) Has the Soldier been medically evaluated to determine the status of his or her infection and FFD?

(9) Has the Soldier been informed that he or she must provide a valid copy of an annual FFD examination performed by a qualified physician to the State HIV program director and/or coordinator?

7–10. U.S. Army Reserve notification and counseling

a. The results from testing will be returned by the designated HIV testing laboratory to the HRC Surgeon's Directorate HIV program manager. All positive HIV tests will be verified by a second independent blood draw. However, the Soldiers must be notified and counseled in accordance with this regulation upon the first positive HIV test.

b. USAR Soldiers who are HIV positive will be notified and counseled in accordance with chapter 4, as applicable. All HIV positive USAR Soldiers and their spouses will be individually and privately notified of all positive HIV test results in a face-to-face interview by their unit commander and telephonically counseled by a qualified AMEDD officer in accordance with chapter 8. All HIV infected USAR Soldiers and their spouses will be counseled regarding the significance of a positive HIV test, current medical knowledge on HIV infections, and ways to prevent transmission of the virus. HIV infected USAR Soldiers will be referred to civilian physicians for medical care and further counseling. The telephone number of local civilian health authorities will be given to Soldiers, if information on local physicians or facilities is requested. For notification and testing of USAR HIV infected Soldiers' spouses see chapter 8.

c. All Soldiers, including IRR, whose initial HIV test is positive, will be notified of the results in a face-to-face interview, by a physician or designated health care provider and counseled via the DA Form 5669 and DA Form 4856 and chapter 4.

d. The HRC HIV program manager will coordinate with the USARC G–1 HIV program manager for a physician or designated health care provider, if necessary, to notify IRR or IMA initial HIV positive Soldiers.

e. Training and information packets will be provided by the USARC POC G–1 HIV program director. Spouses of confirmed HIV infected USAR Soldiers will be notified of the positive test results. The USAR will issue the spouse invitational orders to accompany the Soldier to notification.

f. Physicians or designated health care providers supporting notification to Soldiers with HIV positive test results will refer information provided about spouses or partners with whom the Soldier may have had at-risk contact to the HRC program manager for notification to local public health officials, as prescribed by State and local laws, for further notification and management.

g. HIV infected USAR Soldiers not on ADOS will be counseled regarding the significance of a positive HIV test, current medical knowledge on HIV infections, and ways to prevent transmission of the virus. They will be referred to civilian health care providers for medical care and further counseling. Chapter 8 provides guidance for offering HIV testing and counseling to spouses of HIV infected USAR Soldiers.

h. All of the information contained in paragraph 4–8 and on DA Form 5669 will be covered and copies of the record will be provided to the individual Soldier and commander (or designated commander's representative, if the commander is a general officer) at the time of notification. The counselor's copy will be forwarded through the HIV program POC (regional support command or operational and functional command) channels through the USARC POC to the HRC program manager. Notification to public health authorities will be per procedures published by USARC and per State and local law. All records will be forwarded in a sealed envelope marked "To Be Opened By Addressee Only" via command channels and addressed specifically to the USARC HIV program manager by name. Physicians

performing notification and Soldiers notified of an initial or subsequent positive HIV test will be in an official status (inactive duty training, rescheduled training, ADT, AT, ADOS) at the time of notification.

i. The unit commander of the initial HIV positive USAR TPU Soldier will be immediately available at the time the Soldier is notified by the physician or designated health care provider. Immediately following the preventive medicine counseling, the commander will counsel the Soldier per paragraph 4–9 and complete DA Form 4856. The counseling statement will be destroyed if the Soldier is determined to be uninfected by verification tests.

7–11. Reporting and recording of information

a. Recording of the results of HIV testing will be per chapter 4.

b. Collection procedures and reporting of information for inclusion in the DOD data base will be per chapter 4, section IV.

c. Notification to commanders of results of an FDA-approved testing will be per paragraph 4–3.

d. Notification to public health authorities will be per procedures published by NGB, USAR, and per State and local law.

7–12. Assignment and personnel actions

a. Soldiers confirmed to be HIV infected, but who manifest no evidence of progressive clinical illness or immunological deficiency, will not be separated solely on the basis of their HIV infection. HIV infected Soldiers, not AGR or ADOS may prove fitness for service. HIV infected AGR personnel will complete a medical evaluation to determine if they are FFD. ADOS Soldiers will be processed for involuntary REFRAD upon confirmation of HIV infection. During the REFRAD processing the Soldier may initiate the FFD requirement. HIV infected Soldiers will have 120 days from the date they are notified of their infection to complete a medical evaluation to determine fitness per the established DOD protocol for HIV or other guidance published by OTSG or OCAR. HIV infected Soldiers found to be medically unfit for duty will be separated per paragraph 7–13. Soldiers found fit will be permitted to serve in the Selected Reserve in a nondeployed billet, if available. Grade, MOS, and commuting constraints are applicable per existing regulations. Soldiers meeting fitness standards and placed in nondeployable billets must be re-evaluated at least annually. Initial and subsequent evaluations will be at the Soldier's expense and will be provided by the Soldier to the State or HRC HIV program manager for recording in the individual medical record. Soldiers may request transfer to the Standby Reserve, Retired Reserve (if eligible), or Honorable Discharge under the plenary authority of the Secretary of the Army in lieu of continued service. (See AR 135–175 for resignation of officers and warrant officers who do not meet the medical fitness standards at time of appointment, or AR 135–178 for voluntary separation of enlisted Soldiers on indefinite reenlistments.)

b. HIV infected Soldiers will be involuntarily transferred to the inactive Standby Reserve, following a case-by-case assessment, if they—

(1) Fail to complete the initial or annual medical evaluation in the prescribed period.

(2) Are found fit, but cannot be placed in a Selected Reserve nondeployable billet per grade or MOS.

(3) Are in a Selected Reserve nondeployable billet and do not complete the annual medical evaluation for fitness for duty.

c. The mere fact of HIV infection, in and of itself, will not be used as the basis for—

(1) Disciplinary action against the individual under the UCMJ or State code.

(2) Adverse characterization of service.

(3) Nonselection for a vacant nondeployable billet.

d. Unit commanders who initiate action to transfer HIV infected Soldiers to the USAR control group (Standby) will do so under the provisions of AR 140–10.

e. Assignment and retention policies for ARNG Soldiers who are AGR or on ADOS and are HIV infected will be carried out per chapter 6.

f. HIV infected RC Soldiers will not be ordered to a tour of duty for more than 30 days, nor extended on a tour of duty if the extension will cause the total length to exceed 30 days except under mobilization conditions and as authorized by the Assistant Secretary of the Army (Manpower and Reserve Affairs) (see para 7–2*b*).

g. HIV infected USAR Soldiers who are ordered to AD for over 30 days and identified as positive after verification will be REFRAD.

7–13. Separation procedures

a. HIV infected ARNG Soldiers who demonstrate progressive clinical illness or immunological deficiency, as determined by medical authorities, and who do not meet medical retention standards will be processed under AR 40–501 and NGR 600–200 or NGR 635–101, as appropriate.

b. HIV infected USAR 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 will be processed per AR 135–178 (enlisted) or AR 135–175 (officer).

7–14. Education

a. Training. Unit commanders will ensure that the HIV and/or AIDS information and education requirements in chapter 10 are included in unit training programs. This training will be conducted annually and will be documented in command training records. Commanders are encouraged to use TDA AMEDD officers, mission, and funds permitting. If AMEDD officers cannot be used, trainers may be members of the chain of command, assigned officers or enlisted Soldiers, or nonmilitary personnel from outside sources.

b. Individuals seeking additional information may refer to the following resources:

(1) DCS, G–1 HIV policy and deoxyribonucleic acid (DNA) registration at http://www.armyg1.army.mil/hr/hivdna/.

(2) The USAPHC Health Promotion and Wellness Portfolio has HIV and STI prevention information resources found at http://phc.amedd.army.mil/Pages/default.aspx. The CDC divisions of HIV and/or AIDS prevention, National Center for HIV/AIDS, Viral Hepatitis, STI, and tuberculosis prevention Web site has information resources at http://phc.amedd.army.mil/topics/healthyliving/rsbwh/Pages/HIVandSTDPrevention.aspx.

Chapter 8
Family Member and Civilian Personnel Policies and Procedures

Section I
Human Immunodeficiency Virus Testing for Family Members and Other Health Care Beneficiaries

8–1. Testing of Family members and other health care beneficiaries

Family members and other HCBs may not be compelled to have an HIV test. However, an HIV test may be ordered by a physician or designated health care provider as part one of the clinically indicated laboratory tests required to adequately treat the patient. Patients should be routinely informed that the physician or designated health care provider will order any clinically indicated laboratory tests necessary to include testing for HIV infection unless the patient specifically declines such tests.

8–2. Human immunodeficiency virus testing program components

An HIV test may be clinically indicated for Family members and other nonmilitary HCBs seeking medical care under the circumstances listed below. Those who test HIV positive will be offered medical evaluation and counseling per paragraphs 4–8 and 4–10.

8–3. Consent requirements

HCBs not on AD will be verbally informed by their health care provider of clinically indicated laboratory tests, including HIV testing, required in the course of their medical evaluation. After discussion, HCBs may opt-out of HIV testing. The HCB will not be denied care as a result of refusing HIV testing. However, the HCB will be advised that an assessment of the medical condition for which care is sought may be incomplete.

Section II
Family Member and Other Health Care Beneficiaries Policies and Procedures

8–4. Notification procedures

a. All HCBs and spouses of HIV infected Soldiers will be individually and privately notified of any positive HIV test result in a face-to-face interview with their ordering physician or designated health care provider.

b. The designated physician or health care provider will notify HCBs of the initial positive HIV test. The individual will be informed that he or she has a positive HIV test, that it may mean he or she is infected by HIV and, if confirmed to be infected by a second or subsequent test, he or she will be referred for further medical evaluation. Individuals will be advised not to donate blood/blood products, sperm/semen or eggs, breast milk, tissues, or organs and to refrain from sexual relations until the results of the verification tests are available. Test results of Family members will not be reported to the sponsor's command authorities. The Family member and the sponsor will be advised of the results and counseled per paragraph 4–8 by medical personnel.

c. Notification of contacts of HIV infected personnel will be as follows:

(1) HCBs who are sexual partners of individuals who are HIV infected, or individuals who were transfusion or blood product recipients from HIV infected donors will be advised by medical authorities to seek medical evaluation as soon as possible.

(2) Information should be reported to civilian public health authorities, per local jurisdiction reporting requirements, when information is obtained through the epidemiological assessment interview indicating individuals who—

(a) Are not military personnel or military HCBs who are/were sexual partners of known HIV infected individuals.

(b) Were transfusion or blood product recipients from HIV infected donors.

d. Information pertaining to HIV infected spouses will be reported through designated channels to local public health authorities. For spouses of AD Soldiers, the HIV program coordinator (PHN) will report that information to local public health authorities per local jurisdiction reporting requirements. OTSG will publish guidance for reporting this information. For spouses of RC Soldiers, information will be provided to the State or to the numbered armies in CONUS HIV program POC. That information will, in turn, be provided to the State or local jurisdiction public health authority dealing with HIV and/or AIDS per State or local law or reporting requirements. The NGB and OCAR will publish guidance for reporting this information.

8–5. Testing of spouses of human immunodeficiency virus infected Soldiers

a. Spouses of Active Army Soldiers will be notified of their sponsor's HIV infection by the Soldier and notification confirmed by the preventive medicine HIV program coordinator (PHN). The HIV program coordinator (PHN) will recommend that the spouse be tested for HIV. However, such testing is voluntary. If the spouse chooses to be tested, the HIV program coordinator (PHN) will ensure that appropriate preventive medicine counseling is conducted. DA Form 5669 is not used for Family member counseling.

b. Spouses of RC Soldiers are normally not HCBs. However, spouses of HIV infected RC Soldiers may be designated by the Secretary of the Army as limited HCBs for purposes of receiving HIV testing and counseling, if approved. The NGB and USARC will publish procedures for informing spouses of HIV infected RC Soldiers of the sponsor's infection and for offering voluntary HIV testing and counseling. See chapter 7 for RC personnel policy.

8–6. Accompanied tours

Family members who are HIV infected are not restricted by this policy from accompanying their sponsor overseas; however, host nation rules apply. If initial diagnosis of a Family member occurs while at an overseas location, the Family member will be encouraged to undergo immediate detailed medical evaluation. Test results of Family members will not be reported to the sponsor's command authorities. The Family member concerned will be advised of the results. Notification of Family member's test results to anyone other than the Family member will be provided only in accordance with local jurisdiction reporting and notification requirements. If clinical illness is present or evaluation is desired, the Family member will be processed for medical evacuation to the Army MEDCEN designated and will ordinarily be returned to the overseas location on completion of evaluation.

8–7. Exceptional Family Member Program

When a Family member of an AD Soldier is confirmed as HIV infected or diagnosed with AIDS, either by testing through the MTF or by a civilian practitioner, the primary physician or a member of the HIV clinical staff will notify the Exceptional Family Member Program (EFMP) POC case coordinator for initiation of enrollment in the EFMP per AR 608–75. The primary physician or a member of the HIV clinical staff will counsel the Family member and the sponsor concerning the requirement for mandatory enrollment in the EFMP. The EFMP POC case coordinator, in coordination with the HIV clinical staff, will process the Family member to ensure confidentiality.

8–8. Child, Youth and School Services

a. Placement of an HIV infected child into Army-sponsored Child, Youth and School Services programs will be determined on a case-by-case basis. The goal of the placement decision is to provide the optimal setting for care based on the overall health status of the child. Factors which will be considered in the decision include neurological development, behavior, and immune system status. Consideration will also be given to special circumstances in which the protective environment of a special purpose Family child care home would be more appropriate (that is, need for stringent infection control procedures to protect an HIV infected child from communicable disease).

b. The placement decision will be made by the installation Special Needs Accommodation Program team consisting of the child's parents; PHN; Child, Youth and School Services coordinator; EFMP coordinator; and the Army Community Services director. The PHN will contact the child's physician prior to the Special Needs Accommodation Program team meeting to ensure the child's safety and medical concerns are adequately addressed and to meet the child's safety needs in the least restrictive environment. If this team is unsure of the appropriate placement decision, additional personnel at the MEDCEN servicing that installation's health service region or the installation's management agency region ACOM, ASCC, or DRU headquarters may be consulted. Confidentiality of the information regarding the child and his or her parents will be maintained by all personnel involved in the decision.

c. Knowledge of the child's HIV status will be limited to those who have a legitimate need for that confidential information per HIPAA and taking into account the following:

(1) Specific infection control procedures needed to protect the child or the child's care givers.

(2) Home health procedures dictated by the child's medical treatment plan.

(3) The need for a supportive environment due to developmental, neurological, or behavioral deficiencies.

Section III
Civilian Employees Policies and Procedures

8–9. Testing of civilian employees

a. Normally, neither applicants for employment nor current employees may be required to be tested for the presence of HIV and, if no such host nation requirement exists, care should be taken to ensure that DA civilians' pre- and post-deployment serum specimens are not tested for HIV. However, pursuant to DOD guidance, HIV testing may be authorized when it is required by a host country. Determination of host nation HIV testing requirements will be the responsibility of the employer. Any such testing will be at no cost to the employee. Assignment or employment may be denied to employees who refuse to comply with this testing requirement, or who have a positive HIV test result. Prior approval to require a civilian employee to be tested for HIV must be obtained from Headquarters, Department of the Army (DAPE–CPE), 300 Army Pentagon, Washington, DC 20310–0300, when it is determined that a host country requires proof of negative HIV test results. Requests for approval to require an employee to be tested to meet host country requirements must include documentation of the testing requirement. Requests for exception to the testing policy may not be approved by DA. All requests for exceptions to the testing policy will be forwarded through command channels to Headquarters, Department of the Army (DAPE–CPE), 300 Army Pentagon, Washington, DC 20310–0300 for review and staffing. DA will forward to DOD and request approval of all justified host nation civilian testing requirements and will provide notification of the results of the request to the requesting activity.

b. DA will provide civilian employees who are overseas and authorized medical care at Army MTFs the opportunity to be tested for the presence of HIV on an elective, space-available basis. Positive HIV test results will be confidential information and will not be the basis of any adverse actions concerning the individual's employment (see para *c*, below). Employees and their Family members will be encouraged to obtain further diagnosis or treatment.

c. The presence of HIV and/or AIDS will not, by itself, be the basis of any adverse personnel action against an employee. Existing civilian employment policy provides guidance relating to appropriate action when employees are not physically able to carry out the duties of their job.

d. In the case of HIV infected health care providers, their duties may be restricted when performing those duties that present a risk of transmitting HIV to their patient. This determination will be made by an expert medical review committee as designated by the deputy commander for clinical services. This committee will make recommendations on a case-by-case basis to the MEDDAC/MEDCEN/Dental Activity commander, per AR 40–68, as to the restriction of duties of HIV infected health care providers. The restriction may only be to the extent that the risk is eliminated.

e. Because of the small, but important, risk of health care providers contracting blood-borne infections, such as HIV, all civilian health care workers will be encouraged to be tested periodically, particularly those employees exposed frequently to blood or body fluids from patients.

f. Civilian health care providers sustaining a laceration or needlestick injury with possible transmission of disease will be advised to be tested following injury and at periodic intervals and to be followed medically. Of particular concern are instances where blood or body fluids from an HIV infected patient may be accidentally introduced into the employee. Such employees should be immediately referred to the emergency department for HIV post-exposure prophylaxis evaluation per CDC guidelines. They should be tested at the time of the incident, at 3 months, and again at 6 months after exposure to detect seroconversion in latent infections resulting from the accidental exposure. Employees tested outside the MTF should provide follow-up test results to the MTF occupational medicine provider.

8–10. Guidelines for handling issues related to human immunodeficiency virus infection and Acquired Immune Deficiency Syndrome

a. These guidelines are intended to assist managers and supervisors of civilian employees in dealing with HIV and/or AIDS related personnel issues arising in the workplace. They provide managers and supervisors of civilian employees a basic framework on how to approach and resolve such issues. Specific technical advice and assistance should be obtained from the servicing civilian personnel advisory center (CPAC), MTF, and legal office in resolving individual cases.

b. Guidelines issued by the Public Health Service's CDC dealing with HIV and/or AIDS in the workplace state that "the kind of nonsexual person-to-person contact that generally occurs among workers and clients or consumers in the workplace does not pose a risk for transmission of HIV and/or AIDS." Therefore, employees in the workplace who have been diagnosed as, or suspected of being, HIV infected must be allowed to continue working as long as they are able to maintain acceptable performance and do not pose a risk of substantial harm to the health or safety of themselves or others that cannot be eliminated or reduced by reasonable accommodation. If serious performance or safety problems arise, supervisors and managers should address them by applying existing Federal and Army civilian personnel policies and practices.

c. There is no medical basis for employees refusing to work with fellow employees or agency clients who are, or are suspected of being, HIV infected. Nevertheless, the concerns of employees who fear working with HIV infected co-workers should be taken seriously and should be addressed with appropriate information and counseling. In addition, employees, such as health care providers, who may come into direct contact with HIV infected persons, or with their body fluids, should be provided appropriate information and equipment to minimize the risks of such contact.

d. Managers and supervisors should treat HIV infected employees in the same manner as employees who suffer from other serious illnesses. This means, for example, that employees may be granted sick leave or leave without pay when they are incapable of performing their duties or when they have medical appointments. An employee with HIV and/or AIDS-related conditions may be an "individual with a disability " under the Rehabilitation Act of 1973, as amended, (29 USC 701), the Americans with Disabilities Act, as amended (42 USC 12101), the Americans with Disabilities Act Amendments Act (PL 110–325), and Equal Employment Opportunity Commission regulations and may be entitled to "reasonable accommodation." Managers and supervisors are encouraged to consult with their local legal offices to determine their rights and obligations in any specific cases.

e. Consistent with DA's concern for employees with HIV and/or AIDS infection, the following resources are available:

(1) Management and employee education and information on specific life-threatening illnesses through the activity MTF.

(2) Referral to agencies and organizations which offer support services for personnel with HIV and/or AIDS through the ASAP civilian counseling services, MTF, or the ASAP civilian services employee assistance program screening counseling and referral services.

(3) Benefits consultation from the civilian personnel office to assist employees in effectively managing health benefits, leave, insurance, and other benefits.

f. When dealing with situations involving an employee with HIV and/or AIDS, managers and supervisors should—

(1) Understand that HIV and/or AIDS will not, absent other considerations, be the basis for taking any adverse personnel action against an employee.

(2) Remember that information concerning an employee's health is personal and confidential, and it is covered by the Privacy Act. Accordingly, such information can be released only to agency officials who have a need to know. Further, supervisors and management officials should ensure that precautions are taken to protect all information regarding an employee's health. All information concerning an employee's health must be kept separate from the employee's personnel file and treated as a confidential medical record. (See AR 40–66 and AR 340–21.) Any questions concerning disclosure of such information should be directed to the local staff judge advocate.

(3) Contact the MTF HIV program coordinator (PHN) for information about a specific life-threatening illness or the contagious nature of an illness. The servicing CPAC also should be contacted regarding additional guidance in providing reasonable accommodations for an employee with HIV and/or AIDS.

(4) Contact the MTF program coordinator (PHN) if it is determined additional information should be obtained from the employee's physician to assist in determining if the employee's presence at work will pose any threat to the employee or co-workers.

(5) Be understanding, compassionate, and sensitive to the fact that continued employment for an employee with a life-threatening illness may sometimes be therapeutically important in the remission or recovery process, or may help to prolong the employee's life.

(6) Encourage employees with HIV and/or AIDS to seek assistance from established community support groups for medical treatment and counseling services. Information on these services can be requested through the ASAP, HIV program coordinator (PHN), and/or employee assistance programs.

(7) Be sensitive and responsive to co-workers' concerns, and emphasize employee education available through CPAC and MTF. Give no special consideration beyond supplying appropriate information, counseling, or training to employees who feel threatened by an HIV infected co-worker. Disciplinary action may be taken against any employee whose refusal to work with an HIV infected employee causes disruption in the workplace.

Chapter 9
Limited Use Policy

9–1. Purpose

The purpose of this chapter is to specify limitations on the use of information regarding HIV testing results and medical evaluation.

9–2. Limitations on the use of laboratory test results

a. Test results confirming that a Soldier is HIV infected may not be used against the Soldier—

(1) As the basis for any disciplinary or adverse administrative action, except for the following:

(a) Separation for physical disability. However, Soldiers who are HIV infected but are determined by medical authorities to show no sign of progressive clinical illness or immunological deficiency will not be separated for physical disability solely because of HIV infection.

(b) Separation under the accession testing program of Soldiers meeting the definition of accession (chap 5).

(c) Separation as specifically authorized by paragraphs 6–13 through 6–15.

(2) As a basis for an unfavorable entry in a personnel record (see para 9–5).

(3) To characterize service.

b. This policy does not impose any other restrictions on the use of test results within DOD. Nothing in the restrictions in paragraph *a*, above, precludes the use of such laboratory test results in any other manner consistent with law or regulation including—

(1) To establish the HIV infection status of a Soldier who disobeys the preventive medicine counseling, the commander's counseling, or both, in an administrative or disciplinary action based on such disobedience.

(2) To establish the HIV infection status of a Soldier as an element of any other permissible administrative or disciplinary action (for example, as an element of proof of an offense charged under the UCMJ).

(3) To establish the HIV infection status of a Soldier as a proper ancillary matter in an administrative or disciplinary action (for example, as a matter in aggravation in a court-martial in which the HIV infected Soldier is convicted of an act of rape committed after he is informed that he is HIV infected).

c. Laboratory test results will receive the same protection as any other medical information per AR 40–66. Medical authorities are required to report test results indicating that a Soldier is HIV infected to the Soldier's chain of command. Although the use of this information by commanders is not limited except as described above, commanders will treat the information with due regard for the privacy of the Soldier concerned.

9–3. Limitations on the use of certain other information

a. As part of the effort to control the spread of HIV infection and to develop medical and scientific information concerning the infection, AD Soldiers (including AGR and other Reservists who, because of their status, are entitled to military medical care) who are identified as HIV infected will be questioned by medical authorities concerning possible sources of their exposure to the virus. This medical evaluation process is called an epidemiological assessment. Information that a Soldier may provide to medical authorities during this assessment may not be used against the Soldier or other named third parties except as authorized by this paragraph. Such protected information includes, for example—

(1) Information concerning a Soldier's personal use of drugs.

(2) Information concerning consensual homosexual or heterosexual activity, even if that sexual activity is prohibited by law or regulation.

b. Information obtained during, or as a result of, an HIV epidemiological assessment may not be used against the Soldier or other named third parties—

(1) In a court-martial.

(2) In a nonjudicial punishment action (Article 15, UCMJ).

(3) In a line of duty determination.

(4) As a basis, alone or in conjunction with other information, for the involuntary separation of a Soldier, except a separation for physical disability. If the information is used in a physical disability separation procedure, the information may not be used on the issue of whether the disability was due to the Soldier's own misconduct.

(5) In an administrative or punitive reduction in grade.

(6) For denial of a promotion.

(7) In a bar to reenlistment.

(8) As the basis for an unfavorable entry in a personnel record.

(9) As a basis, in whole or in part, to characterize service or to assign a separation program designator.

(10) In any other action considered to be an adverse personnel action (for example, comment in DA Form 67–9 (Officer Evaluation Report) or DA Form 2166–8 (NCO Evaluation Report)).

9–4. Exclusions

The limitations in paragraph 9–3 on the use of information do not apply to the following:

a. The introduction of evidence for impeachment or rebuttal purposes in any proceeding in which the evidence of drug abuse or relevant sexual activity (or lack thereof) has been first introduced by the Soldier.

b. Disciplinary or other action based on independently derived evidence.

c. Nonadverse personnel actions such as—

(1) Reassignment.

(2) Disqualification (temporary or permanent) from a Personnel Reliability Program.

(3) Denial, suspension, or revocation of a security clearance.

(4) Suspension or termination of access to classified information.

(5) Removal (permanent or temporary) from flight status or other duties requiring a high degree of alertness or stability (for example, explosive ordnance disposal) or restricting the duties of HIV infected health care providers.

d. Any evidence or information derived from sources independent of an epidemiological assessment. For example,

admissions of drug abuse or sexual misconduct by an HIV infected Soldier, not made in the context of an epidemiological assessment, may be used as evidence in an administrative or disciplinary action against the Soldier.

9–5. Entries in personnel records

In the event that personnel actions are taken as a result of, or are supported by, evidence of HIV infection, or information described in paragraph 9–3, care will be taken to ensure that no unfavorable entry is placed in a personnel record in connection with the action. Recording a personnel action in a personnel record is not itself an unfavorable entry in such a record. Also, information that reflects an individual has serologic or other evidence of HIV infection is not an unfavorable entry in a personnel record.

Chapter 10
Human Immunodeficiency Virus Information and Education Plan

10–1. General

This chapter establishes—

a. The minimum requirements for providing information and education about HIV to the Total Army Family.

b. Responsibilities to ensure that the HIV information and education program is successful.

c. Resources available to the Army community in carrying out this information and education plan.

d. See chapter 7 for RC policy.

10–2. Plan components

The HIV information and education plan consists of the following five components:

a. Prevention of HIV, STIs, and unintended pregnancies for Soldiers.

b. Training for UCMJ commanders.

c. Awareness training about Army HIV policies and bloodborne pathogen prevention for health care workers.

d. Training of HIV program directors, coordinators (PHN), and staff.

e. Army Family member education, as needed, based on resources.

10–3. U.S. Army Public Health Command

The USAPHC will develop standardized training and education programs for Soldiers, commanders, health care workers, HIV program directors/coordinators and staff, and community groups using current CDC guidelines and adult learning principles. The Chief Nurse, USAPHC is designated as the HIV and/or AIDS education program coordinator to facilitate implementation of the HIV education program.

10–4. Human immunodeficiency virus education plan for the military community

a. In collaboration with commanders, MTF staff, the public affairs officer, civilian personnel representatives, and other interested installation agencies, the HIV program coordinator (PHN) will implement the standardized training and education programs developed by USAPHC.

b. To execute the HIV education plan for the military community, the following responsibilities are assigned:

(1) The CG, U.S. Army Training and Doctrine Command will ensure that existing health awareness/education blocks of instruction in all Army schoolhouse and initial entry training courses incorporate basic HIV and/or AIDS instruction. This instruction should focus on prevention of HIV, STIs, and unintended pregnancies for Soldiers which place an individual at high risk of exposure to HIV, methods of transmission, measures to protect against exposure, and Army requirements for HIV testing.

(2) Installation commanders will ensure implementation of training for UCMJ commanders, and ensure Soldiers receive AT on prevention of HIV, STIs, and unintended pregnancy. To ensure HIV education programs reach all targeted personnel, classes will be included in the installation's master training calendar.

c. Supervisors of civilian employees will ensure that all civilian employees receive training on HIV infection and AIDS in the workplace, so that employees understand—

(1) The medical ramifications of HIV and/or AIDS as they relate to communicability, and as they affect an employee's ability to perform official duties.

(2) Workplace rights of employees who are HIV positive or have AIDS.

(3) Civilian employees may be excused from HIV and/or AIDS in the workplace training if they believe the training is offensive or may be emotionally or psychologically stressful to them. Managers and supervisors who excuse civilian employees from scheduled training will offer those employees appropriate alternatives to the training, such as written materials on HIV and/or AIDS in the workplace. (Chap 8 provides guidance for handling HIV and/or AIDS in the workplace issues.)

(a) For Family members, HIV education should include an emphasis on high risk behaviors and methods of

preventing infection, including safer sex instruction. Family member education may be accomplished in conjunction with a variety of other installation activities to include—

(b) Community counseling centers.

(c) Health care facilities caring for Family members.

(d) Recreation centers.

(e) Libraries.

(f) Chapel or religious education activities.

(g) Chaplain Family Life Centers.

(h) Youth activity programs.

(4) Unit commanders will ensure that their Soldiers attend at least one HIV education class annually. They will request assistance from their servicing medical facilities, as needed, to comply with this requirement. (See chap 7 for RC policy.)

(a) Because of individual rotation and to provide flexibility in scheduling, commanders will ensure that HIV education is offered at least quarterly. The education plan will be incorporated into the unit's quarterly training schedule.

(b) RC units may conduct this training annually prior to unit testing.

(5) Commanders at all levels will make HIV education a matter of special interest within their organizational inspection programs. The goal of the review should be to assess the existence and effectiveness of installation and unit education programs.

10–5. Educating and training health care providers

OTSG is responsible for ensuring that education and training programs are implemented for health care providers. Included in this group are health educators, primary care providers, STD interviewers and counselors, drug and alcohol counselors, and occupational safety and health personnel. Education for these individuals should focus on enabling them to perform their duties following the guidelines published by the CDC and the Occupational Safety and Health Administration. Their training should also equip them to provide counseling to at-risk patients as a normal part of their duties. MTF commanders are responsible for implementing HIV education and training for health care personnel at their installations per the education plan developed by OTSG.

10–6. Resources

CDC and USAPHC have additional information on their Web sites on HIV and STD prevention.

a. CDC divisions of HIV/AIDS prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and tuberculosis prevention Web site at http://www.cdc.gov/std/.

b. The USAPHC Health Promotion and Wellness Portfolio has HIV and STD prevention information resources available at the following Web site http://phc.amedd.army.mil/topics/healthyliving/rsbwh/Pages/HIVandSTDPrevention.aspx.

Chapter 11
Law Enforcement and Corrections Policies and Procedures

Section I
Army Law Enforcement and Security Personnel

11–1. Purpose

This section provides policies and procedures for Army law enforcement and security personnel to prevent duty-related exposure to HIV infection. The information contained herein is consistent with model HIV policies published by the CDC.

11–2. Precautionary measures against duty-related exposure

As first responders, Army law enforcement and security personnel will frequently encounter situations in which they come in contact with body fluids or objects contaminated with HIV. Examples include serious traffic accidents, injuries, and crimes of violence (murder, rape, robbery, aggravated assault). In situations where exposure to body fluids is likely or possible personnel will take the following precautions:

a. Wear impermeable gloves (rubber or latex).

b. Wear eye protection.

c. Exercise caution to avoid punctures or cuts.

d. Wear protective over garments to include footwear and head gear.

e. Use caution when searching and wear heavy-duty gloves to avoid puncture wounds.

f. Cover and protect open wounds, cuts, and irritations from possible contamination.

g. Use one-way airway devices when administering mouth-to-mouth resuscitation.

h. Use sealable plastic bags to collect soiled and stained items consistent with established crime scene processing procedures (AR 195–5).

i. Avoid or minimize direct contact with body fluid spills or potentially contaminated objects. Should contact with body fluids occur, wash exposed areas with soap and hot water as soon as possible and seek medical evaluation.

11–3. Clean-up and disinfecting procedures

a. Personnel will follow these procedures when cleaning potentially HIV infected items and areas:

(1) Avoid direct contact with soiled or stained items.

(2) Clean spills and stains with approved solutions (1:10 bleach to water mix).

b. In addition, the personal hygiene measures outlined below should be applied after potential exposure:

(1) Avoid eating, drinking, or smoking until after cleaning up.

(2) Shower the entire body with soap and hot water as soon as possible after exposure.

(3) Launder or dry clean soiled clothing before wearing them again.

11–4. Availability of equipment and supplies

a. Installation Directors of Emergency Services and commanders must ensure that all personnel have ready access to protective and decontamination equipment and supplies including—

(1) Impermeable gloves (rubber or latex).

(2) One-way airway devices (adult and pediatric sizes).

(3) Sealable plastic bags.

(4) Suitable protective over garments.

(5) Heavy-duty gloves (for conducting searches).

(6) Decontamination solution (household bleach).

b. The use of disposable items is recommended.

11–5. Actions following possible direct exposure

Installation Directors of Emergency Services and commanders must immediately refer potentially exposed personnel for medical examination and evaluation. They will also ensure exposed personnel comply with follow-up medical evaluations and ensure proper documentation of event and follow-up. Commanders will develop and implement a post exposure prophylaxis plan in consultation with supporting infectious disease and preventive medicine physicians.

11–6. Orientation and training

Army law enforcement and security personnel will attend awareness training on the causes, methods of transmission, and prevention of duty-related HIV infection at least annually. This requirement does not exempt military personnel from the HIV education requirements of chapter 10. Training will be developed in concert with the local MTF and must reflect the basic tenets of DA policy on HIV as outlined in this regulation. (Special attention will be directed toward ensuring law enforcement and security personnel are properly trained on the use of one-way airway devices.) This training will include realistic demonstrations and hands-on practical exercises. Newly assigned personnel will attend training prior to being utilized for operational law enforcement or security duties.

11–7. Policy implementation

Installation Directors of Emergency Services and commanders will develop and implement standard operating procedures necessary to implement the requirements of this regulation. However, in clearly life-threatening situations, the inability to comply with the foregoing policies and procedures, or the lack of prescribed equipment or supplies, is insufficient justification to either delay or deny emergency aid or assistance. First responders are expected to use sound judgment and good common sense in applying these policies.

Section II
Army Corrections System Policies and Procedures

11–8. Human immunodeficiency virus in correctional facilities

HIV has become a major policy and management issue for correctional administrators. Correctional institutions have become a focus of concern for this infection.

11–9. Purpose and applicability

The information and guidelines contained in this section have been developed for correctional staff to assist in the identification and management of prisoners infected with HIV. The policies presented are intended to provide overall guidance in preventing the transmission of HIV within the Army Corrections System as well as protecting the

confidentiality of HIV infected prisoners and reducing the anxiety and misunderstanding about the disease within the Army Corrections System.

11–10. Prisoner testing program

a. All prisoners will be tested for HIV within 24 hours of entering confinement. Prisoners at low risk for HIV infection may be placed in general population while waiting results of tests through routine DOD channels. Prisoners who are determined to be HIV negative will be retested at least annually as part of a program to monitor and detect any transmission of HIV in the facility.

b. Should incidents which could result in the transmission of HIV (for example, sexual contact, tattooing, intravenous drug use, or body fluid transfer) occur in confinement or correctional facilities within the Army Corrections System facilities, the participants will be immediately tested for HIV. If all of the participants are known to be HIV infected, testing is unnecessary. In incidents where at least one of the participants is found to be, or is known to be, HIV infected, all HIV negative prisoners involved in the incident will be retested for HIV at 3 months and 6 months from the date of the incident.

c. Any prisoner who, at any time, shows clinical signs or symptoms of HIV infection as determined by medical authorities will be tested for HIV.

d. Any prisoner who has, or acquires, an STI will be tested for HIV unless medical authority determines testing is unnecessary.

e. Except in cases where HIV testing has been done for other reasons within 90 days of their release dates, all prisoners will be retested for HIV within 30 days of their scheduled date of release from confinement.

f. HIV testing of any inmate may be considered any time the confinement or correctional facility commander, in coordination with the MEDDAC commander, deems it necessary for the safe operation of the facility or health and welfare of the personnel (prisoners and staff) in his or her command.

11–11. Confidentiality

Results of all HIV tests must be kept confidential. Personnel who have access to medical, dental, and correctional records will have current HIPAA privacy and security training. Only those personnel, designated by the facility commander, with a legitimate need to know which prisoners are HIV infected will be informed. Correctional treatment files and other correctional records will not be annotated to reflect the inmate's HIV infection. The electronic medical record will document the Soldier's HIV infection. Prisoners who are HIV infected will be discouraged from telling anyone other than medical, psychological, and dental personnel. Any statements made by prisoners in military and/or correctional records to the effect that they are HIV infected will remain in such records and will not be expunged. Normally, only medical records may contain indications that an inmate is HIV infected.

11–12. Prisoner transfers

All prisoners who are transferred from one Army or Sister Service correctional facility to another will be accompanied by a letter of transmittal from the losing facility commander to the gaining facility commander. The letter of transmittal will inform the gaining facility commander of the prisoner's medical condition. Paragraph 6–9 provides additional guidance for the facility commanders. If a prisoner is transferred with HIV test results pending, those results will be forwarded to the gaining facility commander by preventive medicine personnel as soon as possible per paragraph 4–4.

11–13. Prisoners returning to confinement

All prisoners who return to confinement after having been absent from the facility (temporary home parole, parole revocation, trial by or otherwise in the custody of civil authorities) will be considered for retesting. Factors to be considered include whether the inmate was in a geographic area with a high incidence rate of HIV infection or other high risk situation.

11–14. Prisoner requested testing

Prisoners who voluntarily request HIV testing will be medically evaluated and counseled by appropriate medical staff prior to, and after, being tested.

11–15. Medical center evaluation

a. Within 7 calendar days after receiving results that an inmate is HIV infected, the commander will schedule the prisoner for evacuation to a MEDCEN for initial medical evaluation, counseling, treatment, and other medical attention, as necessary. Immediately following such evaluation and appropriate treatment, the prisoner will be returned to the designated confinement or correctional facility.

b. All HIV infected prisoners will be reexamined and reevaluated by an infectious disease specialist from a participating MEDCEN at least twice per year, or as determined necessary by local medical authorities. The examination will be accomplished at a MEDCEN or the correctional facility, as appropriate.

11–16. Medical management in confinement

a. All HIV infected prisoners will be evaluated and managed on a case-by-case basis per CDC guidelines.

b. The medical condition of HIV infected prisoners will be monitored by the local MEDDAC. Frequency of medical visits will be every 4 to 6 weeks, or as deemed appropriate by medical authorities.

c. All HIV infected prisoners will be provided emotional and psychosocial support by counselors trained in working with HIV infected individuals.

d. Immediately prior to any HIV infected prisoner's release from confinement, military preventive medicine authorities will report applicable information to civilian public health authorities for the State into which the prisoner will be released. Reporting will be per applicable statutes of that State.

11–17. Routine confinement practices

a. HIV infected prisoners will not be segregated from the general inmate population based solely on the fact they are HIV infected.

b. Normally, the handling of laundry and linen of HIV infected prisoners will be no different than for other prisoners. In certain cases, determined by medical authorities, special handling of contaminated laundry or linen may be necessary.

c. Toilet and shower facilities for HIV infected prisoners will not be separate or different from those used by other prisoners in the same custody grades.

d. Food service sanitation provisions for HIV infected prisoners will be no different or separate from that of other prisoners, to include dishwashing and garbage handling procedures.

11–18. Work, training, restoration, parole, and clemency

a. HIV infected prisoners will be assigned to work and training programs per AR 190–47 and this regulation.

b. Recommendations for clemency and parole should not be made based solely upon HIV seropositivity.

11–19. Segregation of human immunodeficiency virus infected prisoners

a. HIV infected prisoners who fear being with the general inmate population will be considered for, and may be placed in, administrative segregation. Upon their request, and as deemed necessary by the facility commander, they may be placed in protective custody.

b. All HIV infected prisoners who are (beyond mere suspicion) sexually active, sexually aggressive, or otherwise physically aggressive, may be placed in administrative segregation in single cells. They should not be permitted to eat, work, train, or have recreation with any other inmate.

11–20. Transfer of human immunodeficiency virus infected prisoners

a. HIV infected prisoners in the Army Corrections System will not be transferred to other confinement or correctional facilities, or centrally confined at any one facility, based solely on their HIV infection status, unless deemed necessary by medical authorities.

b. HIV infected prisoners who medical authorities deem in need of special medical attention will be transferred to the U.S. Disciplinary Barracks. They will be maintained in administratively segregated, special quarters inside the U.S. Disciplinary Barracks. HIV infected prisoners within 90 days of release from confinement will normally not be transferred to the U.S. Disciplinary Barracks. HIV infected prisoners who medical authorities deem in need of special medical attention may be transferred to Federal Bureau of Prisons upon approval by the Office of the Provost Marshal General. HIV infected prisoners within 90 days of release from confinement will normally not be transferred to the Federal Bureau of Prisons.

11–21. Use of force against human immunodeficiency virus infected prisoners

In those circumstances requiring the application of force against an HIV infected prisoner, the force will be applied in a manner consistent with that for force applied to other prisoners.

