EXHIBIT 6

Army Physical Fitness Test Scorecard for Harrison

Army Physical Fitness Test Scorecard

For use of this form, see FM 7-22; the proponent agency is TRADOC.

#624/689

NAME (Last, First, MI)
HARRISON, NICHOLAS

GENDER
MALE

UNIT
276TH MILITARY POLICE COMPANY

TEST ONE			TEST TWO			TEST THREE			TEST FOUR		
DATE: 20141206	GRADE: E5	AGE: 37	DATE	GRADE	AGE	DATE	GRADE	AGE	DATE	GRADE	AGE
HEIGHT (IN INCHES): 75	BODY COMPOSITION WEIGHT: 205 lbs GO / NO-GO: X	BODY FAT: % GO / NO-GO:	HEIGHT (IN INCHES)	BODY COMPOSITION WEIGHT: lbs GO / NO-GO:	BODY FAT: % GO / NO-GO:	HEIGHT (IN INCHES)	BODY COMPOSITION WEIGHT: lbs GO / NO-GO:	BODY FAT: % GO / NO-GO:	HEIGHT (IN INCHES)	BODY COMPOSITION WEIGHT: lbs GO / NO-GO:	BODY FAT: % GO / NO-GO:
PU RAW SCORE: 65	INITIALS: LD	POINTS: 92	PU RAW SCORE	INITIALS	POINTS	PU RAW SCORE	INITIALS	POINTS	PU RAW SCORE	INITIALS	POINTS
SU RAW SCORE: 65	INITIALS: LD	POINTS: 88	SU RAW SCORE	INITIALS	POINTS	SU RAW SCORE	INITIALS	POINTS	SU RAW SCORE	INITIALS	POINTS
2MR RAW SCORE: 15:01	INITIALS: LD	POINTS: 88	2MR RAW SCORE	INITIALS	POINTS	2MR RAW SCORE	INITIALS	POINTS	2MR RAW SCORE	INITIALS	POINTS
ALTERNATE AEROBIC EVENT EVENT: TIME: GO: NO-GO:	TOTAL POINTS: 268		ALTERNATE AEROBIC EVENT EVENT: TIME: GO: NO-GO:	TOTAL POINTS		ALTERNATE AEROBIC EVENT EVENT: TIME: GO: NO-GO:	TOTAL POINTS		ALTERNATE AEROBIC EVENT EVENT: TIME: GO: NO-GO:	TOTAL POINTS	
NCOIC/OIC SIGNATURE: SYDNOR.THOMAS.HOWARD.1180883332			NCOIC/OIC SIGNATURE			NCOIC/OIC SIGNATURE			NCOIC/OIC SIGNATURE		
COMMENTS: PASSED RECORD APFT			COMMENTS			COMMENTS			COMMENTS		

SPECIAL INSTRUCTION: USE INK

LEGEND: PU - PUSH UPS; SU - SIT UPS; 2MR - 2 MILE RUN; APFT - ARMY PHYSICAL FITNESS TEST

DA FORM 705, MAY 2010 PREVIOUS EDITIONS ARE OBSOLETE.

APD LF v1.03ES

TRIAL EXHIBIT
PX105
exhibitsticker.com

US00000323

EXHIBIT 7

Medical Action Detail regarding accession waiver commission for Harrison

MED CHART
Medical Electronic Data Care History And Readiness Tracking

MAJ STEVEN NELSON
Session time remaining:

Home | AVS | DenClass | eCase | eMMPS | HRR | MATS | MRR | OccHealth | CBT | Admin

MATS / Medical Action Detail

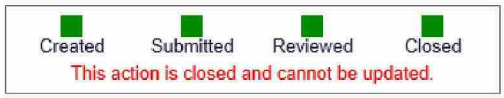
Contact Us | Logout

Accession Waiver Commission for Sergeant (SGT) NICHOLAS HARRISON

<< Display Less User Activity

2014/09/02 10:04:41,	Submit Action,	SFC SCOTT MICHAEL LICHTSINN,	(202) 536-9828
2014/09/02 11:13:59,	Review Action,	CIV RANDY DODSON,	(601) 826-7344
2014/09/02 11:20:08,	Pending More Information,	CIV RANDY DODSON,	(601) 826-7344
2014/12/12 11:43:18,	Submit Action,	SFC SCOTT MICHAEL LICHTSINN,	(202) 536-9828
2014/12/12 12:08:19,	Review Action,	CIV RANDY DODSON,	(601) 826-7344
2014/12/20 09:57:21,	Review Action,	CIV JOHN FANO-SCHULTZE,	(423) 519-7842
2014/12/30 13:02:29,	Review Action,	MAJ Paul D Tumminello,	(702) 607-7146
2014/12/30 13:09:42,	Disapprove Action,	MAJ Paul D Tumminello,	(702) 607-7146
2015/01/15 15:20:54,	Review Action,	MAJ Paul D Tumminello,	(702) 607-7146
2015/01/15 16:32:13,	Review Action,	MAJ Paul D Tumminello,	(702) 607-7146

<< Display Less User Activity



TRIAL EXHIBIT
PX110
exhibitsticker.com

US00003256

EXHIBIT 8

Memorandum from Harrison regarding his request for exception to policy (AR 600-110, DODI 6485.01) with denial

DISTRICT OF COLUMBIA ARMY NATIONAL GUARD
276TH MILITARY POLICE COMPANY
2001 EAST CAPITOL STREET
WASHINGTON, DC 20003-1719

REPLY TO
ATTENTION OF

NGDG-TMP-ZC 08 November 2015

MEMORANDUM THRU MAJ MICHAEL B. FUNDERBURK, Commander, 372nd Military Police Battalion, 2001 East Capitol Street SE, Washington, DC 20003-1719

THRU COL BRIAN E. TATE, Commander, 74th Troop Command, 2001 East Capitol Street SE, Washington, DC 20003-1719

THRU COL WILLIAM J. WALKER, Commander, Land Component Command, 2001 East Capitol Street SE, Washington, DC 20003-1719

THRU MG ERROL R. SCHWARTZ, Commanding General, DC National Guard, 2001 East Capitol Street SE, Washington, DC 20003-1719

THRU LTG JAMES C. MCCONVILLE, Deputy Chief of Staff (G-1), US Army, 300 Army Pentagon, Washington, DC 20310-0300

FOR THE HONORABLE BRAD CARSON, Acting Undersecretary of Defense for Personnel and Readiness, 4000 Defense Pentagon, Washington, D.C. 20301

SUBJECT: Request for Exception to Policy (AR 600-110, DoDI 6485.01)

Executive Summary

1. My name is SGT NICHOLAS HARRISON. I am a member of the DC National Guard and I am writing to request an exception to policy so I can receive a direct commission as a JAG officer.

2. I have been interviewed by the DC National Guard and I have been offered a slot in the legal services office supporting the Director, Army National Guard in Arlington, VA. However, under AR 600-110 and DoDI 6485.01, I am not eligible for a commission because I am HIV positive.

3. I am in receipt of a memorandum from COL ERIC MORAN to MG ERROL SCHWARTZ dated 30 December 2014 denying my request for a medical waiver due to the current policy set forth by AR 600-110 and DoDI 6485.01. This memorandum is going back through my chain of command to the proponents of AR 600-110 and DoDI 6485.01 for further review and consideration.

4. Respectfully, I wish to assert that, generally, this policy is outdated and that, specifically, it makes no sense to deny me a direct commission as a JAG officer.

Background

5. I'm a 37-year-old sergeant in the DC National Guard. I've served 3 years on active duty as an airborne paratrooper stationed at Fort Richardson (Anchorage, Alaska). I've served 11 years in the Army National Guard so far with 2 overseas tours of duty in Afghanistan (2006 - 2007) and Kuwait (2011 - 2012).

6. I completed my education by taking advantage of a variety of military benefits – loan repayment program, GI Bill, National Guard kicker, ROTC stipend, and tuition assistance. I graduated with a JD/MBA from the University of Oklahoma in 2011.

7. I was selected as an alternate during the JAG accessions process in 2011 – which carries with it an automatic slot in the National Guard / Reserves if I wanted it. However, I was deployed before I could take the bar exam and I wasn't able to follow through with it until I returned in 2012.

8. I was diagnosed with HIV shortly after I got back from my second deployment in July 2012. And, I am currently undetectable.

9. In 2013, I was selected as a Presidential Management Fellow and I took a job with the U.S. Small Business Administration. Upon relocating to the Washington DC area, I was interviewed by the Legal Services Office which supports the Director of the Army National Guard Bureau in Arlington, VA and I was offered a slot by them.

10. I completed my physical exam at Walter Reed Army Medical Center last year. Although my PULHES code is 111111, I was advised that my HIV status constitutes a disqualifying condition which does not allow me to become a JAG officer. I submitted a medical waiver and it was denied on 30 December 2014.

Argument

11. The current military policy prohibiting HIV positive personnel from becoming commissioned officers is a relic of the 1980s when people were dying of AIDS. Medical technology has evolved considerably over the past thirty-five years and HIV is more easily manageable than many other health conditions.

12. I have no significant duty limitations. HIV positive personnel can work in health care or food service industries. There are no restrictions on taking federal law enforcement, foreign service, or DOD civilian positions. Even the U.S. Navy recently opened up overseas and large ship platform assignments.

13. The military has already decided that I cannot be discharged for my status. Indeed, current policy affords me with the opportunity to attend NCOES and other MOS-producing courses required for career progression. However, it makes little sense to keep me where I am. I am of limited use to the service in my current billet. The natural career progression for someone like me (upon graduating from law school and passing the bar exam) is to pursue a direct commission as a JAG officer.

14. I attained my education using military benefits. So, there's a case for giving the military a return on its investment. I also would incur no additional service obligation – having already fulfilled my statutory obligation during the past 15 years as an enlisted soldier.

15. The Legal Services Office supporting the Director of the National Guard Bureau wants me. They've told me that my previous combat experience in a line unit would be a real asset to their office. It suits the needs of the Army.

Conclusion

16. While I respectfully disagree with the military's overall policy, this letter is a request for a narrow exception to that policy. I respectfully assert that AR 600-110 and DoDI 6485.01 should not be a bar to someone:

    (a) who is already in the service;
    (b) who has served long enough to fulfill his statutory obligation; and
    (c) who wishes to receive a direct commission into a specialty support branch for which he is well qualified, to serve out the remainder of his military career.

17. Thus, I ask you to grant my request for an exception to policy so that I can take a direct commission as a JAG officer.

18. When you have time, I respectfully request a meeting under the military's open door policy to discuss this matter further. The point of contact for this memorandum is SGT Nicholas Harrison at [redacted]

Nicholas A. Harrison

NICHOLAS A. HARRISON
SGT, DCARNG

DEPARTMENT OF THE ARMY
OFFICE OF THE DEPUTY CHIEF OF STAFF G-1
300 ARMY PENTAGON
WASHINGTON, DC 20310-0300

DAPE-MP

MEMORANDUM THRU Commander, 276th Military Police Company, 2001 East Capitol Street SE, Washington DC 20003-1719

FOR Sergeant Nicholas Harrison, 372nd Military Police Battalion, 2001 East Capitol Street SE, Washington DC 20003-1719

SUBJECT: Request for Exception to Policy (ETP) to Army Regulation 600-110

1. Your request for an ETP to Army Regulation 600-110 was not favorably considered. After thorough review of your arguments in favor of granting an exception, I find that taking such action is not in the best interest of the Army.

2. My point of contact for this action is LTC Lisa M. Lute, (703) 545-1918 or email: lisa.m.lute.mil@mail.mil.

JASON T. EVANS
Major General, GS
Director of Military
Personnel Management

EXHIBIT 9

Harrison's Application to the Board for Correction of Military Records

I declare (or certify, verify, or state) under penalty of perjury under the laws of the United States of America that the information that I provided is true and correct

Submitter/Applicant HARRISON NICHOLAS ALEXANDER 1242539156

Signature (Required) HARRISON NICHOLAS ALEXANDER 1242539156

Digitally signed by HARRISON NICHOLAS ALEXANDER 1242539156
DN c=US o=U S Government ou=DoD ou=PKI ou=CONTRACTOR cn=HARRISON NICHOLAS.ALEXANDER 1242539156
Date 2016 08 01 13 11 07 04 00

Additional Instructions

1 Save the digitally signed Signature page to your computer so that you can browse and find it for later upload to online application

2 If this signature page is not uploaded within 30 days, your application will be automatically deactivated

3 You will be notified by email of receipt of this page and attached supporting documents Please ensure that your email program and SPAM filter will accept email from 'usarmy pentagon hqda-arba mbx acts@mail mil'

Application Summary

Bar Code # **PB49717**

Application Type **DD149 Correction Of Military Records**

Application Date **2016/08/01**

Submitter Information

Salutation **Sergeant**

First Name **Nicholas**

Middle Name **Alexander**

Last Name **Harrison**

Suffix

Email Address [redacted]

Are You the Applicant? **Yes**

If you are not the applicant, what is your relationship to the applicant?

Submitter Phone Information

Phone Type	Country Code	Area Code	Phone Number	Extension
US Cell Phone			[redacted]	

Current Address

Street Address [redacted]

Street Address 2

Street Address 3

Street Address 4

Street Address 5	
City	**Washington**
State/Province/Territory	**District Of Columbia**
Zip Code/Postal Code	[redacted]
Other Country Postal Code or APO	
Country	**United States**

Applicant Information

Social Security Number	[redacted]
Gender	**Male**
For the Period of Service under review, the number of years for which you enlisted (Enlisted members), or for officers, the number of years for which you served (full years)	
Entry Date	
Highest Grade Achieved	
Applicant's present status, if any, with respect to the Armed Forces?	**Inactive National Guard**
If Active Duty Reserve Component, Active Duty Regular Component, Active Guard/Reserve Program, Active Army National Guard or Active Army Reserve (TPU), give current unit of assignment and location (use unit abbreviations)	
What is the applicant s Military Service Number? (prior to 1954)	
Did the applicant serve in the military	**No**

under another name?

Awards and Decorations Received

Award Decoration
No records to display

Board Request Information

Do you desire to appear before the Board in Washington, D C , at no expense to the government? **Yes**

Discharge Information

Date of applicant's discharge or release from Active duty

Are you applying for a discharge upgrade? **No**

What is the characterization of the discharge and reason for discharge the applicant recieved?

Characterization

Reason

Rank at time of discharge

NOTE Please provide a photo copy of the applicant's discharge document, including the bottom section, with the signature page of this application

If the applicant was discharged by court-martial action, state the type of court-martial, the location of the court-martial, and the year (if known)

Court-martial Type

Location

Date of court-martial

The organization or military unit, branch of service, and the location the applicant was in when discharged or released from Active duty?

Branch of Service when discharged or released

Unit

Discharge Location

Correction Information

Please state the error or injustice that needs to be corrected in the applicant's military records

I was denied eligibility for a direct commission due to DoDI 6485 01 -- as implemented by AR 600-110 and AR 40-501.