11–22. Protection of staff

Army Corrections System facility staff should have protective clothing and equipment available to them when there is potential for exposure to the blood or body fluids of any prisoner. One-way airways should be used for all cardiopulmonary resuscitation situations. Additionally, the following protective items should be immediately accessible: impermeable disposable gloves, heavy gloves, coveralls, overshoes or plastic bags to cover shoes, sealable plastic bags, and cleaning solution (household bleach).

11–23. Counseling

a. HIV infected prisoners will be briefed and counseled per paragraphs 4–8 and 4–9. The commander's copy of the counseling should not be kept in the correctional treatment files but, rather, in a separate file. Access to this file will be

limited to use as determined by the installation commander and will be handled per the guidance in paragraph 4–9. Any Family members of HIV infected prisoners who are HCBs will also be counseled per chapter 8.

b. Prior to release from confinement, HIV infected prisoners will again be counseled. During this session, they will be asked if there is any physician to whom a copy of their medical records can be sent to ensure appropriate continuity of health care. After discharge, the Army will honor a request for medical records when properly submitted per AR 40–66.

11–24. Training

Each Army Corrections System facility confinement or correctional facility will have a comprehensive education and training program for all prisoners and staff. This training and education will be conducted per chapter 10 and may be tailored to accommodate concerns of HIV transmission in a confinement or correctional setting.

11–25. Requests for information

Release of HIV infected prisoner population statistics for the U.S. Disciplinary Barracks and regional correctional facilities will be included in statistical data for the installation releasable under existing DOD and DA policy. However, these statistics will not be identified with the confinement or correctional facility; they will merely be included in installation totals. Any request for prisoner population data and statistics will be forwarded to Headquarters, Department of the Army (DAPM–ACC), U.S. Army Corrections Command, 150 Army Pentagon, Washington, DC 20310–0150.

Appendix A
References

Section I
Required Publications

AR 25–55
The Department of the Army Freedom of Information Act Program (Cited in paras 1–5*h*, 1–16*r*(2).)

AR 40–66
Medical Record Administration and Health Care Documentation (Cited in paras 4–13*c*, 8–10*f*(2), 9–2*c*, 11–23*b*.)

AR 40–68
Clinical Quality Management (Cited in paras 6–7*b*, 8–9*d*.)

AR 40–501
Standards of Medical Fitness (Cited in paras 1–16*k*, 2–2*b*(8), 4–110*b*, 4–11*e*(3), 5–3*g*, 6–3*e*, 6–6*a*, 6–14*a*, 6–15*a*, 7–13*a*, 7–13b.)

AR 135–175
Separation of Officers (Cited in paras 7–12*a*, 7–13*b*.)

AR 135–178
Enlisted Administrative Separations (Cited in paras 7–12*a*, 7–13*b*.)

AR 140–10
Assignments, Attachments, Details, and Transfers (Cited in para 7–12*d*.)

AR 140–50
Officer Candidate School, Army Reserve (Cited in para 5–3*h*(3).)

AR 190–47
The Army Corrections System (Cited in para 11–18*a*.)

AR 195–5
Evidence Procedures (Cited in para 11–2*h*.)

AR 340–21
The Army Privacy Program (Cited in paras 1–5*h*, 1–16*r*(2), 8–10*f*(2).)

AR 350–51
United States Army Officer Candidate School (Cited in para 5–3*h*(3).)

AR 600–8–24
Officer Transfers and Discharges (Cited in para 6–13.)

AR 601–100
Appointment of Commissioned and Warrant Officers in the Regular Army (Cited in para 5–2*a*(3).)

AR 601–270
Military Entrance Processing Station (MEPS) (Cited in para 5–3*b*.)

AR 601–280
Army Retention Program (Cited in para 6–6*b*.)

AR 608–75
Exceptional Family Member Program (Cited in para 8–7.)

AR 614–30
Overseas Service (Cited in paras 1–16*f*, 3–2*l*, 6–2*c*, 6–4*b*, 6–8*a*(2), 6–8*a*(3), 6–8*b*(1), 6–11*b*(1).)

AR 614–100
Officers Assignment Policies, Details, and Transfers (Cited in para 6–3*b*(1).)

AR 614–200
Enlisted Assignments and Utilization Management (Cited in para 6–3*b*(1).)

AR 635–40
Physical Evaluation for Retention, Retirement, or Separation (Cited in paras 1–16*k*, 6–8*b*(3), 6–13*g*, 6–14*a*, 6–15*a*.)

AR 635–200
Active Duty Enlisted Administrative Separations (Cited in paras 5–3*h*(3), 6–6*c*(1), 6–6*c*(2), 6–8*d*(2), 6–14.)

DOD 6025.18–R
DOD Health Information Privacy Regulation (Cited in paras 1–5*h*, 1–16*r*(2).)

DODI 6485.01
Human Immunodeficiency Virus (Cited in title page.)

DODI 6490.03
Deployment Health (Cited in para 7–6*b*.)

NGR 351–5
State Military Academies (Available at http://www.ngbpdc.ngb.army.mil/pubs/ARNG%20Series/arngseries.htm.) (Cited in para 5–3*h*(3).)

NGR 600–200
Enlisted Personnel Management (Available at http://www.ngbpdc.ngb.army.mil/pubs/ARNG%20Series/arngseries.htm.) (Cited in para 7–13*a*.)

NGR 635–101
Efficiency and Physical Fitness Boards (Available at http://www.ngbpdc.ngb.army.mil/pubs/ARNG%20Series/arngseries.htm.) (Cited in para 7–13*a*.)

Personnel Policy Guidance
Army G-1 Personnel Policy Guidance (PPG) (Cited in paras 1–16*g*, 7–2*b*.)

PL 110–325
ADA Amendments Act of 2008 (Cited in paras 1–16*q*, 8–10*d*.)

Policy Memorandum, March 29, 2004
Human Immunodeficiency Virus Interval Testing (Available at http://mhs.osd.mil/About_MHS/HA_Policies_Guidelines.aspx.)

5 USC 552
Public information; agency rules, opinions, orders, records, and proceedings (Cited in paras 1–5*h*, 1–16*r*(2).)

10 USC Chapter 61
Retirement or Separation for Physical Disability (Cited in paras 6–13*b*, 6–14*a*(1), 7–1.)

29 USC 701
Findings; purpose; policy (Cited in paras 1–16*q*, 8–10*d*.)

32 USC
National Guard (Cited in para 7–1.)

42 USC 12101
Findings and purpose (Cited in paras 1–16*q*, 8–10*d*.)

Section II
Related Publications

A related publication is merely a source of additional information. The user does not have to read it to understand this publication.

AR 5–9
Area Support Responsibilities

AR 40–5
Preventive Medicine

AR 40–400
Patient Administration

AR 135–18
The Active Guard Reserve (AGR) Program

AR 135–133
Ready Reserve Screening, Qualification Records System, and Change of Address Reports

AR 135–200
Active Duty for Missions, Projects, and Training for Reserve Component Soldiers

AR 600–8–4
Line of Duty Policy, Procedures, and Investigations

AR 600–63
Army Health Promotion

AR 600–85
Army Substance Abuse Program (ASAP)

AR 601–210
Active and Reserve Components Enlistment Program

AR 608–10
Child Development Services

DODI 6130.03
Medical Standards for Appointment, Enlistment, or Induction in the Military Service (Available at http://www.dtic.mil/whs/directives/index.html.)

BPL 09–01
DOD Policy on Blood Donor Screening, Donor Deferral, Notification and Lookback to Include Using Licensed Nucleic Acid Tests (NAT) With Approved Mini-Pool Strategies (Available at http://www.militaryblood.dod.mil/Staff/bpl.aspx.)

BPL 10–01
Department of Defense (DOD) Policy on Blood Donor Screening, Donor Deferral, Notification and Lookback to Include Updated Multiplex HIV/HCV/HBV Nucleic Acid Testing Algorithm (Available at http://www.militaryblood.dod.mil/Staff/bpl.aspx.)

NGR 40–3
Medical Care for Army National Guard Members (Available at http://www.ngbpdc.ngb.army.mil/pubs/ARNG%20Series/arngseries.htm.)

NGR 635–100
Termination of Appointment and Withdrawal of Federal Recognition (Available at http://www.ngbpdc.ngb.army.mil/pubs/ARNG%20Series/arngseries.htm.)

PL 104–191
Health Insurance Portability and Accountability Act of 1996

Policy Memorandum, March 19, 2010
Policy on the Use of Non-U.S. Food and Drug Administration Compliant Blood Products

Recommendations for Preventing Transmission of Infection with Human T–Lymphotropic Virus Type III/ Lymphadenopathy–Associated Virus in the Workplace, dated Novemver 15, 1985
(Available at http://www.cdc.gov/mmwr/preview/mmwrhtml/00033093.htm.)

Section III
Prescribed Forms

Unless otherwise indicated, DA forms are available on the Army Publishing Directorate (APD) Web site (http://www.apd.army.mil).

DA Form 5669
Preventive Medicine Counseling Record (Prescribed in paras 1–14*h*, 2–2, 4–4*e*, 4–5*b*(8) and (9), 4–8, 4–9, 7–9*e*(4), 7–10*c* and *h*, 8–5*a*, B–4*g*.)

DA Form 7303
Donor/Recipient History Interview Form (Prescribed in paras 2–2*b*(17) and (19), 4–5*b*(5), B–4*g*.)

Section IV
Referenced Forms

Unless otherwise indicated, DA forms are available on the Army Publishing Directorate (APD) Web site (http://www.apd.army.mil); DD forms are available on the Office of the Secretary of Defense (OSD) Web site (http://www.dtic.mil/whs/directives/infomtg/forms/formsprogram.htm); and Standard Forms (SF) are available on the U.S. General Services Administration (GSA) Web site (http://www.gsa.gov).

DA Form 11–2
Internal Control Evaluation Certification

DA Form 67–9
Officer Evaluation Report

DA Form 2028
Recommended Changes to Publications and Blank Forms

DA Form 2166–8
NCO Evaluation Report

DA Form 3349
Physical Profile

DA Form 4187
Personnel Action

DA Form 4856
Developmental Counseling Form

DD Form 2808
Report of Medical Examination

SF 600
Medical Record - Chronological Record of Medical Care

Appendix B
Internal Control Evaluation

B–1. Function

The function covered by this evaluation is the Identification, Surveillance, and Administration of Personnel Infected with HIV Program.

B–2. Purpose

The purpose of this evaluation is to assist assessable unit managers and internal control administrators in evaluating key internal controls. It is not intended to cover all controls.

B–3. Instructions

These key internal controls must be formally evaluated at least once every 5 years or whenever the internal control administrator changes. Certification that this evaluation has been conducted must be accomplished on DA Form 11–2 (Internal Control Evaluation Certification). Evaluation test questions are outlined in paragraph B–4, below, and are intended as a starting point for each applicable level of internal control evaluation. Answers must be based on the actual testing of key internal controls (for example, document analysis, direct observation, sampling, simulation, other). Answers that indicate deficiencies must be explained and corrective action indicated in supporting documentation.

B–4. Test questions

a. Are all files kept locked in appropriate containers with access by only those with a need to know?

b. Is there a method in place to ensure Soldiers covered by this regulation are not placed on orders for overseas (for example, TDY or PCS) assignments?

c. Is there a policy and/or plan established and maintained to describe how key internal controls will be evaluated over a 5-year period?

d. Is the commander informed by the HIV program coordinator if his or her Soldier is identified as HIV infected within 4 days?

e. Is there verification of a completed epidemiological assessment or public health department referral for HCBs with a new HIV infection?

f. Are local public health reporting requirements completed for all new diagnosed HIV infections and when a Soldier is in-processing into a new catchment area?

g. Does the duplicate file kept by the HIV program coordinator for Soldiers contain copies of current DA Form 5669, DA Form 4856, DA Form 7303, public health report, and demographics?

h. Is there verification that the AD Soldier is attending infectious disease medical evaluation visits every 6 months and following the medical management plan of his or her physician?

i. Is there verification that the ARNG and Reserve Soldier has completed a FFD physical?

j. Is the commander informed if the Soldier is out of compliance?

k. Does MEDPROS confirm nondeployable status and is there a current PHA?

l. Is HIPAA training current for medical, administrative, and unit staff who, in the performance of their duties, "need to know" a Soldier's HIV positive status?

m. Have all placement personnel been familiarized with the parameters of AR 600–110 relative to military and civilian school assignments?

B–5. Supersession

This evaluation is new and does not replace a previous evaluation.

B–6. Comments

Help to make this a better tool for evaluating internal controls. Submit comments to Deputy Chief of Staff, G–1 (DAPE–HR), 300 Army Pentagon, Washington, DC 20310–0300.

Glossary

Section I
Abbreviations

AC
active component

ACOM
Army command

AD
active duty

ADOS
active duty for operational support

ADT
active duty for training

AGR
Active Guard Reserve

AI
assignment instructions

AIDS
Acquired Immune Deficiency Syndrome

AMEDD
Army Medical Department

AMHRR
Army Military Human Resource Record

AR
Army regulation

ARNG
Army National Guard

ASAP
Alcohol Substance Abuse Program

ASCC
Army service component command

AT
annual training

BPL
Blood Program Letters

CDC
Centers for Disease Control and Prevention

CG
commanding general

COCOM
combatant command

CONUS
continental United States

CPAC
civilian personnel advisory center

DA
Department of the Army

DCS
Deputy Chief of Staff

DD
Department of Defense (forms)

DOD
Department of Defense

DODD
Department of Defense directive

DODI
Department of Defense instruction

DRU
direct reporting unit

EFMP
Exceptional Family Member Program

FDA
Food and Drug Administration

FOIA
Freedom of Information Act

FOUO
for official use only

FST
foreign service tour

FTNGD
full-time National Guard duty

GSA
General Services Administration

HIPAA
Health Insurance Portability and Accountability Act

HIV
human immunodeficiency virus

HQDA
Headquarters, Department of the Army

HRC
Human Resources Command

IMA
individual mobilization augmentee

IRR
individual ready reserve

JAGC
Judge Advocate General's Corps

MEDCEN
medical center

MEDDAC
medical department activity

MEDPROS
Medical Protection System

MEPS
military entrance processing station

MOS
military occupational specialty

MTF
medical treatment facility

NGB
National Guard Bureau

NGR
National Guard regulation

OCAR
Office of the Chief, Army Reserve

OCONUS
outside the continental United States

OCS
Officer Candidate School

OTSG
Office of The Surgeon General

PCS
permanent change of station

PHA
periodic health assessment

PHN
public health nurse

PL
public law

POC
point of contact

PULHES
physical, upper, lower, hearing, eyes, psychiatric

RC
reserve component

REFRAD
release from active duty

ROTC
Reserve Officer Training Corps

SF
standard form

STD
sexually transmitted disease

TDA
table of distribution and allowances

TDY
temporary duty

TPU
troop program unit

U.S.
United States

UCMJ
Uniform Code of Military Justice

USAMEDCOM
U.S. Army Medical Command

USAPHC
U.S. Army Public Health Command

USAR
U.S. Army Reserve

USARC
U.S. Army Reserve Command

USC
United States Code

USMA
U.S. Military Academy

Section II
Terms

ADOS
The Active Duty Operational Support-Reserve Component Program is an authorized tour of active duty performed pursuant to 10 USC 12301(d) and it includes: active duty for training performed at the request of an organizational or operational commander; active duty or ADT performed as a result of reimbursable funding; funeral honors duty performed not in an inactive duty status; and active duty performed by members of the Retired Reserve not receiving regular retired pay. Most tours are only 14 days in length but can go to 2 years depending upon the position filled and additional military requirements. This term replaced extended active duty (EAD) and temporary tour of active duty

(TTAD). The term contingency ADOS (CO-ADOS) replaced voluntary active duty formerly known as contingency EAD (CO-EAD) and contingency TTAD (CO-TTAD). The term ADOS Reserve Component (ADOS-RC) replaced RC-funded, voluntary active duty formerly known as active duty for special work (ADSW).

Biennial
Every 2 years.

Catchment area
Area and population from which an MTF gets its patients/enrollees.

Enzyme linked immunosorbent assay
A commonly used screening test to detect antibodies to HIV.

Designated medical treatment facility
Servicing medical treatment facility.

Epidemiological assessment
Medical evaluation process used by medical personnel/HIV PHN to determine possible sources of exposure to HIV.

Exudative
A discharge of certain elements of the blood into the tissues.

Health care beneficiary
A person who, because of military status, employment, or by legal relationship to a person so entitled, is eligible to receive medical care in military medical treatment facilities.

Human immunodeficiency virus infected
An individual who has been confirmed to be infected with HIV by a positive HIV screening test and at least two separate confirmatory tests.

Human immunodeficiency virus negative
A screening specimen that was not reactive or, if reactive, has been determined not to have HIV antibodies or virus present after confirmatory testing.

Immunological deficiency
Persistent reduction in the level of T-helper lymphocytes below 300 cells per cubic millimeter for greater than one month without other demonstrable cause; reduced or absent delayed hypersensitivity, as measured by the standardized battery of skin tests (in association with other significant clinical findings); development of thrush; increased susceptibility to either common or uncommon infections; and more severe episodes of infection than usually seen with a given organism.

Initial test cycle
A series of HIV tests which includes an initial screening test at a minimum. If the initial test is reactive (positive), the test cycle includes duplicate initial testing and confirmatory tests necessary to determine an individual's HIV status.

Longitudinal
A study conducted from initial diagnosis through termination of the condition.

Major installation
Any installation with a military population of 5000 or more.

Overseas
Outside the 50 States of the United States, the District of Columbia, and Puerto Rico.

Progressive clinical illness
Development of neurological manifestations; Kaposi's sarcoma; other lymphoreticular malignancies; thrombocytopenia; diffuse, persistent lymphadenopathy; or unexplained weight loss, diarrhea, anorexia, fever, malaise, or fatigue.

Reflex
Testing performed when an initial test result is outside of the expected normal range (for example, result is reactive and thus a second test(s) is medically indicated). The primary or initial test result is enhanced by the second test(s) as it

provides diagnostic, prognostic, and/or therapeutic information. (This process is done automatically in order to clarify results.)

Unit commander
Company, troop, battery, or detachment commander.

Western Blot
Laboratory test that detects specific antibodies to components of a virus. Chiefly used to confirm HIV antibodies in specimens found repeatedly reactive using enzyme linked immunosobent assay.

Section III
Special Abbreviations and Terms

DNA
deoxyribo nucleic acid

FFD
fit for duty

HBV
hepatitis B virus

HCB
health care beneficiary

HCV
hepatitis C virus

NAT
nucleic acid test

STI
sexually transmitted infection

EXHIBIT 34

Declaration of Lt. Col. Lisa Lute

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
ALEXANDRIA DIVISION

NICHOLAS HARRISON, et al., Plaintiffs, v. JAMES N. MATTIS, et al., Defendants.	)	Civil Action No. 1:18-cv-00641 (LMB)

DECLARATION OF LTC LISA LUTE

I, Lisa Lute, hereby state and declare as follows:

1. I am a Lieutenant Colonel (LTC) in the U.S. Army currently assigned as the Health Promotion Officer, Office of the Deputy Chief of Staff, G1 ("DCS G1"), within Headquarters, Department of the Army. The DCS G1 is the Army Staff proponent responsible for overseeing all military personnel policies within the Army. I have been in this position for two years and five months. I am responsible to the DCS G1 for personnel-related activities within the organization, including strength management, assignments, the Army's Readiness and Resilient concept, and other personnel policies. I also serve as the executive agent for the Deployment Health Assessment Program and the staff officer proponent for several health-related Army Regulations, including the regulation described in paragraph (3) below.

2. From my official duties related to these responsibilities, I have an understanding of the Army's personnel policies pertaining to applicants and Soldiers infected with the human immunodeficiency virus ("HIV"). I make this declaration based upon my personal knowledge and upon information that has been provided to me in the course of my official duties. I submit this declaration in support of the Defendants' opposition to the Plaintiffs'

motion for a preliminary injunction. In particular, I address below the current status of the Army's policies on military personnel infected with HIV. At this time, notwithstanding recent Department of Defense ("DoD") policies, asymptomatic Soldiers infected with HIV are not subject to involuntary separation through disability processing or administrative separation based on their infection status alone.

Current policy on separation

3. The current operative Army policies on personnel infected with HIV are prescribed by Army Regulation 600-110, *Identification, Surveillance, and Administration of Personnel Infected with Human Immunodeficiency Virus*, dated April 22, 2014 ("AR 600-110").[1] Pursuant to this regulation, Soldiers infected with HIV who do not demonstrate progressive clinical illness or immunological deficiency during periodic evaluations will not be involuntarily separated solely due to their infection status. Infected Soldiers who do show progressive clinical illness or immunological deficiency, however, and who do not meet retention standards in accordance with Army Regulation 40-501, *Standards of Medical Fitness*, dated June 14, 2017 ("AR 40-501"), are subject to disability processing.[2]

Current policy on deployment

4. In accordance with AR 600-110, Soldiers infected with HIV are limited to military duty within the United States and its territories, and may not be stationed at military installations outside of the United States, absent the granting of an Exception to Policy

[1] The Army Regulations referenced in this declaration are publicly available at https://armypubs.army.mil/ProductMaps/PubForm/AR.aspx.

[2] Disability processing under the Integrated Disability Evaluation System is governed by Army Regulation 635-40, *Disability Evaluation for Retention, Retirement, or Separation*, dated January 19, 2017.

("ETP"). Similarly, consistent with DoD policy,[3] infected Soldiers may not be operationally deployed unless a waiver has been granted by the applicable Combatant Command ("COCOM") in consultation with the COCOM's surgeon. I am aware of multiple soldiers who have been granted COCOM waivers to deploy.

Recent DoD guidance

5. On February 14, 2018, the Undersecretary of Defense for Personnel and Readiness issued a memorandum to the Service Secretaries titled DoD Retention Policy for Non-Deployable Service Members. The memorandum issued interim policy guidance until the release of a DoD Instruction ("DoDI") on the reporting and retention of non-deployable Service members. Specifically, the interim guidance was that Service members who have been non-deployable for more than 12 consecutive months, for any reason with the exception of pregnant and post-partum personnel, will be processed for involuntary separation or disability processing, effective October 1, 2018.

6. On July 30, 2018, the Undersecretary of Defense for Personnel and Readiness issued DoDI 1332.45, *Retention Determinations for Non-Deployable Service Members* ("DoDI 1332.45" or "DoDI"). The DoDI rescinded the February 18th memo and generally establishes policy and provides guidance for retention determinations for non-deployable military personnel. The DoDI does not require the Army to refer non-deployable Soldiers into disability processing or initiate their separation, and thus does not supersede the

[3] *See* DoD Instruction 6490.07, *Deployment-Limiting Medical Conditions for Service Members and DoD Civilian Employees*, dated February 5, 2010. The DoD publications referenced in this declaration are available at http://www.esd.whs.mil/Directives/issuances/dodi/.

Army's policies described in paragraph (3) above. Instead, the DoDI requires the Army to conduct retention reviews of non-deployable Solders, beginning on October 1, 2018, to determine whether a member should be retained without further processing, or referred for disability processing or the initiation of administrative separation.

Ongoing Army policy review

7. The Army is currently conducting a policy review in order to determine how to best implement the directives in the DoDI. As a threshold matter, the Army is considering how to interpret which Soldiers are "non-deployable" as contemplated by the DoDI, which does not include Service members who are "deployable with limitations" and have a medical condition that requires additional medical screening, or Combatant Command approval prior to deployment outside the continental United States. Depending on the outcome of the Army's policy review, it is possible that Soldiers infected with HIV will not be considered "non-deployable" for the purposes of complying with the DoDI based on the availability of deployment waivers described in paragraph (4) above. In addition, the Army is currently studying which administrative process(es) would be the most appropriate mechanism for conducting the retention reviews, and to whom the Secretary of the Army may decide to delegate retention authority.

Current litigation

8. I am generally aware of the allegations made by Sergeant Nicholas Harrison and other Soldiers in the filings and associated declarations in *Harrison v. Mattis*, No. 1:18-cv-641, currently pending in the United States District Court for the Eastern District of

Virginia, Alexandria Division. I am aware of Sergeant Harrison's allegation that he fears he will be involuntarily discharged based on the Undersecretary of Defense's now-rescinded February 14th memorandum. The DoDI—the current operative DoD policy—however, does not require the Army to automatically separate personnel infected with HIV. The Army's policies described in paragraph (3) preventing the separation of asymptomatic Soldiers based on their infection status alone remain in effect. The same is true for the individual who submitted a declaration located at Exhibit F to Plaintiffs' motion.

9. Furthermore, depending on the outcome of the Army's review process, the Army may consider asymptomatic HIV-infected personnel "deployable with limitations," thus excluding them from the retention review requirement. Regardless, even if the Army ultimately determines that HIV-infected Soldiers do require a retention review, the Army's retention authority would still have the discretion to retain personnel on a case-by-case basis. Thus, under no circumstances would an asymptomatic, HIV-infected Soldier (including Sergeant Harrison) be involuntarily separated or referred for disability processing until he or she receives a retention determination in accordance with DoDI 1332.45, and the retention authority determines within his or her discretion not to retain the Soldier.

In accordance with 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct. Executed this 16 day of AUGUST 2018.

Lisa M. Lute
Lieutenant Colonel, U.S. Army
Washington, D.C.

EXHIBIT 35

Excerpts from the January 9, 2019 Deposition of Lt. Col. Lisa Lute

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
ALEXANDRIA DIVISION

NICHOLAS HARRISON and OUTSERVE-SLDN, INC., Plaintiffs,	:	
v.	:	No. 1:18-CV-00641-LMB-IDD
JAMES N. MATTIS, in his official capacity as Secretary of Defense; MARK ESPER, in his official capacity as Secretary of the Army; and the UNITES STATES DEPARTMENT OF DEFENSE, Defendants.	:	

Tuesday, January 9, 2019

Videotape Deposition of LT. COL. LISA M. LUTE, taken at the Law Offices of Winston & Strawn LLP, located at 1700 K Street Northwest, Washington, D.C., beginning at 9:26 a.m., before Ryan K. Black, a Registered Professional Reporter, Certified Livenote Reporter and Notary Public in and for the District of Columbia.

you increase the risk and you diminish that negligible status that would be associated.

Q. Are you aware of any documented cases of a battlefield transmission?

MR. NORWAY: So I'm going to object that she's not being offered for that type of medical testimony today.

THE WITNESS: I, personally, am not.

BY MR. SCHOETTES:

Q. Based on the -- the lack of any awareness on your part of a documented battlefield transmission, does it stand to reason that sexual transmission is much more likely than a battlefield transmission?

A. Downrange?

Q. I'm not sure what you -- what you're asking.

A. Well, I guess I need clarification of the question. You -- you're asking me is it more likely that someone would get HIV from a sexual exposure than a blood exposure?

Q. Than a battlefield trans -- yes, from --

A. If the --

Q. -- a battlefield exposure.

this through a different channel?

A. I do not. I -- I recommend to them that -- that they might want to review the DODI and consider using the DODI as a guideline to make their request.

Q. Okay. Going back to your declaration, you make the statement that, I am aware of multiple soldiers who have been granted COCOM waivers to deploy.

MR. NORWAY: Objection; scope.

You may answer.

THE WITNESS: Yes. I said that.

Is that the question? I'm sorry.

BY MR. SCHOETTES:

Q. Yes. No, it is. That was just a baseline.

So are you -- is it -- are you saying that you're aware of soldiers living with HIV who have been granted COCOM waivers to deploy?

MR. NORWAY: Objection; scope.

THE WITNESS: Yes.

BY MR. SCHOETTES:

Q. And how did you become aware that soldiers living with HIV have been granted waivers to deploy?

MR. NORWAY: Objection; scope.

You may answer.

THE WITNESS: Excuse me.

Because working as a public health nurse, as I said earlier, all positive tests come through us. And the first one that I became aware of was because I received the -- I received the test result and, of course, as part of that process, I'm going to see if the individual has ever had a positive test, and I couldn't find any previous tests. So I made an attempt to contact the individual and couldn't locate the individual. So in order to find an individual, you find their command. So I found their command, and their command was -- was a special forces command. And they -- they were aware, and there are certain things I can't see, and so they advised me they were aware and they would address it. And the -- and the individual was --

BY MR. SCHOETTES:

Q. Okay. But you say that there are multiple, so this --

A. The other two --

Q. -- there's been more than one?

MR. NORWAY: Objection; scope.

You can answer.

THE WITNESS: The other two were simply, because, as the public health nurse, you work with a lot of the providers. And when these discussions come up -- and I have -- I did have a -- at one point in time I remember a conversation where one of the providers had stated that there were at least two waivers that they had done for special forces assets.

BY MR. SCHOETTES:

Q. So they were all in the context of special forces, the --

A. The ones --

Q. -- the people that you know were deployed with a waiver?

A. The ones that I am aware of.

Q. And do you know, then, if they were deployed into combat situations?

MR. NORWAY: Objection; scope.

You may answer.

THE WITNESS: I don't know. I know that the one that I was tracking, trying to locate, was -- was deployed downrange at -- at the time. And that's the most that I know,

because I can't see those records.
BY MR. SCHOETTES:
Q. Okay. Do you know anything about how that individual was being provided with their HIV-related treatment?
MR. NORWAY: Objection; scope.
You may answer.
THE WITNESS: I don't know how that individual, specifically, was being provided, no.
BY MR. SCHOETTES:
Q. Or what about the other two individuals of which you're aware that deployed?
MR. NORWAY: Objection; scope.
THE WITNESS: Still I don't know.
BY MR. SCHOETTES:
Q. Okay.
A. I -- I should -- I would like to add something in here, though. Special forces is a little bit different. They have an indigenous medical asset, that's usually a physician's assistant that is with them, or somewhere in the area that they are. So, you know, that -- that would --
Q. All right. So that's not unique to

Lt. Col. Lisa M. Lute

C E R T I F I C A T E

I do hereby certify that the aforesaid testimony was taken before me, pursuant to notice, at the time and place indicated; that said deponent was by me duly sworn to tell the truth, the whole truth, and nothing but the truth; that the testimony of said deponent was correctly recorded in machine shorthand by me and thereafter transcribed under my supervision with computer-aided transcription; that the deposition is a true and correct record of the testimony given by the witness; and that I am neither of counsel nor kin to any party in said action, nor interested in the outcome thereof.

WITNESS my hand and official seal this 24th day of January 2019.

Ryan K. Black

Exhibit 14 to Deposition of Lt. Col. Lisa Lute

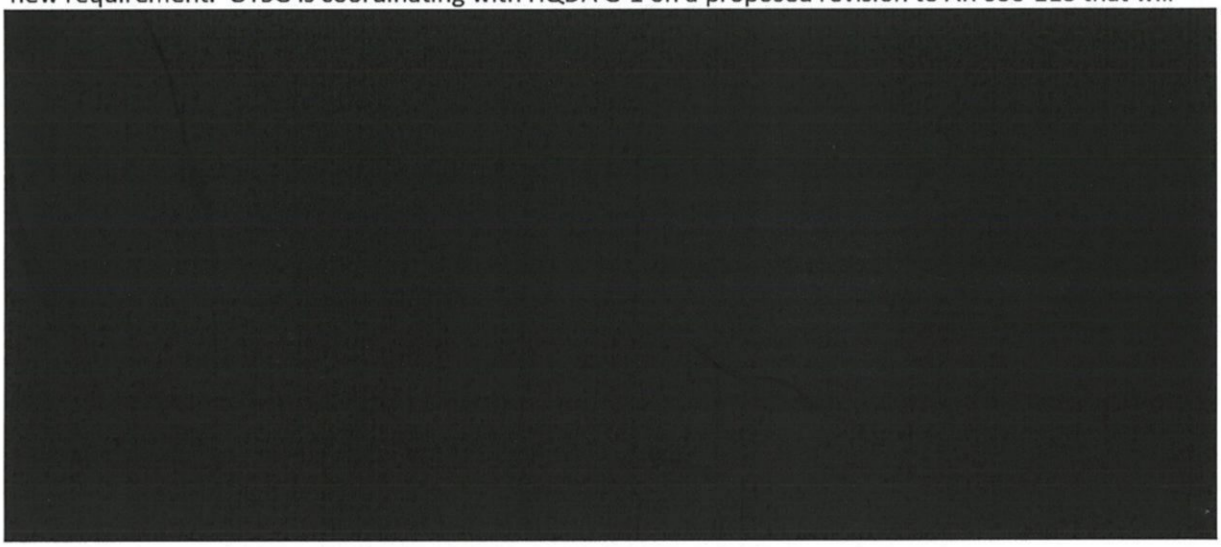
Update to Secretary to the Army from TSG
10 August 2018

UPDATE TO SECRETARY TO THE ARMY FROM TSG – 10AUG18

In response to your question regarding the deployability of HIV-positive Soldiers in light of the recent release of DODI 1332.45 (Retention Determination for Non-Deployable Service Members) the following information summarizes current Army policy and the proposed way forward.

While DODI 6385.01 and DODI 6490.07 authorize deployment of asymptomatic HIV-positive Service Members with a CCMD Surgeon waiver, current Army policy established in AR 600-110 prohibits HIV-positive Soldiers from deployment, assignment or performance of official duties outside the 50 States of the U.S., the District of Columbia and Puerto Rico. This policy categorizes the entire population of HIV-positive Soldiers as non-deployable, despite the population's ability to perform assigned duties in a variety of environments. The Navy, Air Force and Marine Corps already have waiver processes for HIV-positive Service Members and all have deployed such personnel. Additionally, as an exception to the prohibition in AR 600-110, several Army Special Forces Soldiers have deployed with CCMD waivers.

DODI 1332.45, paragraph 3.3, now requires that asymptomatic HIV-positive Service Members be categorized as "Deployable with Limitations." Army policy established in AR 600-110 conflicts with this new requirement. OTSG is coordinating with HQDA G-1 on a proposed revision to AR 600-110 that will



Please let me know if I can provide additional information. Thank you.

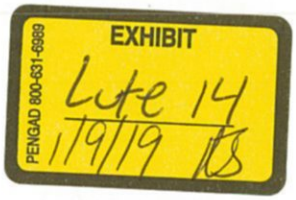


Exhibit 19A to Deposition of Lt. Col. Lisa Lute

Exception to AR 600-110

Exception to AR 600-110					Exception to AR 600-110		
NAME	DATE REQUEST	DATE RESPONSE	APPROVED	DISAPPROVED	REASON	Signature	NOTES
[redacted]	18-Dec-13	7-May-14	X		Attend Degree Producing Program (DCP); Requires ADSO	LTG Howard Bromberg	[redacted]
	22-Dec-15	NO Response located			USAR Soldier requesting orders OCONUS		
	9-Apr-15	27-Apr-15	X		USAREC, Company Commander	LTG James McConville	
		29-Jun-16	X		LTHET	MG Jason Evans	
	7-Apr-16	29-Jun-16	X		USAREC, Supply SGT	MG Jason Evans	
	18-Apr-16	29-Jun-16		X	USAREC - duration of time left in service and reivew of NCOER	MG Jason Evans	
HARRISON, Nicholas SGT	30-Mar-16	29-Jun-16		X	Requesting NG Commission as JAG officer - currently an enlisted Soldier	MG Jason Evans	
[redacted]	5-Jul-16	30-Sep-16	X		USAREC [redacted], Supply SGT	MG Jason Evans	
	28-Aug-16	10-Jan-17	X		Colorado NGB full-time position	MG Evans	
	31-Oct-16	17-Mar-17	X		Recruiting	MG Evans	
	17-Nov-16	15-Dec-16	X		Cadet Command	MG Jason Evans	
	29-Dec-16	21-Feb-17	X		Social Worker Program	MG Jason Evans	
	4-Apr-17	16-May-17	X		ETP to be assinged to MTO&E; All [redacted] are MTOE's.	BG Joseph Calloway	
	2-Jun-17	Recalled by SM			Reuqest ADOS-RC orders> 30 days	ASA M&RA	
	2-Jun-17	20-Jun-17	X		Request assignment to MTOE; 3rd US Infantry Regiment [redacted]	BG Joseph Calloway	
	10-Aug-17	1-Nov-17	X		Request for ETP to serve in the ranks of any TDA unit that is currently precluded by policy. 6-3b.(3)	BG Joseph Calloway	
	30-Aug-18				Request to be assigned to an MTOE as a member of USSOCOM, eligible for Contingency Operations-Active Duty Operational Support (CO-ADOS) and for the Active Guard Reserve (AGR) Program.	MG Joseph Calloway	
	3-Aug-18				Request to attend LTHET.	MG Joseph Calloway	
	9-Oct-18				Request future non-TDA untis,dependnt on unti commanders approval and travel OCONUS for temporary duty or deplyments for duration of 6 months or lesss as long as he remains fit for duty in accordance with medical requirements.	MG Joseph Calloway	
[redacted]		Feb-04	X		Civilian schooling - Approved by LTG Bromberg		
		9-Apr-15	X		USAREC - Approved by LTG McConville		

EXHIBIT 36

AFI 44-178
Human Immunodeficiency Virus Program

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

ACCESSIBILITY: Publications and forms are available on the e-Publishing website at **www.e-Publishing.af.mil** for downloading or ordering.

RELEASABILITY: There are no releasability restrictions on this publication.

OPR: AFMOA/SGHM

Certified by: HQ USAF/SG3
(Brig Gen Charles E. Potter)

Pages: 44

Supersedes: AFI48-135, 7 August 2006

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

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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.

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Signature of Member and Date

EXHIBIT 37

USCENTCOM Individual Protection and Individual Unit Deployment Policy ("MOD-13")

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//

EXHIBIT 38

PPG-TAB A: Amplification of the Minimal Standards of Fitness for Deployment to the CENTCOM AOR (TAB A)

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.