State why you believe the applicant's military records are in error or unjust

I have been denied equal the protection of the law -- as applied to the federal government through the Fifth Amendment in Bolling v Sharpe (1954) There is no rational basis for DoDI 6485 01 I have a PULHES code of 111111, which means that the U S military acknowledges that I have no without medical, physical, or psychiatric limitations which affect my ability to perform my military duties HIV positive personnel can currently work in health care or food service industries There are no restrictions on taking federal law enforcement, foreign service, or DoD civilian positions Even the U S. Navy recently opened up overseas and large-ship platform assignments Indeed, the military has already decided that I cannot be discharged for my status Current policy affords me with the opportunity to attend NCOES and other MOS-producing courses required for career progression However, the natural career progression for someone like me (upon graduating from law school and passing the bar exam) is to pursue a direct commission as a JAG officer

---

Injustice Information

Date that the error or injustice occurred

The organization or military branch, branch of service and the location the applicant was in when the error or injustice occurred

Unit

Service

Location

Rank

Date that the error or injustice was discovered 2016/06/30

If it has been more than three years since the error or injustice was discovered, state why the Board

should find it in the interest of justice to consider this application

Is this a request for reconsideration of a prior application submitted to the Board? **No**

Supporting Documentation Information

Update Document Received Status	Email Applicant	Document Received	Document Name	Document Description
Update	Email Applicant	No	Request and Denial	Exception to Policy
Update	Email Applicant	No	SignaturePage PDF	Signature Pa

Signature Page Received

DISTRICT OF COLUMBIA ARMY NATIONAL GUARD
276TH MILITARY POLICE COMPANY
2001 EAST CAPITOL STREET
WASHINGTON, DC 20003-1719

REPLY TO
ATTENTION OF

NGDG-TMP-ZC

08 November 2015

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THRU MG ERROL R SCHWARTZ, Commanding General, DC National Guard, 2001 East Capitol Street SE, Washington, DC 20003-1719

THRU LTG JAMES C MCCONVILLE, Deputy Chief of Staff (G-1), US Army, 300 Army Pentagon, Washington, DC 20310-0300

FOR THE HONORABLE BRAD CARSON, Acting Undersecretary of Defense for Personnel and Readiness, 4000 Defense Pentagon, Washington, D C 20301

SUBJECT: Request for Exception to Policy (AR 600-110, DoDI 6485.01)

Executive Summary

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3 I am in receipt of a memorandum from COL ERIC MORAN to MG ERROL SCHWARTZ dated 30 December 2014 denying my request for a medical waiver due to the current policy set forth by AR 600-110 and DoDI 6485 01 This memorandum is going back through my chain of command to the proponents of AR 600-110 and DoDI 6485 01 for further review and consideration

4 Respectfully, I wish to assert that, generally, this policy is outdated and that, specifically, it makes no sense to deny me a direct commission as a JAG officer

Background

5 I'm a 37-year-old sergeant in the DC National Guard I've served 3 years on active duty as an airborne paratrooper stationed at Fort Richardson (Anchorage, Alaska) I've served 11 years in the Army National Guard so far with 2 overseas tours of duty in Afghanistan (2006 - 2007) and Kuwait (2011 - 2012)

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9 In 2013, I was selected as a Presidential Management Fellow and I took a job with the U S Small Business Administration Upon relocating to the Washington DC area, I was interviewed by the Legal Services Office which supports the Director of the Army National Guard Bureau in Arlington, VA and I was offered a slot by them

10 I completed my physical exam at Walter Reed Army Medical Center last year Although my PULHES code is 111111, I was advised that my HIV status constitutes a disqualifying condition which does not allow me to become a JAG officer I submitted a medical waiver and it was denied on 30 December 2014

Argument

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12 I have no significant duty limitations HIV positive personnel can work in health care or food service industries There are no restrictions on taking federal law enforcement, foreign service, or DOD civilian positions Even the U S Navy recently opened up overseas and large ship platform assignments

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14 I attained my education using military benefits So, there's a case for giving the military a return on its investment I also would incur no additional service obligation - having already fulfilled my statutory obligation during the past 15 years as an enlisted soldier

15 The Legal Services Office supporting the Director of the National Guard Bureau wants me They've told me that my previous combat experience in a line unit would be a real asset to their office It suits the needs of the Army

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16 While I respectfully disagree with the military's overall policy, this letter is a request for a narrow exception to that policy I respectfully assert that AR 600-110 and DoDI 6485 01 should not be a bar to someone

(a) who is already in the service,
(b) who has served long enough to fulfill his statutory obligation, and
(c) who wishes to receive a direct commission into a specialty support branch for which he is well qualified, to serve out the remainder of his military career

17 Thus, I ask you to grant my request for an exception to policy so that I can take a direct commission as a JAG officer

18 When you have time, I respectfully request a meeting under the military's open door policy to discuss this matter further The point of contact for this memorandum is SGT Nicholas Harrison at [redacted]

Nicholas A. Harrison

NICHOLAS A HARRISON
SGT, DCARNG

EXHIBIT 10

Memo denying Harrison's ABCMR application

DEPARTMENT OF THE ARMY
ARMY BOARD FOR CORRECTION OF MILITARY RECORDS
251 18TH STREET SOUTH, SUITE 385
ARLINGTON, VA 22202-3531

SAMR-RBA

7 September 2018

MEMORANDUM FOR Army Review Boards Agency, Case Management Division, 251 18th Street South, Suite 385, Arlington, VA 22202-3531

SUBJECT: Army Board for Correction of Military Records Record of Proceedings for Harrison, Nicholas Alexander, [redacted], AR20160013555

The application submitted by the individual concerned has been denied by the Army Board for Correction of Military Records.

BY ORDER OF THE SECRETARY OF THE ARMY:

X

Dennis W. Dingle
Director
Signed by: DINGLE.DENNIS.WILLIAM.1073592077

Encl

CF:
( ) OMPF

DEPARTMENT OF THE ARMY
ARMY BOARD FOR CORRECTION OF MILITARY RECORDS
251 18TH STREET SOUTH, SUITE 385
ARLINGTON, VA 22202-3531

September 07, 2018

AR20160013555, Harrison, Nicholas Alexander

SGT Nicholas A. Harrison
[redacted]

Dear Sergeant Harrison:

I regret to inform you that the Army Board for Correction of Military Records denied your application.

The Board considered your application under procedures established by the Secretary of the Army. I have enclosed a copy of the Board's Record of Proceedings. This decision explains the Board's reasons for denying your application.

This decision in your case is final. You may request reconsideration of this decision letter to the above address only if you can present new evidence or argument that was not considered by the Board when it denied your original application.

Sincerely,

X

Dennis W. Dingle
Director
Signed by: DINGLE.DENNIS.WILLIAM.1073592077

Enclosure

ARMY BOARD FOR CORRECTION OF MILITARY RECORDS

RECORD OF PROCEEDINGS

IN THE CASE OF: Harrison, Nicholas Alexander

BOARD DATE: 16 August 2018

DOCKET NUMBER: AR20160013555

BOARD VOTE:

Mbr 1	Mbr 2	Mbr 3	
:	:	:	GRANT FULL RELIEF
:	:	:	GRANT PARTIAL RELIEF
:	:	:	GRANT FORMAL HEARING
:JTM	:RDR	:JC	DENY APPLICATION

2 Enclosures
1. Board Determination/Recommendation
2. Evidence and Consideration

ARMY BOARD FOR CORRECTION OF MILITARY RECORDS

RECORD OF PROCEEDINGS

IN THE CASE OF: Harrison, Nicholas Alexander

BOARD DATE: 16 August 2018

DOCKET NUMBER: AR20160013555

BOARD DETERMINATION/RECOMMENDATION:

The evidence presented does not demonstrate the existence of a probable error. Therefore, the Board determined the overall merits of this case are insufficient as a basis for correction of the records of the individual concerned.

8/16/2018

X John T. Meixell

CHAIRPERSON
Signed by: MEIXELL.JOHN.T.1124210573

I certify that herein is recorded the true and complete record of the proceedings of the Army Board for Correction of Military Records in this case.

Enclosure 1

ARMY BOARD FOR CORRECTION OF MILITARY RECORDS

RECORD OF PROCEEDINGS

IN THE CASE OF: Harrison, Nicholas Alexander

BOARD DATE: 16 August 2018

DOCKET NUMBER: AR20160013555

THE BOARD CONSIDERED THE FOLLOWING EVIDENCE:

1. Application for correction of military records (with supporting documents provided, if any).

2. Military Personnel Records and advisory opinions (if any).

THE APPLICANT'S REQUEST, STATEMENT, AND EVIDENCE:

1. The applicant requests approval of an exception to Army policy for direct commission in the Army National Guard (ARNG).

2. The applicant states:

a. He has been denied equal protection under the law as it applies to the Federal Government through the Fifth Amendment in Bolling v. Sharpe (1954).

b. There is no rational basis for Department of Defense (DOD) Instruction (DODI) 6485.01 (Human Immunodeficiency Virus (HIV) in Military Service Members).

c. He has a physical profile rating of "111111," which means the U.S. military acknowledges he has no medical, physical, or psychiatric limitations that affect his ability to perform his military duties.

d. HIV positive personnel can currently work in health care and food service industries. There are no restrictions on filling Federal law enforcement, foreign service, or DOD civilian positions. Even the U.S. Navy recently opened up overseas and large ship platform assignments.

e. The military has already decided he cannot be discharged based on his HIV status. Current policy affords him the opportunity to attend

Noncommissioned Officer Education System and other military occupational specialty producing courses required for enlisted career progression.

f. The natural progression for him upon graduating from law school and passing the bar examination is to pursue a direct commission as a Judge Advocate General's (JAG) Corps officer.

3. The applicant provides:

- self-authored memorandum for the Undersecretary of Defense for Personnel and Readiness, dated 8 November 2015, subject: Request for Exception to Policy to Army Regulation 600-110 (Identification, Surveillance, and Administration of Personnel Infected with HIV) and Department of Defense Instruction 6485.01
- memorandum from the Department of the Army Office of the Deputy Chief of Staff, G-1, undated, subject: Request for Exception to Policy to Army Regulation 600-110

CONSIDERATION OF EVIDENCE:

1. The applicant is currently assigned to the Inactive National Guard in the enlisted rank of sergeant/E-5 with an expiration term of service date of 22 July 2020.

2. His service medical records are not available for review.

3. He provided a self-authored memorandum for the Undersecretary of Defense for Personnel and Readiness, dated 8 November 2015, subject: Request for Exception to Policy to Army Regulation 600-110 and DODI 6485.01, wherein he stated:

a. As an enlisted member of the District of Columbia ARNG, he requested an exception to policy to receive a direct commission as a JAG officer. He was interviewed by the District of Columbia ARNG and was offered a position in the Legal Services Office supporting the National Guard Bureau Director. However, under the provisions of Army Regulation 600-110 and DODI 6485.01, he is not eligible for commissioning because he is HIV positive.

b. He asserts that these policies are outdated and make no sense to deny him a direct commission as a JAG officer.

c. He served as a paratrooper in the Regular Army for 3 years and he served in the ARNG for 11 years with two overseas tours of duty in Afghanistan and Kuwait.

d. He completed his education by taking advantage of a variety of military benefits. He graduated with a Juris Doctorate/Master of Business Administration degree from the University of Oklahoma in 2011.

e. He was selected as an alternate during the JAG accessions process in 2011, which carries an automatic position in the ARNG/U.S. Army Reserve. However, he was deployed before he could take the bar examination and he wasn't able to follow through until he returned from deployment in 2012.

f. He was diagnosed with HIV shortly after he returned from his second deployment in July 2012 and he is currently undetectable (viral load tests reveal less than 40 copies of the virus per milliliter in blood).

g. In 2013, he was selected as a Presidential Management Fellow and he accepted a position with the U.S. Small Business Administration. He was interviewed by the Legal Services Office that supports the National Guard Bureau upon relocating to the Washington, DC, area and he was offered a position.

h. He completed his physical examination at the Walter Reed National Military Medical Center in 2014. Although his physical profile rating is "111111," he was advised that his HIV status constitutes a disqualifying condition that does not allow him to become a JAG officer. He submitted a request for a medical waiver and it was denied on 30 December 2014.

i. The current military policy prohibiting HIV positive personnel from becoming commissioned officers is a relic of the 1980s when people were dying of acquired immune deficiency syndrome (AIDS). Medical technology has evolved considerably over the past 35 years and HIV is more easily manageable than many other health conditions.

j. He has no significant duty limitations. HIV positive personnel can currently work in health care and food service industries. There are no restrictions on filling Federal law enforcement, foreign service, or DOD civilian positions. Even the U.S. Navy recently opened up overseas and large ship platform assignments.

k. The military has already decided he cannot be discharged based on his HIV status. Current policy affords him the opportunity to attend

Noncommissioned Officer Education System and other military occupational specialty producing courses required for enlisted career progression. It makes little sense to keep him where he is. He is of limited use to the service in his current billet.

l. The natural progression for him upon graduating from law school and passing the bar examination is to pursue a direct commission as a JAG officer.

m. He attained his education using his military benefits, so there's a case for giving the military a return on its investment. He would also incur no additional service obligation, having already fulfilled his statutory obligation during the past 15 years as an enlisted Soldier.

n. The Legal Services Office supporting the Director of the National Guard Bureau wants him and informed him that his previous combat experience in a line unit would be a real asset to their office. It suits the needs of the Army.

o. While he respectfully disagrees with the military's overall policy, he is requesting a narrow exception to that policy. He respectfully asserts that Army Regulation 600-110 and DODI 6485.01 should not be a bar to someone who is already in the service, who has served long enough to fulfill his statutory obligation, and who wishes to receive a direct commission in a specialty support branch for which he is well qualified to serve out the remainder of his military career.

4. He provided a memorandum from the Department of the Army Office of the Deputy Chief of Staff, G-1, undated, subject: Request for Exception to Policy to Army Regulation 600-110, advising him that his request for an exception to policy to Army Regulation 600-110 was not favorably considered. The G-1 found that taking such action was not in the best interest of the Army.

REFERENCES:

1. Army Regulation 40-501 (Standards of Medical Fitness) governs medical fitness standards for enlistment, induction, appointment (including officer procurement programs), retention, and separation (including retirement). Chapter 7 prescribes a system for classifying individuals according to functional abilities. Four numerical designations are used to reflect different levels of functional capacity. The basic purpose of the physical profile serial is to provide an index to overall functional capacity. An individual having a numerical designation of "1" under all factors is considered to possess a high level of medical fitness.

2. Army Regulation 600-110 implements the Office of the Assistant Secretary of Defense Health Affairs Policy Memorandum – HIV Interval Testing, dated 29 March 2004, and DODI 6485.01 and prescribes Army policy, procedures, responsibilities, and standards concerning identification, surveillance, and administration of personnel infected with HIV. Headquarters, Department of the Army, medical and personnel policies on HIV reflect current knowledge of the natural progression of HIV infection, the risks to the infected individual incident to military service, the risk of transmission of the disease to non-infected personnel, the overall impact of infected personnel in Army units and on readiness posture, and the safety of military blood supplies.

a. Paragraph 1-16 provides that HIV infected personnel are not eligible for appointment or enlistment in the Active Army, ARNG, or U.S. Army Reserve.

b. Paragraph 5-2 defines accessions, in part, as first original appointments as commissioned or warrant officers in a Reserve Component (to include both qualifications for Federal recognition and for original appointment as a Reserve of the Army in the ARNG following Federal recognition). Probationary officers are Reserve Component commissioned officers who have less than 5 years of commissioned service. Both active duty and non-active duty commissioned service counts.

c. Paragraph 5-3 states 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 Reserve Officers' Training Corps, direct commissioning, and Officer Candidate School (ARNG, Reserve, or Active Army) programs. For accession purposes, the pre-accession HIV test is valid until the Soldier is ordered to active duty. Upon order to active duty, if the pre-accession test is more than 6 months old, the Soldier will be retested within the first 29 days at the initial active duty installation.

3. DODI 6485.01 establishes policy, assigns responsibilities, and prescribes procedures for the identification, surveillance, and management of members of the military services infected with HIV and for prevention activities to control transmission of HIV. It is DOD policy to deny eligibility for military service to persons with laboratory evidence of HIV infection for appointment, enlistment, pre-appointment, or initial entry training for military service pursuant to DODI 6130.03 (Medical Standards for Appointment, Enlistment, or Induction in the Military Services).

4. DODI 6130.03 establishes policy, assigns responsibilities, and prescribes procedures for physical and medical standards for appointment, enlistment, or induction in the military services. It is DOD policy to ensure that individuals under consideration for appointment, enlistment, or induction into the military services are free of contagious diseases that probably will endanger the health of other personnel; free of medical conditions or physical defects that may require excessive time lost from duty for necessary treatment or hospitalization, or probably will result in separation from the Service for medical unfitness; medically capable of satisfactorily completing required training; medically adaptable to the military environment without the necessity of geographical area limitations; and medically capable of performing duties without aggravation of existing physical defects or medical conditions. The medical standards in Section 5 (Disqualifying Conditions) apply to applicants for appointment as commissioned or warrant officers in the Active and Reserve Components. Section 5 specifies conditions that do not meet the standard by virtue of current diagnosis or for which the candidate has a verified past medical history and includes:

a. current or history of disorders involving the immune mechanism, including immunodeficiencies, and

b. presence of HIV or laboratory evidence of infection or false-positive screening test(s) with ambiguous results by supplemental confirmation test(s).

5. Bolling v. Sharpe, 347 U.S. 497, decided 17 May 1954, is a landmark U.S. Supreme Court case which dealt with civil rights; specifically, racial segregation in the District of Columbia's public schools.

DISCUSSION:

1. The applicant requests approval of an exception to Army Regulation 600-110 for direct commission in the ARNG.

2. Army Regulation 600-110 provides that HIV infected personnel are not eligible for appointment or enlistment in the Active Army, ARNG, or U.S. Army Reserve in accordance with DODI 6485.01.

3. Current DOD policy prohibits persons with laboratory evidence of HIV infection for appointment, enlistment, pre-appointment, or initial entry training for military service. Although the ABCMR may grant exceptions to existing Army policy in order to correct errors or injustices, it lacks any authority to grant exceptions to existing DOD policy. To provide the relief the applicant seeks, the ABCMR would necessarily have to act in contravention of existing DOD policy.

Case 18-cv-01565 DKT 270-11 Filed 5/4/20

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EXHIBIT 12

DoDI 1332.18 Disability Evaluation System (DES)

Department of Defense
INSTRUCTION

NUMBER 1332.18
August 5, 2014
Incorporating Change 1, Effective May 17, 2018

USD(P&R)

SUBJECT: Disability Evaluation System (DES)

References: See Enclosure 1

1. PURPOSE. This instruction:

a. Reissues DoD Directive (DoDD) 1332.18 (Reference (a)) as a DoD instruction (DoDI) in accordance with the authority in DoDD 5124.02 (Reference (b)).

b. Establishes policy, assigns responsibilities, and provides procedures for referral, evaluation, return to duty, separation, or retirement of Service members for disability in accordance with Title 10, United States Code (U.S.C.) (Reference (c)); and related determinations pursuant to sections ~~3501,~~ 6303, 8332, and 8411 of Title 5, U.S.C. (Reference (d)); section 104 of Title 26, U.S.C. (Reference (e)); and section 2082 of Title 50, U.S.C. (Reference (f)).

c. Incorporates and cancels DoDI 1332.38 (Reference (g)) and the Under Secretary of Defense for Personnel and Readiness (USD(P&R)) Memorandums (References (h) through (o)).

2. APPLICABILITY. This instruction applies to the OSD, the Military Departments, the Office of the Chairman of the Joint Chiefs of Staff and the Joint Staff, the Combatant Commands, the Office of the Inspector General of the Department of Defense, the Defense Agencies, the DoD Field Activities, and all other organizational entities within the DoD.

3. POLICY. It is DoD policy that:

a. The DES will be the mechanism for determining ~~return to~~ *fitness for* duty, separation, or retirement of Service members because of disability in accordance with Reference (c).

b. Service members will proceed through one of ~~three~~ *the* DES processes: the Legacy Disability Evaluation System (LDES), *or* the Integrated Disability Evaluation System (IDES)~~, or the Expedited Disability Evaluation System (EDES).~~ DoD's objective in all DES processes is to

collaborate with the Department of Veterans Affairs (VA) to ensure continuity of care, timely processing, and seamless transition of the Service member from DoD to VA in cases of disability separation or retirement. *It is DoD policy for Service members to process through the IDES unless a compelling and individualized reason for process through the LDES is approved by the Secretary of the Military Department.*

c. The standards for all determinations related to disability evaluation will be consistently and equitably applied, in accordance with Reference (c), to all Service members, and be uniform within the components of the Military Departments.

d. Reserve Component (RC) Service members who are not on a call to active duty of more than 30 days and who are pending separation for non-duty related medical conditions may enter the DES for a determination of fitness and whether the condition is duty related.

e. In determining a Service member's disability rating, the Military Department will consider all medical conditions, whether individually or collectively, that render the Service member unfit to perform the duties of the member's office, grade, rank, or rating.

f. Service members who are pending permanent or temporary disability retirement and who are eligible for a length of service retirement at the time of their disability evaluation may elect to be retired for disability or for length of service. However, when retirement for length of service is elected, the member's retirement date must occur within the time frame that a disability retirement is expected to occur.

g. A Service member may not be discharged or released from active duty because of a disability until he or she has made a claim for compensation, pension, or hospitalization with the VA or has signed a statement that his or her right to make such a claim has been explained, or has refused to sign such a statement. The Secretaries of the Military Departments may not deny a Service member who refuses to sign such a claim any privileges within DES policy as noted in this instruction.

h. RC Service members on active duty orders specifying a period of more than 30 days will, with their consent, be kept on active duty for disability evaluation processing until final disposition by the Secretary of the Military Department concerned. *In accordance with DoDI 1241.01 (Reference (p)), RC Service members may elect to be released from active duty before completion of DES processing. These Service members may receive legal counseling in accordance with the regulations of the Military Department concerned.*

i. The Secretaries of the Military Departments may authorize separation on the basis of congenital or developmental defects not being compensable under the Veterans Affairs Schedule for Rating Disabilities (VASRD) if defects, circumstances or conditions interfere with assignment to or performance of duty. ~~These Service members will not be referred to the DES.~~ *The basis for separation will be appropriately documented following guidelines and criteria in accordance with DoDI 6040.42 (Reference (q)). These Service members will not be referred to the DES unless the defect was subject to super imposed disease or injury during military service, or other potentially unfitting conditions exist that may have been incurred or aggravated by*

military service.

4. RESPONSIBILITIES. See Enclosure 2.

5. PROCEDURES. See Enclosure 3 of this instruction. Additional procedural guidance for the LDES is included in DoD Manual (DoDM) 1332.18, Volume 1 (Reference ~~(p)~~*(r)*). Additional procedural guidance for the IDES is included in DoDM 1332.18, Volume 2 (Reference ~~(q)~~*(s)*). ~~Procedural guidance for EDES will be published in a separate DoD issuance.~~

6. INFORMATION COLLECTION REQUIREMENTS

a. The DES Annual Report, referred to in paragraphs ~~1d(6)(a)~~ *1.d.(6)(a)*, ~~1d(6)(b)~~ *1.d.(6)(a)*, and ~~1e(4)~~ *1.e.(4)* of Enclosure 2 of this instruction, has been assigned report control symbol DD-HA(A,Q)2547 in accordance with the procedures in Volume 1 of DoD Manual 8910.01 (Reference ~~(r)~~*(t)*).

b. The DES quarterly data submission, referred to in paragraphs ~~1d(6)(b)~~ *1.d.(6)(b)* and ~~1d(4)~~ *1.d.(4)* of Enclosure 2 of this instruction, has been assigned report control symbol DD-HA(A,Q)2547 in accordance with the procedures in Reference ~~(r)~~*(t)*.

7. RELEASABILITY. **Cleared for public release**. This instruction is available on ~~the Internet from~~ the DoD Issuances Website at ~~http://www/dtic/mil/whs/directives~~ *http://www.esd.whs.mil/DD*.

8. EFFECTIVE DATE. This instruction *is effective August 5, 2014.*~~:~~

~~a. Is effective August 5, 2014.~~

~~b. Will expire effective August 5, 2024 if it hasn't been reissued or cancelled before this date in accordance with DoDI 5025.01 (Reference (s).~~

Jessica L. Wright
Under Secretary of Defense for
Personnel and Readiness

Enclosures
1. References
2. Responsibilities
3. Operational Standards for the DES

Glossary

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ENCLOSURE 1

REFERENCES

(a) DoD Directive 1332.18, "Separation or Retirement for Physical Disability," November 4, 1996 (hereby cancelled)
(b) DoD Directive 5124.02, "Under Secretary of Defense for Personnel and Readiness (USD(P&R))," June 23, 2008
(c) Title 10, United States Code
(d) Title 5, United States Code
(e) Section 104 of Title 26, United States Code
(f) Section 2082 of Title 50, United States Code
(g) DoD Instruction 1332.38, "Physical Disability Evaluation," November 14, 1996, as amended (hereby cancelled)
(h) Under Secretary of Defense for Personnel and Readiness Memorandum, "Policy Guidance for the Disability Evaluation System and Establishment of Recurring Directive-Type Memoranda," May 3, 2007 (hereby cancelled)
(i) Under Secretary of Defense for Personnel and Readiness Memorandum, "Directive-Type Memoranda (DTM) on Standards for Determining Unfitness Due to Medical Impairment (Deployability)," December 19, 2007 (hereby cancelled)
(j) Under Secretary of Defense for Personnel and Readiness Memorandum, "Directive-Type Memorandum (DTM) on Implementing Disability-Related Provisions of the National Defense Authorization Act of 2008 (Pub. L. 110-181)," March 13, 2008 (hereby cancelled)
(k) Under Secretary of Defense for Personnel and Readiness Memorandum, "Policy Memorandum on Implementing Disability-Related Provisions of the National Defense Authorization Act of 2008 (Pub. L. 110-181)," October 14, 2008 (hereby cancelled)
(l) Under Secretary of Defense for Personnel and Readiness Memorandum, "Policy and Procedural Memorandum for the DES Pilot Program," November 21, 2007 (hereby cancelled)
(m) Under Secretary of Defense for Personnel and Readiness Memorandum "Policy and Procedural Update for the Disability Evaluation System (DES) Pilot Program," December 11, 2008 (hereby cancelled)
(n) Under Secretary of Defense for Personnel and Readiness Memorandum "Cross Service Support and Service Organization Role at Disability Evaluation System (DES) Pilot Locations," March 29, 2010 (hereby cancelled)
(o) Under Secretary of Defense for Personnel and Readiness Memorandum, "Directive-Type Memorandum – Integrated Disability Evaluation System," December 19, 2011 (hereby cancelled)
~~(p) DoD Manual 1332.18, Volume 1, "Disability Evaluation System (DES) Manual: General Information and Legacy Disability Evaluation System (LDES) Time Standards," August 5, 2014~~
(p) DoD Instruction 1241.01, "Reserve Component (RC) Line of Duty Determination for Medical and Dental Treatments and Incapacitation Pay Entitlements," April 19, 2016

~~(q) DoD Manual 1332.18, Volume 1, "Disability Evaluation System (DES) Manual: General Information and Legacy Disability Evaluation System (LDES) Time Standards," August 5, 2014~~

(q) DoD Instruction 6040.42, "Management Standards for Medical Coding of DoD Health Records," June 8, 2016

(~~p~~*r*) DoD Manual 1332.18, Volume 1, "Disability Evaluation System (DES) Manual: General Information and Legacy Disability Evaluation System (LDES) Time Standards," August 5, 2014

(~~q~~*s*) DoD Manual 1332.18, Volume 2, "Disability Evaluation System (DES) Manual: Integrated Disability Evaluation System," August 5, 2014

~~(s) DoD Instruction 5025.01, "DoD Issuances Program," June 6, 2014~~

(~~r~~*t*) DoD Manual 8910.01, Volume 1, "DoD Information Collections Manual: Procedures for DoD Internal Information Collections," June 30, 2014*, as amended*

~~(t) Title 38, Code of Federal Regulations, Part 4 (part 4 is also known as "the Department of Veterans Affairs Schedule for Rating Disabilities (VASRD)")~~

(u) DoD Directive 5136.01, "Assistant Secretary of Defense for Health Affairs (ASD(HA))," September 30, 2013, as amended

~~(u) Under Secretary of Defense for Personnel and Readiness Memorandum, "Expedited DES Process for Members with Catastrophic Conditions and Combat-Related Causes," January 6, 2009~~

(~~t~~*v*) Title 38, Code of Federal Regulations, Part 4 (part 4 is also known as "the Department of Veterans Affairs Schedule for Rating Disabilities (VASRD)")

(~~v~~*w*) Memorandum of Agreement Between the Department of Defense and Department of Veterans Affairs, January 16, 2009

(~~w~~*x*) Memorandum of Agreement Between the Department of Defense and Department of Veterans Affairs, June 16, 2010

(~~x~~*y*) DoD 5400.11-R, "Department of Defense Privacy Program," May 14, 2007

~~(y) Section 1612 of Public Law 110-181, "National Defense Authorization Act for Fiscal Year 2008," January 28, 2008~~

~~(z) Joint Federal Travel Regulations, Volume 1, "Uniformed Service Members," current edition~~

~~(aa) Joint Federal Travel Regulations, Volume 2, "Department of Defense Civilian Personnel," current edition~~

~~(ab) DoD Directive 1332.27, "Survivor Annuity Programs for the Uniformed Services," June 26, 2003~~

(z) DoD Directive 5400.11, "DoD Privacy Program," October 29, 2014

(aa) DoD Instruction 1000.30, "Reduction of Social Security Number (SSN) Use Within DoD," August 1, 2012

(ab) Administrative Instruction 15, "OSD Records and Information Management Program," May 3, 2013, as amended

(ac) DoD 6025.18-R, "DoD Health Information Privacy Regulation," January 24, 2003

(~~y~~*ad*) Section 1612 of Public Law 110-181, "National Defense Authorization Act for Fiscal Year 2008," January 28, 2008

(~~z~~*ae*) Joint Federal Travel Regulations, Volume 1, "Uniformed Service Members," current edition

(~~aa~~*af*) Joint ~~Federal~~ Travel Regulations, Volume 2, "Department of Defense Civilian Personnel," current edition

(~~ab~~*ag*) DoD Directive 1332.27, "Survivor Annuity Programs for the Uniformed Services," June 26, 2003

~~(ac) DoD Directive 1332.35, "Transition Assistance for Military Personnel," December 9, 1993~~

(ah) DoD Instruction 1332.35, "Transition Assistance Program (TAP) for Military Personnel," February 29, 2016

(~~ad~~*ai*) DoD Instruction 1332.14, "Enlisted Administrative Separations," January 27, 2014*, as amended*

(~~ae~~*aj*) Section 115 of Title 32, United States Code

(~~af~~*ak*) Title 37, United States Code

(~~ag~~*al*) Title 38, United States Code

~~(ah) DoD Instruction 1332.30, "Separation of Regular and Reserve Commissioned Officers," November 25, 2013~~

(am) DoD Instruction 1332.30, "Commissioned Officer Administration Separations," May 11, 2018

~~(ai) Joint Publication 1-02, "Department of Defense Dictionary of Military and Associated Terms," current edition~~

(an) Office of the Chairman of the Joint Chiefs of Staff, "DoD Dictionary of Military and Associated Terms," current edition

ENCLOSURE 2

RESPONSIBILITIES

1. ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS (ASD(HA)). Under the authority, direction, and control of the USD(P&R), the ASD(HA):

a. Oversees the Director, Defense Health Agency (DHA), in the execution of programmatic and operational responsibilities in accordance with DoDD 5136.01 (Reference (u)).

~~a~~*b*. Establishes the Disability Advisory Council (DAC) to advise and recommend improvement of the DES and designates its chair.

~~b~~*c*. Monitors the performance of the DES and recommends improvements in DES policy.

~~c~~*d*. Reviews DES policies, including those proposed by the Military Departments.

~~d~~*e*. Through the Deputy Assistant Secretary of Defense for ~~Warrior Care Policy (DASD)(WCP))~~ *Health Services Policy and Oversight (DASD(HSP&O))*:

(1) In coordination with the ~~Assistant Secretary of Defense for Reserve Affairs (ASD(RA))~~ *Assistant Secretary of Defense for Manpower and Reserve Affairs (ASD(M&RA))* and the Secretaries of the Military Departments, oversees, assesses, and reports on the performance of the DES and recommends to the ASD(HA) changes in policy, procedure, or resources to improve DES performance.

(2) Monitors changes to military personnel, ~~and~~ compensation statutes and DoD policy, and other pertinent authorities, to assess their impact on disability evaluation, RC medical disqualification, and related benefits.

(3) Reviews Military Departments' policies and procedures for disability evaluation that affect the uniformity of standards for separation or retirement for unfitness because of disability, or separation of RC members for medical disqualification.

(4) Develops quality assurance procedures to ensure that policies are applied fairly and consistently and reports to ASD(HA) the results of Military Department DES quality control programs.

(5) Develops and executes a strategic communications plan for the DES in coordination with:

(a) Assistant *to the* Secretary of Defense for Public Affairs

(b) Secretaries of the Military Departments

(c) Under Secretary for Benefits, Veterans Benefits Administration, VA

(d) Under Secretary for Health, Veterans Health Administration, VA

(6) Establishes reporting requirements necessary to monitor and assess the performance of the DES and compliance of the Military Departments with this instruction.

(a) Not later than July 1 of each year, publishes the information the Military Departments must include in the DES Annual Report.

(b) Analyzes quarterly data submitted by the Military Departments and provides the DES Annual Report to the ASD(HA).

(c) Analyzes monthly DES data to assess trends that might inform policy adjustments.

~~e. Through the Deputy Assistant Secretary of Defense for Health Services Policy and Oversight:~~

(~~1~~*7*) Reviews Military Departments' policies and procedures for disability evaluation that affect the uniformity of standards for separation or retirement for unfitness because of disability or separation of RC members for medical disqualification.

(~~2~~*8*) Monitors changes to the laws, and regulations of the VA to assess their impact on the DoD's application of the VASRD (Reference (~~t~~*u*)) to Service members determined unfit because of disability, and recommends timely guidance to the ASD(HA).

(~~3~~*9*) Recommends guidance and performance monitoring necessary to implement this instruction, including recommending performance metrics and areas of emphasis.

(*1*0) ~~DASD(WCP) advises~~ *Advises* on the accurateness and completeness of the DES Annual Report and DES quarterly data submitted by the Military Departments to propose improvements to the DES based upon the submitted performance data.

(~~5~~*11*) In conjuction with the Secretaries of the Military Departments and the Director, ~~Defense Health Agency~~ *DHA,* develops program planning, allocation, and use of healthcare resources for activities within the DoD related to the DES.

(~~6~~*12*) In coordination with the Military Departments *and DHA* information technology (IT) offices, ensures IT support and access to programs used at the military treatment facilities (MTFs) and other related systems for medical record input and retrieval are available to each Military Department physical evaluation board (PEB).

(~~7~~*13*) Provides grade O-6 or civilian equivalent representation with a sufficient understanding of the DES to the DAC.

2. ~~ASD(RA)~~ *ASD(M&RA)*. Under the authority, direction, and control of the USD(P&R), the ~~ASD(RA)~~ *ASD(M&RA)*:

a. In coordination with the ASD(HA) and the Secretaries of the Military Departments, ensures that policies for the DES are applied for RC personnel consistent with those established for Active Component (AC) personnel and reflect the needs of RC members as required by Reference (c).

b. Provides O-6 level or civilian-equivalent representation with sufficient understanding of the DES to the DAC.

c. Reviews annual DES performance and recommends improvements to ASD(HA) to ensure process efficiency and equity for members of the RC.

3. GENERAL COUNSEL OF THE DEPARTMENT OF DEFENSE (GC DoD). In consultation with the General Counsels and the Judge Advocates General of the Military Departments, the GC DoD provides policy guidance on legal matters relating to DES policy, issuances, proposed exceptions to policy, legislative proposals, and provide legal representation for the DAC as set forth in Enclosure 7 of Reference (~~p~~*r*).

4. SECRETARIES OF THE MILITARY DEPARTMENTS. The Secretaries of the Military Departments:

a. Comply with chapter 61 of Reference (c), this instruction, and any implementing guidance.

b. Implement the DES in accordance with this instruction.

c. Manage the temporary disability retired list (TDRL) in accordance with Appendix 4 of Enclosure 3 of this instruction.

d. Staff and provide resources to meet DES performance goals, without reducing Service members' access to due process consistent with Reference (~~p~~*r*).

e. Establish procedures to develop and implement standardized training programs, guidelines, and curricula for Military Department personnel who administer DES processes, including physical evaluation board liaison officers (PEBLOs), non-medical case managers, and personnel assigned to the medical evaluation board (MEB), the PEB, and appellate review authorities.

f. Establish and execute agreements to support the disability processing of members who receive medical care from another Military Department.

g. Establish procedures to ensure Service members who are hospitalized or receiving treatment at a VA or a non-governmental facility are referred, processed, and counseled in a manner similar to their peers.

h. In consultation with their respective Judge Advocates General, establish policy, training and procedures for the provision of legal counsel to Service members in the DES.

i. Establish a quality assurance process to:

(1) Ensure policies and procedures established by this instruction are fairly and consistently implemented.