EXHIBIT 39

USCENTCOM 0318152 OCT 19 MOD FOURTEEN TO USCENTCOM INDIVIDUAL PROTECTION AND INDIVIDUAL-UNIT DEPLOYMENT POLICY

USCENTCOM 031815Z OCT 19 MOD FOURTEEN TO USCENTCOM INDIVIDUAL PROTECTION AND INDIVIDUAL-UNIT DEPLOYMENT POLICY

UNCLASSIFIED//

SUBJ/MOD FOURTEEN 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/231245MAR17//
AMPN/MOD THIRTEEN TO USCENTCOM INDIVIDUAL PROTECTION AND UNIT DEPLOYMENT POLICY MESSAGE. MOD THIRTEEN IS NO LONGER VALID AND IS SUPERSEDED BY MOD FOURTEEN//

REF/C/DOC/USD(P&R)/19JUN2019//
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/27FEB2017//
AMPN/CH-1 TO COMDTINST M6000.1F/COAST GUARD MEDICAL MANUAL//

REF/F/DOC/HQ USAF/28JAN2018//
AMPN/AFI 48-123 AFGM2018-02/MEDICAL EXAMINATIONS AND STANDARDS //

REF/G/DOC/HQDA/14JUN2017//
AMPN/AR 40-501/STANDARDS OF MEDICAL FITNESS//

REF/H/DOC/BUMED/28 DEC 2018//
AMPN/NAVMED P-117/MANUAL OF THE MEDICAL DEPARTMENT (MANMED)//

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(A&S)/20DEC2011, AS AMENDED 31AUG2018//
AMPN/DODI 3020.41/OPERATIONAL CONTRACT SUPPORT//

REF/K/DOC/USD(P&R)/25JAN2017, AS AMENDED 04JAN2018//
AMPN/ DTM 17-004/DOD CIVILIAN EXPEDITIONARY WORKFORCE//

REF/L/DOC/ASD(FMP)/11MAR2002, AS AMENDED 26DEC2002//
AMPN/DODI 1100.21/VOLUNTARY SERVICES IN THE DEPARTMENT OF DEFENSE//

REF/M/DOC/ASD(P&R)/16JUN2016, AS AMENDED 21DEC2017//
AMPN/DODI 6200.05/FORCE HEALTH PROTECTION QUALITY ASSURANCE (FHPQA) PROGRAM//

REF/N/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/O/DOC/DEPSECDEF/12NOV2015//
AMPN/DEPUTY SECRETARY OF DEFENSE MEMO/CLARIFYING GUIDANCE FOR SMALLPOX AND
ANTHRAX VACCINE IMMUNIZATION PROGRAMS//

REF/P/DOC/DEPSECDEF/12OCT2006//
AMPN/DEPUTY SECRETARY OF DEFENSE MEMO/ANTHRAX VACCINE IMMUNIZATION PROGRAM//

REF/Q/DOC/ASD(HA)/31JUL2009//
AMPN/ASSISTANT SECRETARY OF DEFENSE MEMO/CLINICAL POLICY FOR THE
ADMINISTRATION OF THE ANTHRAX VACCINE ABSORBED//

REF/R/DOC/AFPMB/06NOV2015//
AMPN/PERSONAL PROTECTIVE MEASURES AGAINST INSECTS AND OTHER ARTHROPODS OF
MILITARY SIGNIFICANCE//

REF/S/DOC/USD(P&R)/07JUN2013//
AMPN/DODI 6485.01/HUMAN IMMUNODEFICIENCY VIRUS (HIV) IN MILITARY SERVICE MEMBERS//

REF/T/DOC/ASD(HA)/14MAR2006//
AMPN/ASSISTANT SECRETARY OF DEFENSE MEMO/POLICY FOR PRE AND POST DEPLOYMENT
SERUM COLLECTION//

REF/U/DOC/ASD(P&R)/17JUL2015//
AMPN/DODI 6465.1/ERYTHROCYTE GLUCOSE-6-PHOSPHATE DEHYDROGENASE DEFICIENCY
(G6PD) AND SICKLE CELL TRAIT SCREENING PROGRAMS//

REF/V/DOC/ASD(HA)/20APR2012//
AMPN/ASSISTANT SECRETARY OF DEFENSE MEMO/GUIDELINE FOR TUBERCULOSIS
SCREENING AND TESTING//

REF/W/DOC/ASD(HA)/26JUL2012//
AMPN/ASSISTANT SECRETARY OF DEFENSE MEMO/IMPLEMENTATION OF REVISED
DEPARTMENT OF DEFENSE FORMS 2795, 2796 AND 2900//

REF/X/DOC/USD(P&R)/11SEP2015, AS AMENDED 31MAR2017//
AMPN/DODI 6490.13/COMPREHENSIVE POLICY ON TRAUMATIC BRAIN INJURY-RELATED
NEUROCOGNITIVE ASSESSMENTS BY THE MILITARY SERVICES//

REF/Y/DOC/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/Z/DOC/USD(P&R)/16MAR2018//
AMPN/DODI 1322.24/MEDICAL READINESS TRAINING (MRT)//

REF/AA/USD(I)/20MAR2009, AS AMENDED 25APR2018//
AMPN/DODI 6420.01/NATIONAL CENTER MEDICAL INTELLIGENCE (NCMI)//

REF/BB/DOC/ASD(HA)/15APR2013//
AMPN/GUIDANCE ON MEDICATIONS FOR THE PROPHYLAXIS OF MALARIA//

REF/CC/DOC/ASD(HA)/12AUG2013//
AMPN/ASSISTANT SECRETARY OF DEFENSE MEMO/NOTIFICATION FOR HEALTHCARE PROVIDERS OF MEFLOQUINE BOX WARNING//

REF/DD/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//EE/DOC/J4/02NOV2007//
AMPN/MCM-0028-07/PROCEDURES FOR DEPLOYMENT HEALTH SURVEILLANCE//

REF/FF/DOC/CC/08NOV2017//
AMPN/CCR 40-2/DEPLOYMENT FORCE HEALTH PROTECTION//

REF/GG/DOC/AFHSB/17JUL2017//
AMPN/ARMED FORCES REPORTABLE MEDICAL EVENTS GUIDELINES & CASE DEFINITIONS//

REF/HH/ DOC/CENTCOM/OCT2012//
AMPN/UNITED STATES CENTRAL COMMAND HEALTHCARE INFORMATION SYSTEM USE POLICY//

REF/II/DOC/USD(P&R)/18SEP2012, AS AMENDED 11JUN2018//
AMPN/DODI 6490.11/DOD POLICY GUIDANCE FOR MANAGEMENT OF MILD TRAUMATIC BRAIN INJURY/ AND CONCUSSION IN THE DEPLOYED SETTING//

REF/JJ/DOC/OTSG/25JUL2017//
AMPN/MEDCOM POLICY MEMO 17-044/STINGING INSECT ALLERGY RETENTION AND READINESS POLICY//

REF/KK/DOC/ASD(HA)/07OCT2013//
AMPN/ASSISTANT SECRETARY OF DEFENSE MEMO/CLINICAL PRACTICE GUIDELINES FOR DEPLOYMENT LIMITING MENTAL DISORDERS AND PSYCHOTROPIC MEDICATIONS//

REF/LL/DOC/USD(P&R)/01OCT2016//
AMPN/DODI 1300.28/IN-SERVICE TRANSITION FOR TRANSGENDER SERVICE MEMBERS//

REF/MM/DOC/HHS/OCT2015//
STIMULANT AND RELATED MEDICATIONS: U.S. FOOD AND DRUG ADMINISTRATION-APPROVED INDICATIONS AND DOSAGES FOR USE IN ADULTS//

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

RMKS/1. (U) THIS IS MODIFICATION FOURTEEN TO USCENTCOM INDIVIDUAL PROTECTION AND INDIVIDUAL/UNIT DEPLOYMENT POLICY. IN SUMMARY, MODIFICATIONS HAVE BEEN MADE TO PARAGRAPH 15 FROM MOD THIRTEEN, REF B.
1.A. PARAGRAPH 15 REQUIRED NUMEROUS CHANGES; THEREFORE, IT IS BEING REPUBLISHED IN ITS ENTIRETY. MOD 14 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. HOST NATION IMMUNIZATION AND MEDICAL SCREENING REQUIREMENTS APPLY. PORTIONS OF MOD 14 WILL APPLY AS DELINEATED IN TAB B.
15.A.4. SHIPBOARD PERSONNEL. ALL SHIPBOARD PERSONNEL WHO DEPLOY INTO THE AOR MUST HAVE CURRENT SEA DUTY SCREENING AND REMAIN FULLY MEDICALLY READY FOLLOWING ANNUAL PERIODIC HEALTH ASSESSMENT (PHA). DEPLOYMENT HEALTH ASSESSMENT PER 15.H APPLIES IF DEPLOYED TO OCONUS FOR GREATER THAN 30 DAYS WITH NON-FIXED U.S. MEDICAL TREATMENT FACILITIES (MTF).
15.B. APPLICABILITY. THIS MOD APPLIES TO U. S. MILITARY PERSONNEL, TO INCLUDE ACTIVATED RESERVE AND NATIONAL GUARD PERSONNEL, DOD CIVILIANS, DOD CONTRACTORS, DOD SUB-CONTRACTORS, VOLUNTEERS, AND THIRD COUNTRY NATIONALS (TCN) TRAVELING OR DEPLOYING TO THE CENTCOM AOR AND WORKING UNDER THE AUSPICES OF THE DOD. LOCAL NATIONALS (LN) WILL MEET THE MINIMAL MEDICAL STANDARDS ADDRESSED IN SECTION 15.C.1.F. MILITARY WORKING DOGS (MWD) AND CONTRACT WORKING DOGS (CWD) WILL MEET MINIMAL STANDARDS ADDRESSED IN SECTION 15.C.1.G.
15.C. MEDICAL DEPLOYABILITY. THE FINAL AUTHORITY FOR ENTRY INTO THE CENTCOM AOR RESTS WITH THE CENTCOM SURGEON AND MAY BE DELEGATED TO CENTCOM SERVICE COMPONENT SURGEONS. THE DEPLOYER'S MEDICAL EVALUATING ENTITY OR DEPLOYING PLATFORM OR COMMANDER ARE NOT AUTHORIZED TO WAIVE MEDICAL DEPLOYMENT STANDARDS. DEPLOYED HEALTH SERVICE SUPPORT INFRASTRUCTURE IS DESIGNED AND PRIORITIZED TO PROVIDE ACUTE AND EMERGENCY SUPPORT TO THE EXPEDITIONARY MISSION. ALL PERSONNEL (UNIFORMED SERVICE MEMBERS, GOVERNMENT CIVILIAN EMPLOYEES, VOLUNTEERS, DOD CONTRACTOR EMPLOYEES), CONTRACT WORKING DOGS (CWD) AND MWD TRAVELING TO THE CENTCOM AOR MUST MEET MEDICAL, DENTAL, AND

BEHAVIORAL HEALTH FITNESS STANDARDS, AND BE REASONABLY EXPECTED TO REMAIN SO FOR THE DURATION OF THEIR DEPLOYMENT. INDIVIDUALS DEEMED UNABLE TO COMPLY WITH CENTCOM DEPLOYMENT REQUIREMENTS ARE DISQUALIFIED FOR DEPLOYMENT IAW SERVICE POLICY AND MOD 14. PERSONNEL FOUND TO BE MEDICALLY NON-DEPLOYABLE WHILE OUTSIDE OF THE CENTCOM AOR FOR ANY LENGTH OF TIME WILL NOT ENTER OR RE-ENTER THE THEATER UNTIL THE NON-DEPLOYABLE CONDITION IS COMPLETELY RESOLVED OR AN APPROVED WAIVER FROM A CENTCOM WAIVER AUTHORITY IS OBTAINED. SEE REF D, E, F, G, H. DOD CIVILIAN EMPLOYEES ARE COVERED BY THE REHABILITATION ACT OF 1973. AS SUCH, AN APPARENTLY DISQUALIFYING MEDICAL CONDITION NEVERTHELESS REQUIRES THAT AN INDIVIDUALIZED ASSESSMENT BE MADE TO DETERMINE WHETHER THE EMPLOYEE CAN PERFORM THE ESSENTIAL FUNCTIONS OF THEIR POSITION IN THE DEPLOYED ENVIRONMENT, WITH OR WITHOUT REASONABLE ACCOMMODATION, WITHOUT CAUSING UNDUE HARDSHIP. IN EVALUATING UNDUE HARDSHIP, THE NATURE OF THE ACCOMMODATION AND THE LOCATION OF THE DEPLOYMENT MUST BE CONSIDERED. FURTHER, THE EMPLOYEE'S MEDICAL CONDITION MUST NOT POSE A SUBSTANTIAL RISK OF SIGNIFICANT HARM TO THE EMPLOYEE OR OTHERS WHEN TAKING INTO ACCOUNT THE CONDITIONS OF THE RELEVANT DEPLOYED ENVIRONMENT. SEE REF I.

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

15.C.1.A. MEDICAL READINESS PROCESSING. THE MEDICAL SECTION OF THE DEPLOYMENT SCREENING SITE MAY PUBLISH GUIDANCE, IAW MOD14 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 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 14. UNLESS SPECIFICALLY OBLIGATED BY CONTRACTUAL ARRANGEMENT, EXPEDITIONARY MILITARY MEDICAL ASSETS ARE NOT TO BE USED FOR RE-EVALUATION OF CONTRACTORS TO STAY DEPLOYED. IF INDIVIDUALS ARE UNABLE TO ADEQUATELY COMPLETE THEIR MEDICAL SCREENING EVALUATION IN THE AOR, THEY SHOULD BE REDEPLOYED TO ACCOMPLISH THIS YEARLY REQUIREMENT. PERIODIC HEALTH SURVEILLANCE REQUIREMENTS AND PRESCRIPTION NEEDS ASSESSMENTS SHOULD REMAIN CURRENT THROUGH THE DEPLOYMENT PERIOD.

15.C.1.D. SPECIALIZED GOVERNMENT CIVILIAN EMPLOYEES WHO MUST MEET SPECIFIC PHYSICAL STANDARDS (E.G., FIREFIGHTERS, SECURITY GUARDS, POLICE, AVIATORS, AVIATION

CREW MEMBERS, AIR TRAFFIC CONTROLLERS, DIVERS, MARINE CRAFT OPERATORS, COMMERCIAL DRIVERS, ETC.) MUST MEET THOSE STANDARDS WITHOUT EXCEPTION, IN ADDITION TO BEING FOUND FIT FOR THE SPECIFIC DEPLOYMENT BY A MEDICAL AND DENTAL EVALUATION PRIOR TO DEPLOYMENT IAW MOD 14. CERTIFICATIONS MUST BE VALID AND RENEWED AS REQUIRED THROUGHOUT THE ENTIRETY OF THE DEPLOYMENT. IT IS UP TO THE INDIVIDUAL TO PLAN FOR AND RECERTIFY THEIR RESPECTIVE REQUIREMENTS.

15.C.1.E. DOD CONTRACTOR EMPLOYEES MUST MEET STANDARDS OF FITNESS FOR DEPLOYMENT AND MUST BE DOCUMENTED TO BE FIT FOR THE PERFORMANCE OF THEIR DUTIES, WITHOUT LIMITATIONS, BY MEDICAL AND DENTAL EVALUATION PRIOR TO DEPLOYMENT IAW MOD 14. 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, O. A DISQUALIFYING MEDICAL CONDITION, AS DETERMINED BY AN IN-THEATER QUALIFIED MEDICAL PROVIDER, 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 ARE:

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 FROM ALL REQUIREMENTS LISTED IN 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.1.G. WORKING DOGS. ONLY THOSE ANIMALS FORMALLY CLASSIFIED AS A MILITARY WORKING DOG (MWD) OR CONTRACT WORKING DOG (CWD), AND DEPLOYED WITH APPROPRIATE HANDLERS FOR A SPECIFIC PURPOSE, ARE AUTHORIZED. ENSURE APPROPRIATE KENNELING, VETERINARY SUPPORT, AND FOOD PRIOR TO DEPLOYMENT. MWD DEPLOYING TO THE CENTCOM AOR MUST MEET THE FOLLOWING REQUIREMENTS.

15.C.1.G.1. MWDS/CWDS ARE SUBJECT TO THE IMPORT REQUIREMENTS OF THE COUNTRIES TO WHICH THEY TRAVEL. REQUIREMENTS ARE SUBJECT TO CHANGE WITHOUT OFFICIAL NOTICE TO DOD. VETERINARY CORPS OFFICERS (VCOS) RESPONSIBLE TO PREPARE DOGS FOR DEPLOYMENT WILL REVIEW HOST NATION IMPORT REQUIREMENTS FOR ANY COUNTRIES THE MWDS/CWDS MAY TRAVEL TO, OR TRANSIT THROUGH, TO ENSURE ASSOCIATED REQUIREMENTS ARE MET.

15.C.1.G.2. ONLY MWDS/CWDS ASSIGNED DEPLOYMENT CATEGORY 1 WILL DEPLOY INTO THE CENTCOM AOR. MWDS/CWDS ASSIGNED CATEGORIES 2-4 ARE ONLY AUTHORIZED TO DEPLOY INTO THE CENTCOM AOR AFTER RECEIVING A MEDICAL WAIVER FROM THE ARCENT VCO. MWD/CWD DEPLOYMENT CATEGORIES ARE DEFINED IN PARA 2.15 OF REF NN.

15.C.1.G.3. MWD DEPLOYING TO THE CENTCOM AOR MUST MEET THE FOLLOWING REQUIREMENTS.

15.C.1.G.3.A. BE IMPLANTED WITH A EUROPEAN UNION (EU) APPROVED 15 DIGIT ISO 11784/11785-307 COMPLIANT MICROCHIP.

15.C.1.G.3.B. CURRENT ON RABIES AND DISTEMPER/ADENO/PARVOVIRU (DAP) AND LEPTOSPIROSIS VACCINES, GIVEN WITHIN 2 MONTHS OF DEPLOYMENT.

15.C.1.G.3.C. THE RED SEMI-ANNUAL PHYSICAL EXAMINATION (RSAPE) WITH ALL NECESSARY LABORATORY TESTS COMPLETED PERFORMED PRIOR TO TRAVEL, AS WELL AS 4DX SNAP TESTS FOR DIROFILARIA AND TICK BORNE DISEASES, AND DETAILED ANESTHETIZED ORAL 313 EXAM TO INCLUDE ALL TEETH.

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

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

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

15.C.2. UNFIT PERSONNEL. CASES OF IN-THEATER/DEPLOYED PERSONNEL IDENTIFIED AS UNFIT, IAW THIS MOD 14, DUE TO CONDITIONS THAT EXISTED PRIOR TO DEPLOYMENT WILL BE FORWARDED TO THE APPROPRIATE COMPONENT SURGEON FOR DETERMINATION REGARDING POTENTIAL MEDICAL WAIVER OR REDEPLOYMENT. FINDINGS/ACTIONS WILL BE

FORWARDED TO THE CENTCOM SURGEON AT CENTCOM.MACDILL.CENTCOM-HQ.MBX.CCSG-WAIVER@MAIL.MIL.

15.C.3. MEDICAL WAIVERS.

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

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

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

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

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

15.C.3.B.1. AUTHORIZED AGENTS (LOCAL MEDICAL PROVIDER, COMMANDER/SUPERVISOR, REPRESENTATIVE) WILL FORWARD A COMPLETED MEDICAL WAIVER REQUEST FORM (TAB C), TO BE ADJUDICATED BY THE APPROPRIATE SURGEON IAW PARAGRAPH 15.C.3.C. ADJUDICATION WILL ACCOUNT FOR SPECIFIC MEDICAL SUPPORT CAPABILITIES IN THE LOCAL REGION OF THE AOR. WAIVER SUBMISSION BY OR THROUGH A MEDICAL AUTHORITY IS STRONGLY ENCOURAGED TO AVOID UNNECESSARY ADJUDICATION DELAYS DUE TO INCOMPLETE INFORMATION. THE CASE SUMMARY PORTION OF THE WAIVER SHOULD INCLUDE A SYNOPSIS OF THE CONCERNING CONDITION(S) AND ALL SUPPORTING DOCUMENTATION TO INCLUDE THE PROVIDER'S ASSESSMENT OF ABILITY TO DEPLOY.

15.C.3.B.2. THE SIGNED WAIVER WILL BE RETURNED TO THE REQUEST ORIGINATOR FOR INCLUSION IN THE PATIENT'S DEPLOYMENT MEDICAL RECORD AND THE ELECTRONIC MEDICAL RECORD (EMR). DISAPPROVALS MUST BE DOCUMENTED AND SHOULD NOT BE GIVEN TELEPHONICALLY.

15.C.3.B.3. A CENTCOM WAIVER DOES NOT PRECLUDE THE NEED FOR SERVICE-SPECIFIC MEDICAL WAIVERS (E.G., SMALL ARMS WAIVERS) OR OCCUPATIONAL MEDICAL WAIVERS (E.G., AVIATORS, COMMERCIAL TRUCK DRIVERS, ETC.) IF REQUIRED.

15.C.3.B.4. APPEAL PROCESS. IF THE SENDING UNIT DISAGREES WITH THE COMPONENT SURGEON'S DECISION, AN APPEAL MAY BE SUBMITTED TO THE CENTCOM SURGEON. IF THE DISAGREEMENT IS WITH THE CENTCOM SURGEON'S DECISION, AN APPEAL MAY BE COORDINATED WITH THE INDIVIDUAL'S CHAIN OF COMMAND, THROUGH THE CENTCOM SURGEON, TO THE CENTCOM CHIEF OF STAFF FOR EXEMPTION TO POLICY CONSIDERATION.
15.C.3.B.5. WAIVERS ARE APPROVED FOR A MAXIMUM OF 15 MONTHS OR FOR THE TIMEFRAME SPECIFIED ON THE WAIVER (TAB C). WAIVER COVERAGE BEGINS ON THE DATE OF THE INITIAL DEPLOYMENT.
15.C.3.B.6. WAIVERS MAY BE APPROVED, AT THE WAIVER AUTHORITY'S SOLE DISCRETION, 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.B.7. ALL ADJUDICATING SURGEONS WILL MAINTAIN A WAIVER DATABASE AND RECORD ALL WAIVER REQUESTS.
15.C.3.C. CONTACTS FOR WAIVERS
15.C.3.C.1. CENTCOM SURGEON.
CENTCOM.MACDILL.CENTCOM-HQ.MBX.CCSG-WAIVER@MAIL.MIL ;
CML: 813.529.0361; DSN: 312.529.0361
15.C.3.C.2. AFCENT SURGEON. USCENTAFSG.ORGBOX@AFCENT.AF.MIL;
CML: 803.717.7101; DSN: 313.717.7101
15.C.3.C.3. ARCENT SURGEON. USARMY.SHAW.USARCENT.MBX.SURG-WAIVER@MAIL.MIL;
CML: 803.885.7946; DSN: 312.889.7946
15.C.3.C.4. MARCENT SURGEON. COMUSMARCENTFORCESURGEON@USMC.MIL;
CML: 813.827.7175; DSN: 312.651.7175
15.C.3.C.5. NAVCENT SURGEON. CUSNC.MEDWAIVERS@ME.NAVY.MIL;
CML: 011.973.1785.4558; DSN: 318.439.4558
15.C.3.C.6. SOCCENT SURGEON. SOCCENT.SG@SOCOM.MIL;
CML: 813.828.7351; DSN: 312.968.7351
15.D. PHARMACY.
15.D.1. SUPPLY. PERSONNEL WHO REQUIRE MEDICATION AND WHO ARE DEPLOYING TO THE CENTCOM AOR WILL DEPLOY WITH NO LESS THAN A 180 DAY SUPPLY (OR APPROPRIATE AMOUNT FOR SHORTER DEPLOYMENTS) OF THEIR MAINTENANCE MEDICATIONS WITH ARRANGEMENTS TO OBTAIN A SUFFICIENT SUPPLY TO COVER THE REMAINDER OF THE DEPLOYMENT USING A FOLLOW-ON REFILL PRESCRIPTION. TRICARE ELIGIBLE PERSONNEL WILL OBTAIN FOLLOW-ON REFILL PRESCRIPTIONS FROM THE TRICARE MAIL ORDER PHARMACY (TMOP) DEPLOYED PRESCRIPTION PROGRAM (DPP) OR EXPRESS SCRIPTS. INFORMATION ON THIS PROGRAM MAY BE FOUND AT HTTPS://WWW.EXPRESS-SCRIPTS.COM/TRICARE/TOOLS/DEPLOYEDRX.SHTML .
15.D.2. EXCEPTIONS. EXCEPTIONS TO THE 180 DAY PRESCRIPTION QUANTITY REQUIREMENT INCLUDE:
15.D.2.A. PERSONNEL REQUIRING MALARIA CHEMOPROPHYLACTIC MEDICATIONS (DOXYCYCLINE, ATOVAQUONE/PROGUANIL, ETC.) WILL DEPLOY WITH EITHER ENOUGH MEDICATION FOR THEIR ENTIRE DEPLOYMENT OR WITH ENOUGH TO COVER APPROXIMATELY HALF OF THE DEPLOYMENT WITH PLANS TO RECEIVE THE REMAINDER OF THEIR MEDICATION IN THEATER (EXCLUDING PRIMAQUINE FOR TERMINAL PROPHYLAXIS) BASED ON UNIT PREFERENCE. UNITS WILL DISTRIBUTE TERMINAL PROPHYLAXIS UPON REDEPLOYMENT. THE DEPLOYMENT PERIOD WILL INCLUDE AN ADDITIONAL 28 DAYS AFTER LEAVING THE MALARIA RISK AREA (FOR DOXYCYCLINE) OR 7 DAYS (FOR ATOVAQUONE/PROGUANIL) TO ACCOUNT

FOR REQUIRED PRIMARY PROPHYLAXIS. TERMINAL PROPHYLAXIS WITH PRIMAQUINE FOR 14 DAYS SHOULD BEGIN ONCE THE INDIVIDUAL MEMBER HAS LEFT THE AREA OF MALARIA RISK.
15.D.2.B. PSYCHOTROPIC MEDICATION MAY BE DISPENSED FOR UP TO A 180 DAY SUPPLY WITH NO REFILL.
15.D.2.B.1. THE PROVIDER MAY PRESCRIBE A LIMITED QUANTITY (I.E., AT LEAST A 90 DAY SUPPLY) WITH NO REFILLS TO FACILITATE CLINICAL FOLLOW-UP IN THEATER.
15.D.2.B.2. PSYCHOTROPIC MEDICATIONS AUTHORIZED FOR UP TO A 180 DAYS SUPPLY INCLUDE, BUT ARE NOT LIMITED TO; ANTI-DEPRESSANTS, ANTI-ANXIETY (NON CONTROLLED SUBSTANCES), NON-CLASS 2 (CII) STIMULANTS, AND ANTI-SEIZURE MEDICATIONS USED FOR MOOD DISORDERS. THIS TERM ALSO ENCOMPASSES THE GENERIC EQUIVALENTS OF THE ABOVE MEDICATION CATEGORIES WHEN USED FOR NON-PSYCHOTROPIC INDICATIONS.
15.D.2.C. ALL DRUG ENFORCEMENT AGENCY (DEA) CONTROLLED SUBSTANCES (SCHEDULE I-V) ARE LIMITED TO A 90 DAY SUPPLY WITH NO REFILLS. AN APPROVED WAIVER MUST BE OBTAINED FROM THE CENTCOM WAIVER AUTHORITY PRIOR TO DEPLOYMENT, AND IS REQUIRED FOR ALL RENEWALS. CLINICAL FOLLOW-UP IN THEATER SHOULD BE SOUGHT AT THE EARLIEST OPPORTUNITY TO OBTAIN MEDICATION RENEWALS.
15.D.3. PRESCRIPTION MEDICATION ANALYSIS AND REPORTING TOOL (PMART). SOLDIER READINESS PROCESSING (SRP) AND OTHER DEPLOYMENT PLATFORM PROVIDER/PHARMACY AND UNIT MEDICAL OFFICER PERSONNEL WILL MAXIMIZE THE USE OF THE PRESCRIPTION MEDICATION ANALYSIS AND REPORTING TOOL (PMART) TO SCREEN DEPLOYING PERSONNEL FOR HIGH-RISK MEDICATIONS, AS WELL AS TO IDENTIFY MEDICATIONS WHICH ARE TEMPERATURE-SENSITIVE, OVER THE COUNTER (FOR SITUATIONAL AWARENESS REGARDING MEDICATION INTERACTION), OR NOT AVAILABLE ON THE CENTCOM FORMULARY AND/OR THROUGH THE TMOP/DPP. CONTACT THE DHA PHARMACY ANALYTICS SUPPORT SECTION AT 1.866.275.4732 OR DHA.JBSA.PHARMACY-OPS.MBX.PASS-DMT@MAIL.MIL FOR INFORMATION ON HOW TO OBTAIN A PMART REPORT. INFORMATION REGARDING PMART AS WELL AS THE CENTCOM FORMULARY CAN BE FOUND AT THE HEALTH.MIL WEBSITE AT: WWW.HEALTH.MIL/PMART.
15.D.4. TRICARE MAIL ORDER PHARMACY (TMOP). PERSONNEL REQUIRING ONGOING PHARMACOTHERAPY WILL MAXIMIZE USE OF THE TMOP/DPP SYSTEM (TO INCLUDE MEDICATIONS LISTED IN 15.D.2.B AND 15.D.2.C) WHEN POSSIBLE. THOSE ELIGIBLE FOR TMOP WILL COMPLETE ON-LINE ENROLLMENT AND REGISTRATION PRIOR TO DEPLOYMENT IF POSSIBLE. INSTRUCTIONS CAN BE FOUND AT HTTPS://WWW.EXPRESS-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 IS APPLICABLE TO THE EQUIPMENT, AND VICE VERSA. DURABLE MEDICAL EQUIPMENT USED FOR RELIEF OR MAINTENANCE OF A MEDICAL CONDITION REQUIRES A WAIVER. WAIVER REQUESTS MUST DESCRIBE DEPLOYER'S ABILITY TO MEET MISSION REQUIREMENTS IN THE EVENT OF FAILURE OF THE EQUIPMENT. MAINTENANCE AND

RESUPPLY OF EQUIPMENT IS THE RESPONSIBILITY OF THE INDIVIDUAL.

15.E.3. CONTACT LENSES. PERSONNEL WILL NOT DEPLOY WITH CONTACT LENSES EXCEPT IAW SERVICE POLICY. AUTHORIZED PERSONNEL DEPLOYING WITH CONTACT LENSES MUST RECEIVE PRE-DEPLOYMENT EDUCATION IN THE SAFE WEAR AND MAINTENANCE OF CONTACT LENSES IN THE DEPLOYED ENVIRONMENT AND 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 WILL 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 N. REFER TO THE DHA-IMMUNIZATION HEALTHCARE DIVISION WEBSITE HTTPS://WWW.HEALTH.MIL/MILITARY-HEALTH-TOPICS/HEALTH-READINESS/IMMUNIZATION-HEALTHCARE/VACCINE-RECOMMENDATIONS/VACCINE-RECOMMENDATIONS-BY-AOR OR CONTACT THE CENTCOM DHA-IMMUNIZATION HEALTHCARE SPECIALIST 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. PERSONNEL WITH MEDICAL EXEMPTIONS DO NOT REQUIRE SEPARATE WAIVERS FOR ROUTINE ASSIGNEMENTS, BUT MAY NOT BE ELIGIBLE FOR POSITIONS WHERE THE EXEMPTED VACCINE IS REQUIRED TO ADDRESS A SPECIFIC OCCUPATIONAL OR PUBLIC HEALTH THREAT. CURRENT DOD IMMUNIZATIONS REQUIREMENTS AND RECOMMENDATIONS CAN BE FOUND AT THE DEFENSE HEALTH AGENCY WEBSITE, ON THE CENTCOM TAB, AT HTTPS://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 FOR ALL THREE VACCINE COMPONENTS, 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**. VACCINE MUST BE ADMINISTERED WITHIN 12 MONTHS OF DEPARTING AFGHANISTAN OR PAKISTAN.
15.F.2.D.1 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.2. MEDICAL ASSUMED (MA) AND MEDICAL IMMUNE (MI) EXEMPTIONS ARE NOT ACCEPTED FOR THIS REQUIREMENT.
15.F.2.D.3. 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 O, P, Q AND EXCEPTIONS FOR VACCINATION IN 15.F.6. NOTE THIS IS A DOD REQUIREMENT, AND CANNOT BE WAIVED BY CENTCOM.
15.F.3.A. MILITARY PERSONNEL. REQUIRED.
15.F.3.B. DOD CIVILIANS. REQUIRED AT GOVERNMENT EXPENSE, FOR EMERGENCY-ESSENTIAL AND NON-COMBAT-ESSENTIAL, OR EQUIVALENT, PERSONNEL IAW REF O.
15.F.3.C. DOD CONTRACTORS. REQUIRED AT GOVERNMENT EXPENSE AS DIRECTED IN THE CONTRACT AND IAW REF J AND O.
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 O.
15.F.5. RABIES. PRE-EXPOSURE VACCINATION WILL 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, SERUM SAMPLES SHOULD BE TESTED EVERY TWO YEARS FOR VIRUS NEUTRALIZING ANTIBODIES, WITH BOOSTER DOSES REQUIRED WHEN TITERS FALL BELOW THE MINIMUM STANDARD LEVELS. 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. CHOLERA. ORAL CHOLERA VACCINE IS OF LIMITED OPERATIONAL USE AND NOT RECOMMENDED OR REQUIRED FOR MOST PERSONNEL. THOSE SPECIFICALLY DESIGNATED BY THEIR UNIT OR MISSION REQUIREMENTS TO RECEIVE THE VACCINE SHOULD TAKE THE FOLLOWING INTO ACCOUNT WHEN PLANNING:
15.F.6.A. ORAL CHOLERA VACCINE RECIPIENTS SHOULD NOT BE ON ORAL ANTIBIOTICS FOR FOURTEEN DAYS PRIOR TO, AND TEN DAYS AFTER, VACCINATION, TO INCLUDE MALARIA CHEMOPROPHYLAXIS. RISK FROM MALARIA DUE TO THIS COURSE OF ACTION MUST BE CONSIDERED DURING PLANNING. SEE 15.L.1. AND REF R.
15.F.6.B. ALLOW FOR TEN DAYS FOR ORAL CHOLERA VACCINE TO BE EFFECTIVE.
15.F.6.C. EFFICACY OF ORAL CHOLERA VACCINE IS UNKNOWN PAST 90 DAYS, AND REVACCINATION MAY NEED TO OCCUR WITH SAME PROVISIONS AS 15.F.6.A. TO ENSURE EFFECTIVENESS.
15.F.6.D. FOLLOW STORAGE AND RECONSTITUTION REQUIREMENTS DESCRIBED IN LABELING INCLUDED WITH PRODUCT PACKAGING FOR ORAL CHOLERA VACCINE. .
15.F.7. MWD VACCINATIONS ARE COVERED IN SECTION 15.C.1.G.2.
15.F.8. EXCEPTIONS. REQUIRED IMMUNIZATIONS WILL BE ADMINISTERED PRIOR TO DEPLOYMENT, WITH THE FOLLOWING POSSIBLE EXCEPTIONS:
15.F.8.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.8.B. IAW REF Q, 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.9. 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 WILL BE REPORTED THROUGH THE VACCINE ADVERSE EVENTS REPORTING SYSTEM (VAERS) AT HTTP://WWW.VAERS.HHS.GOV. QUESTIONS OR CONCERNS MAY BE DIRECTED TO THE DHA-IMMUNIZATION HEALTHCARE DIVISION AT (1-877-438-8222).
15.F.10. USCENTCOM AND COMPONENTS WILL MONITOR IMMUNIZATION COMPLIANCE VIA THE CCMDIMMUNIZATION REPORTING DATABASE. SUBORDINATE COMMANDS WILL REQUEST ACCESS TO THE CCMDIMMUNIZATION REPORTING DATABASE BY CONTACTING CCSG AT BRIAN.D.CANTERBURY.CIV@MAIL.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 S, THE CENTCOM 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 T.

15.G.3. G6PD TESTING. DOCUMENTATION OF ONE-TIME GLUCOSE-6-PHOSPHATE DEHYDROGENASE (G6PD) DEFICIENCY TESTING IS IAW REF U. 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. 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 HYSTERECTOMY ARE EXEMPT.

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 D.

15.G.6. TUBERCULOSIS (TB) TESTING. SEE REF V.

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. 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.

15.G.6.C. LATENT TUBERCULOSIS INFECTION (LTBI) MAY NOT BE DISQUALIFYING FOR DEPLOYMENT. SEE TAB A.

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 AND OTHERWISE RESTRICTED AS DIRECTED BY THE THEATER PREVENTIVE MEDICINE CONSULTANT 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. FOR MWD, SEE SECTION 15.C.1.G.3.

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. THIS ASSESSMENT WILL BE COMPLETED ON A DD FORM 2795 IAW REF C, W. 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 X 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 IAW REF Y OR CURRENT DEPARTMENT OF DEFENSE POLICY.

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

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

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

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

15.H.6. POST-DEPLOYMENT HEALTH RE-ASSESSMENT (DD FORM 2900). ALL PERSONNEL WHO WERE REQUIRED TO COMPLETE A PRE- AND POST-DEPLOYMENT HEALTH ASSESSMENT WILL COMPLETE A POST-DEPLOYMENT HEALTH REASSESSMENT (DD FORM 2900) 90 TO 180 DAYS AFTER RETURN TO HOME STATION. SEE WWW.PDHEALTH.MIL FOR ADDITIONAL INFORMATION 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 Z.
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; TACTICAL COMBAT CASUALTY CARE (TCCC), 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. See Tab D
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 AA 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.1.B.3 ASSESSMENT OF DISEASE THREATS AND NEAR REAL-TIME DISEASE OUTBREAK INFORMATION SHOULD BE OBTAINED PRIOR TO DEPLOYMENT BY ACCESSING THE DHA'S ARMED FORCES HEALTH SURVEILLANCE CENTER'S HEALTH SURVEILLANCE EXPLORER (HSE) DYNAMIC MAP APPLICATION. THE HSE IS FOUO AND IS LOCATED ON A CAC-ENABLED SITE AS FOLLOWS: NIPR: HTTPS://WWW.HEALTH.MIL/HSE OR HTTPS://PORTAL.GEO.NGA.MIL/PORTAL/HOME/" SIPR: HTTPS://PORTAL.GEO.NGA.SMIL.MIL/PORTAL/HOME OR HTTPS://PORTAL/GEO.NGA.SMIL.MIL/PORTAL/APPS/WEBAPPVIEWER/INDEX.HTML?ID=53258902FF2E4D9587C7FF379B22A39B**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 AA, BB, AND CC.

15.L.2.B. DOXYCYCLINE OR ATOVAQUONE/PROGUANIL ARE GENERALLY ACCEPTABLE AS A PRIMARY MALARIA CHEMOPROPHYLACTIC AGENT. MEFLOQUINE SHOULD BE CONSIDERED THE DRUG OF LAST RESORT FOR PERSONNEL WITH CONTRAINDICATIONS TO DOXYCYCLINE ORATOVAQUONE/PROGUANIL , SHOULD BE USED WITH CAUTION IN PERSONS WITH A HISTORY OF TBI OR PTSD, AND IS CONTRAINDICATED IN PERSONNEL WITH SOME BEHAVIORAL HEALTH 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 ATOVAQUONE/PROGUANIL (2 WEEKS FOR MEFLOQUINE) AND COMPLETES AFTER 4 WEEKS OF DOXYCYCLINE OR MEFLOQUINE AFTER LEAVING THE AT RISK AREA, OR (1 WEEK OF ATOVAQUONE/PROGUANIL). 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; HTTPS://WWW.ACQ.OSD.MIL/EIE/AFPMB/. SEE REF Q, DD

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. SEE DOD PEST MANAGEMENT MATERIEL OTHER THAN PESTICIDES AT HTTPS://WWW.ACQ.OSD.MIL/EIE/AFPMB/PEST_EQUIPLISTS.HTML
15.L.4. HEALTH SURVEILLANCE. SEE REF C AND EE.
15.L.4.A. JOINT MEDICAL WORKSTATION (JMEWS) THROUGH MEDICAL SITUATIONAL AWARENESS TOOL (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 FF.
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 EE.
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 EE.
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 DD 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 HTTPS://PHC.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 FF.

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 EE.

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 M, FF.

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 GG.

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 C, HH.

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 II.

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 THIRTEEN 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; NIPR: CENTCOM.MACDILL.CENTCOM-HQ.MBX.CCSG-WAIVER@MAIL.MIL//

EXHIBIT 40

Declaration of Kevin Cron

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

EXHIBIT 41

Excerpts from the March 14, 2019 Deposition of Gary Brown

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
ALEXANDRIA DIVISION

- - - - - - - - - - - - - - - - - - - x
NICHOLAS HARRISON and :
OUTSERVE-SLDN, INC., :
Plaintiffs, :
vs. : No. 1:18-cv-00641
JAMES N. MATTIS, In His : LMB-IDD
Official Capacity As Secretary:
of Defense; MARK ESPER, In His:
Official Capacity As the :
Secretary of the Army; and the:
UNITED STATES DEPARTMENT OF :
DEFENSE, :
Defendants. :
- - - - - - - - - - - - - - - - - - - x

VIDEOTAPED 30(b)(6) DEPOSITION OF
DEPARTMENT OF DEFENSE GIVEN BY GARY BROWN

DATE: Thursday, March 14, 2019
TIME: 9:08 a.m.
LOCATION: Winston & Strawn
1700 K Street, N.W.
Washington, D.C.
REPORTED BY: Denise M. Brunet, RPR
Reporter/Notary

him to testify to those particular discussions even if he knew about them.

BY MR. SCHOETTES:

Q Are all members of the Armed Services provided with health care?

A Are all members of the --

Q Actually, let me rephrase that. Are all active duty members of the Armed Services provided with health care?

A Yes.

Q Are all deployed members of the Armed Services active duty?

A They're placed on an active duty order. They may not all have come from the organic active component inventory.

Q Are all of those deployed members provided with health care?

A Yes.

Q Are members of the Armed Forces expected to follow the treatment plan of their medical -- of their health care providers?

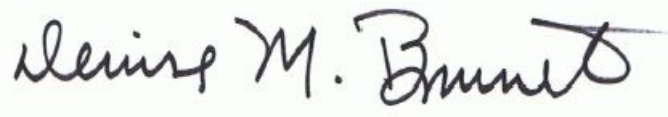
MS. BERMAN: Objection. Outside the scope of what this witness is being offered to testify about.

You can answer if you know.

THE WITNESS: Yes.
BY MR. SCHOETTES:
Q Are members of the Armed Forces, in fact, ordered to adhere to prescribed medical treatments?
MS. BERMAN: Same objection.
You can answer.
THE WITNESS: Ordered to follow? I'm not sure I could answer that.
BY MR. SCHOETTES:
Q What about with respect to HIV specifically? Do you know if service members living with HIV are ordered to adhere to their medical treatment?
MS. BERMAN: Same objection.
You can answer if you know.
THE WITNESS: The ordered part, I'm not -- I can't speak on that. I'm not sure. And the only reason why I say that is, you know, patients have the right to their care requirements and determinations, but I don't know about the ordered part for care. I'm not sure I would be the one that would answer that part.
BY MR. SCHOETTES:
Q I want to move on to the fourth criteria,

CERTIFICATE OF NOTARY PUBLIC

I, Denise M. Brunet, the officer before whom the foregoing deposition was taken, do hereby certify that the witness whose testimony appears in the foregoing deposition was sworn by me; that the testimony of said witness was taken by me stenographically and thereafter reduced to print by means of computer-assisted transcription by me to the best of my ability; that I am neither counsel for, related to, nor employed by any of the parties to this litigation and have no interest, financial or otherwise, in the outcome of this matter.



Denise M. Brunet
Notary Public in and for
The District of Columbia

My commission expires:
December 14, 2022

EXHIBIT 42

Excerpts from the March 20, 2019
Deposition of Lt. Col.
Jason Okulicz, M.D.

UNDER SEAL

EXHIBIT 43

Expert Report of Craig Walter Hendrix, M.D.

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
ALEXANDRIA DIVISION

RICHARD ROE, ET AL., Plaintiffs, v. PATRICK M. SHANAHAN, ET AL., Defendants.	CIVIL ACTION NO. 1:18-cv-01565
NICHOLAS HARRISON, ET AL., PLAINTIFFS, V. PATRICK M. SHANAHAN, ET AL., DEFENDANTS.	CIVIL ACTION NO. 1:18-CV-00641

EXPERT REPORT OF CRAIG W. HENDRIX, M.D.

TABLE OF CONTENTS

I. INTRODUCTION

1. My name is Craig W. Hendrix. I have been retained by counsel for Plaintiffs as an expert in connection with this litigation.

2. I am offering this report to provide my expert opinion regarding the U.S. Department of Defense ("DoD") and U.S. Army and Air Force policies with respect to people living with HIV, including the purported medical justifications for preventing individuals living with HIV from joining the United States military, from being commissioned as officers, and—if already in the military—from deploying outside the United States or from remaining in the Air Force.

3. As detailed below, it is my opinion that there are no medical justifications for excluding individuals from serving in any capacity in the military or from being deployed outside of the United States, including to combat zones, based solely on the fact they are living with HIV.

4. The opinions I express are my own and do not reflect the official policy of any organization with which I am affiliated.

5. My expertise regarding the subjects discussed below is based upon my own knowledge and experience, as well as my review of various materials cited herein.