(2) Establish procedures to ensure the accuracy and consistency of MEB and PEB determinations and decisions.

(3) Establish procedures to monitor and sustain proper performance of the duties of MEBs, PEBs, and PEBLOs.

j. Prepare and forward data submissions for the DES Annual Report to the ~~DASD(WCP)~~ *DASD(HSP&O).*

k. Through their respective Inspectors General, review compliance with the requirements contained in Enclosure 3 of this instruction every 3 fiscal years for the preceding 3-fiscal-year period. Forward a copy of their final Inspectors General compliance reports to the USD(P&R).

l. Investigate all matters of potential fraud pertaining to the DES and resolve as appropriate.

m. Provide grade O-6 or civilian-equivalent representation with a sufficient understanding of the DES to the DAC.

~~n. Comply with USD(P&R) Memorandum (Reference (u)).~~

~~o~~*n*. Comply with the Memorandums of Agreement between the DoD and the VA pertaining to the IDES (References (~~v~~*w*) and (~~w~~*x*)).

~~p~~*o*. Comply with the *privacy* procedures outlined in DoD 5400.11-R (Reference (~~x~~*y*)), *DoDD 5400.11 (Reference (z)), DoDI 1000.30 (Reference (aa)), Administrative Instruction 15 (Reference (ab)), and DoD 6025.18-R (Reference (ac))*.

~~q~~*p*. Establish procedures to ensure that, with the consent of the Service member, the address and contact information of the Service member are transmitted to the department or agency for other appropriate veterans affairs of the State in which the Service member intends to reside after retirement or separation.

~~r~~*q*. Establish procedures to provide, with consent of the Service member, notification of the hospitalization of a Service member under their jurisdiction evacuated from a theater of combat

and admitted to an MTF within the United States to the Senators representing the State, and the Member, Delegate or Resident Commissioner of the House of Representatives representing the district, that includes the Service member's home ~~or~~ *of* record or a different location as provided by the Service member.

~~s~~*r*. Before demobilizing or separating an RC member who incurred an injury or illness while on active duty, provide to the Service member information on:

(1) The availability of care and administrative processing through military-affiliated or community support services.

(2) The location of the support services, whether military-affiliated or community, located nearest to the permanent place of residence of the Service member.

ENCLOSURE 3

OPERATIONAL STANDARDS FOR THE DES

1. OVERVIEW OF THE DES

a. Under the supervision of the Secretary of the Military Department concerned, the DES consists of:

(1) Medical evaluation to include the MEB, impartial medical reviews, and rebuttal.

(2) Disability evaluation to include the PEB and appellate review, counseling, case management, and final disposition.

b. The Secretaries of the Military Departments:

~~(1) Will use the LDES process for non-duty related disability cases and for Service members who entered the DES prior to the IDES being implemented at a given MTF.~~

~~(2) Subject to the written approval of the USD(P&R), may also use the LDES process for Service members who are in initial entry training status, including trainees, recruits, cadets, and midshipmen. Secretaries of the Military Departments who enroll initial entry trainees, recruits, cadets, and midshipmen in the LDES must offer to enroll these Service members in the VA Benefits Delivery at Discharge or Quick Start programs.~~

~~(3) Will use the EDES process for consenting Service members designated with a catastrophic illness or injury incurred in the line of duty.~~

~~(4) May designate a Service member's condition as catastrophic if he or she has a permanent and severely disabling injury or illness that compromises the ability to carry out the activities of daily living. Guidance for procedures unique to the EDES is available in Reference (u).~~

~~c. Except for initial entry trainees, Military Academy cadets, and midshipmen entered into the LDES and catastrophically ill or injured Service members entered in the EDES, will use the IDES process for all newly initiated cases referred under the duty-related process (see Glossary). Guidance for procedures unique to the IDES is available in Reference (q).~~

(1) Will use the IDES process for all newly initiated cases referred under the duty-related process except for Service members approved for the LDES process.

(2) For cases initiated on or after May 17, 2018, may either:

(a) Authorize, if requested by a Service member (to include initial entry trainees, Military Academy cadets, and midshipmen), processing through the LDES rather than the IDES.

Before the Secretary concerned approves such a request, the Service member must acknowledge, in writing, that he or she was offered the opportunity to receive a legal briefing regarding the procedural differences between the LDES and the IDES;

(b) Enroll Service members into the LDES after providing information to these Service members about the VA Benefits Delivery at Discharge program before enrollment; or

(c) Use the LDES process for consenting Service members designated with a catastrophic illness or injury incurred in the line of duty.

~~d.~~*c. LDES and* IDES disability examinations will include a general medical examination and any other applicable medical examinations performed to VA compensation and pension standards. Collectively, the *LDES and IDES* examinations will be sufficient to assess the Service member's referred and claimed condition(s), assist VA in ratings determinations and assist Military Departments to determine if the medical conditions, individually or collectively, prevent the Service member from performing the duties of his office, grade, rank, or rating.

2. MEB

a. Purpose. An MEB *reviews all available medical evidence, to include any examinations completed as a part of DES processing, and* documents the medical status and duty limitations of Service members who meet referral eligibility criteria in Appendix 1 to this enclosure.

b. Composition. The MEB will be comprised of two or more physicians (civilian employee or military). One of these physicians must have detailed knowledge of the standards pertaining to medical ~~fitness~~ *retention standards*, the disposition of patients, and disability separation processing. Any MEB listing a behavioral health diagnosis must contain a thorough behavioral health evaluation and include the signature of at least one psychiatrist or psychologist with a doctorate in psychology.

c. Resourcing. The Secretary of the Military Department concerned will develop standards on the maximum number of MEB cases that are pending before a MEB at any one time.

d. Referral to PEB. The MEB documents whether the Service member has ~~a~~ medical condition*s, whether singularly, collectively or through combined effect,* that will prevent them from reasonably performing the duties of their office, grade, rank, or rating. If the Service member cannot perform the duties of his office, grade, rank, or rating, the MEB refers the case to the PEB.

e. Service Member Medical Evaluations

(1) Medical Evaluations. An MEB will evaluate the medical status and duty limitations of:

(a) Service members referred into the DES who incurred or aggravated an illness or injury while under order to active duty specifying a period of more than 30 days.

(b) RC members referred for a duty-related determination.

(2) MEB Exemptions. An MEB is not required:

(a) For Service members temporarily retired for disabilities who are due for a periodic physical medical examination.

(b) When an RC member *who is not on active duty* is referred for ~~impairments~~ *conditions* unrelated to military status and performance of duty (see Glossary for the definition of non-duty-related ~~impairments~~ *condition*).

(3) MEB Prerequisites. A Service member will not be required to sign a statement relating to the origin, incurrence, or aggravation of a disease or injury.

(4) Impartial Medical Reviews. Consistent with section 1612 of Public Law 110-181 (Reference (~~y~~*ad*)), the Secretary of the Military Department concerned will, upon request of the Service member, assign an impartial physician or other appropriate health care professional who is independent of the MEB to:

(a) Serve as an independent source of review of the MEB findings and recommendations.

(b) Advise and counsel the Service member regarding the findings and recommendations of the MEB.

(c) Advise the Service member on whether the MEB findings adequately reflect the complete spectrum of the Service member's injuries and illnesses.

(5) MEB Rebuttal. Service members referred into the DES will upon request be permitted to at least one rebuttal of the MEB findings.

f. Content

(1) Medical information used in the DES must be sufficiently recent to substantiate the existence or severity of potentially unfitting conditions. The Secretaries of the Military Departments will not perform additional medical exams or diagnostic tests if more current information would not substantially affect identification of the existence or severity of potentially unfitting conditions.

(2) MEBs will confirm the medical diagnosis for and document the full clinical information, including history, treatment status, and potential for recovery of the Service member's medical conditions that, individually or collectively *or through combined effect,* ~~may~~

will prevent the Service member from performing the duties of his office, grade, rank, or rating and state whether each condition is cause for referral to a PEB.

g. Competency. When the Service member's ability to handle his or her financial affairs is unclear, the MEB or TDRL packet will include the results of a competency board.

h. Medical Documentation for RC Members with Non-duty Related Conditions. The medical documentation for RC members with non-duty related conditions referred for disability evaluation must provide clear and adequate written description of the medical condition(s) that, individually or collectively, may prevent the RC member from performing the duties of his office, grade, rank, or rating.

i. Non-medical Documentation. The MTF will forward the cases of Service members with a duty-related determination to the PEB with the MEB documentation and:

(1) The line of duty (LOD) determination, when required by section 6 of Appendix 3 of this enclosure.

(2) Except in cases in which the illness or injury is so severe that return to duty is not likely, a statement from the Service member's immediate commanding officer describing the impact of the member's medical condition on the ability to perform his or her normal military duties.

(3) An official document identifying the next of kin, court-appointed guardian, or trustee when a Service member is determined incompetent to manage his or her financial affairs.

3. DISABILITY EVALUATION

a. Purpose. PEBs determine the fitness of Service members with medical conditions to perform their military duties and, for members determined unfit because of duty-related ~~impairments~~ *conditions*, their eligibility for benefits pursuant to chapter 61 of Reference (c). Service members may appeal the decision of the PEB. The PEB process includes the informal physical evaluation board (IPEB), formal physical evaluation board (FPEB) and appellate review of PEB results.

b. IPEB. The IPEB reviews the case file to make initial findings and recommendations without the Service member present. The Service member may accept the finding, rebut the finding, or request a FPEB. The Secretary of the Military Department concerned will allow the Service member a minimum of 10 calendar days from receipt of the informal findings to rebut the findings of the IPEB or request an FPEB. In addition to this timeline, Military Departments must publish timelines for presentation and consideration of cases.

c. FPEB. In accordance with section 1214 of Reference (c), Service members who are found unfit are entitled to a formal hearing, an FPEB, to contest their IPEB findings. The PEBLO will document the Service member's declination of an FPEB. If the Secretary of the Military

Department concerned changes those findings or determinations following a Service member's concurrence, the Service member will be entitled to a formal hearing to contest the changes.

d. Composition

(1) The IPEB will be comprised of at least two military personnel at field grade or civilian equivalent or higher. In cases of a split opinion, a third voting member will be assigned to provide the majority vote.

(2) The FPEB must be comprised of at least three members and may be comprised of military and civilian personnel representatives. A majority of the FPEB members could not have participated in the adjudication process of the same case at the Informal Physical Evaluation Board.

(a) The FPEB will consist of at least a president, who should be a military ~~O-6~~ *O-6*, or civilian equivalent; a medical officer; and a line officer (or non-commissioned officer at the E-9 level for enlisted cases) familiar with duty assignments.

(b) The physician cannot be the Service member's physician, cannot have served on the Service member's MEB, and cannot have participated in a TDRL re-examination of the Service member.

(c) In the case of RC members, Secretaries of the Military Departments will ensure RC representation on the PEBs is consistent with section 12643 of Reference (c) and related policies. Secretaries of the Military Departments may adjust member composition of the FPEB to enhance the adjudication process consistent with applicable laws and regulations.

(d) Contract personnel may not serve as PEB adjudicators or PEB appellate review members.

e. Eligibility. Service members determined unfit and TDRL members determined fit may demand, and are entitled to, an FPEB. At its discretion, the Military Department may grant a formal hearing to Service members who are determined fit but are not on the TDRL.

f. Resourcing. The Secretary of the Military Department concerned will direct the allocation of additional personnel to the PEB process if deemed appropriate for proper and expeditious adjudication of case load.

g. Issues. At the FPEB, the Service member will be entitled to address issues pertaining to his or her fitness, the percentage of disability, degree or stability of disability, administrative determinations, or a determination that his or her injury or disease was non-duty related.

h. Hearing Rights. Service members will have, at a minimum, the following rights before the FPEB:

(1) To have their case considered by board members, a majority of whom were not voting members of their IPEB.

(2) To appear personally, through a designated representative, by videoconference, or by any other means determined practical by the Secretary of the Military Department concerned. Unless the Secretary of the Military Department directs the FPEB to fund the personal travel and other expenses, RC members with non-duty related determinations are responsible for their personal travel and other expenses.

(3) To be represented by Government appointed counsel provided by the Military Department. Service members may choose their own civilian counsel at no expense to the Government. The PEB president should notify the Secretary of the Military Department concerned if the lack of Government appointed counsel affects timely PEB caseload adjudication.

(4) To make a sworn or an unsworn statement. A Service member will not be required to sign a statement relating to the origin, incurrence, or aggravation of a disease or injury.

(5) To remain silent. When the Service member exercises this right, the member may not selectively respond, but must remain silent throughout the hearing.

(6) To introduce witnesses, depositions, documents, sworn or unsworn statements, declarations, or other evidence in the Service member's behalf and to question all witnesses who testify at the hearing. The FPEB president determines whether witnesses are essential. If the FPEB president determines witnesses essential, travel expenses and per diem may be reimbursed or paid in accordance with the Joint ~~Federal~~ Travel Regulation, Volumes 1 and 2 (References (~~z~~*ae*) and (~~aa~~*af*)). Witnesses not deemed essential by the FPEB president may attend formal hearings at no expense to the Government.

(7) To access all records and information received by the PEB before, during, and after the formal hearing.

i. Record of Proceedings. ~~Upon a Service member's written request, the~~ *The* Military Department will provide the Service member a record of the PEB proceedings. The PEB record of proceedings must convey the PEB findings and conclusions in an orderly and itemized fashion, with specific attention to each issue presented by the Service member regarding his or her case, and the basis for applying total or extra-schedular ratings or unemployability determinations, as applicable.

j. Duty-related Determinations. The record of proceedings for active duty Service members and RC members referred for duty-related determinations will document, at a minimum:

(1) The determination of fit or unfit.

(2) The code and percentage rating assigned an unfitting and compensable disability based on the VASRD. The standards for determining compensable disabilities are specified in Appendix 3 of this enclosure.

(3) The reason an unfitting condition is not compensable.

(a) The specific accepted medical principle, as stated in Appendix 3 of this enclosure, for overcoming the presumption of service aggravation for all cases with a finding of preexisting condition without service aggravation.

(b) The accepted medical principle justifying findings that an RC member performing inactive duty training (IDT), active duty training, or on active duty of 30 days or less, has a preexisting disability that was not permanently aggravated by service.

(c) The rationale justifying findings that a disability that was incurred in the LOD prior to September 24, 1996, and that was not permanently service aggravated since September 23, 1996, was not the proximate result of military service.

(4) For Service members being placed on the TDRL or permanently retired, the nature of the disability and the stability and permanency of the disability.

(5) Administrative determinations made consistent with Appendix 5 of this enclosure.

(6) The record of all proceedings for PEB evaluation including the evidence used to overcome a presumption listed in this instruction and changes made as a result of review by subsequent reviewing authority will include a written explanation in support of each finding and recommendation. If applicable, the basis for applying or not applying total or extra-schedular ratings or unemployability determinations.

k. Non-duty Related Determinations. For RC members referred for non-duty related determinations, the record of proceedings will document only:

(1) The fitness determination.

(2) For RC members determined fit, a determination of whether the member is deployable, if Service regulations require such a determination.

l. Appellate Review. The Military Department will review the findings and recommendations of the FPEB when requested by the Service member or designated representative or as required by the regulations of the Military Department concerned. The Military Department will also provide to the Service member a written response to an FPEB appeal that specifically addresses each issue presented in the appeal.

m. Quality Assurance. Each Military Department will establish and publish quality review procedures particular to the PEB and conduct quality assurance reviews in accordance with the laws, directives, and regulations governing disability evaluation.

4. COUNSELING

a. Purpose. Service members undergoing evaluation by the DES must be advised of the significance and consequences of the determinations being made and their associated rights, benefits, and entitlements. Each Military Department will publish and provide standard information booklets that contain specific information on the MEB and PEB processes. These publications must include the rights and responsibilities of the Service member while navigating through the DES. The information will be made available at the servicing MTFs and PEBs.

b. Topics

(1) PEBLOs will inform Service members of the:

(a) Sequence and nature of the steps in the disability process.

(b) Statutory rights and requirements but will not provide legal advice.

(c) Effect of findings and recommendations.

(d) Process to submit rebuttals.

(e) Probable retired grade.

(f) Estimated timeframe for completing the DES at their installation.

(2) PEBLOs will inform Service members or refer them to the appropriate subject matter experts on:

(a) Potential veterans' benefits.

(b) Post-retirement insurance programs and the Survivor Benefit Plan in accordance with DoDD 1332.27 (Reference (~~ab~~*ag*)), if appropriate.

(c) Applicable transition benefits, in accordance with ~~DoDD~~ *DoDI* 1332.35 (Reference (~~ac~~*ah*)).

(d) Applicable standards detailed in the VASRD, which would have to be recognized to increase the percentage of disability, prior to acting on a Service member's request for a formal PEB.

(e) Services provided by military, veteran, or national service organizations.

(f) Electronic resources for ill and injured Service members such as National Resource Directory, eBenefits, etc.

(g) Availability and processes for obtaining legal counsel to assist in rebutting or appealing MEB and PEB findings.