A. Professional Background & Qualifications

6. I am currently a Professor of Medicine, Pharmacology and Molecular Sciences, and Epidemiology at the Johns Hopkins University School of Medicine. I have 28 years of experience in the design and conduct of translational clinical pharmacology studies, mostly of antiretroviral drugs for HIV treatment and prevention. In 1997, I joined the full-time faculty at The Johns Hopkins University School of Medicine in the Division of Clinical Pharmacology and

Division of Infectious Diseases and have been Director of the Drug Development Unit since 1998. In 2015, I was appointed as the Wellcome Professor and Director, Division of Clinical Pharmacology. In 2018, I received the Distinguished Investigator Award from the American College of Clinical Pharmacology, and in 2017, I was the recipient of the PhRMA Foundation Award in Excellence in Clinical Pharmacology. I have received the John Hopkins Alumni Association Excellence in Teaching Award, as well as the David M. Levine Faculty Mentoring Award.

7. Before joining the Johns Hopkins medical school faculty, I served on active duty for nearly 10 years in the U.S. Air Force ("USAF"). During that time, after completing my medical training, I was the Director of the HIV Medical Evaluation Unit ("MEU") and HIV Program at the Wilford Hall USAF Medical Center in San Antonio, Texas, from July 1989 to June 1994. As Director of the HIV MEU, my responsibilities included monitoring the condition of HIV-positive service members, studying behavioral risk factors associated with HIV, and educating service members about the treatment and prevention of HIV.

8. I received my undergraduate degree in Applied Biology at the Massachusetts Institute of Technology in 1978, and I received my medical degree from Georgetown University, *magna cum laude*, in 1984. I completed internship and residency in internal medicine on the Osler Medical Service, and fellowships in Infectious Diseases and Clinical Pharmacology at The Johns Hopkins Hospital.

9. For nearly 30 years, I have evaluated, treated, and/or conducted research with thousands of individuals living with HIV. I have authored or co-authored over 190 papers in peer-reviewed journals on topics related to HIV treatment, prevention, and education. My current research focuses on development of antiretroviral drugs to prevent HIV infection. This

involves oral, topical, and injectable HIV microbicide development. I conduct small, intensive sampling studies of pharmacokinetics ("PK")[1] and pharmacodynamics ("PD") of drugs for HIV prevention with a focus on developing methods to better understand HIV and drug distribution in the male genital tract, female genital tract, and lower gastrointestinal tract. I also support numerous HIV pre-exposure prophylaxis development studies from phase I to phase III, largely as the leader of the Pharmacology Core Laboratory of both the Microbicide Trial Network and HIV Prevention Trials Network.

10. In addition to research and teaching, I have served on several Food and Drug Administration Advisory Committees (Antiviral, Oncology, Arthritis, Drug Safety and Risk Management), the Institute of Medicine's Ad Hoc Advisory Committee, the National Center for Infectious Diseases' Board of Scientific Counselors, as well as in multiple leadership positions, including on the Board of Directors for the American Society for Clinical Pharmacology and Therapeutics and for the American Board of Clinical Pharmacology.

11. I have not testified as an expert at trial or at deposition in during the previous four years.

12. My curriculum vitae is attached, which describes my education, work experience, and publications. *See* Exhibit 1 (Hendrix CV).

B. Materials Considered

13. In undertaking my analysis, I have considered information from a variety of sources that are identified in Exhibit 2 (Materials Considered), as well as relying on my

[1] Pharmacokinetics describes the drug concentration-time courses in body fluids resulting from administration of a certain drug dose, while pharmacodynamics describes the observed effect resulting from a certain drug concentration.

professional judgement and extensive experience in the fields of clinical pharmacology, drug development, and HIV treatment and prevention, both while in the military services and during civilian employment.

14. I reserve the right to make and use demonstratives to help explain my opinions.

C. Compensation

15. I am not receiving any compensation for my work or testimony in this litigation.

II. SUMMARY OF OPINIONS

16. HIV seropositivity is not inconsistent with the demands of military service. Service members living with well-managed HIV do not pose a cognizable danger to the health of other individuals through battlefield transmission, nor do they have a negative impact on military readiness or military blood supplies.

17. Based on the information I have reviewed, Nicholas Harrison was medically fit to be commissioned as an officer, as well as to be deployed or stationed overseas. My review of his medical records shows that his HIV was virally suppressed and has been for a number of years, his immune system is normal, and he received a strong assessment of his physical skills in his most recent Army physical. Sergeant Harrison was medically fit to serve as a JAG officer.

18. In my opinion, based on the information I have reviewed, Roe and Voe were medically fit to be deployed or stationed overseas. My review of their medical records shows that their HIV was virally suppressed, their immune systems are normal, and they faced no work restrictions because of their HIV status.

19. To the extent the regulations of the Department of Defense, Army, Air Force, and any other military branch do not allow for Sgt. Harrison to commission as an officer or Harrison,

Roe or Voe to deploy, they are not consistent with the current state of medical science regarding HIV.

III. MEDICAL JUSTIFICATIONS OFFERED BY THE MILITARY FOR EXCLUDING PEOPLE LIVING WITH HIV FROM VARIOUS ASPECTS OF MILITARY SERVICE, INCLUDING DEPLOYMENT OUTSIDE THE UNITED STATES, ARE UNFOUNDED

20. Being HIV-positive is entirely compatible with military service. The Department of Defense has recognized this for many years by generally permitting people to continue to serve if they seroconvert (i.e., acquire HIV and develop HIV antibodies) after entering service. Moreover, I understand the Navy has allowed service members with HIV to deploy for selected overseas missions since 2012.[2] As I discuss below, the reasons articulated by the DoD, Army and Air Force for the disparate treatment of people living with HIV do not justify excluding them from or restricting their military service.

A. Military Policies Regarding People Living with HIV

1. Accession Ban

21. I understand that, under Department of Defense ("DoD") Instruction 6485.01 (Human Immunodeficiency Virus (HIV) in Military Service Members),[3] it is the U.S. military's policy to deny the "appointment, enlistment, pre-appointment, or initial entry training for military service" to people living with HIV, pursuant to DoD Instruction ("DoDI") 6130.03,

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[2] U.S. Navy, Sec'y of the Navy Instr. 5300.30E (Management of Human Immunodeficiency Virus, Hepatitis B Virus and Hepatitis C Virus Infection in the Navy and Marine Corps), ¶ 3.c.(2) (Aug. 13, 2012); U.S. Navy, Secretary of the Navy Instruction 5300.30F (Management of Human Immunodeficiency Virus, Hepatitis B Virus, and Hepatitis C Virus Infection in the Navy and Marine Corps), Encl. 5, ¶ 3 (December 27, 2018).

[3] U.S. Dep't of Def. Instr. 6485.01 (Human Immunodeficiency Virus (HIV) in Military Service Members), ¶ 3.a (June 7, 2013), http://www.esd.whs.mil/Portals/54/Documents/DD/issuances/dodi/648501p.pdf.

which sets medical standards for appointment, enlistment, and induction into the military services. In other words, people living with HIV are barred from entering the military or—if they seroconvert after joining the military—from being appointed an officer.

22. Despite this general policy prohibiting people living with HIV from joining the military or being appointed as an officer, DoDI 6485.01 states that an active duty service member with HIV who it has been determined is otherwise "fit for duty will be allowed to serve in a manner that ensures appropriate medical care."[4] According to this regulation, service members with HIV who are determined to be fit for duty may continue to serve.[5]

23. Department of Defense Instruction 6130.03 (Medical Standards for Appointment, Enlistment, and Induction into the Military Services) sets forth guidance regarding the physical and medical standards required for military service.[6] These standards state that individuals who are considered for appointment, enlistment, or induction into the Medical Services must be:

> (1) Free of contagious diseases that may endanger the health of other personnel.
>
> (2) 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.
>
> (3) Medically capable of satisfactorily completing required training and initial period of contracted service.
>
> (4) Medically adaptable to the military environment without geographical area limitations.

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[4] *Id.* at Encl. 3, ¶ 2.c.
[5] *Id.* at Encl. 3, ¶ 2.e.
[6] U.S. Dep't of Def. Instr. 6130.03 (Medical Standards for Appointment, Enlistment, or Induction into the Military Sciences) (May 6, 2018), http://www.esd.whs.mil/Portals/54/Documents/DD/issuances/dodi/613003p.pdf (hereinafter "DoDI 6130.03").

(5) Medically capable of performing duties without aggravating existing physical defects or medical conditions.[7]

24. Despite the fact that people living with HIV who are adherent to their medication regimen would meet all of the requirements set forth in DoDI 6130.03, HIV is among the "disqualifying conditions" specified under that regulation.[8]

25. I also understand that Army Regulation 600-110 (Identification, Surveillance, and Administration of Personnel Infected with Human Immunodeficiency Virus)[9] implements DoDI 6485.01 and describes various policies and responsibilities related to HIV with respect to Army personnel. Specifically, the Army indicates its policies are meant to reflect: [1] the risks incident to military service for the person with HIV; [2] the risk of transmission to other personnel; [3] the overall impact of people living with HIV in Army units and on readiness posture; and [4] the safety of military blood supplies.[10] Similar to DoDI 6485.01, AR 600-110 states that personnel with HIV are not eligible for appointment on enlistment into the active Army, the Army National Guard, or the U.S. Active Reserve.[11] Again, however, the Army regulation states that active duty soldiers with HIV who do not demonstrate progressive clinical illness or immunological

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[7] *Id.* at Sec. 1, ¶ 1.2.c.
[8] *Id.* at Sec. 5, ¶ 5.23.b ("Presence of human immunodeficiency virus or laboratory evidence of infection or false-positive screening test(s) with ambiguous results by supplemental confirmation test(s).").
[9] U.S. Army Reg. 600-110 (Identification, Surveillance, and Administration of Personnel Infected with Human Immunodeficiency Virus) (Apr. 22, 2014), https://armypubs.army.mil/epubs/DR_pubs/DR_a/pdf/web/r600_110.pdf.
[10] *Id.* at Ch. 1, Sec. III, ¶ 1-15.
[11] *Id.* at Ch. 1, Sec. III, ¶ 1-16.a.

deficiency during periodic evaluations will not be involuntarily separated solely because they have HIV.[12]

26. I understand that this regulation defines "progressive clinical illness" as follows:

> Development of neurological manifestations; Kaposi's sarcoma; other lymphoreticular malignancies; thrombocytopenia; diffuse, persistent lymphadenopathy; or unexplained weight loss, diarrhea, anorexia, fever, malaise, or fatigue.[13]

27. I also understand that this regulation also defines "immunological deficiency" as follows:

> Persistent reduction in the level of T-helper lymphocytes below 300 cells per cubic millimeter for greater than one month without other demonstrable cause; reduced or absent delayed hypersensitivity, as measured by the standardized battery of skin tests (in association with other significant clinical findings); development of thrush; increased susceptibility to either common or uncommon infections; and more severe episodes of infection than usually seen with a given organism.[14]

28. In my opinion, the definitions of "progressive clinical illness" and "immunological deficiency" contained in AR 600-110 are reasonable.

29. I further understand that Air Force Instruction 44-178 (Human Immunodeficiency Virus Program)[15] implements DoDI 6485.01 and describes policies related to HIV with respect to members of the Air Force. It states that individuals living with HIV are not eligible for

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[12] *Id.* at Ch. 1, Sec. III, ¶ 1-16.e; *see also* Tumminello Dep. at 91:13–92:1 (Deputy State Surgeon for the D.C. Army National Guard, Lt. Col. Paul Tumminello, testified that whether or not a person living with HIV has a progressive clinical illness or immunological deficiency, they cannot obtain an accessions waiver.).
[13] U.S. Army Reg. 600-110, at 54.
[14] *Id.*
[15] Air Force Instr. 44-178 (Human Immunodeficiency Virus Program) (Mar. 4, 2014), https://static.e-publishing.af.mil/production/1/af_sg/publication/afi44-178/afi44-178.pdf.

enlistment or appointment to the Active Duty Air Force or Air Reserve Component.[16] Although HIV seropositivity alone is not grounds for separation,[17] HIV-positive service members must undergo medical evaluation to determine status for continued military service.[18] According to this regulation, they are evaluated for retention or separation in accordance with Air Force Instruction 36-3212.[19] Service members with HIV who are retained are given an assignment limitation code and returned to duty.[20]

2. Conditions for Deployment and Deployment Restrictions

30. I further understand that Department of Defense Instruction 6490.07 (Deployment-Limiting Medical Conditions for Service Members and DoD Civilian Employees) provides guidance on medical conditions that limit deployment. DoDI 6490.07 indicates that it is DoD policy that service members with existing medical conditions may deploy only when 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 Military Health

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[16] *Id.* at Sec. 2.2.1.
[17] *Id.* at Sec. 2.4.1.
[18] *Id.* at Sec. 2.4.
[19] *Id.* at Sec. A9.2.1.
[20] *Id.* at Sec. A9.2.2. I understand that in another case, the same entity that ordered the discharge or Roe and Voe, the Secretary of the Air Force Personnel Council ("SAFPC"), returned to duty an Air Force service member living with HIV. (Roe Declaration at Ex. A6.) The letter by SAF Personnel Council Director Col. Lisa M. Craig cited AFI 48-178 as providing for retention of Air Force service members with HIV. *Id.* In its decision, the letter cites the service member's "current health status and no requirement for medications requiring special handling . . . ." *Id.* Based on the information that I have reviewed, it is my opinion that the Air Force should have made the same decision in Roe and Voe's cases.

> System. Medication must have no special handling, storage, or other requirements (e.g., refrigeration, cold chain, or electrical power requirements). Medication must be well tolerated within hard 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.)[21]

31. Again, despite the fact that service members with well-controlled HIV would meet all of the requirements set forth in DoDI 6490.07, the regulation specifically identifies HIV as a medical condition that could preclude a service member's deployment outside of the United States.[22] DoDI 6490.07 provides that a service member living with HIV shall not be deployed on a "contingency deployment" (*i.e.,* a deployment of over 30 days located outside the continental United States in a location with medical support from only temporary military medical treatment facilities) unless a medical waiver is granted..[23] Though the first sentence of provision (e)(2) of Enclosure 3 attached to DoDI 6490.07 contemplates the need for a waiver only if the individual has 'progressive clinical illness' or 'immunological deficiency,' Defendants appear to interpret the second sentence as requiring a waiver in all instances of HIV seropositivity.[24]

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[21] Dep't of Def. Instr. 6490.07 (Medical Conditions Usually Precluding Contingency Deployment), Encl. 3, ¶ 4.b (Feb. 5, 2010), http://www.esd.whs.mil/Portals/54/Documents/DD/issuances/dodi/649007p.pdf.

[22] *Id.* at Encl. 3, ¶ e.2.

[23] *Id.* at ¶ 4.c ("Individuals with the conditions in Enclosure 3, based on medical assessments in accordance with Enclosure 2 and Reference (l), shall not deploy unless a waiver can be granted according to the procedures in section 3 of Enclosure 2."); *id. at* Encl. 2, ¶ 2.a ("In general, DoD personnel with any of the medical conditions in Enclosure 3, and based on a medical assessment, shall not deploy unless a waiver is granted. Consideration should be made for the nature of the disability and if it would put the individual at increased risk of injury or illness, or if the condition is likely to significantly worsen in the deployed environment.").

[24] Among others, I understand that the DoD designee on the topic of DoDI 6490.07 interprets that regulation to require a waiver for all people living with HIV engaging in a contingency deployment. *See* Wiesen Dep. at 121:4-123:7 ("Q: Isn't it essentially saying that a waiver is required regardless of

3. "Deploy or Get Out" Policy

32. I understand that on February 14, 2018, the DoD issued the "Retention Policy for Non-Deployable Service Members," often referred to as the "Deploy or Get Out" or "DOGO" policy.[25] This policy states that "[s]ervice members who have been non-deployable for more than 12 consecutive months, for any reason, will be processed for administrative separation."[26]

33. This policy was replaced by DoDI 1332.45 (Retention Determinations for Non-Deployable Service Members) (the "DOGO Instruction"), which classifies individuals with any medical condition listed in DoDI 6490.07 (which includes HIV) as "deployable with limitations."[27] At his deposition, the Department of Defense's 30(b)(6) designee regarding the DOGO Instruction, Michael Melillo, testified that the DoD agrees that persons with asymptomatic HIV should be classified as "deployable with limitations" under DoDI 1332.45 (Melillo Dep. 61:15-24), and that persons classified as "deployable with limitations" should not be subject to retention determinations under DoDI 1332.45 § 1.2 (Melillo Dep. 63:9-64:9).

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whether there is clinical progressive -- I'm sorry -- progressive clinical illness or immunological deficiency?" A: Yes."); *see also* Blaylock Dep. at 194:20-23 ("Q: And all people living with HIV must obtain a waiver to deploy in the Army; is that right? A: Yes."); *id.* at 195:6-10; Lute Dep. 219:2-221:21 (Army's designee on AR 600-110 discussing the Army's policy that all members with HIV must obtain a waiver to be able to engage in a contingency deployment); Soper Dep. at 107:7-108:1 (Air Force designee regarding Air Force personnel policies discussing the Air Force policy that all members with HIV must obtain a waiver to be able to engage in a contingency deployment).

[25] U.S. Dep't of Def. Mem. (Retention Policy for Non-Deployable Service Members) (Feb. 14, 2018) (hereinafter "DOGO Policy"), https://dod.defense.gov/Portals/1/Documents/pubs/DoD-Universal-Retention-Policy.PDF; *see also* Dep't of Def. Instr. 1332.45 (Retention Determination for Non-Deployable Service Members) (July 30, 2018), https://www.esd.whs.mil/Portals/54/Documents/DD/issuances/dodi/133245p.pdf?ver=2018-08-01-143025-053 (hereinafter "DoDI 1332.45").

[26] DOGO Policy at 1; DoDI 1332.45, at Sec. 1, ¶ 1.2.b.

[27] DoDI 1332.45, at Sec 3., ¶ 3.3.

DoDI 1332.45 also gives the secretary of each military department discretion to retain nondeployable service members if their retention would be "in the best interest of the Military Service."[28]

34. On November 8, 2018, the Army published a memo titled "Army Directive 2018-22 (Retention Policy for Non-Deployable Soldiers)," contemplating that some soldiers will be found "deployable with limitations."[29] On February 19, 2019, the Air Force published a memo titled "Air Force Guidance Memorandum Establishing Guidance for Implementing Department of Defense Instruction (DoDI) 1332.45, Retention Determinations for Non-Deployable Service Members."[30] This guidance memorandum does not use the term "deployable with limitations." Instead, this memorandum states that "every Airman is personally responsible to be fit for duty and to maintain a wartime mission-capable status."[31] Under this regulation, this requirement is achieved by accomplishing the following:

> (a) meet[ing] individual medical readiness standards, to include medical, dental, and physical components,
> (b) be[ing] able to execute the wartime mission requirements of their respective career fields, to include technical, educational, and physical proficiency,
> (c) be[ing] current on the Physical Fitness Assessment, and
> (d) be[ing] considered a satisfactory participant in Air Force Reserve and Air National Guard duties, as applicable.[32]

4. "MOD 13"

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[28] *Id.* at Sec. 2, ¶ 4.b.1.
[29] U.S. Army Mem. 2018-22 (Retention Policy for Non-Deployable Soldiers) p. 2 (Nov. 8, 2018).
[30] Air Force Mem. AFGM2019-36-01 (Air Force Guidance Memorandum for Implementing Department of Defense Instruction (DoDI) 1332.45, Retention Determinations for Non-Deployable Service Members) (February 19, 2019).
[31] *Id.* at ¶ 1.c.(1).
[32] *Id.* at ¶ 1.c.(1)(a)-(d).

35. I understand that Modification Thirteen to USCENTCOM Individual Protection and Individual-Unit Deployment Policy ("MOD 13") was published by the United States Central Command in March 2017 and provides medical screening standards for deployment to Central Command ("CENTCOM").[33] Tab A accompanied MOD 13 and "provides amplification of the minimal standards of fitness for deployment to the CENTCOM area of responsibility (AOR)."[34] Tab A lists conditions that require a waiver for deployment, including HIV. Specifically, it states that "confirmed HIV infection is disqualifying for deployment."[35]

5. Disability Evaluation System

36. I understand that Department of Defense Instruction 1332.18 (Disability Evaluation System ("DES")) establishes procedures for the separation or retirement of service members for disability.[36] The Medical Evaluation Board ("MEB") consists of two or more physicians that "confirm the medical diagnosis for and document the full clinical information" of a Service Member with medical conditions that may "prevent the Service member from performing the duties of his office, grade, rank, or rating and state."[37] The MEB then determines if the medical condition warrants a referral to a Physical Evaluation Board.[38]

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[33] U.S. Cent. Command Doc. 231245Z (Modification Thirteen to USCENTCOM Individual Protection and Individual Unit Deployment Policy) (Mar. 2017).
[34] U.S. Cent. Command Doc. 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) (March 2017), https://www.express-scripts.com/TRICARE/tools/USCENTCOM-MOD-13_TAB-A.pdf (Hereinafter "Modification Thirteen, Tab A").
[35] *Id.* at ¶ 7.c.2.
[36] Dep't of Def. Instr. 1332.18 (Disability Evaluation System (DES)) (August 5, 2014), https://warriorcare.dodlive.mil/files/2016/03/DoDI_1332.18.pdf (hereinafter "DoDI 1332.18").
[37] *Id.* at Encl. 3, ¶¶ 2.b, 2.f.(2).
[38] *Id.* at Encl. 3, ¶ 2.f.(2).

37. The Informal Physical Evaluation Board ("IPEB") is made up of two or three military personnel, and makes the "initial findings and recommendations" regarding the Service Members retirement or separation.[39] The Formal Physical Evaluation Board ("FPEB") is comprised of a military officer, a medical officer and a line officer (at minimum), and conducts a formal hearing if the service member challenges the IPEB's determinations.[40]

6. Additional Air Force Guidance

38. The Air Force published several guidance memoranda that provided additional information about how the Air Force's HIV policies would be implemented. On October 11, 2017, the Air Force published a memorandum titled "Retention of Airmen with Asymptomatic HIV," which stated that airmen with laboratory evidence of HIV and without progressive clinical illness or immunological deficiency will be referred to the Air Force Personnel Center Medical Standards Branch for Case Review.[41] However, it also stated that "asymptomatic HIV alone is not unfitting for continued service."[42]

39. On June 6, 2018 the Air Force published a memo titled "Appropriate Evaluation of Fitness for Continued Service for Airmen with Asymptomatic Human Immunodeficiency Virus (HIV)."[43] This memo reiterates that asymptomatic HIV would be evaluated in the same manner as "any Airman with a chronic and/or progressive disease,"[44] and that referral to the DES required the airman to meet the following criteria from DoDI 1332.18:

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[39] *Id.* at Encl. 3, ¶¶ 3.b,3.d(1).
[40] *Id.* at Encl. 3, ¶¶ 3.c 3.d.(2).
[41] Air Force Mem. A-00341 (Retention of Airmen with Asymptomatic HIV) (Oct. 11, 2017).
[42] *Id.*
[43] Air Force Mem. A-00338 (Appropriate Evaluation of Fitness for Continued Service for Airmen with Asymptomatic Human Immunodeficiency Virus (HIV)) (June 6, 2018).
[44] *Id.*

> (1) 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 . . . ;
> (2) Have a medical condition that represents an obvious medical risk to the health of the member or the health or safety of other members; or
> (3) Have a medical condition that imposes unreasonable requirements on the military to maintain or protect the Service member.[45]

40. The Memorandum states that "[a]symptomatic HIV alone is not unfitting for continued service."[46]

41. On September 26, 2018 the Air Force published a memo titled "Airmen with Asymptomatic Human Immunodeficiency Virus (HIV) Disposition."[47] This memo stated that the decision authority or boards will use the criteria in DoDI 1332.18, Enclosure 3, Appendices 1 and 2, *as well as an assessment of the current career point of the Airman*, to evaluate if the Airman should be retained or separated.[48] The memo also clarified that the statement "'asymptomatic HIV alone is not unfitting for continued service' . . . is not a policy statement that asymptomatic HIV Airmen are not to be referred into DES."[49]

7. Department of Defense 2018 Report to Congress

42. I have reviewed Defendants' responses to Interrogatories Nos. 17 and 18 of Plaintiff's First Set of Interrogatories to Defendants (Nos. 1-23) in *Harrison v. Shanahan*, which pose the following questions:

> INTERROGATORY NO. 17: Explain in detail each of the reasons underlying DoD's policies that, absent a medical waiver or exception to policy, prohibit HIV-positive persons from enlisting in the Military Services, being inducted into the Military Services, or being appointed as an officer in the Military Services as set forth in, *inter alia*, DoDI 6485.01 and DoDI 6130.03.

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[45] DoDI 1332.18, at App. 1 to Encl. 3, ¶ 2.a.(1)–(3).
[46] Air Force Mem. A-00338, at 1.
[47] Air Force Mem. A-00339 (Airmen with Asymptomatic Human Immunodeficiency Virus (HIV) Disposition) (Sep. 26, 2018).
[48] *Id.*
[49] *Id.*

> INTERROGATORY NO. 18: Explain in detail each of the reasons underlying DoD's policies that, absent a medical waiver or exception to policy, prohibit HIV-positive persons from deploying to regular operations or contingency operations areas, as set forth in, *inter alia*, DoDI [6490.07].

After lodging their objections, Defendants respond that the DoD set forth its complete reasoning underlying the policies referenced in these interrogatories in the 2014 and 2018 reports to Congress.

43. I understand that in August 2018, at the request of Congress, the DoD submitted a report titled *Department of Defense Personnel Policies Regarding Members of the Armed Forces Infected with Human Immunodeficiency Virus* ("2018 Report").[50] This report provides "[a] description of policies addressing the enlistment or commissioning, retention, deployment, discharge, and disciplinary policies regarding individuals with this condition [HIV]."[51]

44. The 2018 Report discusses the regulations set forth above, including the aforementioned policies underlying the accession and deployment of individuals living with HIV.[52] The 2018 Report also includes a "MEDICAL ASSESSMENT OF POLICIES."[53] Below, I endeavor to address all of the purported medical justifications for the policies as set forth in the 2018 Report. (While also older, the 2014 Report is less detailed and contains no justifications not reiterated in the 2018 Report.)

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[50] Dep't of Def., *Department of Defense Personnel Policies Regarding Members of the Armed Forced Infected with Human Immunodeficiency Virus: Report to the Committees on the Armed Services of the Senate and House of Representatives* (Aug. 2018) (hereinafter "2018 Report").
[51] *Id.* at 1.
[52] *Id.* at 7–18.
[53] *Id.* at 19–23.

45. Regarding the "Deploy or Get Out" policy, the 2018 Report explains, "[t]he overarching policy is that to maximize the lethality and readiness of the Joint Force, all Service members are expected to be deployable."[54] The 2018 Report clarifies that "'non-deployable' and 'deployable with limitations' are two separate categories . . . [and] [t]he 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."[55]

B. Policies Underlying the Physical and Medical Standards for Military Service and Deployment Do Not Justify the Exclusion of or Current Limitations Placed upon People Living with HIV

1. There is No Danger to the Health of Other Personnel

46. People living with HIV in the military pose no cognizable danger to the health of other personnel in the military. HIV cannot be transmitted by working alongside or having casual contact with someone who is living with HIV, including sharing bathroom facilities; sharing equipment, utensils, and tableware; or exercising or engaging in physical activities. This fact is borne out by the military's policy that allows people living with HIV to continue to serve in the military, as long as they are medically fit for duty. As stated above, the Navy has already taken steps to allow service members living with HIV to serve overseas on a case-by-case

[54] *Id.* at 4.
[55] *Id.*

basis.[56] That decision was based on the explicit recognition that: "There is no demonstrated risk of transmission of disease in normal daily activities."[57]

47. Similarly, there is no medical basis for any service member to refuse to serve with people living with HIV. AR 600-110 explicitly acknowledges that "[t]here is no basis for civilian employees to refuse to work with fellow employees, Soldiers, or agency clients who have . . . HIV or AIDS. The concerns of such employees will be addressed with education and counseling."[58]

48. Furthermore, there is no risk—beyond a hypothetical one—of battlefield transmission of HIV. Transmission via the types of exposure that may take place on the battlefield, such as "blood splashes" (which also occur occasionally in the health care setting) or those experienced while a wounded soldier with HIV is receiving or providing care to another wounded soldier (i.e., "wound-to-wound contact," which may occur occasionally in some civilian settings, such as after a car accident or in some sporting activities, such as boxing or sports causing occasional compound fractures)—are not documented routes of transmission. The risk of an exposure that could result in transmission under such circumstances is at most a theoretical risk. For example, in his deposition, Lt. Jason Blaylock, service chief of infectious diseases at Walter Reed National Military Medical Center and the Army's designee regarding the

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[56] NAVSECINS 5300.30E, at ¶ 3.c.(2) ("Selected AC members on a case-by-case basis in consultation with the treating HIV Evaluation and Treatment Unit (HETU), Navy Bloodborne Infection Management Center (NBIMC), and PERS-82 (for sailors) or United States Marine Corp (USMC) Manpower & Reserve Affairs (M&RA) (for Marines) may be assigned to selected ships and Outside the contiguous United States (OCUNUS) commands as agreed on by all three consultants and the receiving command; the receiving command has the final say on acceptance."); 2018 Report, at 17.

[57] NAVSECINS 5300.30E, at ¶ 9.b.1.

[58] U.S. Army Reg. 600-110, *supra* note 9, at Ch.1, Sect. III, ¶ 1-16(p).

purported medical bases for the Army's HIV-related personnel policies, described the risk of transmission of HIV via blood splash or wound-to-wound contact as "negligible" and said he was not aware of there ever being a documented case of transmission of HIV via blood splash, nor was he aware of there ever being a documented instance of HIV transmission on the battlefield.[59]

49. In addition, recent research has established that a person with HIV who is adherent to their medications, and therefore has a suppressed or undetectable viral load, is incapable of transmitting HIV through the most intimate forms of contact.[60] In his deposition, Lt. Col. Blaylock also agreed that the risk of transmission of HIV through sexual exposure with someone with an undetectable viral load is "approximately zero."[61]

50. It is reasonable to conclude the risk of transmission through battlefield activities that present at most a theoretical risk of transmission in the absence of treatment is also effectively zero if the person with HIV has a suppressed or undetectable viral load. In his deposition testimony, Col. Andrew Wiesen, Director of Preventive Medicine in the office of the Deputy Assistant Secretary of Defense for Health Readiness Policy and Oversight and the DoD's designee regarding the deployment restrictions placed on service members living with HIV, testified that DoDI 6130.03's criteria preventing accession based on the existence of a contagious

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[59] Blaylock Dep. at 37:7–21; 122:13–15; Lute Dep. at 51:3–8 (testifying that she is not aware of any documented cases of battlefield transmission of HIV); *see also* Wiesen Dep. at 37:5–9 (testifying that he is not aware of a documented case of transmission of HIV via blood splash).

[60] *See* U.S. Centers for Disease Control and Prevention, *HIV Risk Behaviors: Estimated Per-Act Probability of Acquiring HIV from an Infected Source, by Exposure Act* (Dec. 2015), www.cdc.gov/hiv/risk/estimates/riskbehaviors.html.

[61] Blaylock Dep. at 56:25; *see also* Lute Dep. at 45:22–46:1 ("[I]f the individual was on medication and they're — they were less than 200 [viral load] count, then there would be no — there would be a negligible risk to any of the population.").

disease that may endanger the health of other personnel requires at least a 1 percent chance (annually) of disease transmission.[62] The chances of transmission of HIV are far less than 1 in 100 through the type of exposures contemplated in a combat setting, and no service member is likely to have multiple such exposure incidents in a year, much less the thousands that would be required to bring the risk, if any exists at all, to 1 percent.

51. Finally, in the exceedingly rare event that a battlefield exposure were to occur that presented anything more than a theoretical risk of transmission, post-exposure prophylaxis ("PEP") could be provided to the person exposed, thereby further decreasing whatever minimal hypothetical risk of transmission existed. There is simply no support for the idea that a soldier living with HIV would present a danger to the health and safety of other military personnel, including comrades on the battlefield.

2. The Health Care of an Individual with HIV Does Not Involve Excessive Time or Significant Additional Costs

52. Adherence to an effective ART regimen does not require much time at all—it is as simple as taking medication every day. As Kevin Cron, the DoD's designee on the topic of waivers to deploy despite the existence of a deployment-limiting condition, testified: "It's challenging to find an individual these days who's not on some kind of medication for something[.]"[63] The HIV medications commonly prescribed today have no special handling, storage, or other requirements. These medications generally tolerate hard conditions, such as hot or cold stress and sunlight, well.

53. Taking medication once or twice a day, as people living with HIV do, requires very minimal time, especially if that person is on a single tablet regimen ("STR"), which is

[62] Wiesen Dep. at 61:6–10.
[63] Cron Dep. 111:14-16.

literally one pill taken once a day. The time and effort required is similar to that expended by service members deployed overseas who are prescribed daily medication for prophylaxis of malaria.[64] I understand that Sgt. Harrison, for example, took a daily dose of doxycycline when he was deployed in Afghanistan. Furthermore, based on my review of DoD regulations and policies, I have learned there are other medical conditions requiring daily medication, such as dyslipidemia and hypothyroidism, that are not considered incompatible with military service or world-wide deployment.[65] A service member could bring sufficient supplies of medication based on the duration of the deployment.[66]

54. I also understand that certain witnesses have testified that people living with HIV cannot receive certain live vaccines.[67] However, I am not aware of any live vaccines that are absolutely contraindicated for individuals with HIV who have a suppressed viral load and normal immune function. Some public health authorities recommend specific live virus vaccines if medically indicated. To the extent an individual's HIV might prevent that individual from receiving certain live vaccines, I further note that Col. Wiesen testified regarding the smallpox

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[64] Army Public Health Center, *Malaria Field Guide: The Prevention, Diagnosis and Treatment of Malaria in U.S. Africa Command* (May 2016), https://phc.amedd.army.mil/PHC%20Resource%20Library/TG336_MalariaFieldGuide_May2016.pdf.

[65] *See* DoDI 6130.03, at Sec. 5, ¶ 5.24.k (hypothyroidism); *id.* at 5.24.n (dyslipidemia); DoDI 6490.07, at Encl. 3, ¶ g(1) (hypertension); *id.* at Encl. 3, ¶ d (asthma).

[66] *See* Tumminello Dep. at 152:8–17 (stating that patients who take medication for high cholesterol may deploy without a waiver); *id.* at 153:11–154:18 (stating that patients who taking blood pressure medication would likely be permitted to deploy even though they could face health ramifications immediately upon stopping the medications).

[67] Lute Dep. at 67:9–12.

vaccine that "we do have other people with valid reasons to not take that vaccine as well."[68] He also described any interactions between antimalarial drugs and HIV medications as "minimal."[69]

55. The medical monitoring required for a person living with HIV is also limited. According to U.S. HIV treatment guidelines, viral load should be measured every six months for individuals with well-controlled HIV (i.e., those whose viral load has been suppressed for more than two years and whose clinical and immunologic status is stable).[70] Those who have not yet met this threshold typically should have their viral load measured every four months (approx. 120 day intervals).[71] I note that even this frequency falls within the parameters of MOD 13, Tab A, which considers 90-day intervals between clinical testing to monitor a health condition to be a "reasonable timeframe."[72]

56. It is my understanding that Sgt. Harrison currently has his viral load tested approximately twice a year.[73] This is a standard testing frequency for people living with HIV. Furthermore, according to Dr. Jason Okulicz, Chief of the Infectious Disease Service at the San Antonio Military Medical Center, Roe will only require laboratory testing twice a year and a once-yearly evaluation.[74] In fact, Col. Wiesen testified that a person living with HIV who is in

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[68] Wiesen Dep. at 141:14–22.
[69] *Id*. at 142:16–17.
[70] *See* U.S. Department of Health and Human Services, *Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents Living with HIV* (May 1, 2014), https://aidsinfo.nih.gov/guidelines/html/1/adult-and-adolescent-arv/458/plasma-hiv-1-rna--viral-load--and-cd4-count-monitoring.
[71] *Id*.
[72] *See* Modification Thirteen, Tab A, at ¶¶ 1.D.3, 6.B.2; *see also* Cron Dep. at 113:17-22 ("So, quarterly is where we drew a line in the sand, because it's just convenient to do so. That's once every three months. That's also for controlled substances, the period they need to maintain in order to refill those prescriptions. So, it is an arbitrary standard.").
[73] Decl. of Nicholas Harrison at ¶ 13 (July 19, 2018), Dkt. 26-3.
[74] Decl. of Roe at Ex. A3 (July 18, 2018), ROE-000092.

treatment and has a suppressed viral load would not result in excessive time lost from duties.[75] It is also my opinion that this twice-annual testing does not need to take place at strict six-month intervals. Because these evaluations are monitoring "check-ins" and clinical deterioration is relatively rare once a patient has achieved a suppressed viral load, it is not imperative that this testing occur at exactly six-month intervals.

57. Viral load testing is routine and requires only drawing and testing a blood sample. Where such testing is not immediately available in theater, a blood sample may easily be shipped to a lab that engages in the type of testing required. In his deposition, Lt. Col. Jason Blaylock, service chief of infectious diseases at Walter Reed National Military Medical Center, testified that combat support hospitals, which are available "at major hubs of military bases in the deployed setting," such as in Afghanistan, can conduct the twice-annual blood testing required for a service member living with HIV.[76]

58. When viral load testing is done, routine blood tests are conducted to monitor the effects, if any, of the person's ART regimen on the functioning of the person's organs and other bodily systems. Only a very small percentage of people who start HIV treatment regimens with single daily pill fixed dose combinations discontinue the regimen due to adverse effects. It is even more rare for a person who has already achieved viral suppression on a particular ART regimen to need to change regimens based on side effects the medication is having on the functioning of other organs or bodily systems.

[75] Wiesen Dep. at 82:15–83:9.
[76] Blaylock Dep. at 68:7–15.

59. General practitioner physicians are capable of engaging in the type of medical monitoring and care required for people living with HIV.[77] In the United States, primary care physicians are expected and often called upon to provide care to a person living with HIV. In fact, physicians' assistants and nurse practitioners also often provide HIV-related care in the United States. I disagree with Defendants to the extent they argue that treatment of other medical conditions, such as common infections, would require a full evaluation of a patient's HIV status to ensure proper treatment. For the most part, HIV-related immune deficiency begins slowly after many years of declining CD4+ cells and then is mainly cell mediated immunity. The occurrence of symptoms and signs of infections, consistent with those commonly occurring in daily life, do not automatically indicate a need to do a medical work-up for decline in immune function as they are also common in uninfected persons who have normal immune systems. Therefore, there is no special concern to work-up the HIV condition if an intercurrent infection occurs. It may be routine to check CD4+ cell count as assurance, but such testing is not necessary to make treatment decisions for another infection, assuming the individual's status prior to deployment is a suppressed viral load and normal CD4+ cells.

60. The physicians of the Armed Forces are more than capable of providing necessary care to a person living with HIV, alongside other types of health care provided to all members of the military, regardless of where they are stationed. If additional provider training is required in some instances, such training would be easy for the Armed Services to provide to its healthcare professionals. In the rare event that the expertise of an infectious disease doctor was required to care for a deployed service member, the on-site medical staff could consult with the many

[77] *See* Wiesen Dep. at 171:17–19 ("[A]n internal medicine physician or other specialist should be able to do that evaluation without evacuating the individual out of theater.").

qualified infectious disease doctors employed by the Armed Services or a telemedicine session could be arranged between an infectious disease specialist and the service member with HIV.

3. People with HIV Can Complete Training and Serve Full Terms

61. People living with HIV who adhere to their prescribed ART regimen are physically able to complete training and serve full contract terms in the Armed Forces. There should be no effect on the physical fitness and capabilities of any person with HIV who is adhering to their prescribed ART regimen. As Col. Stephen J. Thomas, U.S. Army Infectious Diseases Consultant, wrote in an email exchange between members of the Department of the Army regarding Sgt. Harrison's application for an exception to policy, "From a purely medical standpoint it is possible for someone with HIV to have a normal life expectancy, experience a high quality of life and health, and be productive."[78] As explained in a 2015 article in the *Medical Surveillance Monthly Report*: "In the past 30 years, HIV-1 infection has gone from an untreatable disease marked by inexorable clinical progression through extreme debility to death to a treatable disease that is compatible with active service throughout a full career in the U.S. military."[79]

62. As far back as 2004, the DoD's Armed Forces Epidemiology Board explained that "[t]here is no evidence that HIV infection, per se, affects physical fitness."[80] The same

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[78] Email from Marguerite Lawrence, Chief Health Promotions Policy, U.S. Army, to Laurie Fontaine and Stephen Thomas, re a medical recommendation concerning Nicholas Harrison, at US0002430 (Dec. 23, 2015, 8:42 EST).

[79] J. Brundage et al., *Durations of Military Service after Diagnoses of HIV-1 Infections Among Active Component Members of the U.S. Armed Forces 1990-2013*, Medical Surveillance Monthly Report, Aug. 2015, at 9, 9–12, https://health.mil/Reference-Center/Reports/2015/01/01/Medical-Surveillance-Monthly-Report-Volume-22-Number-8.

[80] Office of the Assistant Secretary of Defense, Health Affairs Mem. (Policy Memorandum – Human Immunodeficiency Virus Interval Testing) (Mar. 29, 2004),

remains true today. In fact, there is evidence that by some measures the physical fitness of service members increases after they learn they are living with HIV.[81] One retrospective study conducted by, among others, Dr. Okulicz, Chief of the Infectious Disease Service of the Air Force and Director of the HIV Medical Evaluation Unit at the San Antonio Military Medical Center, found that composite fitness scores, mean push-up, and sit-up scores for Airmen living with HIV were higher post-HIV than pre-HIV.[82] I understand that Mr. Harrison, who was diagnosed with HIV in 2012, received a PULHES[83] score in 2014 of "1" for each of the six factors that are considered, reflecting a "high level of medical fitness" under Army Regulation 40-501 (Standards of Medical Fitness).[84] In addition, I understand Mr. Harrison received strong scores on his army physical fitness test (92/100 for pushups, 88/100 for sit ups and 88/100 for a two-mile run) in 2014.[85] In his deposition, Lt. Col. Paul Tumminello, Deputy State Surgeon for the D.C. Army National Guard, testified that his review of Sgt. Harrison's medical evaluations showed that Sgt. Harrison did not exhibit either progressive clinical illness or immunological deficiency.[86]

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https://www.health.mil/Reference-Center/Policies/2004/03/29/Policy-Memorandum---Human-Immunodeficiency-Virus-Interval-Testing.

[81] Asha De et al., *Physical fitness characteristics of active duty US Air Force members with HIV infection*, Medicine 95:44 (2016).

[82] J. Okulicz et al., *Review of the U.S. Military's Human Immunodeficiency Virus Program: A Legacy of Progress and a Future of Promise*, Medical Surveillance Monthly Report, Sept. 2017, at 2, 2–7, https://health.mil/Reference-Center/Reports/2017/01/01/Medical-Surveillance-Monthly-Report-Volume-24-Number-9.

[83] U.S. Army Reg. 40-501 (Standards of Medical Fitness) Glossary, Sec. 1, p. 136 (June 14, 2017) (defining PULHES as an acronym for Physical stamina, Upper extremities, Lower extremities, Hearing/ears, Eyes, and Psychiatric).

[84] *Id.* at Ch. 7, ¶ 7-3.d(1) ("An individual having a numerical designation of '1' under all factors is considered to possess a high level of medical fitness.").

[85] N. Harrison, Army Physical Fitness Test Scorecard (Dec. 6, 2014), US00000323.

[86] Tumminello Dep. at 87: 7–11.

63. I also understand that Dr. Okulicz, Chief of the Infectious Disease Service for the Air Force and Director of the HIV Medical Evaluation Unit at the San Antonio Military Medical Center, stated that Roe "has no physical limitation that would prevent him from conducting his duties."[87] I have reviewed Roe's Member Individual Fitness Report, which evaluates the following fitness metrics: (1) height, (2) weight, (3) body mass index, (4) aerobic time, (5) abs score, (6) push-ups score, and (7) sit-ups score. From this review, I understand that Roe has passed all his fitness evaluations from August 2012 to March 2018, and received a score of 98.25 out of 100 on his most recent evaluation.[88] I further understand that the Physical Evaluation Board found Voe's "HIV condition well controlled and [that] he is currently asymptomatic." Additionally, they acknowledged that Voe "exhibited no evidence of infection related to his HIV diagnosis" and "does not have evidence of immune compromise."[89] I understand Voe has passed all physical fitness assessments during his time in the military, and received a score of 84.2 out of 100 on his most recent evaluation.[90]

64. Similarly, any person with HIV who is adhering to their prescribed ART regimen will be able to serve without aggravating their condition. People living with HIV who are virally suppressed are very unlikely to experience any HIV-related symptoms or complications of any kind related to their HIV. Evidence of essentially normal immune function is indicated by a normal CD4+ cell count. Provided they are able to continue taking their medications, inhospitable environmental conditions and/or challenging work conditions should have no effect

[87] Decl. of Roe at Ex. A3 (July 18, 2018), ROE-000092
[88] Roe, Air Force Individual Fitness Report (Apr. 2, 2018), ROE-000089.
[89] Decl. of Voe at Ex. B2 (July 18, 2018), VOE-000021–23.
[90] Memorandum from Voe, Appeal of Findings of the Formal Physical Evaluation Board (FPEB) (Dec. 20, 2017), VOE-000033.

on the person living with HIV's health or their ability to serve. Col. Wiesen agreed that individuals taking their medication during their military duty would be capable of performing their duties without aggravating their HIV.[91]

65. The 2018 Report contains a section on "Recent Findings Signifying Impairments Despite Viral Suppression and Asymptomatic HIV."[92] Specifically, the Report suggests that people living with HIV on ART may develop certain types of neuro-cognitive impairment ("NCI").[93] I understand that Dr. Hardy is addressing neurocognitive impairments in his report; however, I wish to note several things about their effect—or lack thereof—on a service member's ability to perform their duties: 1) though limited in number in the age of antiretroviral therapy, particularly among younger individuals who have not lived with HIV for an extended period of time, those with the most serious form of HIV-associated neurocognitive impairments should be relatively easy to identify and restrict to certain types of duties or to discharge if disabled by NCI's; 2) by definition, asymptomatic NCI's will have no noticeable effect on the service members ability to perform their duties; and 3) the medical fitness standards for service members are designed to weed out individuals who have symptomatic neurocognitive impairments that will affect their ability to perform their duties.[94] Dr. Jason Okulicz, Chief of the Infectious Disease Service for the Air Force and Director of the HIV Medical Evaluation Unit testified that he does not test his HIV patients for neurocognitive impairments because he does "not have a clinical perception that HIV impacts their neurocognition to the point that it affects either their day-to-day life or their job doing their - - doing [their] duties." Okulicz Dep.

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[91] Wiesen Dep. at 92:13–21.
[91] 2018 Report at 20.
[92] *Id*.
[94] DoDI 6130.03, Sec. 5, ¶ 5.26 (Neurologic Conditions).

(rough draft) at 116:23-117:1. Furthermore, for those with highly specialized duties (such as fighter pilots), additional testing could be conducted to ensure that neurocognitive function is at the level necessary to perform in these elite roles.[95] The relative infrequent incidence of NCI's among people living with HIV certainly does not justify the group-wide restrictions on their accession or deployment.

4. People with HIV Are Adaptable to the Military Environment Without Geographical Area Limitations

66. People living with HIV are adaptable to the military environment and can deploy worldwide without geographical limitations. As described above, the military environment—regardless of the geographic specifics of that environment—should have no effect on a person with HIV's health or ability to serve. Because it is relatively easy to provide the health care necessary to a person living with HIV (also described in detail above)—and has been for more than a decade—there should be no geographic limitations on an HIV-positive person's service. People living with HIV, particularly those with well-controlled HIV, are not more susceptible to the vicissitudes of heat, cold, humidity, dryness, etc. or conditions of moderate dehydration than those who are not living with HIV. For individuals with reconstituted immune systems as a result of treatment, concerns regarding "immune system dysregulation," as described in the 2018 Report,[96] are overblown and overly protective to the point of patronization. All service members are subject to the stressors of the military environment, and there is no reason to believe that

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[95] Okulicz Dep. (rough draft) at 58:17-19 ("There [is] testing available to assess whether or not a person may have neurocognitive impairment whether it's symptomatic or asymptomatic."); *id.* at 59:2-6 ("If it is felt that a person on flying status should be assessed for neurocognition, then I think there are testing available that could help answer that question for jobs that would require a neurocognitive assessment.")

[96] 2018 Report at 9.

service members with HIV will be any less able to tolerate these environmental conditions than other service members who are not living with HIV. Again, I understand the Navy has already adopted policies to allow service members living with HIV to serve outside of the continental United States. Due to this policy, as of September 2017, approximately 55 sailors have been assigned to various overseas and/or operational assignments without any adverse events.[97] There are no geographic locations that would pose an issue for a person living with HIV, as long as that individual adheres to their ART regimen.

5. There is No Danger to the Safety of Military Blood Supplies

67. Allowing people living with HIV to serve poses no danger to the safety of military blood supplies. Since 1962, the Armed Services Blood Program has provided blood products for all service members, working to collect, process, store, distribute, and transfuse blood worldwide.[98] People who have been diagnosed with HIV are informed that they can no longer donate blood, and service members newly-diagnosed with HIV are instructed that they are not to donate blood. In addition, along with blood type, it could be indicated on a service member's "dog tags" that they are ineligible to donate blood.

68. The 2018 Report suggests that "in emergency battlefield circumstances it is impossible to eliminate all risk of communicability through blood transfusion."[99] This is undoubtedly true (in part because it is impossible to eliminate *all* risk in any setting), but it is

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[97] J. Okulicz et al., *Review of the U.S. Military's Human Immunodeficiency Virus Program: A Legacy of Progress and a Future of Promise*, Medical Surveillance Monthly Report, Sept. 2017, at 2, 2–7, https://health.mil/Reference-Center/Reports/2017/01/01/Medical-Surveillance-Monthly-Report-Volume-24-Number-9.

[98] Armed Services Blood Program, *About Us*, http://www.militaryblood.dod.mil/About/default.aspx (last visited Mar. 21, 2019).

[99] 2018 Report at 22.

also undoubtedly true that the primary risk to the blood supply in terms of HIV transmission arises from those who are unaware they are living with HIV. However, the military has protocols in place to prevent donations from those who are unaware they are HIV-positive, has screened service members for decades and closely monitors which service members are living with HIV as part of its plan to protect the battlefield blood supply.[100] These efforts have been successful. For example, one study of HIV among U.S. Army soldiers found that, of service members who seroconverted while deployed in Afghanistan or Iraq over the period 2001–07, "[n]one were emergency blood transfusion donors or recipients."[101] Indeed, for the general public, the National Institute of Health has stated: "Your risk of getting HIV from a blood transfusion is lower than your risk of getting killed by lightning. Only 1 in 2 million donations might carry HIV and transmit HIV if given to a patient."[102] Allowing people living with HIV to serve will not change the screening measures already in place to protect the blood supply, which are primarily aimed at preventing transmission from those who are undiagnosed.

69. Furthermore, there are various other factors that often disqualify or severely limit individuals as emergency blood donors, such as blood type[103] or same-sex sexual activity between men—making people living with HIV no different in this respect from these other groups who are allowed to serve and deploy. Under the Armed Services Blood Program Medical

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[100] J. Okulicz et al., at 2–7.
[101] P. Scott et al., *Short Communication: Investigation of Incident HIV Infections Among U.S. Army Soldiers Deployed to Afghanistan and Iraq, 2001-2007*, 28 AIDS Research and Human Retroviruses 1308, 1308–1312 (2012).
[102] U.S. Department of Health & Human Services, National Heart, Lung, and Blood Institute, *Blood Transfusion*, https://www.nhlbi.nih.gov/health-topics/blood-transfusion (last visited Mar. 22, 2019).
[103] Borden Institute, *Emergency War Surgery*, 467–488 (4th ed. 2014), http://www.cs.amedd.army.mil/FileDownloadpublic.aspx?docid=189c4a13-522f-4d91-9236-a109d7b5ee4d.

Conditions List, conditions such as Addison's Disease, Hepatitis B or C, even receiving a blood transfusion in the UK or France since 1980 or a tattoo in certain states, can limit or prevent an individual from being a blood donor.[104] In the context of battlefield emergency transfusions, i.e., the "walking blood bank," the safety of the blood supply may be ensured by continuing to screen service members for HIV and informing any individuals who test HIV-positive that they cannot act as emergency blood transfusion donors. Allowing service members with HIV to deploy into combat zones will have no effect on the safety of the military's blood supply, and the inability of service members with HIV to donate blood will have negligible impact on the availability of blood for battlefield transfusions. Not only are battlefield transfusions relatively rare,[105] the percentage of service members living with HIV is and would continue to be relatively low (i.e., people living with HIV comprise approximately one-third of one percent of the population of the United States, and currently just 0.027% of active duty service members).[106]

7. The Other Requirements of DoDI 6490.07(b) Are Met

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[104] Armed Services Blood Program Medical Conditions List (February 2019), Taylor Dep. at Ex. 4, pp. 1, 5, 16, 31.

[105] *See* T. Ballard et al., *Transfusion-Transmissible Infections Among U.S. Military Recipients of Emergently Transfused Blood Products, June 2006-December 2012*, Medical Surveillance Monthly Report, November 2014, at 2, 2–7 (stating that "[a]ccording to the Armed Services Blood Program (AFBP), the U.S. military transfused 237,100 units of blood products between June 2006 and December 2012. Thus, the 4,857 non-FDA-compliant units represented approximately 2% of the total blood products" and indicating that "[n]o cases of HIV" resulted from these transfusions).

[106] United States Census Bureau, *American Factfinder: Monthly Population Estimates for the United States: April 1, 2010 to December 1, 2016* (December 2017) https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=PEP_2017_PEPMONTHN&prodType=table; Armed Forces Health Surveillance Center (AFHSC), *Update: Routine Screening for Antibodies to Human Immunodeficiency Virus, Civilian Applicants for U.S. Military Service and U.S. Armed Forces, Active and Reserve Components, January 2010–June 2015*, Medical Surveillance Monthly Report, Aug. 2015, at 2, 2-8.

70. According to DoDI 6490.07(b), a service member may deploy if their medical condition: (1) is not subject to unexpected worsening, and physical trauma is not likely to have a grave medical outcome or negative impact on mission execution; (2) is stable and not expected to worsen during deployment; (3) is not reliant on health care unavailable in theater or medication with special handling or storage requirements, and (4) will not require routine evacuation out of theater for diagnostics or evaluation.

71. As discussed above in § II.B.3, controlled HIV will not unexpectedly worsen during deployment, leading to a grave medical outcome or negative impact on mission execution. Also, as I discussed above in § III.B.2, the health care and medicinal requirements of service members living with HIV are available in theater and can be satisfied for the duration of deployment. Therefore, there is also no need for routine evacuation for diagnostics or evaluation, and therefore, there should not be excessive time lost from duty for follow-up medical monitoring. My review of Harrison, Roe and Voe's records also does not reveal any sign of progressive clinical illness or immunological deficiency, which would not be present in an individual with well-controlled HIV.

8. CENTCOM's Interpretation of MOD 13 Is Not Supported by the State of Medical Science Regarding HIV

72. In my opinion, CENTCOM's implementation of MOD 13 is not supported by medical science and the current state of HIV treatment. MOD 13 explicitly requires a waiver for individuals living with HIV to deploy to CENTCOM.[107] I understand that Lt. Col. Kevin Cron, who currently serves as the primary waiver action officer for CENTCOM, has never "granted a

[107] U.S. Cent. Command Doc. 231245Z (Modification Thirteen to USCENTCOM Individual Protection and Individual Unit Deployment Policy) (Mar. 2017).

deployment waiver for a HIV-positive Service member" and is not aware that such a waiver has ever been granted.[108] Therefore, as implemented, MOD 13 entirely precludes service members from being able to deploy to CENTCOM, which therefore prevents service members from being designated worldwide deployable. For the reasons discussed above, it is my opinion that a categorical CENTCOM deployment bar for service members with HIV has no basis in medical science. Certainly, this categorical bar should not be the basis for discharging members of the service who are permitted to deploy elsewhere.

73. Even in the unusual circumstance that a service member with HIV no longer had access to their HIV medications, I understand it would take multiple weeks for their viral load to increase to levels above a suppressed viral load, longer for the viral load to reach a level at which a genotype of that person's virus could be performed, and years, typically, before the person's immune system is likely to deteriorate to a point which could result in an opportunistic infection or irreversible damage to their immune system. MOD 13 provides that "personnel who require medication and who are deploying to the CENTCOM [or] will deploy with no less 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."[109] The risks associated with not taking medications is no greater for patients with HIV than for patients with other conditions, such as dyslipidemia, hypertension, and asthma.

IV. MEDICAL JUSTIFICATIONS FOR DENYING MR. HARRISON'S EXCEPTION TO POLICY ARE UNFOUNDED

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[108] Decl. of Cron at ¶ 11; Cron Dep. 60:5-61:22.
[109] U.S. Cent. Command Doc. 231245Z (Modification Thirteen to USCENTCOM Individual Protection and Individual Unit Deployment Policy) (Mar. 2017).

74. Sgt. Harrison meets the accessions medical standards, and there is no medical justification for not allowing Sgt. Harrison to become an officer. I understand that when Sgt. Harrison requested an exception to policy to AR 600-110, the Army Reserve National Guard, Office of the Chief Surgeon ("OTSG") provided a Medical Opinion regarding his request.[110] The Chief Surgeon made the following "observations:" (1) "Due to the risks from blood borne transmission, SGT Harrison is not deployable into a combat zone; waivers are not possible[;]" and (2) "The medications required to control the primary condition do not allow individuals to be stationed overseas where these medications cannot be guaranteed."[111] The Chief Surgeon further stated that "advances in medical treatments allow SGT Harrison's primary condition to meet retention standards. However, medical advances have not been made yet that would allow this Soldier to be deployable, or stationed overseas."[112]

75. It is worth noting that prior to issuance of this opinion, the OTSG had first been informed that "The OTSG Infectious Disease Consultant has reviewed the submitted documentation. The Consultant noted that there is ***no medical restriction related to the Service Member accepting the position being offered within the parameters outlined in AR 600-110***."[113] Eight months later, however, just a month prior to the issuance of the OTSG medical opinion, the Consultant appears to have had a change of opinion. Specifically, the Consultant provided an updated recommendation to deny Mr. Harrison's exception to policy request based

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[110] National Guard Bureau Mem. ARNG-CSG (Request for a Medical Opinion, Roe) (Feb. 29, 2016), US00001135.
[111] *Id.* at ¶ 2.
[112] *Id.* at ¶ 3.
[113] Dep't of the Army Mem. DASG-HCO (Request for Medical Opinion, Roe) ¶ 2 (Apr. 30, 2015) (emphasis added), US00001136.

on "an increased risk of associated medical conditions and side effects of lifelong medication treatment, as well as deployment limitations."[114]

76. For the reasons set forth above, I disagree with the OTSG assessment. Medical advances have been made that would allow Mr. Harrison to deploy to a combat zone. There are no demonstrable risks of HIV transmission through consensual sexual contact for someone who is virally suppressed, as explained above. There is only a theoretical, vanishingly small risk of transmission through battlefield activities (e.g., via "blood splash" or wound-to-wound contact in the provision of "buddy aid"), which is also further reduced if a person with HIV has an undetectable viral load. In fact, Defendants' witnesses admitted at their depositions that they are not aware of such a transmission ever occurring. Moreover, the medications for service members living with HIV and monitoring for health effects can be as easily provided overseas as any other deployable condition needing medications, such as malaria prophylaxis or treatment for dyslipidemia or hypothyroidism.

77. Furthermore, as described above in Section III.B.3, under current treatment regimens, the side effects of HIV medication are limited. For example, in an email exchange, Col. Thomas, wrote that "[I]t is possible for someone with HIV to have a normal life expectancy, experience a high quality of life and health, and be productive."[115] I also understand that Dr. Hardy is addressing the advances in HIV treatment in the past few decades. There is no medical rationale for categorically not allowing people with HIV to deploy. Therefore, there is no

[114] Dep't of the Army Mem. DASG-HCZ (Request for Medical Opinion, Roe) ¶ 2 (Jan. 12, 2016), US00001137.
[115] Email from Marguerite Lawrence, at US00002430.

medical or scientific basis for denying Sgt. Harrison's request for an exception to policy and allowing him to accede.

V. ROE AND VOE'S SEPARATIONS ARE NOT MEDICALLY JUSTIFIED

78. I understand both Roe and Voe were scheduled to be separated based on Defendants' contention that they are not worldwide deployable because of their HIV status. In my opinion, the current state of the medical science regarding HIV does not support this decision. Based on my review of their medical records and other documents involving Roe and Voe, they are deployable without any limitation.

79. Roe's commanding officer, Lt. Col. Kenneth Beebe III, recommended Roe be retained, and his primary care doctor, Captain Daniel Cieslak, recommended he be returned to duty.[116] Since Roe began antiretroviral treatment following his October 2017 diagnosis, his viral load remained undetectable.[117] I also understand he has continued to serve as a specialist in logistics without any work restrictions due to his HIV.[118] As, Dr. Okulicz wrote, Roe "will require continuation of his 1 pill daily treatment with laboratory testing approximately every 6 months and once yearly evaluation for HIV infection at the [USAF HIV Medical Evaluation Unit]."[119] Dr. Okulicz's "assessment [] did not reveal a medical reason to explain why he would not be returned to duty . . . ."[120]

80. However, the Informal Physical Evaluation Board found that although Roe was able to perform his duties and his commander recommended retention, his "medical condition is

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[116] Kenneth Beebe III and Daniel Cieslak Mem. (Commander's Impact Statement for Medical Evaluation Board) 3–4 (Dec. 2017-Jan. 2018), ROE000014.
[117] Decl. of Roe at ¶ 8 (July 18, 2018), Dkt. 31.
[118] *Id.* at ¶¶ 20–21.
[119] *Id.* at Ex. A3, Roe000092.
[120] *Id.*

subject to sudden and unpredictable progression" and "will result in deployment restrictions that prevent him from being fully worldwide qualified."[121] While the formal PEB affirmed the informal PEB's decision, it also found that Roe "is asymptomatic" and that "[h]is commander reports he is able to perform all in-garrison duties of his AFSC and recommends his retention."[122] The PEB's decision appears to have been based on an assumption that Roe could not be deployed worldwide.[123]

81. In fact, the letter sent on behalf of the Secretary of the Air Force ordering Roe's discharge stated that while the Air Force Personnel Board ("AFPB") found no medical reasons to deny Roe's retention, "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 [CENTCOM] . . . ."[124] The letter based the decision on "his inability to deploy . . . ."[125]

82. However, there is no medical justification to support that decision. There is no reason to believe that Roe's medical condition will suddenly or unpredictably progress. I agree with Dr. Okulicz's assessment of May 29, 2018 — "there is no physical limitation that would prevent [Roe] from conducting his duties."[126] Given Roe has had a suppressed viral load since he first began ART treatment, he is unlikely to "be subject to sudden and unpredictable progression."

83. As in the case of Roe, I understand Voe's HIV has been stable and well-managed, and is unlikely to be subject to sudden regression. After Voe's diagnosis in March 2017, I

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[121] *Id*. at Ex. A2, Roe000003–4.
[122] *Id*. at Ex. A4, Roe000001–2.
[123] *Id.*
[124] *Id.* at Ex. A5, Roe000005–8.
[125] *Id.*
[126] *Id*. at Ex. A3, Roe000092.

understand he began antiretroviral therapy, and by August 2017, he had an undetectable viral load, which he has maintained since that time. I also understand that none of Voe's physicians recommended restricting his work as a result of his HIV.[127]

84. The IPEB found that although Voe was able to perform his duties and his commander recommended retention, "[Voe's] medical condition prevents him from reasonably performing the duties of his office. . . represents a medical risk to the health of the SM [Voe] 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."[128] As discussed previously, a service member living with HIV but with a suppressed viral load—like Voe—is entirely capable of performing his duties and does not represent a threat to the health of others, including when deployed to any location in the world. In fact, the formal PEB decision states that Voe "has exhibited no evidence of infection related to his HIV diagnosis."[129]

85. In addition, the Air Force Personnel Board, which made the final retention decision, initially voted unanimously on May 4, 2018, to retain Voe, finding that he "meets criteria for retention." *See* A01074. However, without explanation, another AFPB voted unanimously on October 28, 2018 to separate Voe, though that AFPB also found that Voe "[met] criteria for retention . . . ." A01072. The letter on behalf of the Secretary of the Air Force discharging Voe does not base the decision on any medical reasoning. The letter states that "the

[127] *Id*. at ¶ 11, Dkt. 31.
[128] Decl. of Voe at Ex. B1 (July 18, 2018), Dkt. 30, Voe000025–27.
[129] *Id.* at Ex. B2, Voe000021–23.

member's condition precludes him from being able to deploy world-wide without a waiver and renders him ineligible for deployment to [CENTCOM] . . . ."[130]

86. In short, based on my review of the records available to me, Roe and Voe were fit for duty when they were separated. Both had undetectable viral loads and their doctors have never suggested they needed to restrict their work.[131] My review of the facts in this case, including Roe's and Voe's medical records, shows they are able to meet the requirements of DoDI 6490.07 in that their conditions meet the requirements of ¶ 4.b(1)–(4) and their diagnoses obviously do not include "the presence of progressive clinical illness or immunological deficiency." *Id.* at Enclosure 3(e)(2).

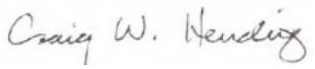
[130] *Id*. at Ex. B3, Voe000031–32.
[131] Decl. of Roe at ¶ 9 (July 18, 2018), Dkt. 31; Decl. of Voe at ¶ 11 (July 18, 2018), Dkt. 30.

VI. CONCLUSION

87. In my opinion, there is no medical justification for preventing or restricting the military service and overseas deployment, including to combat zones, of people living with HIV.

I declare under penalty of perjury that the foregoing is true and correct.

Executed this 22th day of March, 2019.



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Craig W. Hendrix, M.D.

EXHIBIT 1

CURRICULUM VITAE

The Johns Hopkins University School of Medicine

20 MAR 2019

Craig W. Hendrix (Date of this version)

DEMOGRAPHIC AND PERSONAL INFORMATION

Current Appointments

University

Wellcome Professor and Director, Division of Clinical Pharmacology
Appointment effective 1/1/2015

Professor of Medicine, Division of Clinical Pharmacology (Primary)
Appointment effective 1/1/2009

Professor of Medicine, Division of Infectious Diseases (Secondary)
Appointment effective 1/1/2009

Professor of Pharmacology and Molecular Sciences (Secondary)
Appointment effective 1/1/2009

Professor of Epidemiology (Secondary)
Appointment effective 1/1/2009

Director, Drug Development Unit, Division of Clinical Pharmacology
Appointment effective 7/1/1998

Hospital

Medical Staff, The Johns Hopkins Hospital
Appointment effective 8/1/1994.

Personal Data

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EDUCATION AND TRAINING

Year	*Degree/Cert.*	*Institution*	*Discipline*
1978	S.B.	Massachusetts Institute of Technology	Applied Biology
1984	M.D.	Georgetown University	Medicine
7/84-6/85	Intern	The Johns Hopkins Hospital	Internal Medicine
7/85-6/87	Resident	The Johns Hopkins Hospital	Internal Medicine
9/86-7/89	Post-Doctoral Fellow	Johns Hopkins University	Infectious Diseases
7/87-7/89	Post-Doctoral Fellow	Johns Hopkins University	Clinical Pharmacology Mentor: Paul S. Lietman

PROFESSIONAL EXPERIENCE

Dates	*Position*	*Institutions*
1989-1994	Clinical Assistant Professor	Department of Medicine University of Texas Health Sciences Center San Antonio, TX
1989-1994	Staff Physician	Department of Infectious Diseases Division of Medicine Wilford Hall USAF Medical Center Lackland AFB, TX
1989-1994	Director	Human Immunodeficiency Virus Unit Department of Infectious Diseases Wilford Hall USAF Medical Center Lackland AFB, TX
1993-1994	Director	Human Immunodeficiency Virus Research & Education Program Department of Infectious Diseases Wilford Hall USAF Medical Center Lackland AFB, TX
1990-1993	Assistant Professor	Department of Medicine Uniformed Services University of Health Sciences Bethesda, MD

PROFESSIONAL EXPERIENCE

Dates	*Position*	*Institutions*
1992-1994	Associate Scientist (Adjunct)	Southwest Foundation for Biomedical Research and Education San Antonio, TX
1993-1996	Associate Professor	Department of Medicine Uniformed Services University of Health Sciences Bethesda, MD
1994-2000	Senior Scientist	Department of Prevention Research, Division of Retrovirology Walter Reed Army Institute of Research Rockville, MD
1994-1996	Associate Professor (Part-Time)	Division of Clinical Pharmacology, Department of Medicine Johns Hopkins University School of Medicine (JHUSOM) Baltimore, MD
1997-1999	Ind. Mobilization Augmentee	U.S. Air Force Reserve Preventive Medicine Division Office of the Surgeon General Bolling AFB, DC
1997- 2008	Associate Professor	Division of Clinical Pharmacology Department of Medicine, JHUSOM Baltimore, MD
1997-1998	Clinical Director	Drug Development Unit Division of Clinical Pharmacology Department of Medicine, JHUSOM Baltimore, MD
1998-2001	Director (Acting)	Division of Clinical Pharmacology Department of Medicine, JHUSOM Baltimore, MD
1998-2008	Associate Professor	Division of Infectious Diseases Department of Medicine, JHUSOM Baltimore, MD

PROFESSIONAL EXPERIENCE

Dates	*Position*	*Institutions*
1998-present	Director	Drug Development Unit Division of Clinical Pharmacology Department of Medicine, JHUSOM Baltimore, MD
1999-2008	Associate Professor	Department of Pharmacology and Molecular Sciences, JHUSOM Baltimore, MD
1999-2008	Associate Professor	Department of Epidemiology Johns Hopkins University Bloomberg School of Public Health Baltimore, MD
1998-2008	Associate Professor	Division of Infectious Diseases Department of Medicine, JHUSOM Baltimore, MD
2007-2013	Co-Director	Drug Development Core Institute for Clinical and Translational Research Johns Hopkins University Baltimore, MD
2007-2014	Director (Interim)	Division of Clinical Pharmacology Department of Medicine, JHUSOM Baltimore, MD
2007-2014	Director (Interim)	Clinical Pharmacology Analytical Laboratory Division of Clinical Pharmacology Department of Medicine, JHUSOM Baltimore, MD
2009-present	Professor	Division of Clinical Pharmacology Department of Medicine Johns Hopkins University School of Medicine Baltimore, MD
2009-present	Professor	Department of Pharmacology and Molecular Sciences Johns Hopkins University School of Medicine Baltimore, MD

PROFESSIONAL EXPERIENCE

Dates	*Position*	*Institutions*
2009-present	Professor	Department of Epidemiology Johns Hopkins University Bloomberg School of Public Health Baltimore, MD
2012-2014 2014-present 2014-present	Co-Director Director Member	Behavioral Science Core Laboratory Core Executive Committee Center for AIDS Research Johns Hopkins University Baltimore, MD
2014-present	Deputy Director Director	Institute for Clinical and Translational Research Translational Sciences Core Johns Hopkins University School of Medicine Baltimore, MD
2014-present	Affiliated Faculty Member	Center for Nanomedicine Wilmer Eye Institute, JHUSOM Baltimore, MD
2015-present	Director	Division of Clinical Pharmacology Wellcome Professor of Clinical Pharmacology Department of Medicine, JHUSOM Baltimore, MD
2016-present	Director (Contact)	Clinical Pharmacology Training Program Division of Clinical Pharmacology, JHUSOM Baltimore, MD
2018-present	Director	Precision Medicine Center of Excellence Division of Clinical Pharmacology

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Original Research

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Invited Review Articles

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2. **Hendrix CW**, Cao YJ, Fuchs EJ. Topical Microbicides to Prevent HIV: Clinical Drug Development Challenges. Ann Rev Pharmacol Toxicol 2009; 49:349–75.

3. Morrow KM, **Hendrix CW**. Clinical evaluation of microbicide formulations. J Antiviral Res 2010;88S:S40-S46. PMCID: PMC3053029

4. **Hendrix CW**. The Clinical Pharmacology of Antiretrovirals for HIV Prevention. Curr Opin HIV AIDS 2012 Nov;7(6):498-504.

5. **Hendrix CW**. Exploring concentration-response in HIV Pre-Exposure Prophylaxis to optimize clinical care and trial design. Cell 2013 Oct 24;155(3):515-8.

6. Carballo-Diéguez A, Lentz C, Giguere R, Fuchs EJ, **Hendrix CW**. Rectal Douching Associated with Receptive Anal Intercourse: A Literature Review. AIDS Behav. 2017 Nov 2. doi: 10.1007/s10461-017-1959-3. PMC5878987

7. **Hendrix CW**. HIV Antiretroviral Pre-Exposure Prophylaxis: Development Challenges and Pipeline Promise. Clin Pharmacol Ther. 2018 Dec;104(6):1082-1097 *PMCID Pending*

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Book Chapters, Monographs

1. Flexner CF and **Hendrix CW**. Pharmacology of Antiretroviral Agents. In: DeVita VT, Hellman S, Rosenberg SA, AIDS: biology, diagnosis, treatment and prevention. 4th ed. Philadelphia: Lippincott-Raven, 1997.

2. **Hendrix CW**, Sulkowski MS. Hepatotoxicity of antiretroviral therapy and drug-drug interactions with antiviral therapies for hepatitis C infection. In: Strategies for the Management of HIV/HCV Co-infection. Seacaucus: Projects in Knowledge, 2002.

Proceedings Reports

1. Committee on the role of institutional review boards in health services research data privacy protection. Institutional Review Boards and Health Services Research Data Privacy. A Workshop Summary. Institute of Medicine, Washington, D.C. May 2000.

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Editorials (Invited)

1. **Hendrix CW**. When is a PrEP candidate ready for phase 3? Lancet HIV DOI: http://dx.doi.org/10.1016/S2352-3018(16)30162-X

Letters, Correspondence

1. Blatt SP, **Hendrix CW**. Delayed-Type Hypersensitivity and AIDS. Ann Intern Med 1994;120(4):343-44. (Letter)

2. **Hendrix CW**. Consideration of the prevalence of CMV retinitis alters the assessment of a serum cytomegalovirus DNA test. J Infect Dis 1995;171(6):1688. (Letter)

3. Bray PF, Goldschmidt-Clermont P, Furman MI, Michelson AD, Barnard MR, Mascelli MA, **Hendrix CW**, Coleman L, Hamlington J, Kickler T, Christie DJ, Kundu S. Platelet glycoprotein IIIa PIA polymorphism and effects of aspirin on thrombin generation - Response Circulation 103(6):E33-E34 FEB 13 2001 (Letter)

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Letters, Correspondence (continued)

4. **Hendrix CW**. Seizing the Opportunity. HIV Prevention in Military Communities. Civil-Military Alliance Newsletter. 1995;1(4):9.

5. Kingma SJ, **Hendrix CW**, Yeager R, Miller NN, D'Amelio R, Wouters R, "Analysis of global questionnaire on HIV/AIDS prevention, testing and care in current military medical practice." Occasional Paper, Civil-Military Alliance to Combat HIV and AIDS, 1996.

6. Yeager R, **Hendrix CW**. Global survey of military HIV/AIDS policies and programs. Civil-Military Alliance Newsletter. 1997;3(1): S1.

7. **Hendrix CW**. Behavioral surveillance and intervention in the military environment. Civil-Military Alliance Newsletter. 1997;3(4):5.

8. **Hendrix CW**. AIDS in the Public Eye: AIDS Fatigue or Healthy Maturation. Lutheran AIDS Network Newsletter. 9(2);4-5;2000.

9. Lu Y, Fuchs EJ, **Hendrix CW**, Bumpus NN. Response to "Clinical Relevance of CYP3A5 Genotype on Maraviroc Exposures". Drug Metab Dispos. 2015 May;43(5):773

10. Dalesio NM, Lee CKK, **Hendrix CW**. In Response. Anesth Analg. 2017 Jul;125(1):362-363

FUNDING

Extramural Funding (current, pending, previous)

Current

Dates:	01/09/2017-01/01/2019
Title:	A Phase I Multi-Compartment Pharamcokinetic Study of Cabotegravir Long-Acting in Healthy Adult Volunteers
Grant Number:	GSK Protocol 201767
Sponsor:	ViiV/GSK
Total Direct Costs:	$729,798
Principal Investigator:	**C. Hendrix**
Role:	**PI**. Provide protocol development/execution and PK/PD data analysis and interpretation for clinical development of long-acting implantable HIV prevention strategy.
Effort:	10%

Dates:	07/07/2015-06/30/2020
Title:	Sustained Long Acting Prevention Against HIV Program Operation
Grant Number:	UM1 AI120184-01 (Program Project Grant)
Sponsor:	NIH
Total Direct Costs:	$72,770
Principal Investigator:	Thomas Hope (Northwestern University)
Role:	**Project Co-Leader, Site PI**. Provide protocol development/execution and PK/PD data analysis and interpretation for clinical development of long-acting implantable HIV prevention strategy.
Effort:	20%

Dates:	07/01/2014 - 06/30/2019
Title:	Development of Rectal Enema As Microbicide (DREAM)
Grant Number:	U19 AI113127-01 (Program Project Grant)
Sponsor:	NIH
Total Direct Costs:	$ 16,323,328
Total Costs:	$ 20,677,877
Principal Investigator:	**C. Hendrix**
Effort:	20%

Dates:	07/01/2014 - 06/30/2019
Title:	Systemic development of microbicide Intravaginal rings for HIV prevention
Grant Number:	U19AI113048-01
Sponsor:	NIH
Total Direct Costs:	$ 16,662,549
Principal Investigator:	Marc Baum (Oak Crest Institute of Science)
Effort:	5%
Role:	**Project PI**. Design, conduct, and data analysis of clinical studies to develop a combination vaginal microbicide ring.