(h) The appropriate Defense Finance and Accounting Service finance representative for payment calculations for severance pay or retirement pay.

c. Incompetent Service Members. When a Service member has been determined incompetent by a competency board, his or her designated representative (e.g., court appointed guardian, trustee, or primary next of kin) will be counseled and afforded the opportunity to assert the rights granted to the Service member, unless prohibited by law.

d. Pre-separation Counseling. Service members on orders to active duty for more than 30 days will not be separated or retired because of disability before completing pre-separation counseling pursuant to Reference (~~a~~*ah*).

5. CASE MANAGEMENT

a. Service members undergoing evaluation by the DES must be advised on the status of their case, issues that must be resolved for their case to progress, and expected time frame for completing DES at their installation.

b. PEBLOs will contact Service members undergoing disability evaluation at least monthly and provide any necessary DES assistance.

6. FINAL DISPOSITION. After adjudicating all appeals, the personnel authorities specified in Appendix 6 to this enclosure will:

a. Issue orders and instructions to implement the determination of the respective Service's final reviewing authority.

b. Consider Service member requests to continue on active duty or in the RC in a permanent limited duty status if the member is determined unfit.

7. ADMINISTRATIVE DECISIONS

a. The Secretary of the Military Department concerned may:

(1) Direct the PEB to reevaluate any Service member determined to be unsuitable for continued military service.

(2) Retire or separate for disability any Service member determined upon re-evaluation to be unfit to perform the duties of the member's office, grade, rank, or rating.

b. The Secretary of the Military Department concerned may not:

(1) Authorize the involuntary administrative separation of a member based on a determination that the member is unsuitable for deployment or worldwide assignment after a PEB has found the member fit for the same medical condition; or

(2) Deny the member's request to reenlist based on a determination that the member is unsuitable for deployment or worldwide assignment after a PEB has found the member fit for the same medical condition.

c. Consistent with DoDI 1332.14 (Reference (~~ad~~*ai*)), any Service member found fit for duty by the PEB but determined unsuitable for continued service by the Secretary of the Military Department concerned for the same medical condition considered by the PEB may appeal to the Secretary of Defense, who is the final authority.

8. TRAINING AND EDUCATION

a. Assignment of Personnel to the DES. The Secretaries of the Military Departments will certify annually that the following personnel assigned to or impacting the DES were formally trained prior to being assigned to performing DES duties.

(1) Medical officers.

(2) PEBLOs.

(3) Patient administration officers.

(4) PEB adjudicators.

(5) PEB appellate review members.

(6) Judge advocates.

(7) Military Department civilian attorneys.

b. Training. Training programs for all personnel assigned to the DES must be formal and documented. At a minimum, training curricula will consist of:

(1) An overview of the statutory and policy requirements of the DES, the electronic and paper recordkeeping policies of the Military Department, customer service philosophies, and VA processes, services and benefits.

(2) Familiarization with medical administration processes.

(3) Knowledge of online and other resources pertaining to the DES and DoD and VA services, the chain of supervision and command, and the Military Department Inspectors General hotlines for resolution of issues.

c. Mentoring. Individuals assigned for duty as PEBLOs must receive at least 1 week of on-the-job training with an experienced PEBLO.

Appendixes

1. DES Referral
2. Standards for Determining Unfitness Due to Disability or Medical Disqualification
3. Standards for Determining Compensable Disabilities
4. TDRL Management
5. Administrative Determinations
6. Final Disposition

APPENDIX 1 TO ENCLOSURE 3

DES REFERRAL

1. GENERAL. The Secretary of the Military Department concerned will refer Service members who meet the criteria for disability evaluation regardless of eligibility for disability compensation.

2. CRITERIA FOR REFERRAL

a. When the course of further recovery is relatively predictable or within 1 year of diagnosis, whichever is sooner, medical authorities will refer eligible Service members into the DES who:

(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 including those duties remaining on a Reserve obligation for more than 1 year after diagnosis;

(2) Have a medical condition that represents an obvious medical risk to the health of the member or to the health or safety of other members; or

(3) Have a medical condition that imposes unreasonable requirements on the military to maintain or protect the Service member.

b. In all cases, competent medical authorities will refer into the DES eligible Service members who meet the criteria in paragraph ~~2a~~ *2.a. of this appendix* within 1 year of diagnosis.

3. ELIGIBILITY FOR REFERRAL

a. Duty-related Determinations. Except as provided in section 4 of this appendix, the following categories of Service members who meet the criteria in section 2 of this appendix are eligible for referral to the DES for duty-related determinations:

(1) Service members on active duty or in the RC who are on orders to active duty specifying a period of more than 30 days.

(2) RC members who are not on orders to active duty specifying a period of more than 30 days but who incurred or aggravated a medical condition while the member was ordered to active duty for more than 30 days.

(3) Cadets at the United States Military Academy, the United States Air Force Academy, or Midshipmen of the United States Naval Academy.

(4) Service members previously determined unfit, serving in a permanent limited duty status, and for whom the period of continuation has expired.

(5) Other Service members who are on orders to active duty specifying a period of 30 days or less if they have a medical condition that was incurred or aggravated in the LOD while the Service member was:

(a) Performing active duty or IDT.

(b) Traveling directly to or from the place at which such duty is performed.

(c) Remaining overnight immediately before the commencement of IDT or while remaining overnight between successive periods of IDT at or in the vicinity of the site of the IDT.

(d) Serving on funeral honors duty pursuant to section 12503 of Reference (c) or section 115 of Title 32, U.S.C. (Reference (~~ae~~*aj*)) while the Service member was traveling to or from the place at which the member was to serve; or while the member remained overnight at or in the vicinity of that place immediately before serving.

(6) Service members with duty-related determinations, as described in paragraph 3.a. of this appendix, will be referred into the DES for a determination of fitness. If found unfit, a determination will be made as to the Service member's entitlement to separation or retirement for disability with benefits pursuant to chapter 61 of Reference (c) and administrative determinations in accordance with Appendix 5 to this enclosure.

(7) A member of a*n* RC who is ordered to active duty for a period of more than 30 days and is released from active duty within 30 days of commencing such period of active duty for failure to meet physical standards for retention due to a pre-existing condition not aggravated during the period of active duty or medical or dental standards for deployment due to a pre-existing condition not aggravated during the period of active duty will be considered to have been serving under an order to active duty for a period of 30 days or less.

b. Non-duty Related Determinations. Members of the RC with non-duty related determinations, who are otherwise eligible as described in section 2 of this appendix, will be referred solely for a fitness for duty determination when one of the following exist:

(1) The RC member does not qualify under paragraph ~~3a~~ *3.a.* of this appendix.

(2) The RC member requests referral for a fitness determination upon being notified that they do not meet medical retention standards.

(3) Service regulations direct the RC member be referred to the DES for a determination of fitness before being separated by the Reserve for not meeting medical retention standards.

4. INELIGIBILITY FOR REFERRAL

a. Service members are ineligible for referral to the disability evaluation process when:

(1) The Service member has a condition, circumstance, or defect of a developmental nature, not constituting a physical disability, as described in paragraph ~~3i~~ *3.i.* above the signature of this instruction, that interferes with assignment to or performance of duty and that was not service aggravated.

(2) The Service member is pending an approved, unsuspended punitive discharge or dismissal, except as provided by Service regulations.

(3) The Service member is pending separation under provisions that authorize a characterization of service of under other than honorable conditions, except as provided by Service regulations. This restriction is based on the provisions upon which the member is being separated and not on the actual characterization the member receives.

(4) The Service member is not physically present or accounted for.

(5) Disability results from intentional misconduct or willful neglect or was incurred during a period of unauthorized absence or excess leave.

b. However, the Secretaries of the Military Departments should normally evaluate for disability those Service members who would be ineligible for referral to the DES due to paragraphs ~~4a(2)~~ *4.a.(2)* and ~~4a(3)~~ *4.a.(3)* of this appendix when the medical ~~impairment~~ *condition* or disability evaluation is warranted as a matter of equity or good conscience.

5. SERVICE MEMBERS WITH MEDICAL WAIVERS

a. Provided no permanent aggravation has occurred, Service members who enter the military with a medical waiver may be separated without disability evaluation when the responsible medical authority designated by Service regulations determines within 6 months of the member's entry into active service that the waivered condition represents a risk to the member or prejudices the best interests of the Government.

b. Once 6 months have elapsed the Secretary of the Military Department concerned will refer the Service member for disability evaluation when the Service member meets the criteria in section 2 of this appendix and is eligible for referral in accordance with section 3 of this appendix.

c. Members who entered the Service with a medical waiver for a pre-existing condition and who are subsequently determined unfit for the condition will not be entitled to disability separation or retired pay unless military service permanently aggravated the condition. Members granted medical waivers will be advised of this provision at the time of waiver application and when it is granted.

6. WAIVER OF PEB EVALUATION. Except as prohibited by section 7 of this appendix, Service members may waive referral to the PEB with the approval of the Secretary of the Military Department concerned.

a. The Service member must be counseled on the DES process, the right to a PEB, and the potential benefits of remaining in an active duty or active reserve status to complete evaluation by the DES.

b. The Service member must request a waiver in writing and such request or an affidavit must attest that the member has received the counseling described and declines referral to the PEB.

7. PROHIBITION FROM WAIVING DISABILITY EVALUATION. A Service member approved for voluntary early separation from active duty who incurs a Reserve obligation and who has conditions that are cause for referral into the DES cannot waive disability evaluation.

8. REFERRAL IMPLICATIONS. Neither referral into the DES nor a finding of unfitness constitutes entitlement to disability benefits.

APPENDIX 2 TO ENCLOSURE 3

STANDARDS FOR DETERMINING UNFITNESS DUE TO DISABILITY OR MEDICAL DISQUALIFICATION

1. UNIFORMITY OF STANDARDS. The standards listed in this instruction for determining unfitness due to disability will be followed unless the USD(P&R) approves exceptions on the basis of the unique needs of the respective Military Department.

2. GENERAL CRITERIA FOR MAKING UNFITNESS DETERMINATIONS

a. A Service member will be considered unfit when the evidence establishes that the member, due to disability, is unable to reasonably perform duties of his or her office, grade, rank, or rating, including those during a remaining period of Reserve obligation.

b. A Service member may also be considered unfit when the evidence establishes that:

(1) The Service member's disability represents a decided medical risk to the health of the member or to the welfare or safety of other members; or

(2) The Service member's disability imposes unreasonable requirements on the military to maintain or protect the Service member.

3. RELEVANT EVIDENCE. The Secretaries of the Military Departments will consider all relevant evidence in assessing Service member fitness, including the circumstances of referral. To reach a finding of unfit, the PEB must be satisfied that the evidence supports that finding.

a. Referral Following Illness or Injury. When referral for disability evaluation immediately follows acute, grave illness or injury, the medical evaluation may stand alone, particularly if medical evidence establishes that continued service would be harmful to the member's health or is not in the best interest of the respective Service.

b. Referral for Chronic ~~Impairment~~ *Condition*. When a Service member is referred for disability evaluation under circumstances other than as described in paragraph ~~3a~~ *3.a.* of this appendix, an evaluation of the Service member's performance of duty by supervisors may more accurately reflect the capacity to perform. Supervisors may include letters, efficiency reports, credential reports, status of physician medical privileges, or personal testimony of the Service member's performance of duty to provide evidence of the Service member's ability to perform his or her duties.

c. Cause-and-effect Relationship. Regardless of the presence of illness or injury, inadequate performance of duty, by itself, will not be considered evidence of unfitness due to disability, unless a cause-and-effect relationship is established between the two factors.

4. REASONABLE PERFORMANCE OF DUTIES

a. Considerations. Determining whether a Service member can reasonably perform his or her duties includes consideration of:

(1) Common Military Tasks. Whether the Service member can perform the common military tasks required for the Service member's office, grade, rank, or rating including those during a remaining period of Reserve obligation. Examples include routinely firing a weapon, performing field duty, or wearing load-bearing equipment or protective gear.

(2) Physical Fitness Test. Whether the Service member is medically prohibited from taking the respective Service's required physical fitness test. When an individual has been found fit by a PEB for a condition that prevents the member from taking the Service physical fitness test, the inability to take the physical fitness test will not form the basis for an adverse personnel action against the member.

(3) Deployability. Whether the Service member is deployable individually or as part of a unit, with or without prior notification, to any vessel or location specified by the Military Department. When deployability is used by a Service as a consideration in determining fitness, the standard must be applied uniformly to both the AC and RC of that Service.

(4) Special Qualifications. For Service members whose medical condition disqualifies them for specialized duties, whether the specialized duties constitute the member's current duty assignment; the member has an alternate branch or specialty; or reclassification or reassignment is feasible.

b. General, Flag, and Medical Officers. An officer in pay grade O-7 or higher, or a medical officer in any grade, being processed for retirement by reason of age or length of service, will not be determined unfit unless the determination of the Secretary of the Military Department concerned with respect to unfitness is approved by the USD(P&R) on the recommendation of the ASD(HA).

c. Service Members on Permanent Limited Duty. A Service member previously determined unfit and continued in a permanent limited duty status or otherwise continued on active duty will normally be found unfit at the expiration of his or her period of continuation. However, the Service member may be determined fit when the condition has healed or improved such that the Service member would be capable of performing his or her duties in other than a limited-duty status.

d. Combined Effect. A Service member may be determined unfit as a result of the combined effect of two or more ~~impairments~~ *conditions* even though each of them, standing alone, would not cause the Service member to be referred into the DES or be found unfit because of disability. *The PEB will include in its official findings, in cases where two or more medical conditions (referred or claimed) are present in the service treatment record, that the combined effect was*

considered in the fitness determination as referred by the MEB. Combined effect includes the pairing of a singularly unfitting condition with a condition that standing alone would not be unfitting.

5. PRESUMPTION OF FITNESS

a. Application. The DES compensates disabilities when they cause or contribute to career termination. Service members who are pending retirement at the time they are referred for disability evaluation are presumed fit for military service.

(1) Service members may overcome this presumption by presenting a preponderance of evidence that he or she is unfit for military service. The presumption of fitness may be overcome when:

(a) An illness or injury occurs within the presumptive period that would prevent the Service member from performing further duty if they were not retiring.

(b) A serious deterioration of a previously diagnosed condition, including a chronic one, occurs within the presumptive period, and the deterioration would preclude further duty if the Service member were not retiring.

(c) The condition for which the Service member is referred is a chronic condition and a preponderance of evidence establishes that the Service member was not performing duties befitting either his or her experience in the office, grade, rank, or rating before entering the presumptive period because of the condition.

(2) Service members are not presumed fit for military service in these instances of a pending retirement:

(a) The disability is one for which a Service member was previously determined unfit and continued in a permanent limited duty status. The presumption of fitness will be applied to other medical ~~impairments~~ *conditions* unless the medical evidence establishes they were impacted by the original unfitting disabilities.

(b) Selected Reserve members who are eligible to qualify for non-regular retirement pursuant to the provisions of section 12731b of Reference (c).

(c) RC members referred for non-duty-related determinations.

b. Presumptive Period. The Secretaries of the Military Departments will presume Service members are pending retirement when the ~~preparation of the Service member's MEB narrative summary~~ *Service member's referral into the DES* occurs after any of these circumstances:

(1) A Service member's request for voluntary retirement has been approved. Revocation of voluntary retirement orders for purposes of referral into the DES does not negate application of the presumption.

(2) An officer has been approved for selective early retirement or is within 12 months of mandatory retirement due to age or length of service.

(3) An enlisted member is within 12 months of his or her retention control point or expiration of active obligated service, but will be eligible for retirement at his or her retention control point or expiration of active obligated service.

(4) An RC member is within 12 months of mandatory retirement or removal date and qualifies for a 20-year letter at the time of referral for disability evaluation.

(5) A retiree is recalled, to include those who transferred to the Retired Reserve, with eligibility to draw retired pay upon reaching the age prescribed by statute unless the recalled retiree incurred or aggravated the medical condition while on their current active duty orders and overcomes the presumption of fitness.

6. EVIDENTIARY STANDARDS FOR DETERMINING UNFITNESS BECAUSE OF DISABILITY

a. Objective Evidence

(1) The Secretary of the Military Department concerned must cite objective evidence in the record, as distinguished from personal opinion, speculation, or conjecture, to determine a Service member is unfit because of disability.

(2) Doubt that cannot be resolved with evidence will be resolved in favor of the Service member's fitness through the presumption that the Service member desires to be found fit for duty.

b. Preponderance of Evidence. With the exception of presumption of fitness cases, the Secretary of the Military Department concerned will determine fitness or unfitness for military service on the basis of the preponderance of the objective evidence in the record.

APPENDIX 3 TO ENCLOSURE 3

STANDARDS FOR DETERMINING COMPENSABLE DISABILITIES

1. OVERVIEW OF DISABILITY COMPENSATION CRITERIA. Service members who are determined unfit to perform the duties of the member's office, grade, rank, or rating because of disability in accordance with Appendix 2 of this enclosure may be eligible for disability benefits when:

a. The disability is not the result of the member's intentional misconduct or willful neglect and was not incurred during unauthorized absence or excess leave.

b. The Service member incurred or aggravated the disability while he or she was:

(1) A member of a regular component of the Military Services entitled to basic pay;

(2) A member of the Military Services entitled to basic pay, called or ordered to active duty (other than for training pursuant to section 10148 of Reference (c)) for a period of more than 30 days;

(3) A member of the Military Services on active duty for a period greater than 30 days but not entitled to basic pay pursuant to section 502(b) of Title 37, U.S.C. (Reference (~~af~~*ak*)) due to authorized absence to participate in an educational program or for an emergency purpose, as determined by the Secretary of the Military Department concerned;

(4) A cadet at the United States Military Academy or the United States Air Force Academy or a midshipman of the United States Naval Academy after October 28, 2004; or

(5) A member of the Military Services called or ordered to active duty for a period of 30 days or less, performing IDT or traveling directly to or from the place of IDT, to funeral honors duty, or for training pursuant to section 10148 of Reference (c).