FUNDING

Extramural Funding (current, pending, previous)

Current

Dates:	04/01/2014-03/31/2019
Title:	HIV-1 reservoir dynamics in the female genital tract
Grant Number:	R01 AI08538091-02
Sponsor:	NIH
Total Direct Costs:	$43,580
Principal Investigator:	Athe Tsibris (University of Washington)
Role:	Pharmacologist. Relationship between antiretroviral (ARV) drug concentrations in the blood and female genital tract is a key component of understanding HIV persistence and decay in anatomic reservoirs.
Effort:	2%

Dates:	01/01/2014-11/30/2020
Title:	Pharmacology Network Lab, HIV Prevention Trials Network (HPTN)
Grant Number:	UM1AI068613-08
Sponsor:	NIH
Total Direct Costs:	$ 2,577,018 (Pharmacology Network Lab)
Principal Investigator:	**C. Hendrix**
Role:	Principal Investigator Pharmacology Group. Design and analysis of pharmacology studies and coordination of analytical laboratory to support HPTN clinical studies of HIV pre-exp[osure prophylaxis.
Effort:	10%

Dates:	01/01/2014-11/30/2020
Title:	Pharmacology Network Laboratory, Microbicide Trials Network (MTN)
Grant Number:	UM1AI106707 (Laboratory Center [LC]), UM1AI068633 (Leadership & Operations Center [LOC])
Sponsor:	NIH
Total Direct Costs:	$1,832,004 (Pharmacology Network Lab)
Principal Investigator:	**C. Hendrix**
Role:	Director, Rectal Microbicide Program (LOC), Pharmacology Core Leader Laboratory Center; Principal Investigator for design, execution, and analysis of MTN clinical trials.
Effort:	15%

Dates:	07/01/2013 - 06/30/2018 (NCE)
Title:	The effect of Depo-Provera on HIV susceptibility, immune activation, and PrEP PK
Grant Number:	1R01HD077887-01
Sponsor:	NIH
Total Direct Costs:	1,749,106
Principal Investigator**:**	**C. Hendrix** (Multi-PI with Jenell Coleman). Clinical studies to describe interaction between tenofovir and depo-medroxyprogesteron and impact on pharamcology, immunology, endocrinology, and virology.
Effort:	20%

FUNDING

Extramural Funding (current, pending, previous)

Current

Dates:	07/01/2011-06/30/2018 (NCE)
Title:	Mucus Penetrating Particles For Rectal Microbicides
Grant Number:	R33 AI094519-03
Sponsor:	NIH
Total Direct Costs:	$ 282,000
Principal Investigator:	Justin Hanes
Role:	Pharmacologist. This project will develop mucus penetrating particles for colorectal drug delivery of rectal microbicides for protection against HIV and other STDs. Role is to provide clinical pharmacology for product development to maintain feasibility for future human use of the products.
Effort:	5%

Dates:	09/17/2007-05/31/2018
Title:	Institutional Clinical and Translational Science Award (CTSA)
Grant Number:	NCATS 1UL1TR001079-01
Sponsor:	NIH
Total Direct Costs:	$ 7,485,218
Principal Investigator:	D. Ford
Role:	**Deputy Director ICTR, Translational Science Core Director**
Effort:	10%

Dates:	08/01/2012-07/31/2019 (NCE)
Title:	Development and Evaluation of Dual Compartment Microbicides
Grant Number:	1U19AI101961
Sponsor:	NIH/NIAID
Total Direct Costs:	$3,224,012
Principal Investigator:	Buckheit (ImQuest Pharmaceuticals, Inc.)
Role:	**Project PI**. Design, conduct, and analysis of clinical studies to develop a combination rectal microbicide IQP-0528/tenofovir.
Effort:	21%

Dates:	09/01/2012-08/31/2018 (NCE)
Title:	Efficacy & Safety of Multitargeted Combination Microbicides to Prevent HIV & HSV
Grant Number:	5U19AI076980
Sponsor:	NIH/NIAID
Total Direct Costs:	$ 2,874,915
Principal Investigator:	Herold (Albert Einstein College of Medicine)
Role:	**Core PI**. Design, sample analysis, PK/PD analysis, vaginal microbicide
Effort:	5%

FUNDING

Extramural Funding (current, pending, previous)

Previous

Dates:	04/01/2014 - 03/31/2018
Title:	Pharmacostatistical Modeling and Simulation of Randomized Clinical PrEP Trials
Grant Number:	ID OPP1099837
Sponsor:	Bill and Melinda Gates Foundation
Total Direct Costs:	$925,281
Principal Investigator:	**C. Hendrix.** Pooled data from 5 RCTs to estimate concentration-response within and among PrEP RCTS. Development and integration of PK, PD, and disease response models to perform clinical trial simulation.
Effort:	5%

Dates:	07/01/10-05/31/15 (NCE)
Title:	Exploratory pharmacokinetics of UC781 and Tenofovir vaginal microbicide gel v film
Grant Number:	1U19AI082639
Sponsor:	NIH
Total Direct Costs:	$1,599,703
Principal Investigator:	Hillier (Magee Women's – University of Pittsburgh)
Role:	**Project PI**. Develop combination antiretroviral vaginal microbicide formulation, in both a gel and film formulation.
Effort:	18%

Dates:	9/23/09-8/31/14 (NCE)
Title:	Combination HIV Antiretroviral Rectal Microbicide Program (CHARM)
Grant Number:	1U19AI082637
Sponsor:	NIH/NIAID
Total Direct Costs:	$2,240,713 year 1
Principal Investigator:	McGowan (Magee Women's Research Institute, Univ Pittsburgh)
Role:	**Site PI**. Design, conduct, and analysis of clinical studies and laboratory operations to develop a combination rectal microbicide.
Effort:	18%

Dates:	06/04/08-06/03/15
Title:	Provision and management of a Phase 1 Clinical Trial Unit for Therapeutics Against Infectious Diseases.
Grant Number:	HHSN272200800026C
Sponsor:	NIH-NIAID-DMID
Total Direct costs:	$886,965
Principal Investigator:	Zenilman
Role:	**Site PI.** Management of Johns Hopkins East Baltimore Phase I site; study design, execution, data analysis
Effort :	10%

FUNDING

Extramural Funding (current, pending, previous)

Dates:	07/01/06 - 12/31/13
Title:	Pharmacology Network Lab, HIV Prevention Trials Network (HPTN)
Grant Number:	UM1 AI 068613
Sponsor:	NIH
Total Direct Costs:	$ 1,599,150 (Pharmacology Network Lab)
Principal Investigator:	**C. Hendrix**
Role:	Principal Investigator Pharmacology Core Lab. Design and analysis of pharmacology studies and co-supervision of analytical laboratory to support HPTN clinical studies to investigate the use of anti-retroviral drugs for the prevention of transmission of HIV.
Effort:	5%

Dates:	07/01/06 - 12/31/13
Title:	Pharmacology Network Laboratory, Microbicide Trials Network (MTN)
Grant Number:	U01 AI 068633 subaward 26-3301-4221
Sponsor:	NIH
Total Direct Costs:	$1,777,370 (Pharmacology Network Lab)
Principal Investigator:	**C. Hendrix**
Role:	Principal Investigator for design, execution, and analysis of MTN clinical trials; Supervision of Pharmacology Network Laboratory providing analytical support to the MTN; Scientific leadership at the Executive Committee and Biomedical Science Committee
Effort:	20%

Dates:	02/01/10-01/31/14
Title:	Impact of maternal HAART on HIV-infected breastfeeding infants: Malawi
Grant Number:	1R01AI087139-01A1
Sponsor:	NIH/NIAID/DAIDS
Total Direct Costs:	$373,102
Principal Investigator:	Eshleman
Role:	Co-Investigator – Pharmacologist responsible for PK data analysis
Effort:	1%

Dates:	12/01/09-11/30/13
Title:	Origin and evolution of HIV-1 drug resistance in the RT-SHIVmne Macaque Model
Grant Number:	1R01AI080290-01A2
Sponsor:	NIH
Total Direct Costs:	$42,684(total direct, JHU project)
Principal Investigator:	Ambrose (Univ of Pittsburgh)
Role:	Site PI. Pharmacology design, assay development, and PK data analysis
Effort:	3%

FUNDING

Extramural Funding (current, pending, previous)

Previous

Dates:	09/01/09-08/31/13
Title:	Safety, Efficacy, Mechanisms of Ginseng in HIV-related Fatigue
Grant Number:	R01 AT005526-01
Sponsor:	NCCAM
Total Direct Costs:	$1,330,311
Principal Investigator:	Andrade
Role:	Director of clinical research unit, PK data analysis.
Effort:	4%

Dates:	09/01/09-12/31/12
Title:	Pre-exposure HIV prophylaxis adherence in rural Uganda
Grant Number:	Partners PrEP Study (Bangsberg at MGH)-JHU subaward
Sponsor:	Bill and Melinda Gates Foundation
Total Direct costs:	$400,000
Principal Investigator:	Bangsberg
Role:	Design/analysis of the pharmacokinetic aspects of the study and laboratory assays to examine the relationship between drug level, adherence, and product sharing.
Effort:	5%

Dates:	09/01/09-12/31/12
Title:	Pre-exposure HIV prophylaxis adherence in rural Uganda
Grant Number:	Partners PrEP Study (Bangsberg at MGH)-JHU subaward
Sponsor:	Bill and Melinda Gates Foundation
Total Direct costs:	$400,000
Principal Investigator:	Bangsberg
Role:	Design/analysis of the pharmacokinetic aspects of the study and laboratory assays to examine the relationship between drug level, adherence, and product sharing.
Effort:	5%

Dates:	11/01/09-04/30/12
Title:	A pilot study of Pre-Exposure Prophylaxis (PrEP) to evaluate safety, acceptability, and adherence in at-risk populations in Kenya, Africa
Grant Number:	JHURSA0901
Sponsor:	International AIDS Vaccine Initiative
Total Direct Costs:	$72,326
Principal Investigator:	**Hendrix**
Role:	Pharmacological sub-study design and analysis. Supervision of lab assay of samples for drug concentration.
Effort:	2%

FUNDING

Extramural Funding (current, pending, previous)

Previous

Dates:	09/01/09-08/28/11
Title:	Pharmacokinetic interactions of Ribavirin and Abacavir in healthy volunteers
Grant Number:	Contract
Sponsor:	GlaxoSmithKline
Total Direct costs:	$367,185
Principal Investigator:	Andrade
Role:	**Pharmacologist.** Support in design and analysis of investigator initiated Ribavirin-Abacavir drug-drug interaction study.
Effort:	1%

Dates:	05/01/09-04/30/10
Title:	Distribution of orally-administered Tenofovir into colon and vaginal tissue for the prevention of sexual HIV transmission.
Grant Number:	Contract
Sponsor:	Gilead
Total Direct costs:	$78,358
Principal Investigator:	**C. Hendrix**
Role:	Design, execution, analysis of study of tenofovir to evaluate the PK of the drug and phosphorylated moieties in blood, tissue (colon and vaginal) and cells using LC/MS/MS and accelerator mass spectrometry.
Effort:	1%

Dates:	01/01/07 – 12/31/08
Title:	Epithelial Injury and HIV Penetration after Simulated Ejaculation
Grant Number:	106755-41-RGMT
Sponsor:	amfAR (American Foundation for AIDS Research)
Total Direct Costs:	$ 100,000
Principal Investigator:	**C. Hendrix**
Role:	Principal Investigator (design, execution, and analysis) of study is to evaluate the effect of anal sexual practices on the rectum and distal colon which might affect the study and development of effective HIV microbicides for rectal use.
Effort:	4%

FUNDING

Extramural Funding (current, pending, previous)

Previous

Dates:	09/01/06-09/01/07
Title:	Prophylactic Antimalarial Activity of DB289 in Volunteers Challenged with *Plasmodium falciparum*
Grant Number:	C06-015
Sponsor:	Immtech Pharmaceuticals
Total Direct Costs:	$ 466,548
Principal Investigator:	T. Shapiro
Role:	Contribute to design and pharmacokinetics data analysis. Investigator-initiated prophylactic antimalarial activity of DB289 in volunteers challenged with plasmodium falciparum.
Effort:	10%

Dates:	8/01/06 - 7/31/09
Title:	Microbicide Development Program.
Grant Number:	NIH U19 AI060614
Sponsor:	NIH
Total Direct Costs:	$ 1,429,670
Principal Investigator:	P. Anton (UCLA)
Role:	Project PI. Project 5 to evaluate pharmacokinetics, toxicity, and acceptability of enema and gel as drug delivery device for UC781, a non-nucleoside reverse transcriptase inhibitor, as topical HIV microbicides.
Effort:	30%

Dates:	04/01/06 – 03/31/07
Title:	CV-N Microbicide Program: A Phase I Study to Determine the Safety, Tolerance, and Acceptability of the Vaginal Distribution of Cyanovirin.
Grant Number:	U19 AI051650 Program Project Grant (R. Bax, Biosyn, PI)
Sponsor:	NIH
Total Direct Costs:	$ 237,747
Principal Investigator:	**C. Hendrix** (Project)
Role:	Project PI responsible for design, execution, analysis of phase I Cyanovirin vaginal microbicide safety and pharmacokinetics.
Effort:	10%

FUNDING

Extramural Funding (current, pending, previous)

Previous

Dates:	1/1/06-12/31/07
Title:	The Distribution of CD4 Cells and HIV-sized Particles Following Simulated Vaginal Intercourse.
Grant Number:	GPOA 0005004100
Sponsor:	US Agency for International Development (through International Partnership for Microbicides)
Total Direct Costs:	$ 157,896
Principal Investigator:	**C. Hendrix**
Role:	Principal investigator for design and conduct of a clinical study to image T-cell and HIV-sized particle migration in the female genital tract lumen and tissue following exogenous administration of radiolabeled autologous lymphocytes using simulated coitus.
Effort:	5%

Dates:	01/18/06-01/17/07
Title:	Correlation of Free and Total Indinavir Concentrations in Seminal Plasma with the Concentrations in Blood Plasma in HIV-Infected Patients
Grant Number:	Medical School Project
Sponsor:	Merck Pharmaceuticals
Total Direct Costs:	$ 20,816
Principal Investigator:	**C. Hendrix**
Role:	Phase I study of HIV infected and healthy volunteers to explore the exposure of protein free indinavir in blood and semen. Principal investigator supervising post-doctoral fellow on the project.
Effort:	1%

Dates:	11/04/05-11/03/06
Title:	A Study of the Pharmacokinetic Interaction between AMD11070 and Substrates of CYP 3A4 and 2D6 Enzymes in Healthy Volunteers
Grant Number:	C-308 CTA
Sponsor:	AnorMED
Total Direct Costs:	$ 211,050
Principal Investigator:	**C. Hendrix**
Role:	An investigator-initiated phase I study of the pharmacokinetic interaction of AMD11070 and two CYP 450 probe drugs, midazolam (CYP 3A4) and dextromethorphan (CYP 2D6). Principal investigator responsible for protocol design, execution, data analysis.
Effort:	10%

FUNDING

Extramural Funding (current, pending, previous)

Previous

Dates:	07/1/05-06/30/08
Title:	Safety and Efficacy of Tenofovir as Pre-Exposure Prophylaxis of HIV infection in Heterosexually Active Young Adults in Botswana and Injection Drug Using Adults in Thailand.
Grant Number:	GAB-05-C-0459
Sponsor:	Centers for Disease Control
Total Direct Costs:	$ 178,565
Principal Investigator:	**C. Hendrix**
Role:	Design and analysis of pharmacokinetic-pharmacodynamic sub-study of daily Tenofovir Disoproxil Fumarate for the prevention of HIV infection in heterosexually active young adults in Botswana; supervision of laboratory sample analysis for tenofovir drug levels in study.
Effort:	5%

Dates:	04/01/05-03/31/08
Title:	Distribution of HIV in the Distal Gastrointestinal Tract
Grant Number:	P30 AI042855
Sponsor:	NIH (Hopkins Center for AIDS Research [CFAR])
Project Direct:	$ 59,792
Principal Investigator:	**C. Hendrix** (Project)
Role:	Principal Investigator of Developmental Pilot Grant from CFAR to describe the distribution of HIV and CD4 cells in the distal gastrointestinal tract following simulated coitus in order to establish the distribution of infectious material following receptive anal intercourse.
Effort:	1%

Dates:	12/04/04-12/03/06
Title:	A Phase I, drug interaction study to assess steady-state plasma methadone enantiomer pharmacokinetics following co-administration of methadone qd with Fosamprenavir 700 mg bid + RTV 100 mg bid in opiate-dependent, HIV-adult subjects.
Grant Number:	COL 012577 CTA
Sponsor:	GlaxoSmithKline
Total Direct Costs:	$ 383,729
Principal Investigator:	**C. Hendrix**
Role:	PI, design, execution, data analysis of investigator-initiated phase II study of the PK/PD methadone and fosamprenavir.
Effort:	1%

FUNDING

Extramural Funding (current, pending, previous)

Previous

Dates:	7/23/04-4/23/07
Title:	Pharmacokinetics of Efavirenz during treatment of HIV-1 infected subjects with hepatic impairment.
Grant Number:	M01 RR000052; AI266-917
Sponsor:	NIH; Bristol Myers Squibb
Total Direct Costs:	$ 128,843
Principal Investigator:	**C. Hendrix**
Role:	Site principal investigator, a multi-center phase I study of the pharmacokinetics of Efavirenz in HIV infected persons.
Effort:	1%

Dates:	11/01/02 – 04/30/07
Title:	Candida Ecology in the Intensive Care Unit.
Grant Number:	M01 RR00052
Sponsor:	NIH
Total Direct Costs:	GCRC Clinical Study Support
Principal Investigator:	**C. Hendrix**
Role:	Study Candida in ICU following several years of antifungal prophylaxis.
Effort:	1%

Dates:	11/01/02 – 10/30/03
Title:	Sampling Frequency Limitations of Drugs in Whole Semen Ejaculates.
Grant Number:	M01 RR00052
Sponsor:	NIH
Total Direct Costs:	GCRC Clinical Study Support
Principal Investigator:	**C. Hendrix**
Role:	Design/execution of study to determine the sampling interval for semen that does not interfere with local drug permeability.
Effort:	1%

Dates:	1/1/02 – 06/30/06
Title:	A Phase I First in Human Dose Escalation Study of the Pharmacokinetics and Safety of AMD070 in Healthy Volunteers
Grant Number:	U01AI 27668-18S1 Adult AIDS Clinical Trials Unit (Flexner, PI)
Sponsor:	NIH
Total Direct Costs:	$ 4,527,600 (full U19, not project)
Principal Investigator:	**C. Hendrix** (Project)
Role:	Protocol Chair for Multi-center phase I first-in-human, pharmacokinetic study, responsible for protocol design and coordinating study execution.
Effort:	*10%*

FUNDING

Extramural Funding (current, pending, previous)

Previous

Dates:	10/01/01 – 12/31/07
Title:	A U.S. Clinical Trial Site to Conduct Evaluations of Topical Microbicides in Men Who Have Sex with Men (MSM).
Grant Number:	200-2001-08015
Sponsor:	Centers for Disease Control
Total Direct Costs:	$ 1,748,272
Principal Investigator:	**C. Hendrix**
Role:	Design and execution of clinical studies to develop methods for the assessment of distribution and clearance of candidate microbicides.
Effort:	10%

Dates:	10/01/01- 9/30/03
Title:	Prevention of Adenoviral Infection in Basic Military Trainees
Grant Number:	DAMD17-02-1-0213
Sponsor:	US Army Medical Research and Materiel Command
Total Direct Costs:	$243,452
Principal Investigator:	**C. Hendrix**
Role:	Design, execution, and analysis of In vitro and clinical evaluation of nucleoside analogues to prevent adenoviral infection in military trainees.
Effort:	10%

Dates:	07/01/01 – 06/30/02
Title:	The Ecological Impact of Antifungal Prophylaxis in the ICU.
Grant Number:	M01 RR00052
Sponsor:	NIH
Total Direct Costs:	GCRC Clinical Trial Support
Principal Investigator:	**C. Hendrix**
Role:	PI, epidemiology of SICU Candida following fluconazole prophylaxis.
Effort:	1%

Dates:	02/01/01-01/01/02.
Title:	Antiretroviral pharmacodynamics in the male genital tract. (Developmental Pilot Project) Hopkins Center for AIDS Research
Grant Number:	P30 AI042855 (Bartlett, PI)
Sponsor:	NIH (Hopkins Center for AIDS Research [CFAR])
Total Direct Costs:	$ 55,000.
Principal Investigator:	**C. Hendrix** (Project)
Role:	Design, execution, and analysis of clinical studies to localize drugs within the male genital tract.
Effort:	10%

FUNDING

Extramural Funding (current, pending, previous)

Previous

Dates:	09/01/00-06/30/05
Title:	Pharmacology of Antiretroviral Drugs in the Genital Tract to prevent HIV Transmission.
Total Direct Costs:	$ 533,040.
Grant Number:	K24 AI 01825
Sponsor:	NIH
Principal Investigator:	**C. Hendrix**
Role:	Midcareer Investigator Award for Patient-Oriented Research is to support academic career development and mentoring of fellows
Effort:	50%

Dates:	09/29/00 – 02/28/04
Title:	HIV-HCV Coinfection: Antiviral therapy and fibrosis.
Grant Number:	R01 DA13806-01
Sponsor:	NIH
Total Direct Costs:	$ 1,696,615
Principal Investigator:	D. Thomas
Role:	Pharmacokinetic/pharmacodynamic study of HIV/HCV treatment.
Effort:	10%

Dates:	10/01/99 – 09/30/02
Title:	Tuberculosis Treatment Consortium Grant.
Sponsor:	CDC
Principal Investigator:	R. Chaisson
Role:	Site investigator; development of clinical protocols for pharmacokinetic studies of anti-TB drugs.
Effort:	10%

Dates:	06/1/99 – 08/31/04
Title:	Graduate Training Program in Clinical Investigation.
Grant Number:	T32 HL04141
Sponsor:	NIH
Principal Investigator:	F. Adkinson
Role:	Course director, lecturer “Principles of Drug Development”; Research Committee.
Effort:	3%

FUNDING

Extramural Funding (current, pending, previous)

Previous

Dates:	03/01/99 - 02/28/06
Title:	Pharmacology Core Laboratory, HIV Prevention Treatment Network (HPTN)
Grant Number:	U01AI46745-05
Sponsor:	NIH
Total Direct Costs:	$ 627,980
Principal Investigator:	**C. Hendrix** (B. Jackson, HPTN Laboratory, PI)
Role:	Pharmacologist for HPTN drug studies. Develop of novel methods to assess pharmacology of drugs in the male genital tract.
Effort:	10%

Dates:	02/01/99-01/31/02
Title:	Effect of AMD-3100 on HIV positive Patients.
Grant Number:	M01 RR000052; AMD3100-2001
Sponsor:	NIH; AnorMED
Total Direct Costs:	$ 207,659
Principal Investigator:	**C. Hendrix**
Role:	PI, design and analysis for 6-site phase II PK-PD study of novel antiretroviral chemokine receptor blocker.
Effort:	10%

Dates:	02/0l/99 - 01/31/00
Title:	The Effect of Accutane on the Pharmacokinetics and Pharmacodynamics of Oral Contraceptive Tablets in Healthy Pre-menopausal Women with Severe Recalcitrant Nodular Acne.
Grant Number:	M01 RR000052; NR15888/M01508
Sponsor:	NIH; Roche
Total Direct Costs:	$ 328,832
Principal Investigator:	**C. Hendrix**
Role:	Principal investigator of investigator-initiated single site pharmacokinetic-pharmacodynamic drug interaction study; developed protocol collaboratively with sponsor; responsible execution, analysis.
Effort:	10%

FUNDING

Extramural Funding (current, pending, previous)

Previous

Dates:	02/01/99-01/31/00
Title:	Methadone in combination with amprenavir in opiate abusers.
Grant Number:	M01 RR000052; COL30330
Sponsor:	NIH; Glaxo
Total Direct Costs:	$ 252,561
Principal Investigator:	**C. Hendrix**
Role:	Protocol design, single site principal investigator, and data analysis for investigator-initiated drug interaction study with pharmacokinetic and pharmacodynamic endpoints.
Effort:	10%

Dates:	09/01/98-08/31/99
Title:	Phase I/II study of the pharmacokinetic of efavirenz when added to a ritonavir-saquinavir-containing an antiretroviral regimen in HIV.
Grant Number:	NIH M01 RR000052; DMP 266-046
Sponsor:	NIH; DuPont-Merck
Total Direct Costs:	$ 284,618
Principal Investigator:	**C. Hendrix**
Role:	Principal investigator, protocol design, execution, and data analysis of investigator-initiated single site of antiretroviral drug interactions.
Effort:	10%

Dates:	09/01/98-07/01/99
Title:	Safety, pharmacokinetics, and tolerability of intravenously administered AMD 3100 in normal healthy volunteers.
Grant Number:	M01 RR000052; 98-01
Sponsor:	NIH; AnorMED
Total Direct Costs:	$ 72,644
Principal Investigator:	**C. Hendrix**
Role:	Principal investigator responsible for study design, execution, and data analysis of first-in-human study of novel CXCR-4 receptor inhibitor.
Effort:	10%

Dates:	07/0l/98 – 06/30/99
Title:	Phosphorylation of Nucleoside Analogs: Treatment-Experienced
Total Direct Costs:	$ 259,211
Grant Number:	M01 RR000052; Glaxo Contract
Sponsor:	NIH; Glaxo
Principal Investigator:	C. Flexner
Role:	Analysis for clinical study of antiretroviral intracellular phosphorylation.
Effort:	5%

FUNDING

Extramural Funding (current, pending, previous)

Previous

Dates:	06/01/98-12/31/98
Title:	Safety of orally administered SP303 for the treatment of AIDS diarrhea.
Grant Number:	M01 RR000052; 37,554-210
Sponsor:	NIH; Shaman Pharmaceuticals
Total Direct Costs:	$ 173,995
Principal Investigator:	**C. Hendrix**
Role:	Site principal investigator of multi-center, industry-sponsored study of novel natural product to reduce AIDS-related diarrhea.
Effort:	1%

Dates:	01/01/98-06/30/99
Title:	Fluconazole prophylaxis in the surgical intensive care unit.
Grant Number:	Unrestricted Educational Grant
Sponsor:	Pfizer
Total Direct Costs:	$ 825,104
Principal Investigator:	**C. Hendrix**
Role:	Principal investigator, clinical trial design, study management, execution, data analysis for phase III randomized clinical trial.
Effort:	35%

Dates:	01/0l/98 – 02/28/99
Title:	A Phase I/II Study of the Potential Interaction Between S-1153 and the Protease Inhibitors Nelfinavir and Indinavir in HIV-1 Infected Adults Treated with 3TC and ZDV or D4T.
Grant Number:	M01 RR000052; AG1549-535
Sponsor:	NIH; Agouron Pharmaceuticals
Total Direct Costs:	$ 186,127
Principal Investigator:	**C. Hendrix**
Role:	Protocol development and site principal investigator for 3 site dose escalation study of novel antiretroviral agent (capravirine).
Effort:	10%

Dates:	01/01/98-12/31/98
Title:	A phase I trial to evaluate the intravitreal penetration of 1263W94 after multiple-dose oral administration in AIDS patients with CMV retinitis
Grant Number:	M01 RR000052; CMAA1004
Sponsor:	NIH; Glaxo
Total Direct Costs:	$ 56,651
Principal Investigator:	**C. Hendrix**
Role:	Protocol design assistance, site principal investigator, data analysis, intravitreal and blood pharmacokinetics of anti-CMV drug.
Effort:	10%

FUNDING

Extramural Funding (current, pending, previous)

Previous

Dates:	01/01/98-02/28/98
Title:	Utilization of PK/PD model to optimize 1263W94 dosing against CMV.
Grant Number:	Contract
Sponsor:	Glaxo
Total Direct Costs:	$ 33,714
Principal Investigator:	F. Hamzeh
Role:	Surrogates of blood contamination of sampling in vitrectomy.
Effort:	1%

Dates:	07/01/97-06/30/00
Title:	Faculty Development Award
Sponsor:	Pharmaceutical Research and Manufacturer's Association.
Total Direct Costs:	$ 120,000
Principal Investigator:	**C. Hendrix**
Role:	Leadership and management of reorganized Drug Development Unit to provide complete phase I study services as a core faculty resource.
Effort:	10%

Dates:	01/01/97-12/31/01
Title:	International Military Prevention Research.
Grant Number:	Contract
Sponsor:	Department of Defense (through Henry M. Jackson Foundation)
Total Direct Costs:	$ 191,000
Principal Investigator:	**C. Hendrix**
Role:	HIV prevention program development and process research among foreign military leadership in coordination with the UNAIDS, UNDPKO, and the Civil-Military Alliance to Combat HIV/AIDS.
Effort:	35%

Dates:	01/01/97 - 12/31/00
Title:	AIDS Clinical Trials Group Advanced Technology Laboratory, Pharmacology Research Resource Unit.
Grant Number:	U01 AI27668-PP003
Sponsor:	NIH
Total Direct Costs:	$ 66,964
Principal Investigator:	C. Flexner
Role:	Clinical trial design, execution, and data analysis for antiretroviral drug development studies, principal investigator for multi-center studies.
Effort:	10%

FUNDING

Extramural Funding (current, pending, previous)

Previous

Dates:	01/01/97-12/31/97
Title:	Candida/VRE Surveillance in the Intensive Care Unit.
Grant Number:	Unrestricted Educational Grant.
Sponsor:	Pfizer
Total Direct Costs:	$ 100,000
Principal Investigator:	**C. Hendrix**
Role:	Principal Investigator, study management, data analysis of pilot study to develop sample size estimates for prophylactic interventions in the ICU
Effort:	10%

Dates:	01/01/97-12/31/97
Title:	Pharmacokinetics and safety of lobucavir in subjects with hepatic impairment.
Grant Number:	M01 RR000052
Sponsor:	NIH; Bristol-Myers Squibb
Total Direct Costs:	$ 400,319
Principal Investigator:	**C. Hendrix**
Role:	Site principal investigator of multi-center pharmacokinetic study.
Effort:	10%

Dates:	01/01/97 - 12/31/97
Title:	Phase I/II randomized double blind placebo controlled study of the safety, tolerance and pharmacokinetics and antiretroviral activity of PMPA Prodrug in HIV-infected patients.
Grant Number:	NIH M01 RR000052; Gilead contract
Sponsor:	NIH; Gilead Pharmaceuticals
Total Direct Costs:	$ 268,239
Principal Investigator:	P. Barditch-Crovo
Role:	Data analysis of single center antiretroviral pharmacokinetic study.
Effort:	1%

Dates:	01/01/97 - 10/30/97
Title:	Clinical Pharmacology of generic and antiviral drugs.
Grant Number:	Cooperative Agreement
Sponsor:	FDA
Total Direct Costs:	$ 1,981,673
Principal Investigator:	P. Lietman
Role:	Data analysis of several investigator-initiated clinical studies of drug interactions and toxicity.
Effort:	10%

CLINICAL ACTIVITIES

Certification

Medical Licensure
State of Maryland, issued 10/1/94, # D46682 (current)
Commonwealth of Pennsylvania, issued 12/2/92, MD 043514 L, (inactive 12/31/94)

Medical Boards or Other Specialty Certification
National Board of Medical Examiners, Parts I-III, 6/85
American Board of Internal Medicine, 9/87
American Board of Internal Medicine, Infectious Diseases, 11/1990-11/2000, #116631
American Board of Clinical Pharmacology, 10/2016

Membership in or Examiner for Specialty Board
2018-present Board of Directors, American Board of Clinical Pharmacology

EDUCATIONAL ACTIVITIES

Teaching

Classroom Instruction

School of Medicine

Physician and Society (medical student curriculum)
"Scientific Misconduct" 2001

Medical Pharmacology (medical student curriculum)

Lectures
"Pharmacokinetics I: Introduction, Membranes, Bioavailability" 1995-present
"Pharmacokinetics II: Volume, Clearance, Half-life" 1995-present
"Pharmacokinetics III: Dosing Regimens" 1995-present
"Pharmacokinetics IV: Mixed Order Kinetics, Applications" 2000-present
"Pharmacokinetic Clinical Problem Solving I and II" eLectures 2015-present
"Introduction to Antibiotics" 1998-present
"Cell wall active antibiotics I: Penicillins" 1998-present
"Cell wall active antibiotics I: Cephalosporins, Vancomycin" 1998-present
"Ribosomal inhibiting antibiotics I: Aminoglycosides" 1998-present
"Ribosomal inhibiting antibiotics II: Others" 1998-present
"Antifungal Drugs" 2001
"Pharmacokinetics of anti-seizure drugs" 1995-1999
"Pharmacology of immunotherapeutics in neurology" 2000
"Aspirin and NSAIDs" 1998-2004, 2017
"Opiates" 1994-2004
"Quinolones" 2007

Small group/tutorials
Intersession Small Group Co-Leader (Clinical-Basic Science correlations) 2011-present
Pharmacokinetics problem-solving (2, 2-hour sessions) 1995-present
Infectious Diseases small group discussion (4, 2-hour sessions) 1994-2003
Pharmacology tutorial "Clinical Investigation" (5, 2-hour sessions) 1994-2012
Vaccine small group discussion (1, 2-hour session) 1997-2000
Metabolism small group 2012-2015
Pharmacology medical student jornal club 2012-2015
Tutorial "My Favorite Drug (Drug Develolpment)" 2016

Rational Therapeutics (created course; required 4th year medical student course)
"Practical Pharmacokinetics" 1995-2004
"Drug Interactions" 2004
"Rational Use of Antibiotics" 2005-2006

Pharmacology (Pharmacology Graduate Students):
"Pharmacokinetics I: Introduction, Membranes, Bioavailability" 2000-present
"Pharmacokinetics II: Volume, Clearance, Half-life" 2000-present
"Pharmacokinetics III: Mixed Order Kinetics" 2000-present
"Antibiotics" 2000-2006
"Aspirin and NSAIDs" 2000-2004
Pharmacology tutorial "Clinical Investigation" (5, 2-hour sessions) 2010-present

EDUCATIONAL ACTIVITIES

Teaching

Classroom Instruction- continued

Analytical Methods of Clinical Pharmacology (Fellowship 24-hour curriculum) 2000-present
- "Principles of PK/PD in Drug Development"
- "Curve Stripping"
- "Non-Compartmental Analysis"
- "Compartmental Analysis"
- "Pharmacodynamic Studies"
- "Pharmacodynamic Data Analysis"
- "PK/PD Linkage Analysis"
- "Population PK Analysis Overview"
- "Clinical Trial Simulation Overview"

Laboratory Science of rthe Clinical Investigator – Short Course 2017-present
- Coruse creator and co-director with S. Nimmagadda

Osler House Staff Noon Teaching Conference 2004 - 2012
- "Practical Pharmacokinetics for the House Officer" 2004-2012
- "Pharmacokinetics in Special Populations" 2004-2012
- "Rational Therapeutics of COX-2 Selective and Non-selective NSAIDs" 2004-2010
- "Making Drugs Safer" 2005-2012
- "Aminoglycoside Dosing Strategies" 2007-2012
- "Integrating HIV Prevention into an Internal Medicine Practice", 2011-2012

School of Nursing

"Pharmacology of Immune Suppressive Drugs", Graduate Student Curriculum, 1998-9

School of Public Health

Principles of Drug Development, (required GTPCI Course) 1994-2003
- "Overview of the drug development process" 1999-2003
- "Pharmacokinetics for Drug Development" 1999-2003
- "Pharmacokinetic and Safety Studies" 1994-2003
- "Pharmacokinetic and Safety Studies - practicum" 1999-2003
- "Pharmacokinetic and Safety Studies – student project critique" 1999-2003
- "Learning vs. Confirming Studies" 1999-2003
- "Learning vs. Confirming Studies - practicum" 1999-2003
- "Learning vs. Confirming Studies - student project critique" 1999-2003
- "Clinical Trial Simulation" 2001-2003

EDUCATIONAL ACTIVITIES

Teaching

Classroom Instruction - continued

Analytical Methods in Clinical Investigation (required GTPCI Course),
"Databases: How to use and abuse them I: Principles" 1997-2002
"Databases: How to use and abuse them II: Applications" 1997-2002

Topics in Clinical Investigation (required GTPCI Course)
"Scientific Misconduct" 1995-present

Epidemiology and Natural History of Human Viral Infections
"Antiviral Therapy" 1997 - present

Epidemiology and Public Health Impact of HIV and AIDS
"Antiretroviral Therapy" 2004 - present

Graduate Summer Institute of Epidemiology and Biostatistics, Advanced Issues in HIV/AIDS Course, "HIV Chemoprevention Drug Development Issues", 2005 – present

Advanced Topics on the Control and Prevention of HIV/ AIDS
"HIV Chemoprevention" 2006 - present

Epidemiology of Infectious Disease Journal Club, Faculty discussant, 2007

Doctoral Seminar in International Health, "Pharmacology in Public Health", 2009-2011

Clinical Instruction

Clinical Skills (required 2nd year Course), Preceptor, 1997

Internal Medicine Inpatient Service, Teaching Attending, 1995-1996

PerdanaUniversity Graduate School of Medicine (Kuala Lumpur, Malaysia)

Scientific Foundations of Medicine Course
Introduction to Pharmacology Section (2013-present)
"Receptors and Enzymes"
"Drug Metabolism"
"Pharmacokinetics I-IV"
"Pharmacokinetic Case Studies – Problem Solving"
"Autonomic Pharmacology I-II"
"Drug Safety"
"Drug Development"
"Complementary and Alternative Medicine"
"Drug Resistance"

EDUCATIONAL ACTIVITIES

Teaching

Continuing Medical Education – Military

US Air Force Annual HIV/AIDS Train-the-trainer Short Course 1991-1999
Course Director, Instructor 1991-1999

International Military HIV/AIDS Education (in collaboration with UNAIDS)

Harare, Zimbabwe, Regional Training Seminar, 6 East and Southern African National Delegations, Speaker/Facilitator, 1995

Cha-Am, Thailand, Regional Training Seminar, 7 South and Southeast Asian National Delegations, Speaker/Facilitator, 1995

Kampala, Uganda, Regional Training Seminar, West African National Delegations, Presentation provided, 1996

Windhoek, Namibia, Regional Training Seminar, 14 East and Southern African National Delegations, Speaker/Facilitator, 1997

Hanoi, Republic of Vietnam, Country Site Visit Team, Speaker, Military Consultant, 1998

Moscow/Saint Petersburg, Russian Federation, Country Site Visit, Speaker, Military Consultant, 1998

"HIV Military Threat Assessment and Response." Annual HIV Prevention Education Train-the-Trainer Course, San Antonio, Texas. May 1999.

Continuing Medical Education- Civilian

"Clinical Pharmacology of Antiretroviral Drugs." Curriculum Review Course, American Society of Clinical Pharmacology and Therapeutics, New Orleans, Louisiana. March 1998. International. Audience: Clinical Pharmacologists faculty and post-doctoral trainees.

"Clinical Pharmacology of Antiretroviral Drugs." Curriculum Review Course, American Society of Clinical Pharmacology and Therapeutics, San Antonio, Texas. March 1999. International. Audience: Clinical Pharmacologists faculty and post-doctoral trainees.

"New Antibacterial Drugs." Pediatric Trends Course, Johns Hopkins University School of Medicine, Office of Continuing Medical Education. Baltimore, Maryland. April 1999. JHMI. Clinical faculty and post-doctoral trainees.

"New Antiviral Drugs". Pediatric Trends Course. Johns Hopkins University School of Medicine, Office of Continuing Medical Education. Baltimore, Maryland. April 1999. JHMI. Clinical faculty and post-doctoral trainees.

EDUCATIONAL ACTIVITIES

Teaching

Continuing Medical Education – Civilian continued

"COX-2 Inhibitors: New NSAIDs on the Block." Conjoint Clinic, Johns Hopkins University School of Medicine, Office of Continuing Medical Education. Baltimore, Maryland. May 1999. JHMI. Clinical faculty and post-doctoral trainees.

"New Drugs for HIV Infection." Clinical Care of the Patient with HIV Infection. Baltimore, Maryland. April 1999. JHMI. Clinical faculty and post-doctoral trainees.

"New Drugs for HIV." The Johns Hopkins AIDS Service HIV Management Preceptorship Program, Baltimore, Maryland. April 1999. JHMI. Clinical faculty and post-doctoral trainees.

"Databases and Clinical Research: How to Use and Abuse Them." Johns Hopkins University School of Medicine, Office of Continuing Medical Education, Baltimore, Maryland. May 1999. JHMI. Clinical faculty and post-doctoral trainees.

"New Drugs for HIV Infection." Clinical Care of the Patient with HIV Infection. Baltimore, Maryland. April 2000. JHMI. Clinical faculty and post-doctoral trainees.

"Databases and Clinical Research: How to Use and Abuse Them." Johns Hopkins University School of Medicine, Office of Continuing Medical Education, Baltimore, Maryland. May 2000. JHMI. Clinical faculty and post-doctoral trainees.

"NSAIDS and COX-2 Inhibitors: Current Status." Conjoint Clinic, Johns Hopkins University School of Medicine, Office of Continuing Medical Education. Baltimore, Maryland. February 2001. JHMI/Regional. Clinical faculty and post-doctoral trainees.

"Databases and Clinical Research: How to Use and Abuse Them." Johns Hopkins University School of Medicine, Office of Continuing Medical Education, Baltimore, Maryland. April 2001. JHMI. Clinical faculty and post-doctoral trainees.

"Tools for Pre-Approval Drug Safety Evaluation", Academics to CDER Series: Annual Continuing Medical Education Course May 2003. Regional. FDA Professional Staff Development.

"Aminoglycoside and Vancomycin Therapeutic Drug Monitoring." Johns Hopkins Distance Learning (Bermuda Site), Office Of Continuing Medical Education, Baltimore, Maryland. May 2005. JHMI/Regional. Clinical faculty and post-doctoral trainees.

"Practical Pharmacokinetics for Primary Care." Anne Arundel Community College, Physician Assistant Curriculum, Arnold, Maryland, 2005. Regional. Physician Assistant candidates.

EDUCATIONAL ACTIVITIES

Teaching

Continuing Medical Education – Civilian continued

"Relationships between Academia and the Pharmaceutical Industry." American Medical Student Association (Johns Hopkins University Chapter), November 2006.JHMI. Medical Students.

"Development of Topical HIV Microbicides." Division of Infectious Diseases, Fellows' Conference, December 2006. JHMI. Clinical faculty and post-doctoral trainees.

"Clinical Pharmacology of Antiretroviral Drugs." Curriculum Review Course, American Society of Clinical Pharmacology and Therapeutics, Anaheim, California. March 2007. International. Audience: Clinical Pharmacologists faculty and post-doctoral trainees.

"Pharmacodynamics of Antibiotics." Division of Infectious Diseases, Fellows' Conference, November 2007. JHMI. ID faculty and post-doctoral fellows.

"Pharmacological Principles of Antiretroviral Drugs" Curriculum Review Course. ASCPT, March 2009. International. Audience: Clinical Pharmacologists faculty and post-doctoral trainees.

"Pharmacological Principles of Antiretroviral Drugs" Curriculum Review Course. ASCPT, March 2013. International. Audience: Clinical Pharmacologists faculty and post-doctoral trainees.

"Pharmacogenomics: One Aspect of Precision Medicine in Primary Care" Curriculum Review Course. American Medical Forum. Washington, DC. November 2017. National. Audience: Internal Medicine & Primary Care Physicians.

"Pharmacogenomics: One Aspect of Precision Medicine in Primary Care" Curriculum Review Course. American Medical Forum. Washington, DC. June 2018. National. Audience: Internal Medicine & Primary Care Physicians.

"HIV Prevention with Drugs: Pre-Exposure Prophylaxis (PrEP) in Primary Care." Curriculum Review Course. American Medical Forum. Washington, DC. June 2018. National. Audience: Internal Medicine & Primary Care Physicians.

"HIV Prevention with Drugs: Pre-Exposure Prophylaxis (PrEP) in Primary Care." Curriculum Review Course. American Medical Forum. Washington, DC. November 2017. National. Audience: Internal Medicine & Primary Care Physicians.

EDUCATIONAL ACTIVITIES

Mentoring

Principal Mentor

Stephen P. Blatt, M.D., 1990-1991
Infectious Disease Fellow, Wilford Hall USAF Medical Center
Current position: Private Practice, Dayton, OH (1994-present)

Janet M. J. Hammond, M.D., Ph.D., 1995-1998
Clinical Pharmacology Fellow; Graduate Training Program in Clinical Investigation, Johns Hopkins University School of Hygiene and Public Health
Thesis "Emerging Pathogens in Intensive Care"; Sc.M. granted 5/25/99.
Current Position: Vice President of Infectious Diseases Development, AbbVie, Lake Forest, IL.

Robert Pelz, M.D., 1997-2000
Infectious Diseases Fellow
Graduate Training Program in Clinical Investigation, Ph.D. 2000
Research: Epidemiology and treatment of ICU infections
Awards: Infectious Diseases Society of America 1998 Fellows Award for Scientific Excellence. "Do surveillance cultures predict fungal infection in critically ill pts?"
Society of Critical Care Medicine 2000 In-training Fellow Award. "A double blind placebo controlled trial of prophylactic fluconazole to prevent Candida infections in critically ill surgical patients"
Society of Critical Care Medicine 2000 Educational Scholarship Award "Fluconazole blood concentrations after enteral administration in critically ill surgical patients exceed most Candida minimal inhibitory concentrations in a double-blind, placebo-controlled trial in which fluconazole prevented Candidal infections."
Johns Hopkins University Helen B. Taussig Young Investigators Award. "Nosocomial Fungal Infections in the Critically Ill: Dx and Prevention."
Current Position: Clinical Assistant Professor of Medicine, Oregon Health and Science University, School of Medicine, Portland, OR

Thomas Ndovi, M.D., 1999-2005
Clinical Pharmacology Fellow
Graduate Training Program in Clinical Investigation, 1999-2005, Ph.D. 2005
Fogarty International Fellow 1999-2001, 2003-2004
Merck International Fellow in Clinical Pharmacology 2001-2003
Research: Pharmacology of antiretroviral drugs in genital compartments
Awards: Department of Medicine Research Retreat Clinical Fellow Poster Finalist 2005
British Journal of Clinical Pharmacology Prize 2007
Last Position: Assistant Professor of Medicine, University of Malawi; Director, Johns Hopkins-Malawi Clinical Research Unit, Blantyre, Malawi (Deceased 2007)

EDUCATIONAL ACTIVITIES

Mentoring

Principal Mentor - continued

Shelley Sylvester Magill, M.D., 2000-2007
Infectious Diseases Fellow/Assistant Professor
Graduate Training Program in Clinical Investigation, Ph.D. 2007
Awards: Pfizer Mycology Fellowship Award Recipient 2001-2003;
Clinical Scientist Award 2003 (Johns Hopkins University, declined)
Research: Ecology and prevention of fungal infections in the ICU
Position: Assistant Professor, Division of Infectious Diseases, Johns Hopkins University School of Medicine 2004 - 2007
Current Position: Medical Officer, Mycotic Diseases Branch, CDC, Atlanta, GA (2007-present)

Lewis Radonovich, M.D., 2000-2002
Clinical Pharmacology Fellow
Graduate Training Program in Clinical Investigation, Ph.D. Candidate
PhRMA Fellowship in Pharmacology 2001-2002
Research: Chemoprophylaxis of adenoviral infections
Previous Position: Assistant Professor of Medicine, University of Florida, Gainesville FL (2002-2015
Current Position: Centers for Disease Control, NIOSH, Pittsburgh, PA (2015-present)

Thanyawee Puthanakit, M.D., 2001-2002
International Fogarty Fellow; Clinical Pharmacology Fellow
Graduate Training Program in Clinical Investigation; MHS degree 2002
Research: Pharmacokinetics of Antiretroviral Drugs, Drug interactions in the ICU
Assistant Professor, Chiang Mai University Medical Faculty, 2002-2005
Current Position: Associate Professor, Department of Pediatrics, Chulalongkorn University, Bangkok, Thailand; The HIV Netherlands Australia Thailand Research Collaborative.(2002-present)

Nimalie Stone, M.D., 2003-2004
Clinical Pharmacology Fellow
Research: Chemokine receptor inhibition phase I studies; Anti-infective drug utilization
Current Position: Medical Officer, CDC, Atlanta, Georgia

Wasif Khan, M.D., 2003-2005
Clinical Pharmacology Fellow
Graduate Training Program in Clinical Investigation, M.H.S. 2005
Merck International Fellow in Clinical Pharmacology 2003-2005
Research: Pharmacology of antiretroviral drugs, microbicide distribution
Current Position: Research Physician, International Center for Diarrheal Disease Research, Dhaka, Bangladesh. (2005-present)

EDUCATIONAL ACTIVITIES

Mentoring

Principal Mentor – continued

Ying-Jun Cao, M.D., 2004-2007
Clinical Pharmacology Fellow
Graduate Training Program in Clinical Investigation, Ph.D. 2007
Research in Progress: Development of methods to describe pharmacokinetics in the male genital tract; Quantitative methods to assess colon microbicide and HIV distribution
Awards: Department of Medicine Research Retreat Clinical Fellow Poster Finalist 2005;
American Society for Clinical Pharmacology and Therapeutics Young Investigator Award 2006-7;
Conference Retroviruses and Opportunistic Infections, Young Investigator Award 2007
British Journal of Clinical Pharmacology Prize 2012
Positions: Assistant Professor of Medicine, Division of Clinical Pharmacology, Johns Hopkins University School of Medicine. 2007-2008; 2008-present (Adjunct).
Director Science, Global Clinical Pharmacology & Exploratory Development, Astellas Pharmaceuticals, 2008-present.