2. DISABILITY RETIREMENT CRITERIA FOR REGULAR COMPONENT MEMBERS AND MEMBERS ON ACTIVE DUTY FOR MORE THAN 30 DAYS. Service members described in paragraphs ~~1a~~ *1.a.* and ~~1b(1)~~ *1.b.(1)* through ~~1b(4)~~ *1.b.(4)* of this appendix will be retired with disability benefits when:

a. The disability is permanent and stable.

b. The member has:

(1) At least 20 years of service computed in accordance with section 1208 of Reference (c); or

(2) A disability of at least 30 percent, pursuant to Reference (~~t~~*v*), and that disability:

(a) Was not noted at the time of the member's entrance on active duty unless the Secretary of the Military Department concerned demonstrates with clear and unmistakable evidence that the disability existed before the member's entrance on active duty and was not aggravated by active military service;

(b) Is the proximate result of performing active duty;

(c) Was incurred in the LOD in time of war or national emergency; or

(d) Was incurred in the LOD after September 14, 1978.

3. DISABILITY RETIREMENT CRITERIA FOR MEMBERS ON ACTIVE DUTY FOR 30 DAYS OR LESS, ON IDT, FUNERAL HONORS DUTY, OR TRAINING PURSUANT TO SECTION 10148 OF REFERENCE (C). Service members described in paragraphs ~~1a~~ *1.a.* and ~~1b(5)~~ *1.b.(5)* of this appendix will be retired with disability benefits when:

a. The disability is permanent and stable.

b. The Service member has:

(1) At least 20 years of service computed in accordance with section 1208 of Reference (c); or

(2) A disability of at least 30 percent, pursuant to Reference (~~t~~*u*), and that disability meets at least one of the following criteria:

(a) The disability was incurred or aggravated before September 24, 1996, as the proximate result of:

1. Performing active duty or IDT;

2. Traveling directly to or from the place of active duty or IDT; or

3. An injury, illness, or disease incurred or aggravated immediately before the commencement of IDT or while remaining overnight, between successive periods of IDT, at or in the vicinity of the site of the IDT, if the site of the IDT is outside reasonable commuting distance of the Service member's residence.

(b) The disability is a result of injury, illness, or disease that was incurred or aggravated in the LOD after September 23, 1996:

1. While performing active duty or IDT;

2. While traveling directly to or from the place of active duty or IDT;

3. While remaining overnight immediately before the commencement of IDT; or

4. While remaining overnight between successive periods of IDT at or in the vicinity of the site of the IDT.

(c) The disability is a result of an injury, illness, or disease incurred or aggravated in the LOD:

1. While serving on funeral honors duty pursuant to section 12503 of Reference (c) or section 115 of Reference (~~ae~~*aj*);

2. While the Service member was traveling to or from the place at which the member was to serve; or

3. While the Service member remained overnight at or in the vicinity of that place immediately before serving, if it is outside reasonable commuting distance from the member's residence.

4. DISABILITY SEPARATION CRITERIA FOR REGULAR COMPONENT MEMBERS AND MEMBERS ON ACTIVE DUTY FOR MORE THAN 30 DAYS. Service members described in paragraphs ~~1a~~ *1.a.* and ~~1b(1)~~ *1.b.(1)* through ~~1b(4)~~ *1.b.(4)* of this appendix will be separated with disability benefits when:

a. The Service member has less than 20 years of service.

b. The disability meets one of the following criteria:

(1) Is or may be permanent and less than 30 percent, pursuant to Reference (~~t~~*v*), and:

(a) Is the proximate result of performing active duty;

(b) Was incurred in the LOD in time of war or national emergency; or

(c) Was incurred in the LOD after September 14, 1978.

(2) Is less than 30 percent, pursuant to Reference (~~t~~*v*), at the time of the determination and was not noted at the time of the Service member's entrance on active duty (unless clear and unmistakable evidence demonstrates the disability existed before the Service member's entrance on active duty and was not aggravated by active military service).

(3) Is at least 30 percent, pursuant to Reference (~~t~~*v*), and at the time of the determination, the disability was neither:

(a) The proximate result of performing active duty;

(b) Incurred in the LOD in time of war or national emergency; nor

(c) Incurred in the LOD after September 14, 1978, and the Service member had less than 8 years of service computed pursuant to section 1208 of Reference (c) on the date when he or she:

1. Would otherwise be retired pursuant to section 1201 of Reference (c); or

2. Was placed on the TDRL pursuant to section 1202 of Reference (c).

5. DISABILITY SEPARATION CRITERIA FOR MEMBERS ON ACTIVE DUTY FOR 30 DAYS OR LESS, ON IDT, FUNERAL HONORS DUTY, OR TRAINING PURSUANT TO SECTION 10148 OF REFERENCE (C)

a. Service members described in paragraphs ~~1a~~ *1.a.* and ~~1b(5)~~ *1.b.(5)* of this appendix will be separated with disability benefits when:

(1) The Service member has less than 20 years of service.

(2) The disability meets one of the following criteria:

(a) Is or may be permanent.

(b) Is the result of an injury, illness, or disease incurred or aggravated in line of duty while:

1. Performing active duty or IDT;

2. Traveling directly to or from the place of active duty;

3. Remaining overnight immediately before the commencement of IDT, between successive periods of IDT, at or in the vicinity of the site of the IDT if the site is outside reasonable commuting distance of the Service member's residence; or

4. Serving on funeral honors duty pursuant to section 12503 of Reference (c) or section 115 of Reference (~~ae~~*ai*) while the Service member was traveling to or from the place at which he or she was to serve; or while the Service member remained overnight at or in the vicinity of that place immediately before serving.

(c) Is less than 30 percent under the VASRD at the time of the determination and, in the case of a disability incurred before October 5, 1999, was the proximate result of performing active duty or IDT or of traveling directly to or from the place at which such duty is performed.

b. If the Service member is eligible for transfer to the inactive status list pursuant to section 1209 of Reference (c) and chooses to, he or she may be transferred to that list instead of being separated.

6. LOD REQUIREMENTS. In the DES, LOD determinations assist the PEB and appellate review authority in meeting the statutory requirements under chapter 61 of Reference (c) for separation or retirement for disability.

a. Relationship of LOD Findings to DES Determinations

(1) LOD determinations will be made in accordance with the regulations of the respective Military Department. When an LOD determination is required, the DES will consider the finding made for those issues mutually applicable to LOD and DES determinations. These issues include whether a condition is pre-existing and whether it is aggravated by military service and any issues of misconduct or negligence.

(2) When the PEB has reasonable cause to believe an LOD finding appears to be contrary to the evidence, disability evaluation will be suspended for a review of the LOD determination in accordance with Service regulations. The PEB will forward the case to the final LOD reviewing authority designated by the Secretary of the Military Department concerned with a memorandum documenting the reasons for questioning the LOD finding.

b. Referral Requirement. When an LOD determination is required, it will be done before sending a Service member's case to the PEB.

c. Presumptive Determinations. The determination is presumed to be in the LOD without an investigation in the case of:

(1) Disease, except as described in paragraphs ~~6e(1) to 6e(6)~~ *6.d.(1) to 6.d.(6)* of this appendix.

(2) Injuries clearly incurred as a result of enemy action or attack by terrorists.

(3) Injuries while a passenger in a common commercial or military carrier.

d. Required Determinations. At a minimum, LOD determinations will be required in these circumstances.

(1) Injury, disease, or medical condition that may be due to the Service member's intentional misconduct or willful negligence, such as a motor vehicle accident.

(2) Injury involving the abuse of alcohol or other drugs.

(3) Self-inflicted injury.

(4) Injury or disease possibly incurred during a period of unauthorized absence.

(5) Injury or disease apparently incurred during a course of conduct for which charges have been preferred.

(6) Injury, illness, or disease of RC members on orders specifying a period of active duty of 30 days or less while:

(a) Performing active duty or IDT;

(b) Traveling directly to or from the place of active duty;

(c) Remaining overnight immediately before the commencement of IDT, between successive periods of IDT, at or in the vicinity of the site of the IDT if the site is outside reasonable commuting distance of the Service member's residence; or

(d) Serving on funeral honors duty pursuant to section 12503 of Reference (c) or section 115 of Reference (~~a~~*ai*) while the Service member was traveling to or from the place at which he or she was to serve; or while the Service member remained overnight at or in the vicinity of that place immediately before serving.

7. EVIDENTIARY STANDARDS FOR DETERMINING COMPENSABILITY OF UNFITTING CONDITIONS

a. Misconduct and Negligence. LOD determinations concerning intentional misconduct and willful negligence will be judged by the evidentiary standards established by the Secretary of the Military Department concerned.

b. Presumption of Sound Condition for Members on Continuous Orders to Active Duty Specifying a Period of More Than 30 Days

(1) The Secretaries of the Military Departments will presume Service members, including RC members and recalled retirees, on continuous orders to active duty specifying a period of more than 30 days entered their current period of military service in sound condition when the disability was not noted at the time of the Service member's entrance to the current period of active duty.

(2) The Secretaries of the Military Departments may overcome this presumption if clear and unmistakable evidence demonstrates that the disability existed before the Service member's entrance on their current period of active duty and was not aggravated by their current period of military service. Absent such clear and unmistakable evidence, the Secretary of the Military Department concerned will conclude that the disability was incurred or aggravated during their current period of military service.

(3) The Secretary of the Military Department concerned must base a finding that the Service member's condition was not incurred in or aggravated by their current period of military service on objective evidence in the record, as distinguished from personal opinion, speculation, or conjecture. When the evidence is unclear concerning whether the condition existed prior to their current period of military service or if the evidence is equivocal, the presumption of sound condition at entry to the current period of military service has not been rebutted and the Secretary of the Military Department concerned will find the Service member's condition was incurred in or aggravated by military service.

(4) Any hereditary or genetic disease will be evaluated to determine whether clear and unmistakable evidence demonstrates the disability existed before the Service member's entrance on active duty and was not aggravated by their current period of military service. However, even if the disability is determined to have been incurred prior to entry on their current period of active duty, any aggravation of that disease, incurred during the Service member's current period of active duty, beyond that determined to be due to natural progression will be determined to be service-aggravated.

(5) There is no presumption of sound condition for RC members serving on orders of 30 days or less.

c. Presumption of Incurrence or Aggravation in the LOD for Members on Continuous Orders to Active Duty Specifying a Period of More Than 30 Days

(1) The Secretaries of the Military Departments will presume that diseases or injuries incurred by Service members on continuous orders to active duty specifying a period of more than 30 days were incurred or aggravated in the LOD unless the disease or injury was noted at time of entry into service. The Secretaries of the Military Departments may overcome the presumption that a disease or injury was incurred or aggravated in the LOD only when clear and unmistakable evidence indicates the disease or injury existed prior to their current period of military service and was not aggravated by their current period of military service.

~~(2) There is no presumption of incurrence or aggravation in the LOD for RC members serving on orders of 30 days or less.~~

(~~3~~2) Pursuant to the provisions of sections 1206(a) and 1207(a) of Reference (c), a preexisting condition is deemed to have been incurred while entitled to basic pay and will be considered for purposes of determining whether the disability was incurred in the LOD when:

(a) The Service member was ordered to active duty for more than 30 days (other than for training pursuant to section 10148(a) of Reference (c)) when the disease or injury was determined to be unfitting as subsequently determined by the PEB.

(b) The Service member was not a member of the RC released within 30 days of his or her orders to active duty in accordance with section 1206a of Reference (c) due to the identification of a preexisting condition not aggravated by the current call to duty.

(c) The Service member will have a career total of at least 8 years of active service at the time of separation.

(d) The disability was not the result of intentional misconduct or willful neglect or was incurred during a period of unauthorized absence.

d. RC Members Serving on Orders of 30 Days or Less.

(1) The Secretary of the Military Department concerned will determine if injuries and diseases to RC members serving on orders of 30 days or less were incurred or aggravated in the LOD as described in section 4 of this appendix.

(2) For RC members being examined in accordance with section 3 of this appendix, aggravation must constitute the worsening of a preexisting medical condition as a direct result of military duty and over and above the natural progression of the condition.

(3) There is no presumption of incurrence or aggravation in the LOD for RC Service members serving on orders of 30 days or less.

e. Prior Service ~~Impairment~~ *Condition*. Any medical condition incurred or aggravated during one period of active service or authorized training in any of the Military Services that recurs, is aggravated, or otherwise causes the member to be unfit, should be considered incurred in the LOD, provided the origin of such ~~impairment~~ *condition* or its current state is not due to the Service member's misconduct or willful negligence, or progressed to unfitness as the result of intervening events when the Service member was not in a duty status.

f. Medical Waivers

(1) Service members who entered the Military Service with a medical waiver for a preexisting condition and are subsequently determined unfit for the condition will not be entitled to disability separation or retired pay unless:

(a) Military service permanently aggravated the condition or hastened the condition's rate of natural progression; or

(b) The member will have 8 years of active service at the time of separation.

(2) Service members granted medical waivers will be advised of the waiver application process when applying for a waiver and when it is granted.

g. Treatment of Pre-existing Conditions. Generally recognized risks associated with treating preexisting conditions will not be considered service aggravation. Unexpected adverse events, over and above known hazards, directly attributable to treatment, anesthetic, or operation performed or administered for a medical condition existing before entry on active duty, may be considered service aggravation.

h. Elective Surgery or Treatment. A Service member choosing to have elective surgery or treatment done at his or her own expense will not be eligible for compensation in accordance with the provisions of this instruction for any adverse residual effect resulting from the elected treatment, unless it can be shown that such election was reasonable or resulted from a significant impairment of judgment that is the product of a ratable medical condition.

i. Rating Disabilities. When a disability is established as compensable, it will be rated in accordance with Reference (~~t~~*v*). When after careful consideration of all procurable and assembled data, a reasonable doubt arises regarding the degree of disability, such doubt will be resolved in favor of the Service member.

APPENDIX 4 TO ENCLOSURE 3

TDRL MANAGEMENT

1. INITIAL PLACEMENT ON THE TDRL

a. A Service member will be placed on the TDRL when the member meets the requirements for permanent disability retirement except that the disability is not determined to be stable but may be permanent. A disability will be determined stable when the preponderance of medical evidence indicates the severity of the condition will probably not change enough within the next ~~5~~ *3* years to increase or decrease the disability rating percentage*, pursuant to section 1210 of Reference (c)*.

b. Service members with unstable conditions rated at a minimum of 80 percent that are not expected to improve to less than an 80 percent rating will be permanently retired.

2. TDRL RE-EVALUATION. The TDRL will be managed to meet the requirements for periodic disability examination, suspension of retired pay, and prompt removal from the TDRL pursuant to chapter 61 of Reference (c), including the reexamination of temporary retirees at least once every 18 months to determine whether there has been a change in the disability for which the member was temporarily retired.

a. Initiating the TDRL Re-evaluation Process. No later than 16 months after temporarily retiring a Service member for disability or after his or her previous re-evaluation, the Military Department will obtain and review available DoD medical treatment documentation and VA or veteran-provided medical treatment, or disability examination that occurred within 16 months of being placed on the TDRL, and rating documentation. If the documents reviewed are deemed sufficient and consistent with the requirements of chapter 61, of Reference (c), the Military Department may rely on that documentation to determine whether there has been a change in disability for which the Service member was temporarily retired. The PEB will review the available evidence to determine if the documentation is sufficient to:

(1) Fully describe each disability that the Secretary of the Military Department concerned determined was unfitting and may be permanent but was unstable at the time the Service member was placed on the TDRL, the current status of such disabilities, the progress of the disability and a suggested time frame (not to exceed 18 months) for the next examination.

(2) Fully describe, including treatment and etiology, any new disability that was caused by or directly related to the treatment of a disability for which the Service member was previously placed on the TDRL.

b. Conduct of Disability Re-examinations. If the Military Department determines the available medical records and examination reports, including those available from VA, do not meet the requirements in paragraphs ~~2a(1)~~ *2.a.(1)* and ~~2a(2)~~ *2.a.(2)* of this appendix, the Military

Department will comply with their responsibilities in chapter 61 of Reference (c) regarding the TDRL, to include performing TDRL examinations that meet the requirements of paragraph ~~2a(1)~~ *2.a.(1)* and ~~2a(2)~~ *2.a.(2)* of this appendix.

c. PEB Re-adjudication. The Military Department will request that VA provide their most current rating and medical evidence upon which the most current rating was based for the condition for which the veteran was placed on the TDRL. The PEB ~~may use~~ *will consider* the future examination requirements set by the disability rating activity site (D-RAS) as an indicator of stability when making the recommendations of stability determinations and case disposition to the Secretary of the Military Department. If the PEB decides to continue a Service member on temporary retirement for disability for which the D-RAS has not scheduled a future examination, the Military Department will execute required TDRL examinations and ratings in accordance with chapter 61 of Reference (c).

d. PEB Disposition

(1) If the PEB finds the veteran fit for duty for the condition(s) for which he or she was placed on the TDRL; that the condition(s) is now stable; and the veteran wishes to return to active duty, the Military Department will administer any additional examinations required to evaluate whether the veteran is otherwise fit for duty in accordance with the Military Department's regulations and the guidance in this instruction. The Military Department will administer other dispositions in accordance with the guidance in this instruction.