Sridhar Nimmagadda, Ph.D., 2005-2008
Post-doctoral Fellow in Pharmacology and Radiology (Martin Pomper co-mentor)
Research: Quantitative luminal and tissue distribution of HIV and CD4 cells in the human vagina and colon following simulated receptive intercourse
Positions: Associate Professor of Radiology, Johns Hopkins University School of Medicine, 2009-present.

Kelly Brungardt Stein, MD, 2006-2007
Joint Clinical Pharmacology – Infectious Diseases Fellow
Graduate Training Program in Clinical Investigation, ScM 2009
Research: Protein binding of antiretrovirals in semen; vaginal distribution of HIV & CD4 cells.
Current Position: Instructor, Rush University Medical Center 2008-present

Nicolette Louissaint, PhD, 2006-2013
Pharmacology Training Program, Department of Pharmacology (2006 – 2010)
Ph.D. Candidate (PhD conferred May 2010), Post-doctoral fellow (May 2010-present)
Research in Progress: Quantitative luminal and tissue distribution of HIV and CD4 cells in the human vagina and colon following simulated receptive intercourse
Awards: Keystone Symposia Minority Scholarship, 2008
Department of Medicine Research Retreat Clinical Research Fellow Poster Finalist, 2009
American Society for Clinical Pharmacology and Therapeutics (ASCPT) Presidential Trainee Award 2010
ASPET Integrative Research in Pharmacology Awards 2012
AAAS Fellow – US Department of State 2013-2014
Current Position: Director of Healthcare Ready, AAAS Science and Technology Policy Fellow, Foreign Affairs Officer, US Department of State, 2014 - present

EDUCATIONAL ACTIVITIES

Mentoring

Principal Mentor - continued

Lindsay Brooke Avery, BS, 2008-2012
Pharmacology Training Program, Department of Pharmacology
Ph.D. Candidate; PhD conferred August 2012
Research: Efavirenz protein binding, compartmental distribution, and antiviral effect
Awards: American Society for Clinical Pharmacology and Therapeutics (ASCPT) Presidential Trainee Award 2010
Young Investigator Award. 20th Conference on Retroviruses and Opportunistic Infections 2013
Positions: Post-doctoral fellow, Namandje Bumpus Lab, Johns Hopkins University 2012-2014;
Current position: Pharmaceutical Development, Pfizer, Inc. Boston, MA, 2014-present

Liye Li, MD, PhD. 2009-2010
Clinical Pharmacology Fellow
Research: Development of candidate topical rectal microbicides.
Current Position: Nuclear Medicine private practice 2010 - present

Francisco Leyva, Md. PhD, 2009-2013
Clinical Pharmacology Fellow
Graduate Training Program in Clinical Investigation, M.H.S. 2012
Research: Development of candidate topical rectal microbicides.
Current Position: National Institutes of Health, Division of Microbiology and Infectious Diseases

Yanhui Lu, BS, 2010-2014
Pharmacology Training Program, Department of Pharmacology
Ph.D. Candidate; PhD conferred March 2014
Research: Identification of Novel Phase I and Phase II Metabolites of Maraviroc
Awards:
Junghea Park Memorial Travel Award 2012
Scheinberg Travel Award for spring 2011
Graduate Student Travel Award, ASPET Annual Meeting 2012
2012 Chinese Government Award for Outstanding Self-financed Students Abroad (China Scholarship Council)
2014 Bae Gyo Jung Young Investigator Day Award. Johns Hopkins University
Current Position: Office of Clinical Pharmacology, FDA 2015-present

Jenell Fenell Coleman, MD, 2010 – 2014
Assistant Professor, Department of Obstetrics and Gynecology
Harold Amos Medical Faculty Development Award
Research: Contraceptive – Antiretroviral drug interactions
Current Position: Associate Professor, Obstetrics & Gynecology, Johns Hopkins University

EDUCATIONAL ACTIVITIES

Mentoring

Principal Mentor - continued

Salee Parichat, MD, M.P.H. 2011-2012
International Fogarty Fellow, Thailand; Epidemiology, Masters of Public Health 2012, Bloomberg School of Public Health,
Research: Pre-exposure Prophylaxis adherence measured by plasma drug levels in MTN-001: comparison between vaginal gel and oral tablets in two geographic regions.
Current Position: RIHES, Chiang Mai University, Thailand

Hiwot Hiruy, MD, 2011-2015
Joint Clinical Pharmacology – Pediatric Infectious Diseases Fellow
Graduate Training Program in Clinical Investigation, PhD 2015
Research: Gastrointestinal tract pharmacology of topical HIV microbicides
Current Position: Medical Officer, FDA 2015-present

Jenny Robinson, MD, 2012-2014
Clinical Pharmacology Fellow
Graduate Training Program in Clinical Investigation, PhD Candidate
Research in progress: Female Genital tract pharmacology of topical HIV microbicides
Current Position: Assistant Professor, Obsetetrics & Gynecology, Johns Hopkins University 2014-present

Ethel Weld, MD, 2013-2016
Joint Clinical Pharmacology –Infectious Diseases Fellow
Graduate Training Program in Clinical Investigation, PhD 2019
Research in progress: Gastrointestinal tract pharmacology of topical HIV microbicides
Awards:
The Pearl M. Stetler Research Fund for Women Physicians Award 2015-2016
Research Scholars Junior Faculty Award (KL2) 2017-2018
Current Position: Assistant Professor, Department of Medicine (Clinical Pharmacology), Johns Hopkins University, 2016-present
Funding: KL2 NCTS Johns Hopkins ICTR

Jackson Mukonzo, PhD, 2014
Fulbright Faculty Scholar
Research in progress: Polymorphisms uniquely impacting HIV treatment in African populations
Current Position: Director (Acting), Department of Pharmacology & Therapeutics, Makerere University, College of Health Science, Kampala, Uganda

Eugenie Shieh, MD, 2014-2017
Joint Clinical Pharmacology–Gastroenterology Fellow
Graduate Training Program in Clinical Investigation, PhD Candidate
Research in progress: Gastrointestinal tract pharmacology of topical HIV microbicides
Private practice gastroenterology, CA 2017-present

EDUCATIONAL ACTIVITIES

Mentoring

Principal Mentor - continued

Victoria Ojeda, 2015-present
Assocaite Professor, University of California, San Diego
HIV Prevention Trials Network Scholar
Research in Progress: Impact of staff-particpant relationships on adherence in randomized controlled PrEP trials
Current Position: Associate Professor, University of California at San Diego, School of Public Health, San Diego, CA

Rachel Scott, MD, 2016-present
Assistant Professor, Georgetown University
Mid Atlantic CFAR Mentoring
Research in progress: ARV & PrEP PK in pregnancy and post-partum
Current Position: Assistant Professor of Medicine, Georgetown University, Washington, DC
Funding: K23 NIMH

Zachary Janik, 2016-present
Medical Student, Research Mentor
Research in Progress: Quantiative assessment of White Coart Adherence in HIV Pre-Exposure Prophylaxis.

Katherine Huether, 2017-2018
Medical Student, Drug Development Research Rotation

Secondary Sub-Specialty Mentoring

Normalynn Garrett, PhD candidate, Nursing; Pharmacology mentoring, 1998-1999
Andre Agthe, Neonatal Fellow, GTPCI; Pharmacology mentor, 2000-2004
Amy Ginsberg, Infectious Diseases Fellow; Pharmacology mentor, 2002-2003

Advisor (when not Primary Mentor) – GTPCI - continued

Rodney Willoughby, MD, Pediatrics Faculty, GTPCI; Pharmacology mentor, 1999-2004

Lawrence Lee, Clinical Pharmacology Fellow; Pharmacokinetics mentor, 2003-2004

Devi Chittineni, Clinical Pharmacology Fellow; Pharmacokinetics mentor, 2004 – 2006

Myaing Nyunt, Clinical Pharmacology Fellow, GTPCI; Pharmacokinetics mentor, 2005 - 2008
Current Position: Assistant Professor of Medicine, University of Maryland Medical Center

EDUCATIONAL ACTIVITIES

Advisor (when not Primary Mentor) – GTPCI - continued

Kelly Dooley, MD, Joint Clinical Pharmacology – Infectious Diseases Fellow, GTPCI;
Pharmacokinetics Mentor, 2006 – 2010
Current Position: Associate Professor of Medicine, Johns Hopkins University

Sofia Perea, Pharm.D., Ph.D., 2002-2004
Oncology Post-Doctoral Fellow
Graduate Training Program in Clinical Investigation, Ph.D. Candidate

Kai Zhang, M.D., 2003-2004
Post-Doctoral Fellow
Graduate Training Program in Clinical Investigation, Ph.D. Candidate

Victor Crentsil, M.D., 2005 – 2007
Division of Geriatric Medicine
Graduate Training Program in Clinical Investigation, M.H.S. Degree 2007
Current Position: FDA Medical Officer

Romanee Chaiwarith, M.D. 2006 - 2007
Post-Doctoral Fellow
Graduate Training Program in Clinical Investigation, M.H.S. Candidate
Current Position: Assistant Professor, Medicine, Chiang Mai University

Tamorah Lewis, MD, Joint Clinical Pharmacology – Neonatology Fellow, GTPCI;
Pharmacokinetics Mentor, 2010 – 2014, Fellowship Advisory Committee, 2010-2014
Current Position: Assistant Professor, Pediatrics, Mercy Children's Hospital, Kansas City (2014-present)

Pranita Tamma, M.D. 2010-2011
Post-Doctoral Fellow Pediatric Infectious Diseases
Graduate Training Program in Clinical Investigation, M.H.S. Candidate
Current Position: Assistant Professor, Pediatrics (Infectious Diseases), Johns Hopkins University (2011-present)

Berkley Limketkai MD 2011 – 2017
Post-Doctoral Fellow Gastroenterology
Graduate Training Program in Clinical Investigation, Ph.D. 2017
Current Position: Assistant Professor, Medicine (Gastroenterology) Stanford University (2014-present)

Erica Shelton MD 2012 – 2014
Instructor, Emergency Medicine
Graduate Training Program in Clinical Investigation, Ph.D. Candidate

Current Position: Assistant Professor, Emergency Medicine, Johns Hopkins University (2014-present)

Omamah Alfarisi PharmD 2012 – present
Post-Doctoral Fellow Clinical Pharmacology
Graduate Training Program in Clinical Investigation, Ph.D. Candidate, pharmacokinietics mentor

Kattayoun Kordy MD, 2014-2016
Clinical Pharmacology UCLA, F32, Pharmacokinetics mentor
Current Position: Assistant Professor, Medicine (Gastroenterology) University of Southern California (2016-present)

Mentoring Committees

Adriana Andrade, MD 2007-2018
Associate Professor of Medicine (Infectious Diseases)
Research in Progress: HIV Clinical Pharmacology, Drug interactions with complementary medicine products and antiretroviral drugs, Adherence to therapeutic regimens.

Myaing Nyunt, MD, PhD 2008-2013
Assistant Professor of International Health (School of Public Health)
Research in Progress: Clinical pharmacology of malaria therapeutics and prevention
Previous Position: Assistant Professor, Medicine, University of Maryland, Baltimore, MD (2014-2017)
Current Position: Assitant Professor, Medicine, Duke University, Durham, NC (2017-present)

Mentoring

Thesis/Oral Examination Committees

Janet Hammond, "Emerging Pathogens in Intensive Care", M.H.S. thesis, Graduate Training Program in Clinical Investigation, School of Hygiene and Public Health, Thesis advisor, Thesis Committee Member 1996-1999.

Normalynn Garrett, "Effects of LY235959 on surgery-induced immunosuppression and increased metastasis in rats", Ph.D. thesis, School of Nursing, Thesis Committee Member, 1998-9.

Robert Pelz, "Prophylaxis of invasive fungal infections in the Surgical Intensive Care Unit: Efficacy, Pharmacology, and Cost Analysis", Ph.D. thesis, Graduate Training Program in Clinical Investigation, School of Hygiene and Public Health, Thesis advisor, Thesis Committee Member, 1997-2001.

Rodney Willoughby, "Developmental Kinetics of Cytokines in Cerebral Palsy", Ph.D. thesis, Graduate Training Program in Clinical Investigation, School of Hygiene and Public Health, Thesis Committee Member, 1999-2008.

EDUCATIONAL ACTIVITIES

Mentoring

Thesis/*Oral Examination *Committees – continued

Claudine Woo, "Subgroup analyses in clinical trials", PhD thesis; Ph.D. 2006, Clinical Trials Program, Department of Epidemiology. School of Public Health, Preliminary Oral Examination Committee Member, 2001; Thesis Committee Member, 2003 - 2006.

Leena Choi, "Modeling biomedical data and the foundations of bioequivalence", Ph.D. Thesis, Department of Biostatistics, School of Public Health, Preliminary Oral Examination Committee Chairman, 2001; Thesis Committee Chairman, 2005.

Elizabeth Lowe, "Phase I and Pharmacokinetic Study of Liposomal Doxorubicin (TLC D-99) in Pediatric Patients with Refractory Solid Tumors", M.H.S. thesis, Graduate Training Program in Clinical Investigation, School of Public Health, Thesis Reader, 2002.

Melanie Rusch, "Were Sexual Risk Behaviors Changing in Injection Drug Users in the ALIVE Cohort Before HAART was Readily Available in this Population", M.H.S. Candidate, Department of Epidemiology, School of Public Health, Thesis reader, 2002.

Alex Agthe, "Clonidine and opiates in the treatment of neonatal abstinence syndrome", Ph.D. candidate, Graduate Training Program in Clinical Investigation, School of Public Health, Preliminary Oral Examination Committee, 2002 Thesis Committee Member, 2007-2008.

Thomas Ndovi, "Compartmental Kinetics of Antiretroviral Drugs (ARVs) in the human Male Genital Tract", PhD Thesis, Graduate Training Program in Clinical Investigation, School of Public Health, Preliminary Oral Examination Committee Member, 2003; Thesis Committee Member, 2003-2005.

Michael Gibson, Ph.D. candidate, Department of Oncology, Graduate Training Program in Clinical Investigation, School of Public Health, Thesis Committee Member, 2002-2007.

Ricardo Carvalho, "Unidirectional Transscleral Delivery from Episcleral Implants", Sc.M. Thesis, Graduate Training Program in Clinical Investigation, School of Public Health, Thesis Committee Member, 2003-2006, Thesis Reader 2006.

Shelley Sylvester Magill, PhD Candidate, Department of Medicine, Graduate Training Program in Clinical Investigation, School of Public Health, Preliminary Oral Examination Committee Member 2004, Thesis Committee member, 2004-2007.

Courtney Silverthorn, Ph.D. Candidate, Department of Pharmacology, School of Medicine, Preliminary Oral Exam Committee Member, 2004.

Lawrence Soon-U Lee, "Antioxidant and phase 2 enzyme induction activity of ginseng in humans", PhD Candidate, Graduate Training Program in Clinical Investigation, School of Public Health, Oral Examination Committee, 2005; Thesis Committee, 2007.

Moira McMahon, Ph.D. Candidate, Department of Pharmacology, School of Medicine, Preliminary Oral Exam Committee Member, 2006.

EDUCATIONAL ACTIVITIES

Mentoring

Thesis/Oral Examination Committees – continued

Ying-Jun Cao, "Antiretroviral Drug Penetration into the Male Genital Tract," PhD Candidate, Graduate Training Program in Clinical Investigation, School of Public Health, Preliminary Oral Examination Committee Member, 2006; Thesis Defense Committee, 2007.

Lijuan Deng, "Spline Based Curve Fitting with Application to Kinetic Imaging M.S." Candidate, Department of Biostatistics, Bloomberg School of Public Health, Thesis Reader 2006.

AeRang Kim, Ph.D. candidate, Department of Oncology, Graduate Training Program in Clinical Investigation, School of Public Health, Thesis Committee Member, 2006-2009.

Michael Yu, Ph.D. candidate, Department of Oncology, Graduate Training Program in Clinical Investigation, School of Public Health, Thesis Committee Member, 2006-2010.

Susanna Nazarian, PhD candidate, Graduate Training Program in Clinical Investigation, School of Public Health, Thesis Committee Member, 2008-2009.

Jean Wang, "Predicting Cancer in Barrett's Esophagus", PhD candidate, Graduate Training Program in Clinical Investigation, School of Public Health, Thesis Committee Member, 2008-2009.

Nicolette Louissaint, PhD candidate, Pharmacology and Molecular Sciences, School of Medicine, Thesis Committee Member, 2008-2010.

Benjamin Jilek, PhD candidate, Biochemistry, Cellular and Molecular Biology (BCMB) Graduate Program, School of Medicine, Thesis Committee Member, 2008-2011.

Jonathan Neiswinger, PhD candidate, Pharmacology and Molecular Sciences, School of Medicine, Oral Examination Committee Member, 2009.

Ying-Chun Lo, PhD candidate, Pharmacology and Molecular Sciences, School of Medicine, Oral Examination Committee Member, 2009.

Meng-Jung Chiang, PhD candidate, Pharmacology and Molecular Sciences, School of Medicine, Oral Examination Committee Member (Alternate), 2009.

Jeff Goldsmith, PhD candidate, Biostatistics, Bloomberg School of Public Health, Oral Examination Committee member. 2010. Thesis Committee member, 2011-2012.

Lindsay B. Avery, PhD Candidate. Pharmacology and Molecular Sciences, School of Medicine, Thesis Committee Member, 2011-2012.

Salee Parichat, MD, M.P.H. Candidate. Epidemiology, Bloomberg School of Public Health, Thesis Committee, 2011-2012.

Ryan Westergaard, PhD candidate, Graduate Training Program in Clinical Investigation, School of Public Health, Thesis Committee Member, 2012.

Melissa Zarr, PhD Candidate. Pharmacology and Molecular Sciences, School of Medicine, Thesis Committee Member, 2012 – 2014. Thesis Reader 2014.

EDUCATIONAL ACTIVITIES

Mentoring

Thesis/Oral Examination Committees – continued

Laura Ensign, PhD candidate, Chemical and Biomolecular Engineering, School of Engineering, Thesis Committee, 2012.

Tamara Lewis, PhD candidate, Graduate Training Program in Clinical Investigation, School of Public Health, Thesis Committee Member, 2012-2015.

Jenny Robinson, PhD candidate, Graduate Training Program in Clinical Investigation, School of Public Health, Thesis Committee Member, 2013-present.

Yanhui Lu, PhD Candidate, Pharmacology and Molecular Sciences, School of Medicine, Thesis Committee Member, Thesis Advisor, 2012-2014.

Berkeley Limetkai, PhD candidate, Graduate Training Program in Clinical Investigation, School of Public Health, Preliminary Oral Exam Committee Member, 2013; Thesis Committee Member, 2013-2017.

Elaine To, PhD candidate, Department of Pharmacology and Molecular Sciences, School of Medicine, Thesis Committee, 2013-2014.

Chen Yue, PhD candidate, Biostatistics, Bloomberg School of Public Health, Oral Examination Committee member. 2013. Thesis Committee member, 2013-2016.

Evelyn Eisele, PhD Candidate, Pharmacology and Molecular Sciences, School of Medicine, Thesis Committee Member, 2013-2016.

Katharina Maisel, PhD Candidate, Biomedical Engineering, School of Engineering, Thesis Committee Member, 2013-2014.

Kai Deng, PhD Candidate, Biochemistry, Cellular and Molecular Biology (BCMB) Graduate Program, Thesis Committee Member, 2013-2014.

Christopher Saeui, PhD candidate, Biomedical Engineering. Oral exam committee. 2014

Julie Lade, PhD Candidate, Pharmacology and Molecular Sciences. Thesis Committee. 2014-2016

Ethel Weld, PhD Candidate, Graduate Training Program in Clinical Investigation, School of Public Health, Preliminary Oral Exam Committee Member, 2015; Thesis Committee Member, 2015-2019

Dominique Figueroa, PhD Candidate, Pharmacology and Molecular Sciences. Thesis Committee. 2015-2016

Clare Ruberman, PhD Candidate, Biostatistics. Oral Examination Committee, Member 2015. Thesis Committee Chair 2015-2018

Hugh Giovinazzo, PhD Candidate, Pharmacology and Molecular Sciences. Oral Examination Committee. 2015

Eugenie Shieh, PhD Candidate, Graduate Training Program in Clinical Investigation, School of Public Health, Preliminary Oral Exam Committee Member, 2016; Thesis Committee Member, 2015-present

EDUCATIONAL ACTIVITIES

Mentoring

Thesis/Oral Examination Committees – continued

Thuy Huang, PhD Candidate, Pharmacology and Molecular Sciences. Oral Examination Committee. 2015-present

Matthew Ippolito, PhD Candidate, Graduate Training Program in Clinical Investigation, School of Public Health, Preliminary Oral Exam Committee Member, 2016; Thesis Committee Member, 2017-present

Taarika Babu, PhD Candidate, Pharmacology and Molecular Sciences. Thesis Committee Member. 2017-present

Omamah Alfarisi, PhD Candidate, Graduate Training Program in Clinical Investigation, School of Public Health, Thesis Committee Member, 2018-present

Huilei Wang, PhD Candidate, Biomedical Engineering. Oral Exam Committee (Alternate) 2018.

Christy Pickering, PhD Candidate, Biomedical Engineering. Oral Exam Committee Chair 2018.

Inez Lam, PhD Candidate, Biomedical Engineering. Oral Exam Committee Chair 2018.

EDUCATIONAL ACTIVITIES

Mentoring

Training Grant Participation

Grant #: 4T32GM066691
Title: Clinical Pharmacology Training Program
Principal Investigator: C. Hendrix (as of 2016 multi-PI with K. Dooley)
Date: 07/01/08-06/30/2023
Award: $196,485 current year direct costs
Role: Mentor Clinical Pharmacology Fellows in clinical research; pharmacokinetics teaching

Grant #: 1UL1TR001079-01
Title: Institutional Clinical and Translational Science Award
Principal Investigator: D. Ford
Dates: 9/17/07 – 4/30/18
Award: $$7,485,218
Role: Mentor post-doctoral fellows in Graduate Training Program in Clinical Investigation

Grant #: 5T32GM08763-14
Title: Pharmacology Training Grant
Principal Investigator: J. Liu
Date: 07/01/00 – 06/30/20
Award: $312,004
Role: Train graduate students in clinical pharmacology teaching and research.

Grant #: 2T32AI007291-21
Title: Research Training in Microbial Diseases
Principal Investigator: K. Gebo
Date: 08/01/01 – 08/31/16
Award: $267,125 current year direct costs
Role: Mentor Infectious Diseases Fellows in clinical research

Grant #: 5R25DA021630
Title: Pediatric Training Grant: Immersion in Drug Abuse Research
Principal Investigator: E. Gauda
Dates: 07/01/07-04/30/13
Award: $301,715
Role: Johns Hopkins/Morgan State University research training aspects of illicit drug use.

Grant #: 5D43TW00010
Title: Fogarty AIDS International Training & Research Program
Principal Investigator: C. Beyrer
Dates: 07/01/07-05/31/13
Award: $695,000
Role: Mentoring of international post-doctoral clinical research fellows.

EDUCATIONAL ACTIVITIES

Educational Program Building / Leadership / Administration

School of Medicine

Educational Policy and Curriculum Committee (EPCC), Student Assessment and Program Evaluation (SAPE) Subcommittee, member 2015-present

Medical Pharmacology (2nd year medical school)
- Course Co-Director 1997-2001
- Sectional Focus Group Leader (Introduction, Infectious Diseases, Rheumatology, Hepatology, Pain) 1997- 2003

Rational Therapeutics (4th year medical school, required course)
- Initial Course Developer 1995
- Course Director 1995-2004
- Sessions jointly taught by experienced clinician and clinical pharmacologist to emphasize rational approach to therapeutic problems; focus on topics of keen interest to soon-to-be interns.

Analytical Methods in Clinical Pharmacology (Fellowship training curriculum, required course)
- Initial Course Developer 2000
- Course Director 2000-present
- Cognitive and skill-based curriculum introduces quantitative aspects of clinical pharmacology in small-group problem-solving sessions.

Laboratory Science for the Clinical Investigator (Fellowship training curriculum, required coruse)
- Initial Course developer 2017
- Designed to provide an overview to clinical post-doctoral fellows and junior faculty planning clinical research studiesthat will rely on laboratory collaboration to support the clinical research. Curriculum covers a broad array of laboratory methods that describe quantitative laboratory methods, process of validation, quality control, and culture of laboratory-clinical interactions.

School of Public Health

Principles of Drug Development, (required GTPCI Course)
- Course Director 1999-2003
- Curriculum oriented around small-group “pharmaceutical team” skill-building exercises supplemented by didactic sessions (course director, industry and FDA medical reviewers) to provide fundamentals of the drug development process. Final exam includes visiting senior leadership from FDA to hear fully developed drug development plans designed by student teams.

EDUCATIONAL ACTIVITIES

Educational Program Building / Leadership - continued

US Air Force

US Air Force HIV Force wide Base Level Prevention & Education Program
Initial Program Development 1991
Course director1991-1999
Lecturer/ Small Group leader 1991-1999
US Air Force wide HIV prevention program implemented based on identification and training of small multi-disciplinary base-level HIV prevention teams comprised of physician, nurse educator, public health officer and other health professionals who develop a local prevention plan tailored to meet local needs. Team building and training carried out initially and sustained over time at annual HIV/AIDS Train-the-trainer Short Course (24 hour CME units).

National

"Principles and Practice of Drug Development"
Sanctioned by Institute of Medicine, concept developed at Institute of Medicine Forum
Sponsored by Stanford University, The Burroughs Wellcome Fund, and The Doris Duke Charitable Foundation
2006 - Curriculum development consultant
2006 - Lectures (delivered at Stanford University and internet broadcast to dozens of registered U.S. university campuses via the Stanford University Center for Professional Development)
"Role of pharmacokinetics-pharmacodynamics in drug development"
"Pharmacokinetics bridging process and practice in drug development"
"Pharmacokinetic-Pharmacodynamic models in drug development"

Food and Drug Administration

"Academics to CDER" Annual CME Curriculum Development
Jointly developed curriculum between FDA Center for Drug Evaluation and Research Office of Training and Communication staff and Baltimore-Washington area academics
Target audience Baltimore-Washington Clinical Pharmacology Programs and FDA staff
2001-2004 Curriculum Development Committee
2003 "Tools for Pre-Approval Drug Safety Evaluation", Course Director, Session Moderator, Lecturer

RESEARCH ACTIVITIES

Research Program Building / Leadership

Dates, name of research / basic science program, role

1989 – 1994	US Air Force/Henry M. Jackson Foundation HIV Research Program. Transitioned and substantially expanded existing observational database focused research program to integrated interventional clinical research organization collaborating in tri-service military medical consortium. Provided leadership and management of program during growth from initial staff of 4 to over 50 FTEs in clinical research program. Served initially as Research and Evaluation Unit Director (1989-1992), then Program Director (1992-1994).
1997 – Present	Drug Development Unit (Division of Clinical Pharmacology) Reorganization. Reorganized existing clinical research unit, which focused on internal pharmaceutical industry-funded studies, to expand capacity to support investigator-initiated studies for faculty throughout the School of Medicine and refocused internal research portfolio to a primarily federally-funded clinical research enterprise. Served initially as Clinical Director (1997-1998), then overall Director (1998-Present).

ORGANIZATIONAL ACTIVITIES

Institutional Administrative Appointments (committees, dates)

Johns Hopkins University School of Medicine Committees:

Johns Hopkins Medicine Institutional Review Board (JHM IRB)
Member 2001- present
Co-Chairman IRB #2 – 2001 - 2007
Pharmacy & Therapeutics Liaison to JHM IRB 2001-present

Selection Committee, David S. Levine Award for Excellence in Mentoring, Department of Medicine, 2008

Department of Medicine, Appointment and Promotion Committee, 2009-present

Student Promotions Committee – Third and Fourth Years, 1996-2004

Student Promotions Committee – Second Year, 2000-2001

Joint Committee on Clinical Investigations, 1998-2001
Subcommittee (Pharmacy & Therapeutics Representative) 1998-2001

Graduate Training Program in Clinical Investigation,
Research Review Committee, 2/00-9/2006

Search Committee, Chief, Division of Infectious Diseases, Department of Medicine, 2004-2005

Search Committee, Clinical Pharmacology Faculty, Department of Medicine, 2004-2005

Search Committee, Pharmacology Faculty, Department of Pharmacology, 2004

The Johns Hopkins Hospital Committees:

Pharmacy and Therapeutics Committee, 1995-present
Joint Antibiotic Subcommittee, Chairman, 1998-2002

Editorial Activities

Journal Editorial Board
Clinical Pharmacology and Therapeutics (2005 – 2008)

Clinical and Translational Science (2007 – 2015)

Pharmacology Research & Perspectives (2017-present)

ORGANIZATIONAL ACTIVITIES

Journal Peer Review Activities

AIDS Research and Human Retroviruses (2006 – present)
Antiviral Research (2001 – present)
Clinical Drug Investigation (2006 – present)
Clinical Infectious Diseases (2006 – present)
Clinical Pharmacokinetics (2014-present)
Clinical Pharmacology and Therapeutics (2002 – present)
Clinical and Translational Science (2007 – present)
Contraception (2006 – present)
International Journal of STD & AIDS (2014-present)
Journal of Acquired Immune Deficiency Syndromes (2003 – present)
Journal of Antimicrobial Chemotherapy (2014-present)
Journal of Clinical Pharamcology (2014-present)
Journal of Infectious Diseases (2006 – present)
Journal of Pharmacology and Experimental Therapeutics (2002 – present)
Lancet HIV (2016 – present)
Medicine (2009 – present)
Neurology (2011 – present)
PLOS One (2014 – present)

Advisory Committees, Review Groups/Study Sections (sponsor, role, date)

Office of AIDS Research Advisory Committee, National Institutes of Health, *ex officio* member Department of Defense, 1995-1999

AIDS Clinical Trials Group IBT RAC, General Immune Modulation Subcommittee, National Institutes of Health, 1997-1998

General Clinical Research Centers, Division of Research Resources, National Institutes of Health; Study Section, Site Reviewer, 1998

Therapeutics Research Working Group, Office of AIDS Research Advisory Committee, National Institutes of Health, 1999-present

General Clinical Research Centers, Division of Research Resources, National Institutes of Health; Study Section, Site Reviewer, 2002

Institute of Medicine, Panel Member, Panel on "Institutional Review Boards: Health Services Research Data Privacy Protection", 2000

U.S. Dept. of Agriculture, National Organic Standards Board, Technology Advisory Panel, Reviewer, 2002

ORGANIZATIONAL ACTIVITIES

Advisory Committees, Review Groups (sponsor, role, date) – continued

Centers for Disease Control and Prevention, Chairman, Special Grant Review Panel, PA "Clinical Evaluation and Testing of Vaginal Microbicide Candidates." August 2003

National Institutes of Health, NIAID special review meeting PAR 03-138 entitled "Novel HIV Therapies: Integrated Preclinical/Clinical Program" March 2004

National Institutes of Health, NIGMS, Clinical Pharmacology Training Grant (T32), Special Emphasis Panel; Site Visit team. July 2004

National Institutes of Health, NIAID Special Emphasis Panel RFA-AI 04-047 "Partnership for Topical Microbicides" Review Committee, April 2005

National Institutes of Health, NIGMS, Clinical Pharmacology Training Grant (T32), Special Emphasis Panel. June 2005

Centers for Disease Control and Prevention (CDC), Board of Scientific Counselors, National Center for Infectious Diseases, March 2005 – 2007

Medical Research Council of Ireland, Clinical Research Infrastructure Grant Reviewer, 2006

American Foundation for AIDS Research (amfAR), Rectal HIV Transmission Targeted RFP, Scientific Reviewer, August 2006

SyNCH Trial (Single and Multiple Dose Escalation Phase I Study to Evaluate the Safety, Tolerability, and Pharmacokinetics of Orally Administered Silymarin (Legalon®) in Non-Cirrhotic Subjects with Chronic Hepatitis C or Non-Alcoholic Fatty Liver Disease), Safety Monitor, 2006

Food and Drug Administration (FDA),
Antiviral Drugs Advisory Committee, 2007 – 2010
Oncology Drugs Advisory Committee 2017
Arthritis Advisory Committee 2018
Drug Safety and Risk Management Advisory Committee 2018

National Institutes of Health, NIAID Special Emphasis Panel RFA-AI-07-019 "Novel HIV Therapies: Integrated Preclinical/Clinical Program (U19)" Review Committee, October 2007

Population Council Microbicides Scientific Advisory Board, 2009 – present

National Institutes of Health, NIGMS, Clinical Pharmacology Training Grant (T32), Special Emphasis Panel; Study Section, Site Visit team. July 2014, July 2015

PREVENT U19 Program Project Grant, University of Louisville, KY, Scientific Advisory Board (2017-present)

UNC Chapel Hill Center for AIDS Research Scientific Advisory Board (2016-present)

ORGANIZATIONAL ACTIVITIES

Professional Societies (membership, committees, dates, role)

Alpha Omega Alpha Honor Medical Society 1983-present

Infectious Diseases Society of America 1989-1998

Civil-Military Alliance to Combat HIV/AIDS, 1996-2002; Steering Committee, 1999-2002

Armed Forces Infectious Diseases Society, 1997-1999

International Society of Antiviral Research
- Scientific Program Committee Reviewer 2001

International AIDS Society 1997 - present
- Industry Liaison Forum 2005

American Society for Clinical Pharmacology and Therapeutics (ASCPT) 1997 – present
- Board of Directors, 2010 – 2012
- Coordinating Committee on Scientific Sections, 2004-2010
  - Chairman 2010-2012
  - Vice Chairman 2008 – 2010
- Infectious Diseases and Antimicrobial Agents Section, 1997-present
  - Chairman 2005 – 2008
  - Vice Chairman 2004 – 2005
  - Steering Committee 2018-present
- Scientific Program Committee, 1998-2002, 2005-2008
- ASCPT Nominating Committee, 2004-2005, 2014-2015
- Education Committee-1999-2002, 2015-present
- Social Media Task Force 2014-2015
- Mentor Task Force 2015-present
- Career Development Committee 2016-present
- Webinar Committee 2017

International Society of Pharmacometrics 2011 – 2015

American College of Clinical Pharmacology 2018-present
- Member 2018
- Fellow 2019

ORGANIZATIONAL ACTIVITIES

Conference Organizer, Session Chair (sponsor, date, role) - continued

Thirty-First International Congress of Military Medicine, "Medical Response to Chemical Warfare", Beijing, People's Republic of China, Symposium Co-Chair, December 1996.

Third Congress on AIDS in Asia and the Pacific, "Military AIDS Symposium", Manila, Philippines, December 1997, Symposium Co-chair.

American Society for Clinical Pharmacology and Therapeutics, "Post-Marketing Surveillance", San Antonio, Texas March 1999, Symposium Co-Chair.

American Society for Clinical Pharmacology and Therapeutics, "Novel Pharmacokinetic Methods for Developing HIV Chemoprevention Strategies", Orlando, Florida March 2005, Workshop Organizer, Co-Chair.

American Society for Clinical Pharmacology and Therapeutics, "Pharmacokinetics and Clinical Applications", Baltimore, Maryland, March 2006, Session Co-Chair.

Microbicides 2012, "Can we determine who uses? Self reports and objective measures of adherence in microbicide & PrEP trials". Sydney. April 2012. Symposium committee.

American College of Clinical Pharmacology. "Symposium VII: Adherence: Missing Link in the Puzzle of Clinical Pharmacology". Bethesda, MD. September 2013. Session Co-Chair.

HIV Research for Prevention (HIVR4P). "Long-acting Drug Release Systems for PrEP and Treatment." Chicago, IL. October 2016. Session Co-Chair.

HIV Research for Prevention (HIVR4P). "Choosing ARVs for Prevention: Ensuring and Measuring Effective Tissue Delivery" Chicago, IL. October 2016. Session Co-Chair.

Conference on Retroviruses and Opportunistic Infections (CROI). "Of Mice, Monkeys, and Men: Prep from Preclinical to Population Level Impact". Boston, MA. March 2018. Session Co-Chair.

RECOGNITION

Awards, Honors

Distinguished Military Graduate, Massachusetts Institute of Technology, AFROTC, 1978

Air Force Commendation Medal (USAF), 1980

Alpha Omega Alpha Honor Medical Society, 1983

Department of Medicine Award for Outstanding Academic Performance, Georgetown University, School of Medicine, 1984

Cahill Award for Academic Excellence in Surgery, Georgetown Univ., School of Medicine, 1984

Magna cum Laude Graduate, Georgetown University, School of Medicine, 1984

Meritorious Service Medal (USAF), 1994

Meritorious Service Medal, First Oak Leaf Cluster (USAF), 1997

Pharmaceutical Research and Manufacturers Association Faculty Development Award, 1997

Outstanding Pharmacology Professor (Basic Sciences), Medical Student Association, 2001-2002

Student Marshal, Medical School Graduation, Class of 2002

Johns Hopkins Alumni Association Excellence in Teaching Award, 2003

David M. Levine Faculty Mentoring Award (Department of Medicine) 2007

PhRMA Foundation Award in Excellence 2017

American College of Clinical Pharmacology (ACCP), Distinguished Investigator Award 2018

American Socity of Clinical Pharmacology & Therapeutics (ASCPT) – Food and Drug Administration (FDA) William F. Abrams Award 2019

RECOGNITION

Invited Talks, Panels

1. "A Risk-Benefit Perspective on Universal HIV Screening in the United States Air Force." 1991, Buenos Aires, Argentina. Invited Talk, 17th Meeting of the Committee on Medicine in the Air Forces in the Americas. Sponsor: Committee on Medicine in the Air Forces in the Americas.

2. "International Security Impact of the HIV/AIDS Epidemic". 1995. Kampala, Uganda. Invited Talk, Africa Regional AIDS Conference, Military AIDS Symposium. Sponsor: UNAIDS.

3. "HIV Prevention Policy in Military Organizations". December 1996. Beijing, People's Republic of China. Invited Talk, Thirty-First International Congress of Military Medicine, Beijing, China. Sponsor: Peoples Liberation Army, People's Republic of China.

4. "Planning Effective HIV Prevention Interventions in the Military". October 1998. St. Petersburg, Russian Federation. Invited Talk, Kirov Military Medical Academy. Sponsor: Russian Federation Ministry of Defense.

5. "Drug Interaction Research Issues in Heavily Treated HIV-infected Patients". May 1999. Toronto, Canada. Invited Talk, International AIDS Society – Industrial Liaison Forum: The Challenge of Clinical Trial Design in Evaluating HIV Antiretroviral Use in Heavily-Pre-Treated Patients (Conference). Sponsor: International AIDS Society.

6. "Pharmacology of Antiretroviral Drugs in the Genital Tract". August 1999. Atlanta, Georgia. Invited Talk, National HIV Prevention Conference. Sponsor: CDC.

7. "COX-2 Inhibitors: Evaluation of New NSAIDs". September 1999. Towson, Maryland. Invited Talk, Arthritis Foundation of Maryland (Sponsor).

8. "Potential Drug Interactions in Antiviral Therapy". May 2000. Madrid, Spain. Invited Talk, European Congress on Chemotherapy-3 (Sponsor).

9. "Clinical Pharmacology of Rectal Microbicides". Atlanta, February 2001. Invited Talk, Centers for Disease Control (CDC) Conference on Rectal Microbicides, Sponsor: CDC.

10. "Preventing Fungal Infections". May 2001. Baltimore. Medical Grand Rounds, Johns Hopkins University School of Medicine. Sponsor: Department of Medicine.

11. "Pharmacologic Studies in the Development of Rectal Microbicides", June 2001. Baltimore. Invited Talk, Rectal Microbicide Workshop. Sponsor: NIH Office of AIDS Research.