(2) If upon re-evaluation while on the TDRL, the Service member is still found unfit ~~for~~ *due to* the unstable condition for which he or she was placed on the TDRL, evaluation of other conditions is not required. If the Service member is no longer found unfit for the unstable condition for which he or she was placed on the TDRL, an assessment will be made as to whether any other condition exists that would prevent a return to duty. If other conditions exist that render the Service member unfit, a determination will be made that the condition is unfitting but not compensable in the DES.

e. Cases on VA Appeal. When a Service member who was temporarily retired for disability has appealed a VA decision and the appeal resides with the Board of Veterans Appeals or Court of Appeals for Veterans' Claims, the Military Department will obtain from the VA a copy of the most current rating and medical evidence available.

(1) The Military Department will obtain and review the available DoD and the VA medical treatment and disability examination documentation available for the condition for which the Service member was placed on the TDRL.

(2) The Military Department will review the available medical evidence to determine if the documentation is sufficient to conduct the TDRL re-evaluation process without a disability examination of the Service member.

(3) If the PEB determines that the Service member requires an additional disability examination, the PEB will coordinate the actions needed to meet the statutory, 18-month

examination requirement in chapter 61 of Reference (c). Upon receipt of all necessary medical evidence, the PEB will adjudicate the case.

f. Administrative Finality. During TDRL re-evaluation, as described in paragraph ~~2a~~ *2.a.* of this appendix, previous determinations concerning application of any presumption established by this instruction, LOD, misconduct, and whether a medical ~~impairment~~ *condition* was permanent, service-incurred, or preexisting and aggravated will be considered administratively final for conditions for which the Service member was placed on the TDRL unless there is:

(1) Evidence of fraud.

(2) A change of diagnosis that warrants the application of accepted medical principles for a preexisting condition.

(3) A correction of error in favor of the Service member.

g. Required Determinations. The Secretary of the Military Department concerned will determine whether the conditions for which the Service member was placed on the TDRL are unfitting and compensable. When, upon re-evaluation, a temporarily retired veteran is determined fit for the conditions for which he or she was placed on the TDRL and has no other DoD compensable disabilities, the veteran will be separated from the TDRL without entitlement to DoD disability benefits.

h. Service Member Medical Records. The Service member will provide to the examining physician, for submission to the PEB, copies of all his or her medical records (e.g., civilian, VA, and military) documenting treatment since the last TDRL re-evaluation.

i. Compensability of New Diagnoses. Conditions newly diagnosed during temporary retirement will be compensable when:

(1) The condition is unfitting and;

(2) The condition was caused by or directly related to the treatment of a condition for which the Service member was previously placed on the TDRL.

(3) To correct an error in favor of the Service member, the Secretary of the Military Department concerned determines the condition was unfitting and compensable at the time the member was placed on the TDRL.

j. Current Physical Examination. Service members on the TDRL are not entitled to permanent retirement or separation with disability severance pay without a current periodic physical examination acceptable to the Secretary of the Military Department concerned as required by chapter 61 of Reference (c).

k. Refusal or Failure to Report. In accordance with chapter 61 of Reference (c), when a Service member on the TDRL refuses or fails to report for a required periodic physical

examination or provide his or her medical records in accordance with paragraph ~~2h~~ *2.h.* of this appendix, disability retired pay will be suspended.

(1) If the Service member later reports for the physical examination, retired pay will be resumed effective on the date the examination was actually performed.

(2) If the Service member subsequently shows just cause for failure to report, disability retired pay may be paid retroactively for a period not to exceed 1 year prior to the actual performance of the physical examination.

(3) If the Service member does not undergo a periodic physical examination after disability retired pay has been suspended, he or she will be administratively removed from the TDRL on the ~~fifth~~ *third* anniversary of the original placement on the list.

l. Priority. TDRL examinations, including hospitalization in connection with the conduct of the examination, will be furnished with the same priority given to active duty members.

m. Reports From Non-MTFs. MTFs designated to conduct TDRL periodic physical examinations may use disability examination reports from any medical facility or physician. The designated MTF remains responsible for the adequacy of the examination and the completeness of the report. The report must include the competency information specified in paragraph ~~2e~~*2.e.* of this appendix.

n. Incarcerated Members. A report of disability examination will be requested from the appropriate authorities in the case of a Service member imprisoned by civil authorities. In the event no report, or an inadequate report, is received, documented efforts will be made to obtain an acceptable report. If an examination is not received, disposition of the case will be in accordance with paragraph ~~2k~~ *2.k.* of this appendix. The Service member will be advised of the disposition and that remedy rests with the respective Military Department Board for Correction of Military Records.

APPENDIX 5 TO ENCLOSURE 3

ADMINISTRATIVE DETERMINATIONS

1. ADMINISTRATIVE DETERMINATIONS FOR PURPOSES OF EMPLOYMENT UNDER FEDERAL CIVIL SERVICE

a. The PEB renders a final decision on whether an injury or disease that makes the Service member unfit or that contributes to unfitness was incurred in combat with an enemy of the United States, was the result of armed conflict, or was caused by an instrumentality of war during war.

b. These determinations pertain to whether a military retiree later employed in federal civil service is entitled to credit of military service toward a federal civil service retirement in accordance with sections 8332 and 8411 of Reference (d); in accordance with section 2082 of Reference (f); ~~retention preference in accordance with section 3501 of Reference (d);~~ credit of military service for civil service annual leave accrual in accordance with section 6303 of Reference (d); and exclusion of federal income taxation in accordance with section 104 of Reference (e).

(1) Incurred in Combat with an Enemy of the United States. The disease or injury was incurred in the LOD in combat with an enemy of the United States.

(2) Armed Conflict. The disease or injury was incurred in the LOD as a direct result of armed conflict (see Glossary) in accordance with section~~s 3501 and~~ 6303 of Reference (d). The fact that a Service member may have incurred a disability during a period of war, in an area of armed conflict, or while participating in combat operations is not sufficient to support this finding. There must be a definite causal relationship between the armed conflict and the resulting unfitting disability.

(3) Instrumentality of War During a Period of War. The injury or disease was caused by an instrumentality of war, incurred in the LOD during a period of war as defined in sections 101 and 302 of Title 38, U.S.C. (Reference (~~ag~~*al*)), and makes the Service member unfit in accordance with section~~s 3501 and~~ 6303 of Reference (d). Applicable periods are:

(a) World War II. The period beginning December 7, 1941, and ending December 31, 1946; and any period of continuous service performed after December 31, 1946, and before July 26, 1947, if such period began before January 1, 1947.

(b) Korean Conflict. The period beginning June 27, 1950, and ending January 31, 1955.

(c) Vietnam Era. The period beginning August 5, 1964, and ending May 7, 1975.

(d) Persian Gulf. The period beginning August 2, 1990, through date to be prescribed by Presidential proclamation or law.

2. DETERMINATIONS FOR FEDERAL TAX BENEFITS. Disability evaluation includes a determination and supporting documentation on whether the Service member's disability compensation is excluded from federal gross income in accordance with Reference (e). For compensation to be excluded, the Service member must meet the criteria in either paragraph ~~2a~~ *2.a.* or ~~2b~~ *2.b.* of this appendix.

a. Status. On September 24, 1975, the individual was a military Service member, including the RC, or was under binding written agreement to become a Service member.

(1) A Service member who was a member of an armed force of another country on that date is entitled to the exclusion.

(2) A Service member who was a contracted cadet of the Reserve Officers Training Corps on that date is entitled to the exclusion.

(3) A Service member who separates from the Military Service after that date and incurs a disability during a subsequent enlistment is entitled to the exclusion.

b. Combat Related. This standard covers injuries and diseases attributable to the special dangers associated with armed conflict or the preparation or training for armed conflict. A disability is considered combat-related if it makes the Service member unfit or contributes to unfitness and the preponderance of evidence shows it was incurred under any of the following circumstances.

(1) As a Direct Result of Armed Conflict. The criteria are the same as those in paragraph 1.b. of this appendix.

(2) While Engaged in Hazardous Service. Such service includes, but is not limited to, aerial flight duty, parachute duty, demolition duty, experimental stress duty, and diving duty.

(3) Under Conditions Simulating War. In general, this covers disabilities resulting from military training, such as war games, practice alerts, tactical exercises, airborne operations, and leadership reaction courses; grenade and live fire weapons practice; bayonet training; hand-to-hand combat training; rappelling; and negotiation of combat confidence and obstacle courses. It does not include physical training activities, such as calisthenics and jogging or formation running and supervised sports.

(4) Caused by an Instrumentality of War. Occurrence during a period of war is not a requirement to qualify. If the disability was incurred during any period of service as a result of wounds caused by a military weapon, accidents involving a military combat vehicle, injury or sickness caused by fumes, gases, or explosion of military ordnance, vehicles, or material, the criteria are met. However, there must be a direct causal relationship between the instrumentality

of war and the disability. For example, an injury resulting from a Service member falling on the deck of a ship while participating in a sports activity would not normally be considered an injury caused by an instrumentality of war (the ship) since the sports activity and not the ship caused the fall. The exception occurs if the operation of the ship caused the fall.

3. RECOUPMENT OF BENEFITS. In accordance with sections 303a and 373 of Reference (~~af~~*ak*), when a Service member is retired, separated or dies as a result of a combat-related disability and has received a bonus, incentive pay, or similar benefit, the Secretary of the Military Department concerned:

a. Will not require repayment by the Service member or his or her family of the unearned portion of any bonus, incentive pay, or similar benefit previously paid to the Service member.

b. Will require the payment to the Service member or his or her family of the remainder of any bonus, incentive pay, or similar benefit that was not yet paid to the member, but to which he or she was entitled immediately before the death, retirement, or separation.

c. Will not apply paragraphs ~~3a~~ *3.a.* and ~~3b~~ *3.b.* of this appendix if the death or disability was the result of the Service member's misconduct.

4. DETERMINATION FOR RC MEMBERS WHO ARE TECHNICIANS AND DETERMINED UNFIT BY THE DES. In accordance with section 10216(g) of Reference (c), the record of proceedings for RC members who are technicians and determined unfit by the DES must include whether the member was determined unfit due to a combat-related event.

APPENDIX 6 TO ENCLOSURE 3

FINAL DISPOSITION

1. FINAL DECISION AUTHORITY

a. Secretary of Defense. The Secretary of Defense, after considering the recommendation of the USD(P&R), approves or disapproves the appeal of any Service member found fit for duty by the PEB but determined unsuitable for continued service by the Secretary of the Military Department concerned for the same medical condition considered by the PEB.

b. USD(P&R). The USD(P&R), after considering the recommendation of the ASD(HA), approves or disapproves the disability retirement of any general or flag officer or medical officer being processed for, scheduled for, or receiving non-disability retirement for age or length of service.

c. Secretaries of the Military Departments. Except as stated in paragraphs ~~1a~~ *1.a.* and ~~b~~ *b* of this appendix, the Secretary of the Military Department concerned has the authority to make all determinations in accordance with this instruction regarding unfitness, disability percentage, and entitlement to disability severance and retired pay.

2. GENERAL RULES REGARDING DISPOSITION

a. Retirement

(1) Except for Service members approved for permanent limited duty consistent with section 3 of this appendix, any Service member on active duty or in the RC who is found to be unfit will be retired, if eligible, or separated. This general rule does not prevent disciplinary or other administrative separations from the Military Services.

(2) Selected Reserve members with at least 15 but no more than 20 years of qualifying service pursuant to section 12732 of Reference (c) who are to be separated, may elect either separation for disability or early qualification for retired pay at age 60 pursuant to sections 12731 and ~~12731(b)~~ *12731b* of Reference (c). However, the separation or retirement for disability cannot be due to the member's intentional misconduct, willful failure to comply with standards and qualifications for retention, or willful neglect, and cannot have been incurred during a period of unauthorized absence or excess leave.

b. Removal From the TDRL. Service members determined fit as a result of TDRL re-evaluation will be processed as:

(1) Appointment and/or Enlistment. Upon the Service member's request, and provided he or she is otherwise eligible, the Secretary of the Military Department concerned will appoint

or enlist the Service member in the applicable grade and component as outlined in section 1211 of Reference (c).

(2) Recall to Active Duty

(a) Regular Officers and Enlisted Members. Subject to their consent, regular officers and enlisted members will be recalled to duty, if they are otherwise eligible and were not separated in accordance with law or regulation at the time they were placed on the TDRL. They will be deemed medically qualified for those conditions on which a finding of fit was determined. Any new condition arising between DES evaluation and recall must meet the respective Military Service's medical standards for retention.

(b) RC. Subject to their consent, RC officers, warrant officers, and enlisted members will be reappointed or reenlisted as a Reserve for service in their respective RC in accordance with section 1211 of Reference (c). RC members determined fit by TDRL re-evaluation will not be involuntarily assigned to the Individual Ready Reserve.

(3) Separation. In accordance with section 1210(f) of Reference (c), Service members required to be separated or retired for non-disability reasons at the time they were referred for disability evaluation and placed on the TDRL, if determined fit, will be separated or retired, as applicable.

(4) Termination of TDRL Status. TDRL status and retired pay will terminate upon discharge, recall, reappointment, or reenlistment, as outlined in section 1211 of Reference (c).

(5) Right to Apply for VA Benefits. A Service member may not be discharged or released from active duty due to a disability until he or she has been counseled on their right to make a claim for compensation, pension, or hospitalization with the VA.

3. CONTINUANCE OF UNFIT SERVICE MEMBERS ON ACTIVE DUTY OR IN THE RESERVES. Upon the request of the Service member or upon the exercise of discretion based on the needs of the Military Departments, the Secretary of the Military Department concerned may allow unfit Service members to continue in a permanent limited-duty status, either active or reserve duty in the same or different rating or occupational specialty. Such continuation may be justified by the Service member's service obligation or special skill and experience. The Secretaries of the Military Department concerned may also consider transfer to another Military Service.

4. TRANSITION BENEFITS. AC and RC members on active duty are entitled to the transition benefits established by Reference (~~a~~*eah*) when being separated or retired for disability unless waived by the DoD or prohibited by federal law.

5. DISPOSITIONS FOR UNFIT SERVICE MEMBERS

a. Permanent Disability Retirement. If the Service member is unfit, retirement for a permanent and stable compensable disability is directed pursuant to section 1201 or 1204 of Reference (c) either:

(1) When the total disability rating is at least 30 percent in accordance with the VASRD and the Service member has less than 20 years of service computed pursuant to section 1208 of Reference (c); or

(2) When the Service member has at least 20 years of service computed pursuant to section 1208 of Reference (c) and the disability is rated at less than 30 percent.

b. Placement on the TDRL. Retirement is directed pursuant to section 1202 or 1205 of Reference (c) when the requirements for permanent disability retirement are met, except the disability is not stable and may be permanent.

c. Separation With Disability Severance Pay

(1) Criteria. Separation is directed pursuant to section 1203 or 1206 of Reference (c) when the member is unfit for a compensable disability determined in accordance with the standards of this instruction, and the following requirements are met. Stability is not a factor for this disposition.

(a) The Service member has less than 20 years of service computed pursuant to section 1208 of Reference (c).

(b) The disability is rated at less than 30 percent.

(2) Service Credit

(a) Pursuant to section 1212 of Reference (c), a part of a year of active service that is 6 months or more is counted as a whole year, and a part of a year that is less than 6 months is disregarded.

(b) The Secretary of the Military Department concerned will credit members separated from the Military Services for a disability with a minimum of 3 years of service.

(c) The Secretary of the Military Department concerned will credit members separated from the Military Services for a disability incurred in the LOD in a designated combat zone tax exclusion area or incurred during the performance of duty in combat-related operations consistent with the criteria in paragraph ~~2b~~ *2.b.* of Appendix 5 to this enclosure with a minimum of 6 years of service.

(d) For the purposes of calculating active service for disability severance pay, the Secretary of the Military Department concerned will consider disabilities to be incurred in

combat-related operations when they are consistent with the criteria in paragraph ~~2b~~ *2.b.* of Appendix 5 to this enclosure.

(3) Transfer to Retired Reserve

(a) Pursuant to section 1209 of Reference (c), RC members who have completed at least 20 qualifying years of Reserve service and who would otherwise be qualified for retirement may forfeit disability severance pay and request transfer to an inactive status list for the purpose of receiving non-disability retired pay at age 60. The Secretary of the Military Department concerned may offer the member the option to transfer to the Retired Reserve.

(b) When disability severance pay is accepted, the Service member forfeits all rights to receive retired pay pursuant to chapter 1223 of Reference (c) at age 60. There are no provisions pursuant to Reference (c) to repay disability severance pay to then receive retired pay.

(4) Selected Reserve Early Qualification for Retired Pay. ~~Pursuant to section 12731 of Reference (c),~~ RC members with at least 15 and less than 20 years of qualifying service who would otherwise be qualified for ~~nonregular~~ *non-regular* retirement may waive disability disposition and request early qualification for retired pay in accordance with ~~12731(b)~~ *section 12731b* of Reference (c).

d. Separation Without Entitlement to Benefits. Discharge is directed in accordance with section 1207 of Reference (c) when the Service member is unfit for a disability incurred as a result of intentional misconduct or willful neglect or during a period of unauthorized absence.

e. Discharge Pursuant to Other Than Chapter 61 of Reference (c). An unfit Service member is directed for discharge in accordance with other provisions of Reference (c) and Reference (~~ad~~*ai*) and DoDI 1332.30 (Reference (~~ah~~*am*)) when he or she is not entitled to disability compensation due to the circumstances when either:

(1) The Service member is not entitled to disability compensation, but may be entitled to benefits under section 1174 of Reference (c)~~.~~*; or*

(2) The medical ~~impairment~~ *condition* of an RC member is non-duty related and it disqualifies the member for retention in the RC.

f. Revert with Disability Benefits. Revert with disability benefits is used to return a retiree recalled to active duty who was:

(1) Previously retired for disability.