12. "Development of Beta-Cyclodextrin as a Topical HIV Microbicide Candidate", August 2001. Rockville. Invited Talk, NIH Division of Antiviral Drug Products. Sponsor: FDA.

13. "Drug Interactions in Combined Hepatitis C-HIV Chemotherapy", April 2002. Aspen. Strategies for the Management of HIV/HCV Coinfection. Sponsor: Perspectives in Medicine.

RECOGNITION

Invited Talks, Panels – continued

14. "Quantitative Safety Assessment in Microbicide Development", May 2002. Antwerp, Belgium. Invited Talk, Microbicides 2002. (Cancelled)

15. "Distribution of Candidate Microbicide Gel and Simulated Ejaculate in the Lower Gastrointestinal Tract", June 2003. Los Angeles. Invited Talk, UCLA Center for HIV and Digestive Diseases (Sponsor).

16. "Clinical Development of a CXCR4 Chemokine Inhibitor", June 2003. New York City. Invited Talk, Entry Inhibitor Special Issue Advisory Board. Sponsor: Glaxo-Smith-Kline.

17. "Rational Development of Rectal Microbicides: Pharmacology, Toxicity, and Acceptability", July 2003. Atlanta. Invited Talk, National HIV Prevention Conference. Sponsor: CDC.

18. "Development of a CXCR4 Chemokine Receptor Inhibitor for HIV Infection", December 2003. Towson. Invited Talk, Towson University. Sponsor: Towson University.

19. "Distribution of Rectal Microbicide Vehicle and Simulated Ejaculate following Simulated Coital Activity" January 2004. New York City. Invited Talk, Columbia University. Sponsor: Columbia University, School of Medicine.

20. "Delivery of Microbicide to "At Risk" Intestinal Mucosa" March 2004. London. Invited Talk, Challenges to Rectal Microbicide Development (Satellite): Microbicides 2004.

21. "Critical Pharmacologic Issues in Vaginal and Rectal Microbicide Development" October 2004. Providence. Visiting Professor. Sponsor: Tufts University - Brown University Center for AIDS Research.

22. "Pharmacologic Issues in HIV Chemoprevention." February 2005. Boston. Invited Talk, International AIDS Society - Industry Liaison Forum, 12th National Conference on Retroviruses and Opportunistic Infections. Sponsor: International AIDS Society.

23. "Clinical Pharmacokinetics and Pharmacodynamics of Chemokine Inhibitors." February 2005. Boston. Invited Talk, 12th National Conference on Retroviruses and Opportunistic Infections. Sponsor: International AIDS Society.

24. "Adaptations of Radiologic Methods With Coital Simulations To Assess The Pharmacokinetics Of Topical Microbicides In The Vagina And Rectum", March 2005. Orlando. Invited Talk, Workshop on "Novel Pharmacokinetic Methods for Developing HIV Chemoprevention Strategies" Sponsor: American Society for Clinical Pharmacology and Therapeutics.

25. "Microbicides for HIV Prevention: Development Challenges for Clinical Pharmacology". April 2005. Quebec City. Invited Talk, 6th International Workshop on Clinical Pharmacology of HIV Therapy (Sponsor).

RECOGNITION

Invited Talks, Panels – continued

26. "Pharmacological Aspects of Microbicide Development". July 2005. Rio de Janeiro. Invited Talk, Challenges in HIV Microbicide Development. UCLA AIDS Institute and Brazilian STD/AIDS Program (Satellite Meeting): 3rd International AIDS Society Conference on HIV Pathogenesis and Treatment. Sponsor: International AIDS Society

27. "Clinical Pharmacology Challenges in Topical HIV Microbicide Development". September 2005. Buffalo. Visiting Professor. University of Buffalo School of Pharmacy and Pharmaceutical Sciences and School of Medicine/VA Medical Center.

28. "Making Drugs Safer" November 2005. Baltimore. Invited Talk, A Woman's Journey. Sponsor: Johns Hopkins University.

29. "HIV Chemoprevention: Evolving Approaches to Prevent HIV Infection with Drugs" Baltimore, January 2006. Invited Talk, Department of Medicine Grand Rounds (Sponsor).

30. "Rectal Microbicide Development: Measuring Gel & Virus Distribution" Web-Cast Teleconference, March 2006. Invited Talk, International Rectal Microbicides Working Group

31. "Drug Distribution & Formulation Issues in Rectal Microbicide Development" Cape Town, April 2006. Invited Talk, Rectal Microbicide Satellite Meeting. Microbicides 2006. Sponsor: UCLA AIDS Institute.

32. "Role of pharmacokinetics-pharmacodynamics in drug development"; "Pharmacokinetics bridging process and practice in drug development"; "Pharmacokinetic-Pharmacodynamic models in drug development". Palo Alto, National Webcast, April 2006. Invited talks, Principles and Practice of Drug Development Course. Sponsor: Stanford University and Institute of Medicine

33. "Rectal Microbicide Development: Contrasts to Traditional Drug and Vaginal Microbicide Development", Washington, D.C., May 2006. Invited Talk, Department of Health Policy, School of Public Health, George Washington University (Sponsor)

34. "Rectal HIV Microbicide Pharmacology & Drug Development" Raleigh-Durham, June 2006. Visiting Professor, Duke University Pratt School of Engineering, Department of Biomedical Engineering (Sponsor).

35. "Debate: Why Microbicides Will Fail" Arlington, September 2006. Invited Talk, Biomedical Interventions for HIV Prevention Working Group Meeting. Sponsor: Forum for Collaborative HIV Research Workshop.

36. "Topical HIV Microbicide Development: Evolving Challenges", Baltimore, November 2006. Invited Talk, Department of Pathology Grand Rounds (Sponsor).

RECOGNITION

Invited Talks, Panels – continued

37. "A Phase I, Dose-Rising Study of AMD11070 in HIV-Seronegative Men to Assess the Safety and Pharmacokinetics after Single or Multiple Doses," Baltimore, December 2006. Invited Talk, Plenary session, AIDS Clinical Trials Group. Sponsor: NIH.

38. "Reporting Scientific Misconduct – Deciding When and How to Act." Washington, D.C., December 2006. Invited Talk, Panel Member. Compliance and Investigator Fraud in Clinical Trials. Sponsor: CBI.

39. "Topical HIV Microbicide Development." Philadelphia. March 2007. Visiting Professor, Thomas Jefferson University, Division of Clinical Pharmacology (Sponsor).

40. "How Does Clinical Pharmacology Enhance HIV Microbicide Development?" Boston. April 2007. Visiting Professor, Tufts University, Division of Infectious Diseases (Sponsor).

41. "Pharmacology and Comparative Properties of NSAIDs." Miami, May 2007. Invited Talk, Panel member, Osteoarthritis and NSAIDs: Scientific Expert Panel Meeting. Sponsor: MDG

43. "HIV Microbicide Development from a Clinical Pharmacology Perspective." Seattle, July 2007. Invited Talk. Center for AIDS Research Pathogenesis Seminar Series, University of Washington.

44. "Clinical Study Design in Drug Development." Chicago, September 2007. Invited Talk. Science for Managers, Kellogg School of Management, Northwestern University.

45. "Distribution of Microbicide and HIV Surrogates in the Rectum and Distal Colon to Inform Rational Rectal Microbicide Development". Durban, South Africa., October 2007. Invited Talk. Nelson R. Mandela School of Medicine, University of KwaZulu-Natal, South Africa.

46. "Sparse Sampling Strategies in the Development of Vaginal Microbicide Candidates to Relationships Between Drug Exposure and Seroconversion Outcomes". Durban, South Africa, October 2007. Invited Talk: South Africa Medical Research Council, HIV/AIDS Lead Programme and HIV Prevention Research Unit.

47. "Pharmacokinetic Issues in ARV Microbicide Resistance". New Delhi, February 2008. Invited Talk, Microbicides 2008.

48. "Methods to Develop a Rectal-Specific Microbicide". New Delhi, February 2008. Invited Talk. Microbicides 2008.

49. "New Methods in Prevention of HIV Infection". Ames, March 2008. Invited Talk. Stupka Symposium, Iowa State University.

RECOGNITION

Invited Talks, Panels – continued

50. "Antiretroviral -based Microbicides Pharmacokinetics-Pharmacodynamics and Resistance". Cape Town, September 2008. Invited Talk. International Partnership for Microbicides Annual Meeting.

51. "Unique Contributions of MTN-001 to Microbicide Development Methodology". Cape Town, September 2008. Invited Talk. Microbicide Trial Network, Regional Investigator's Meeting.

52. "Pharmacokinetics & Future Pharmacodynamic Links". Cape Town, September 2008. Invited Talk. Microbicide Trial Network, Regional Investigator's Meeting.

53. "Microbicide Development Pipeline: Candidates, Mechanisms, Formulations, Clinical Phase" Cape Town September 2008. International Partnership for Microbicides Annual Meeting.

54. "Clinical Study Design in Drug Development" Chicago, September 2007. Invited Talk. Science for Managers, Kellogg School of Management, Northwestern University.

55. "Academic Contributions to Translational Drug Development". Shanghai, September 2008. International Clinical Research and Translational Medicine Symposium, Fudan University.

56. "Clinical Pharmacology Approach to HIV Chemoprevention Drug Development". Rochester, MN, October 2008. Invited Talk. Mayo Clinic.

57. "PK-PD in HIV Chemoprevention Studies" Atlanta. December 2008. AIDS Vaccine Advocacy Coalition (AVAC) sponsored meeting on Intermittent PrEP Development.

58. "Three-dimensional Problems in Imaging Drugs for HIV Chemoprevention" Baltimore 2008. Department of Biostatistics Grand Rounds, Johns Hopkins University School of Public Health.

59. "Drug Concentrations as an adherence biomarker in HIV prevention" New York January 2009. Quick Clinical Trials Working Group meeting on measuring adherence in HIV prevention trials.

60. "HIV Prevention with Drugs: Using Clinical Pharmacology to Put "Rational "Back in Drug Development." Baltimore March 2009. Department of Medicine, Grand Rounds.

61. "HIV Prevention with Topical Microbicides: Using Clinical Pharmacology to Put 'Rational' Back in Drug Development" Amsterdam April 2009. 10th HIV Clinical Pharmacology Workshop.

62. "Quantitative Pharmacokinetics of the Male Genital Tract and Applications in Drug Development". Invited Lecture. Atlanta March 2010. 111th Annual meeting of the American Society for Clinical Pharmacology and Therapeutics.

RECOGNITION

Invited Talks, Panels – continued

63. "HIV Prevention with Drugs". Invited plenary speaker. Hopkins-Brazil HIV Conference, Rio de Janeiro, April 2010.

64. "Pharmacology methods in prevention trials: assessing compartments and adherence". Invited talk, Laboratory Plenary Session, HIV Prevention Trials Network Annual Meeting. Washington, DC. April 2010.

65. "Pharmacokinetic Assessment of Adherence". Invited Talk. Microbicides 2010, May 2010, Pittsburgh.

66. "What Role Pharmacokinetics-Pharmacodynamics?" Invited Talk. Cape Town October 2010. Africa Regional Meeting of Microbicide Trial Network.

67. "Pharmacokinetics and Adherence in PrEP Development". Invited Talk. San Francisco. November 12, 2011 Forum for Collaborative HIV Research: 5th PrEP Working Group.

68. "The Role of Clinical Pharmacology in the Development of Topical HIV Microbicides" Visiting Professor. Pittsburgh. January 2011.University of Pittsburgh.

69. "MTN-001 Phase 2 Adherence and Pharmacokinetic Study of Oral and Vaginal Preparations of Tenofovir." Invited Talk. Microbicide Trial Network Annual Meeting. Arlington. March 2011.

70. "Use of Pharmacokinetics for Understanding Outcomes in HIV Prevention Trials" Invited Talk. Lab Plenary HIV Prevention Trials Network Annual Meeting, Washington, DC. June 2011.

71. Pharmacological assessment of medication adherence – Oral PrEP and Microbicides". Invited Talk. 19th International Society for STD Research. Quebec City. July 2011.

72. "Pharmacokinetics and Tissue Concentrations of Tenofovir and Emtricitabine: What is Needed to Prevent Transmission?" Invited Talk. Plenary HIV Vaccine Trials Network Annual Meeting. Seattle. November 2011.

73. "Clinical Pharmacology in HIV Pre-Exposure Prophylaxis Drug Development: Developing and Applying Tools when the Train has left the Station." Invited Talk. FDA Office of Translational Science. Silver Spring. January 2012.

74. "Attempts to Improve the Rational Development of HIV Pre-Exposure Prophylaxis through Clinical Pharmacology". Invited Talk. Mercer University. School of Pharmacy. Atlanta. February 2012

RECOGNITION

Invited Talks, Panels – continued

75. "Clinical Pharmacology in PrEP Development: Can small intensive studies inform RCTs?" Invited Talk. Microbicide Trials Network Annual Meeting. Bethesda, February 2012.

76. "Exploring Outcome Variability Across HIV Pre-Exposure Prophylaxis (PrEP) Trials", Anti-infective Section, ASCPT Annual Meeting. National Harbor, MD March 2012.

77. "Antiretroviral Pharmacology for PrEP: Enhancing RCT Understanding with Small Intensive Studies", Treatment as Prevention/Pre-Exposure Prophylaxis Summit. London, June 2012.

78. "Making Sense of Oral PrEP trials: Little Studies Informing Big Studies", Plenary Session, HPTN Annual Meeting. Washington, DC, June 2012.

79. "Oral & Topical PrEP: Unifying RCT Outcomes", Invited Talk, 7th HIV Transmission Workshop, Washington, DC. June 2012.

80. "Pharmacokinetic Assessment of PrEP Adherence", Invited talk, NIH DAIDS Behavioral Science Working Group Data Capture Technologies Focus Group, 11 October 2012.

81. "A Pharmacological Perspective on HIV Explant Challenge", invited talk, Biopsy Challenge meeting, NIH-Bill and Melinda Gates Foundation, Washington, DC, 29 November 2012.

82. "Genital and Anal Tract PrEP Pharmacokinetics", Office of AIDS Research Advisory Council Annual Meeting, Washington, DC, 8 November 2012.

83. "Measuring PK & Adherence in PrEP Trials: Explanation & Prediction", invited talk, RIHES, Chiang Mai University, Chiang Mai, Thailand, 7 January 2013.

84. "Clinical Pharmacology Approach to Rational Rectal Microbicide Development", Invited talk, Thai Red Cross/HIV-NAT, Chulalongkorn Univ, Bangkok, Thailand, 10 January 2013.

85. "Measuring PK & Adherence in PrEP Trials: Explanation & Prediction", Invited talk, Department of Medicine, University of Malaya, Kuala Lumpur, Malaysia, 15 January 2013.

86. "Pharmacological Approach to Monitoring Drug Adherence", Plenary Lecture, Microbicide Trials Network Annual Meeting. Bethesda, MD. February 2013.

87. "Enriching the design of clinical PK/PD studies of novel drug delivery systems", Invited Talk, Bill & Melinda Gates Foundation – NIH Think Tank on HIV Prevention Drug Delivery Systems. Washington, DC. February 2013.

88. "PK Assessment of Adherence in PrEP Trials" Pharmacometrics in Antiviral Drug Development Symposium, Annual Meeting of ASCPT, Indianapolis, 8 March 2013.

RECOGNITION

Invited Talks, Panels – continued

89. "Pharmacometric approaches to adherence assessment in HIV prevention trials." Mercer University Invited talk. Atlanta, 5 March 2013.

90. "How PK (could) inform PrEP Trials". Invited Talk, NIH, Division of AIDS Seminar, Bethesda, 15 March 2013.

91. "Pharmacological Aspects of PrEP", Invited Talk, Hopkins-Brazil HIV conference, Rio de Janeiro, Brazil 19 April 2013.

92. "Pharmacological Challenges for Next Generation PrEP", Invited Talk, 14th International Workshop on Clinical Pharmacology of HIV Therapy, Amsterdam, Netherlands, 23 APR 2013.

93. "Making sense out of oral and topical PrEP trials: Using little studies to understand big studies," Invited Talk, Annual Meeting of HIV Prevention Trials Network, Washington, DC, 6 May 2013.

94. "Scientific Misconduct". Invited Talk. FDA Office of Criminal Investigations. Charleston, SC, 18 June 2013.

95. "Exploring concentration-response in HIV Pre-Exposure Prophylaxis to optimize clinical care and trial design." Cell-Lancet Conference "What will it take for an AIDS Free World". San Francisco, 4 November 2013.

96. "HIV Pre-Exposure Prophylaxis: Clinical Pharmacology Insights". Invited Talk, 21st Conference on Retroviruses and Opportunistic Infections, Boston, Mar 4, 2014.

97. "Adherence : Impact on Study Results" CONRAD/AVAC Adaptive Trial Designs Conference. Washington, DC. June 23, 2014.

98. "The Role of Pharmacokinetics in selecting PrEP strategies". Invited Talk, 54th Interscience Conference on Antibiotics and Antimicrobical Therapy. Washington, D.C. September 9, 2014.

99. "HIV Pre-exposure Prophylaxis (PrEP) Trials: Making the Complex Simpler through Clinical Pharmacology". Invited Talk, Medical Grand Rounds, Western Ontario University, London, Ontario, September 17, 2014.

100. "Combining Pharmacology and Behavioral Science to Develop a Rectal Microbicide for HIV PrEP that People will Enjoy Using". Invited talk, Columbia University. Sponsor: Columbia University, School of Medicine. December 18, 2014.

RECOGNITION

Invited Talks, Panels – continued

101. "HIV Pre-Exposure Prophylaxis: Clinical Pharmacology Enriching Drug Development". Invited Talk, Dartmouth University, Division of Clinical Pharmacology. Lebanon, NH 23 June 2015.

102. "Pharmacokinetics in Microbicide Development". Invited Talk. NIH/DAIDS MTN Conference, "The Use of Mucosal Assays in Microbicide Trials" Arlington, VA 25-26 August 2015.

103. "Real-Time" Pharmacologically-based Adherence Testing". Invited Talk. NIH/DAIDS Conference "Optimizing Adherence Post-VOICE", Rockville, MD 2-3 September 2015.

104. "HIV Pre-Exposure Prophylaxis (PrEP) & Development of Microbicides". Invited Talk. American College of Clinical Pharmacology Annual Meeting, "An Update on HIV Treatment, Prevention and Drug Development Symposium", San Francisco, CA 28 September 2015.

105. "HIV Pre-Exposure Prophylaxis (PrEP) & Development of Microbicides". Invited Talk. University of California at San Diego Center for AIDS Research, San Diego, CA 23 October 2015.

106. "HIV Pre-Exposure Prophylaxis Drug Development". Invited Talk. Medical Grand Rounds, General Hospital, Tijuana, Mexico, 26 October 2015.

107. "Pharmacologic Adherence Assessment & Application in PrEP". Invited Talk. 2015 Center for AIDS Research (CFAR) Social and Behavioral Sciences Research Network Conference, Baltimore, MD 29 October 2015.

108. "Developing Behaviorally-Congruent Rectal Microbicides: A Clinical Pharmacology Approach". US-Japan Conference USAID, Bethesda, MD. 12 January 2016.

109. "Lessons Learned from Antiretroviral Testing". Invited Talk . UCLA CFAR-Sponsored Substance Use Meeting: Advancing the Field of Biobehavioral Substance Use Measurement for HIV Positive and At-risk Populations. Los Angeles, CA. 1 February 2016.

110. "Development of HIV Pre-exposure Prophylaxis: A Clinical Pharmacologist's Inside View". Invited Talk. University of North Texas Health Science Center. Fort Worth, TX. 8 April 2016

111. "Building on Oral PrEP Success: Rectal Microbicide Development". Invited Talk. DC Center for AIDS Research, Howard University, Washington, DC. 4 May 2016.

112. "HIV Pre-Exposure Prophylaxis Development: A Clinical Pharmacologist's Inside View". Invited Talk. KU Leuven, Leuven, Belgium. 17 May 2016.

RECOGNITION

Invited Talks, Panels – continued

113. "PK-PD Data to Advance Topical PrEP Products to Phase III". Invited Talk. Clinical Trial Evaluation Workshop for MPTs. Initiative for Multipurpose Prevention Technologies (IMPT). Washington, DC. 13 September 2016.

114. "Rectal vs. Vaginal Compartment Pharmacology." Invited talk. Contribution of Sexual Behaviour in the Global Heterosexual HIV Epidemic Workshop. NIH/DAIDS. Bethesda, MD. 15 September 2016.

115. "Pharmacologic Considerations for HIV Prevention Strategies". Invited talk.Western New York HIV Prevention Network Meeting. University of Buffalo, Buffalo, NY. 19 September 2016

116. "HIV Pre-exposure Prophylaxis Development: A Clinical Pharmacologist's Inside View". Invited talk. Combating HIV/AIDS: Tx, PGx and PrEP Workshop, ACCP Annual Meeting. HIV symposium. San Diego, CA. 24 September 2016.

117. "Quantitative Assessment of Adherence: Experiences in HIV Prevention". Invited Talk. National Institute of Drug Abuse, Baltimore, MD 20 December 2016.

118. "Rectal Microbicide Development & DREAM Progress". Invited talk. Tenofovir Development Meeting, MTN Annual Meeting. Bethesda, MD. 20 March 2017.

119. "Developing Alternatives to Oral HIV PrEP: Rectal Microbicides & Long-Acting Formulations". Invited Talk. University of Texas Health Science Center, Galveston. April 2017.

120. "For Something Completely Different: Development of a Rectal Enema as Microbicide". Invited Talk. Oak Crest Institute of Science, Monroeville, CA May 2017.

121. "Rectal Microbicide Development: How Did We Get Here? What Have we Learned?" Invited webnar talk. Sponsored by AIDS Vacine Advocacy Coalition (AVAC) and International Rectal Microbicide Advocates (iRMA). August 2017.

122. "Rectal Microbicides: Where We're Heading". Invited webinar talk. Sponsored by AIDS Vacine Advocacy Coalition (AVAC) and International Rectal Microbicide Advocates (iRMA). August 2017.

123. "Impact of adherence on the development of HIV Pre-exposure Prophylaxis" Invited Symposium Talk (delivered Mark Sales), American College of Clinical Pharmacology Annual Meeting. San Diego, CA. September 2017.

RECOGNITION

Invited Talks, Panels – continued

124. "Advances in Formulations in HIV PrEP: Topical Products - Rings, Gels, Implants, etc." Invited Symposium talk (delivered Marc Baum), American College of Clinical Pharmacology Annual Meeting. San Diego, CA. September 2017.

125. "Review of the Current Rectal Microbicide Context". Invited Talk. Reboot the Booty Think Tank. Sponsored by AIDS Vacine Advocacy Coalition (AVAC) and International Rectal Microbicide Advocates (iRMA). New York, NY. September 2017.

126. "Lube Safety 101". Symposium on Lubricant Safety, US Conference on AIDS. Washington, DC. September 2017.

127. "Next Generation PrEP? Injectable & Implantable ARVs". Plenary Talk. Microbicide Trial Network Regional Meeting, Cape Town, RSA. September 2017.

128. "The Path Ahead for Rectal Microbicides". Plenary Talk. Microbicide Trials Network Regional Meeting, Cape Town, RSA. September 2017.

129. "DREAM Program for Rectal Microbicide Prevention". Invited talk. PREVENT Program Project Annual Meeting. Louisville, KY. October 2017.

130. "Promise & Progress of Rectal Microbicides for HIV Pre-Exposure Prophylaxis". Invited Talk. Center for AIDS Research. University of Alabama, Birmingham, AL. November 2017.

131. "Microbicides: Where We're Heading" Invited Talk. Second Annual Biomedical HIV Prevention Summit (NMAC). New Orleans, LA. December 2017

132. "Clinical Pharmacology of HIV Pre-Exposure Prophylaxis (PrEP) – Where are we now?" Visiting Professor. University of Liverpool. Liverpool, UK. February 2018.

133. "Beyond Oral PrEP: Promise and Challenges of Alternative Antiviral Dosing Methods for PrEP". Invited Lecture. Office of AIDS Research Brown Bag Seminar. Brockville, MD. February 2018.

134. "Beyond Oral PrEP: Promise and Challenges of Alternative Antiviral Dosing Methods for PrEP" Invited Talk. 8th International Workshop on HIV & Women. Boston, MA. March 2018.

135. "Proof-of-Concept for On Demand, Behaviorally-Congruent Rectal Microbicide Douche". Plenary Lecture. MTN Annual Meeting. Bethesda, MD March 2018.

136. "Success, Disappointment, & *Hope* in the Development of HIV Pre-Exposure Prophylaxis". Invited Talk. Walter Reed Army Institute of Research, Silver Spring, MD. April 2018.

RECOGNITION

Invited Talks, Panels – continued

137. "Rectal Microbicide Product Development". Invited talk. Oak Crest Institute of Science Program Project Annual Meeting. Monrovia, CA. May 2018.

138. "Pharmacology Lab Contributions to PrEP Product Development". Invited Talk. HPTN Annual Meeting. Washington, DC. May 2018.

139. "Clinical Pharmacology of HIV Pre-Exposure Prophylaxis (PrEP) – Where are we now?" Invited Talk. International Workshop on Clinical Pharmacology of Antiviral Therapy. Baltimore, MD. May 2018.

140. "DREAM Program: On Demand, Behaviorally-Congruent Rectal Microbicide Douche". Invited webinar talk. Sponsored by AIDS Vacine Advocacy Coalition (AVAC) and International Rectal Microbicide Advocates (iRMA). June 2018.

141. "Rectal Microbicide Protocol Status". Invited webinar talk. Sponsored by AIDS Vacine Advocacy Coalition (AVAC) and International Rectal Microbicide Advocates (iRMA). Septemebr 2018.

142. "On Demand Topical Agents for HIV Pre-exposure Prophylaxis." Invited plenary talk. HIV Research for Prevention (HIV R4P). Madrid, Spain. October 2018.

143. "Estrogen Decreases Tenofovir & Emtricitabine Concentrations in Transgender Women Taking Estrogen". Invited talk. HIV Research for Prevention (HIV R4P). Madrid, Spain. October 2018.

144. "Tenofovir/Emtricitabine and Estrogen Drug-Drug Interactions". Invited webinar talk. NIAID Transgender Research Working Group. January 2019.

145. "The Winding Road to On Demand, Topical, Behaviorally-Congruent HIV Pre-Exposure Prophylaxis. " Medical Grand Rounds, Bayview Medical Center, Baltimore, MD. January 2019.

EXHIBIT 2

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DOCUMENT	**BATES NUMBER**
U.S. Army Regulation 600-110 (Apr. 22, 2014), at https://armypubs.army.mil/epubs/DR_pubs/DR_a/pdf/web/r600_110.pdf	NH-000023 - 85
U.S. Department of Defense Retention Policy for Non-Deployable Service Members (Feb. 14, 2018), at https://dod.defense.gov/Portals/1/Documents/pubs/DoD-Universal-Retention-Policy.PDF	NH-000086 - 87
Department of Defense Instruction 6490.07 (Feb. 5, 2010), at http://www.esd.whs.mil/Portals/54/Documents/DD/issuances/dodi/649007p.pdf	NH-000088 - 101
Department of Defense Instruction 1332.45 (Retention Determination for Non-Deployable Service Members) (July 30, 2018), at https://www.esd.whs.mil/Portals/54/Documents/DD/issuances/dodi/133245p.pdf?ver=2018-08-01-143025-053	NH-000102 - 121
Department of Defense, *Department of Defense Personnel Policies Regarding Members of the Armed Forced Infected with Human Immunodeficiency Virus: Report to the Committees on the Armed Services of the Senate and House of Representatives* (August 2018)	NH-000122 - 156
U.S. Department of Defense Instruction 6485.01 (June 7, 2013), at http://www.esd.whs.mil/Portals/54/Documents/DD/issuances/dodi/648501p.pdf	NH-000157 – 164
U.S. Navy, Secretary of the Navy Instruction 5300.30E (Management of Human Immunodeficiency Virus, Hepatitis B Virus and Hepatitis C Virus Infection in the Navy and Marine Corps) (Aug. 13, 2012)	NH-000165 - 187
Army Public Health Center, *Malaria Field Guide: The Prevention, Diagnosis and Treatment of Malaria in U.S. Africa Command* (May 2016), at https://phc.amedd.army.mil/PHC%20Resource%20Library/TG336_MalariaFieldGuide_May2016.pdf	NH-000188 – 254

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DOCUMENT	BATES NUMBER
U.S. Department of Health and Human Services, *Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents Living with HIV* (May 1, 2014), https://aidsinfo.nih.gov/guidelines/html/1/adult-and-adolescent-arv/458/plasma-hiv-1-rna--viral-load--and-cd4-count-monitoring	NH-000255 – 262
Declaration of Nicholas Harrison (DKT 26-3) (July 19, 2018)	NH-000263 - 299
U.S. Department of Health and Human Services, *Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents Living with HIV* (May 1, 2014), https://aidsinfo.nih.gov/guidelines/html/1/adult-and-adolescent-arv/459/cost-considerations-and-antiretroviral-therapy	NH-000300 - 309
Office of the Assistant Secretary of Defense, Health Affairs Mem. (Policy Memorandum – Human Immunodeficiency Virus Interval Testing) (Mar. 29, 2004), https://www.health.mil/Reference-Center/Policies/2004/03/29/Policy-Memorandum---Human-Immunodeficiency-Virus-Interval-Testing	NH-000310 – 324
J. Brundage et al., *Durations of Military Service after Diagnoses of HIV-1 Infections Among Active Component Members of the U.S. Armed Forces 1990-2013*, Vol. 22 No. 8 Medical Surveillance Monthly Report, pp. 9–12 (Aug. 2015), https://health.mil/Reference-Center/Reports/2015/01/01/Medical-Surveillance-Monthly-Report-Volume-22-Number-8	NH-000325 - 348
U.S. Army Regulation 40-501 (Standards of Medical Fitness) (June 14, 2017)	NH-000349 - 499
J. Okulicz, C. Beckett, J. Blaylock, S. Hakre, B. Agan, N. Michael, S. Peel, P. Scott, and S. Cersovsky, *Review of the U.S. Military's Human Immunodeficiency Virus Program: A Legacy of Progress and a Future of Promise*, Armed Forces Health Surveillance Center, *Medical Surveillance Monthly Report*, Vol. 24, No. 9 (Sept. 2017), https://health.mil/Reference-Center/Reports/2017/01/01/Medical-Surveillance-Monthly-Report-Volume-24-Number-9	NH-000500 - 523
U.S. Department of Defense Instruction 6025.19 (Individual Medical Readiness), (June 9, 2014), http://www.esd.whs.mil/Portals/54/Documents/DD/issuances/dodi/602519p.pdf	NH-000524 - 538

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DOCUMENT	BATES NUMBER
Armed Services Blood Program, About Us, at http://www.militaryblood.dod.mil/About/default.aspx	NH-000539 - 540
P. Scott et al., *Short Communication: Investigation of Incident HIV Infections Among U.S. Army Soldiers Deployed to Afghanistan and Iraq, 2001-2007*	NH-000541 – 545
U.S. Department of Health & Human Services, National Heart, Lung, and Blood Institute, Blood Transfusion, at https://www.nhlbi.nih.gov/health-topics/blood-transfusion	NH-000546 – 552
T. Ballard, P. Rohrbeck, M. Kania, & L. Johnson, *Transfusion-Transmissible Infections Among U.S. Military Recipients of Emergently Transfused Blood Products, June 2006-December 2012*, Medical Surveillance Monthly Report, Vol. 21, No. 11 (Nov. 2014)	NH-000553 – 572
United States Census Bureau. *American Factfinder: Monthly Population Estimates for the United States: April 1, 2010 to December 1, 2016* (last visited July 18, 2018), at https://factfinder.census.gov/faces/tableservices/jsf/pages/productionview.xhtml?pid=PEP+2017_PEPMONTHN&prodType=table	NH-000573 - 575
Armed Forces Health Surveillance Center (AFHSC), *Update: Routine Screening for Antibodies to Human Immunodeficiency Virus, Civilian Applicants for U.S. Military Service and U.S. Armed Forces, Active and Reserve Components, January 2010–June 2015*, Medical Surveillance Monthly Report, Aug. 2015, 2-8	NH-000576 - 603
U.S. Department of Defense Instruction 6130.03 (May 6, 2018), at http://www.esd.whs.mil/Portals/54/Documents/DD/issuances/dodi/613003p.pdf	NH-000604 - 652
Emergency War Surgery, 4th ed. (2014), Chapter 33 (Battlefield Transfusions), at http://www.cs.amedd.army.mil/FileDownloadpublic.aspx?docid=189c4a13-522f-4d91-9236-a109d7b5ee4d	NH-000653 - 674
U.S. Centers for Disease Control and Prevention, *HIV Risk Behaviors: Estimated Per-Act Probability of Acquiring HIV from an Infected Source, by Exposure Act* (Dec. 2015), at www.cdc.gov/hiv/risk/estimates/riskbehaviors.html.	OutServe_RV-000138

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DOCUMENT	BATES NUMBER
Asha De et al., *Physical fitness characteristics of active duty US Air Force members with HIV infection*, Medicine (2016) 95:44	OutServe_RV-000219 - 226
Air Force Mem. AFGM2019-36-01 (Air Force Guidance Memorandum for Implementing Department of Defense Instruction (DoDI) 1332.45, Retention Determinations for Non-Deployable Service Members) (February 19, 2019)	OutServe_RV-000275 - 281
Air Force Instruction 36-3212 (February 2, 2006, incorporating through change 2, November 27, 2009)	OutServe_RV-000618 - 715
Air Force Instruction 44-178, Human Immunodeficiency Virus Program, March 4, 2014 (Certified Current June 28, 2016)	OutServe_RV-000716 - 759
Air Force Mem. AFGM2019-36-01 (Air Force Guidance Memorandum for Impletmenting Department of Defense Instruction (DoDI) 1332.45, Retention Determinations for Non-Deployable Service Members) (February 19, 2019)	OutServe_RV-000275-281
Dep't of Def. Instr. 1332.18 (Disability Evaluation System (DES)) (August 5, 2014), https://warriorcare.dodlive.mil/files/2016/03/DoDI_1332.18.pdf	OutServe_RV-000900-907
Commander's Impact Statement for Medical Evaluation Board regarding [redacted] (12/08/17), Addendum (01/16/18), Fitness & Job Performance Report, Consultation Summary, Ancillary Study Summary, History of Present Illness, and Memorandum for Medical Evaluation Board (01/15/18)	ROE-000014 - 22
Air Force Individual Fitness Report for [redacted] (April 2, 2018)	ROE-000089 - 90
N. Harrison, Army Physical Fitness Test Scorecard (Dec. 6, 2014)	US00000323
Information Paper, Accession Qualification Standards for Human Immunodeficiency Virus (HIV) Infection (Sept. 2015)	US00000656 - 657
Department of Defense, *Report to Congressional Defense Committees on Department of Defense Personnel Policies Regarding Members of the Armed Forces with HIV or Hepatitis B* (July 30, 2014)	US00000659 - 674

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DOCUMENT	BATES NUMBER
Memorandum for the Directorate of Military Personnel Management (Feb. 29, 2016)	US00001135
Dep't of the Army Mem. DASG-HCO (Request for Medical Opinion, Roe) (Apr. 30, 2015)	US00001136
Dep't of the Army Mem. DASG-HCZ (Request for Medical Opinion, Roe) ¶ 2 (Jan. 12, 2016)	US00001137
January 5, 2016 Email from Laurie Fontaine (CIV) to Marguerite Anne Lawrence LTC, GS re a medical recommendation concerning Nicholas Harrison	US00002428 - 433
Antinori, A. et al., *Updated research nosology for HIV-associated neurocognitive disorders*, Neurology. 2007 October 30; 69(18): 1789–1799	US00003666 - 386
Consensus Statement: Rick of Sexual Transmission of HIV from a Person Living with HIV who has an Undetectable Viral Load, U.S. Prevention Access Campaign (issued July 21, 2016)	US00004410 - 417
Grant, I. et al., *Asymptomatic HIV-associated neurocognitive impairment increases risk for symptomatic decline*, Neurology 82, June 10, 2014, 2055-2062	US00004418 - 425
Kuhar, D. et al., *Updated US Public Health Service Guidelines for the Management of Occupational Exposures to Human Immunodeficiency Virus and Recommendations for Postexposure Prophylaxis, Infection Control and Hospital Epidemiology*, September 2013, Vol. 34, No. 9, 875-893	US00004426 - 445
Crum-Cianflone, N. et al., *Low prevalence of neurocognitive impairment in early diagnosed and managed HIV-infected persons*, Neurology 80, January 22, 2013, 371-379	US00004446 - 454
Patel, P. et al., *Estimating per-act HIV transmission risk: a systematic review*, AIDS 2014, 28:000-000	US00004565 - 582
De Souza, E. et al., *Risk factors for neurocognitive impairment in HIV-infected patients and comparison of different screening tools*, Dement Neuropsychol 2016 March; 10(1):42-46	US00004960 - 964

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DOCUMENT	BATES NUMBER
Price, R., *HIV-associated neurocognitive disorders: Epidemiology, clinical manifestations, and diagnosis – UpToDate*, last updated February 14, 2017, literature review current through October 2018, https://www.uptodate.com/contents/hiv-associated-neurocognitive-disorders-epidemiology-clinical-manifestations-and-diagnosis	US00005269 - 291
Military Infectious Diseases Research Program (MIDRP) (Last Modified Date: March 22, 2010)	US00005292 - 295
Joint Trauma System Clinical Practice Guideline (JTS CPG): Whole Blood Transfusion (CPG ID:21) (May 15, 2018)	US00005296-334
Department of Defense Instruction 1332.18 (Disability Evaluation System (DES)) (August 5, 2014), https://warriorcare.dodlive.mil/files/2016/03/DoDI_1332.18.pdf	US00007238 - 7292
U.S. Cent. Command Doc. 231245Z (Modification Thirteen to USCENTCOM Individual Protection and Individual Unit Deployment Policy) (March 2017)	US00009910 - 931
U.S. Cent. Command Doc. 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) (March 2017), https://www.express-scripts.com/TRICARE/tools/USCENTCOM-MOD-13_TAB-A.pdf	US00010225 - 234
U.S. Navy, Secretary of the Navy Instruction 5300.30F (Management of Human Immunodeficiency Virus, Hepatitus B Virus, and Hepatitis C Virus Infection in the Navy and Marine Corps) (December 27, 2018)	US00031478 - 513
Memorandum for SAF/MRBP regarding the Appeal of the Findings of the Formal Physical Evaluation Board (FPEB) for [redacted] (Dec. 20, 2017)	VOE-000033 - 34
Air Force Mem. A-00338 (Appropriate Evaluation of Fitness for Continued Service for Airmen with Asymptomatic Human Immunodeficiency Virus (HIV)) (June 6, 2018) (1:18-cv-01565, DKT 50-2)	US00031051

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DOCUMENT	BATES NUMBER
Air Force Mem. A-00339 (Airmen with Asymptomatic Human Immunodeficiency Virus (HIV) Disposition) (Sep. 26, 2018) (1:18-cv-01565, DKT 50-2)	US00031049-50
Air Force Mem. A-00341 (Retention of Airmen with Asymptomatic HIV) (Oct. 11, 2017) (1:18-cv-01565, DKT 50-2)	US00031061
Chronological Record of Medical Care of [redacted] (1:18-cv-01565, DKT 57, pp. 55-70)	N/A
Chronological Record of Medical Care of [redacted] (1:18-cv-01565, DKT 56, pp. 40-47)	N/A
U.S. Army Mem. 2018-22 (Retention Policy for Non-Deployable Soldiers) (Nov. 8, 2018)	N/A
Declaration of Senior Airman [redacted] in Support of Motion for Preliminary Injunction with exhibits (01/11/18) (1:18-cv-01565) (Filed Under Seal Pursuant to 1/11/19 Motion) ("Voe Declaration")	N/A
Declaration of Staff Sergeant [redacted] in Support of Plaintiff's Motion for Preliminary Injunction with exhibits (1:18-cv-00641) (07/18/18) (Filed Under Seal Pursuant to 1/11/19 Motion) ("Roe Declaration")	N/A
Declaration of Staff Sergeant [redacted] in Support of Plaintiff's Motion for Preliminary Injunction with exhibits (1:18-cv-00641) (01/11/18) (1:18-cv-01565) (Filed Under Seal Pursuant to 1/11/19 Motion)	N/A
Declaration of Kevin Cron in Support of Plaintiff's Motion for Preliminary Injunction (January 25, 2019)	N/A
Expert Declaration of Carlos Del Rio, M.D. in Support of Plaintiffs' Motion for Preliminary Injunction (1:18-cv-00641, DKT 0026-2) (July 19, 2018)	N/A
Expert Declaration of Craig W. Hendrix, M.D. in Support of Plaintiffs' Motion for Preliminary Injunction (1:18-cv-00641, DKT 0026-5) (July 19, 2018)	N/A

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DOCUMENT	BATES NUMBER
Sacktor, N., Changing clinical phenotypes of HIV-associated neurorocognitive disorders, J. Neurovirol. (2018) 24:141–145	N/A
Supplemental Administrative Record (02/22/19) (1:18-cv-01565) (Sealed Version)	N/A
Deposition of Lt. Col. Lisa M. Lute with Exhibits (January 9, 2019)	N/A
30(b)(6) Deposition of United States Army Given By Dr. Jason Blaylock with Exhibits (February 27, 2019)	N/A
Deposition of Lt. Col. Paul Tumminello with Exhibits (February 13, 2019)	N/A
30(b)(6) Deposition of Defendants Given By Andrew Wiesen with Exhibits (February 22, 2019)	N/A
30(b)(6) Deposition of Defendants Given By Audra L. Taylor with Exhibits (March 1, 2019)	N/A
Deposition of Kevin Cron and Exhibits (March 15, 2019)	N/A
Expert Report of W. David Hardy, M.D. (March 22, 2019)	N/A