(2) Determined unfit during the period of recall. For Service members previously retired for age or years of service, the compensable percentage of disability must be 30 percent or more to receive disability benefits.

GLOSSARY

PART I. ABBREVIATIONS AND ACRONYMS

AC	Active Component
ASD(HA)	Assistant Secretary of Defense for Health Affairs
~~ASD(RA)~~	~~Assistant Secretary of Defense for Reserve Affairs~~
ASD(M&RA)	*Assistant Secretary of Defense for Manpower and Reserve Affairs*
DAC	Disability Advisory Council
~~DASD(WCP)~~	~~Deputy Assistant Secretary of Defense for Warrior Care Policy~~
DASD(HSP&O)	*Deputy Assistant Secretary of Defense for Health Services Policy and Oversight*
DES	disability evaluation system
DoDD	DoD Directive
DoDI	DoD Instruction
D-RAS	disability rating activity site
~~EDES~~	~~Expedited Disability Evaluation System~~
FPEB	formal physical evaluation board
GC DoD	General Counsel of the Department of Defense
IDES	Integrated Disability Evaluation System
IDT	inactive duty training
IPEB	informal physical evaluation board
IT	information technology
LDES	Legacy Disability Evaluation System
LOD	line of duty
MEB	medical evaluation board
MTF	military treatment facility
PEB	physical evaluation board

PEBLO	physical evaluation board liaison officer
RC	Reserve Component
TDRL	temporary disability retired list
U.S.C.	United States Code
USD(P&R)	Under Secretary of Defense for Personnel and Readiness
VA	Department of Veterans Affairs
VASRD	Department of Veterans Affairs Schedule for Rating Disabilities

PART II. DEFINITIONS

Unless otherwise noted, these terms and their definitions are for the purpose of this instruction.

accepted medical principles. Fundamental deductions, consistent with medical facts, that are so reasonable and logical as to create a virtual certainty that they are correct. *The Service PEB will state with specificity the basis(es) for the conclusion.*

active duty. Defined in ~~Joint Publication 1-02~~ *the DoD Dictionary of Military and Associated Terms* (Reference (~~a~~*ian*)).

acute. Characterized by sharpness or severity.

armed conflict. A war, expedition, occupation of an area or territory, battle, skirmish, raid, invasion, rebellion, insurrection, guerilla action, riot, or any other action in which Service members are engaged with a hostile or belligerent nation, faction, force, or terrorist. Armed conflict may also include such situations as incidents involving a member while interned as a prisoner of war or while detained against his or her will in the custody of a hostile or belligerent force or while escaping or attempting to escape from such confinement, prisoner-of-war, or detained status.

catastrophic injury or illness. A permanent, severely disabling injury, disorder, or disease incurred or aggravated in the LOD that compromises the ability to carry out the activities of daily living to such a degree that a Service member requires personal or mechanical assistance to leave home or bed or requires constant supervision to avoid physical harm to self or others.

clear and unmistakable evidence. Undebatable information that the condition existed prior to military service or if increased in service was not aggravated by military service. In other words, reasonable minds could only conclude that the condition existed prior to military service from a review of all of the evidence in the record.

compensable disability. A medical condition that is determined to be unfitting due to disability and that meets the statutory criteria of chapter 61 of Reference (c) for entitlement to disability retired or severance pay.

competency board. A board consisting of at least three medical officers or physicians (including one psychiatrist) convened to determine whether a member is competent (capable of making a rational decision regarding his or her personal and financial affairs).

DAC. A DoD-only group that evaluates DES functions, identifies best practices, addresses inconsistencies in policy, discusses inconsistencies in law, addresses problems and issues in the administration of the DES, and provides a forum to develop and plan improvements.

DES. The DoD mechanism for determining return to duty, separation, or retirement of Service members because of disability in accordance with chapter 61 of Reference (c).

disability. Any ~~impairment~~ *condition* due to disease or injury, regardless of degree, that reduces or prevents an individual's actual or presumed ability to engage in gainful employment or normal activity. The term "disability" or "physical disability" includes mental disease, but not such inherent defects as developmental or behavioral disorders. A medical ~~impairment~~ *condition*, mental disease, or physical defect standing alone does not constitute a disability. To constitute a disability, the medical ~~impairment~~ *condition*, mental disease, or physical defect must be severe enough to interfere with the Service member's ability to adequately perform his or her duties.

duty-related medical conditions. Conditions that were incurred or aggravated while the AC or RC Service member was performing duty.

~~EDES. A voluntary expedited process to authorize benefits, compensation, and specialty care to Service members who sustain catastrophic injuries or illnesses.~~

elective surgery. Surgery that is not essential, especially surgery to correct a condition that is not life-threatening; surgery that is not required for survival.

final reviewing authority. The final approving authority for the findings and recommendations of the PEB.

grave. Very serious: dangerous to life-used of an illness or its prospects.

IDES. The joint DoD -VA process by which DoD determines whether ill or injured Service members are fit for continued military service and DoD and VA determine appropriate benefits for Service members who are separated or retired for disability.

instrumentality of war. A vehicle, vessel, or device designed primarily for military service and intended for use in such service at the time of the occurrence or injury.

LDES. A DES process by which DoD determines whether eligible wounded, ill, or injured Service members are fit for continued military service and determines appropriate benefits for Service members who are separated or retired for disability. Service members processed through the LDES may also apply for veterans' disability benefits through the VA pre-discharge Benefits Delivery at Discharge or Quick Start programs, or upon attaining veteran status.

LOD determination. An inquiry to determine whether an injury or illness was incurred when the Service member was in a military duty status. If the Service member was not in a military duty status, whether it was aggravated by military duty; or whether it was incurred or aggravated due to the Service member's intentional misconduct or willful negligence.

MEB convening authority. A senior medical officer, appointed by the MTF commander, who has detailed knowledge of standards of medical fitness and disposition of patients and disability separation processing and who is familiar with the VASRD.

MEB process. For Service members entering the DES, the MEB conducts the medical evaluation on conditions that potentially affect the Service member's fitness for duty. The MEB documents the Service member's medical condition(s) and history with an MEB narrative summary as part of an MEB packet.

medical ~~impairment~~ *condition*. Any disease or residual of an injury that results in a lessening or weakening of the capacity of the body or its parts to perform normally, according to accepted medical principles.

non-duty-related medical conditions. ~~Impairments~~ *Conditions* that were neither incurred nor aggravated while the *AC or RC Service* member was performing duty.

office, grade, rank, or rating

office. A position of duty, trust, and authority to which an individual is appointed.

grade. A step or degree in a graduated scale of office or military rank that is established and designated as a grade by law or regulation.

rank. The order of precedence among members of the Military Services.

rating. The name (such as "Boatswain's Mate") prescribed for Service members of a Military Service in an occupational field.

PEBLO. The non-medical case manager who provides information, assistance, and case status updates to the affected Service member throughout the DES process.

permanent limited duty. The continuation on active duty or in the Ready Reserve in a limited-duty capacity of a Service member determined unfit because of disability evaluation or medical disqualification.

presumption. An inference of the truth of a proposition or fact reached through a process of reasoning and based on the existence of other facts. Matters that are presumed need no proof to support them, but may be rebutted by evidence to the contrary.

proximate result. A permanent disability the result of, arising from, or connected with active duty, annual training, active duty for training, or IDT, to include travel to and from such duty or remaining overnight between successive periods of IDT. Proximate result is a statutory criterion for entitlement to disability compensation under chapter 61 of Reference (c) applicable to RC members who incur or aggravate a disability while performing an ordered period of military duty of 30 days or less.

retention standards. Guidelines that establish medical conditions or physical defects that could render a Service member unfit for further military service and may be cause for referral of the Service member into the DES.

service aggravation. The permanent worsening of a pre-Service medical condition over and above the natural progression of the condition.

service treatment record. ~~A chronological record documenting the medical care, dental care and treatment received primarily outside of a hospital (outpatient), but may contain a synopsis of any inpatient hospital care and behavioral health treatment.~~ *The chronologic record of medical, dental, and mental health care received by Service members during the course of their military career. It includes documentation of all outpatient appointments (i.e., without overnight admittance to a hospital, clinic, or treatment facility), as well as summaries of any inpatient care (discharge summaries) and care received while in a military theater of operations. The service treatment record is the official record used to support continuity of clinical care and the administrative, business-related, and evidentiary needs of the DoD, the VA, and the individual.*

EXHIBIT 13

Administrative Records of Roe and Voe

UNDER SEAL

Case 18-cv-01565 DKT 270-14 Filed 5/4/20

Placeholder cover page for Ex. 14

EXHIBIT 15

Air Force Personnel Vote Sheet Regarding Victor Voe
May 4, 2018

UNDER SEAL

EXHIBIT 16

Air Force Personnel Vote Sheet
Regarding Victor Voe
October 18, 2018

UNDER SEAL

EXHIBIT 17

Excerpts from the March 6, 2019
Deposition of Martha Soper

UNDER SEAL

EXHIBIT 18

Excerpts from the February 28, 2019
Deposition of Anthony Blevins

UNDER SEAL

EXHIBIT 19

Plaintiff OutServe-SLDN's Second Supplemental Responses to Defendants' First Set of Interrogatories

UNDER SEAL

EXHIBIT 20

Expert Report of W. David Hardy, 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 W. DAVID HARDY, M.D.

I. INTRODUCTION

1. My name is W. David Hardy. 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 opinions regarding HIV—its etiology, the mechanism by which it operates to undermine a person's immune system, the routes and relative risks of transmission, the care and treatment of people living with HIV, the effect of treatment with antiretrovirals on the immunological and overall health of people living with HIV, and the effect of treatment on the risks of transmission.

3. The opinions I express are my own and do not reflect the official policy of any organization with which I am affiliated. I am not receiving any compensation for my work.

4. I am knowledgeable about the matters set forth below based upon my own knowledge and experience, as well as my review of various materials cited herein.

5. In the past four years, I have not offered testimony at trial or at a deposition.

II. PROFESSIONAL BACKGROUND & QUALIFICATIONS

6. I am currently the Chairman of the Board ("Chair") of the HIV Medicine Association and an Adjunct Professor of Medicine at the Johns Hopkins University School of Medicine. I have 36 years of experience in the care and treatment of people living with HIV, including 34 years of experience researching opportunistic infections, antiretroviral agents, immunotherapies, retroviral vector research, and gene therapy. My curriculum vitae is attached, which describes my education, work experience, and publications. *See* Attach. 1 (Hardy CV).

7. While serving as Chair of the HIV Medicine Association, I also served as Senior Director of Research at Whitman-Walker Health in Washington, DC, from 2015 to 2018. From 2013 to 2015, I was the Chief Medical Officer of Calimmune, a translational science company investigating gene-modified cellular therapies as a potential cure for HIV. Prior to that, I was the Director of the

Division of Infectious Diseases at Cedars-Sinai Medical Center and a Professor of Medicine at the David Geffen School of Medicine at UCLA from 2002 to 2013.

8. I received my medical degree from Baylor College of Medicine. I completed my residency in internal medicine at Harbor-UCLA Medical Center and completed a clinical fellowship in infectious diseases/immunology and clinical research at the UCLA School of Medicine from 1984 to 1986 under the direction of Dr. Michael Gottlieb, the physician who recognized and reported the first cases of AIDS. I later completed a post-doctoral fellowship at UCLA with Irvin Chen, PhD, focusing on molecular retrovirology.

9. For more than 30 years, I have been dedicated to the treatment of people living with HIV. In addition to research and teaching, I have served as Editor-in-Chief of *Fundamentals of HIV Medicine for the HIV Specialist*, the comprehensive textbook of the American Academy of HIV Medicine, and currently serve on that organization's Board of Directors as the Chair of the Education Committee. I also have a long history of working with a number of community-based organizations that provide or provided critical services for persons living with HIV, including AIDS Research Alliance, Alliance for Housing and Healing, Being Alive-Empowering People with HIV/AIDS, Project Angel Food, and AIDS Project Los Angeles.

III. BACKGROUND ON THE HUMAN IMMUNODEFICIENCY VIRUS

A. An Introduction to HIV

10. Since the Acquired Immune Deficiency Syndrome (AIDS) was first identified as a high-mortality disease in the United States in 1981, there has been incredible progress in better understanding its causative agent, the human immunodeficiency virus (HIV), as well as in the development of highly effective treatment of this disease.[1] Once considered invariably fatal

[1] *See generally*, Am. Acad. of HIV Med., *Fundamentals of HIV Medicine* (W. David Hardy ed., CME ed. 2017) (hereinafter "*Fundamentals of HIV Medicine*").

within a matter of years, HIV is now considered a chronic, treatable condition.[2] Today, persons with HIV who are diagnosed in a timely manner and engaged in medical care and treatment with antiretroviral medications experience minimal effects on their physical health and increasingly enjoy the life expectancy of those who do not have HIV.[3]

11. HIV attacks the body's immune system. Specifically, HIV attacks and progressively depletes the body's CD4+ T cells, commonly referred to as T cells. When HIV infects and takes over a CD4+ T cell, it uses the cell's biosynthetic resources to produce multiple copies of itself and then releases them to attack other CD4+ T cells, leaving the previous producer cell to die.

12. CD4+ T cells are an essential component of the human immune system, protecting the body from many types of infections and cancers. As HIV unrelentingly reduces the number of CD4+ T cells in the body, the weakened immune system progressively fails to protect a person from life-threatening infections and cancer.

13. Following the acute stage of infection, a person living with HIV enters a period of clinical latency that can last years. After 4–10 years, however, if the person does not receive appropriate treatment, the amount of virus in their blood (i.e., "viral load") will progressively rise and their CD4+ T cells dwindle away to low levels. Eventually, an untreated individual's CD4+ T cell count will drop below 200/mm^3 and/or the person will develop an opportunistic infection, one to which the body would not be susceptible without HIV-induced immunodeficiency. At this point, that person would be diagnosed as having AIDS.

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[2] *See id.*
[3] *See id.*

B. The Treatment of HIV

14. At almost any point along the course of HIV infection, treatment with modern antiretroviral therapy will halt and reverse the downward slope in immune function and restore the person to good health.

15. The early days of developing treatment for HIV (i.e., 1985–1995) produced dismal or only short-term beneficial results. Finally, in 1996, effective triple-combination antiretroviral therapy (ART) became available. Medical researchers discovered that to fight a rapidly replicating, rapidly mutating, diabolical virus, a combination of at least three antiretroviral medications that hit the virus in at least two vital areas could not only shut down HIV from reproducing and allow the immune system to rebuild, but could also prevent the virus from mutating and becoming resistant to the medications. This had been the major problem with previous mono- and dual-therapy approaches. Since 1996, the development of ART has advanced substantially. Initial triple-combination regimens required a person with HIV to take as many as 24 tablets daily, spread over 2–3 dosages each day, with and without food. These early regimens carried significant side effects, severe enough that fewer than 50% of those who started could tolerate the regimen for more than 6 months. Today, ART development has produced more potent drugs that suppress HIV quicker than before and are extremely well-tolerated and easy to take. These advances have led to the point where, today, multiple single-tablet regimens—combinations of 3 or 4 drugs co-formulated into one tablet—have made it possible to treat HIV with "one pill once a day."

16. With consistent adherence to their ART regimen, a person living with HIV sees their viral load drop and their CD4+ T cell count rebound.[4] Within 4–6 weeks, most people's HIV will become "virally suppressed," defined as fewer than 200 copies of the virus per milliliter of blood,[5] and shortly after that, they would have an "undetectable"[6] viral load, which is generally defined as fewer than 50 copies per milliliter of blood.

17. Persons living with HIV who consistently adhere to their antiretroviral medications will achieve and maintain an undetectable viral load.[7] There is an effective treatment regimen for virtually every person living with HIV. Reasons for not reaching an undetectable viral load are related to a lack of consistent access to the health care and/or other social determinants of health, such as unstable housing or food insecurity, that make medication adherence more difficult. Once a person is consistently taking an effective ART regimen and has achieved an undetectable viral load, their medical care needs become quite simple. The DHHS Guidelines recommend medical monitoring visits only once every 6 months to re-check viral

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[4] *See Fundamentals of HIV Medicine*, at Ch. 17: Overview of ARV Therapy.

[5] *See* U.S. Centers for Disease Control and Prevention, *Evidence of HIV Treatment and Viral Suppression in Preventing the Sexual Transmission of HIV* (Dec. 2018), https://www.cdc.gov/hiv/pdf/risk/art/cdc-hiv-art-viral-suppression.pdf; U.S. Centers for Disease Control and Prevention, *HIV Treatment as Prevention* (Dec. 18, 2018), https://www.cdc.gov/hiv/risk/art ("[V]iral suppression [is] defined as having less than 200 copies of HIV per milliliter of blood.")

[6] At one time, the testing technologies were not sensitive enough to reliably detect the virus below approximately 50 copies per milliliter. Newer testing technologies are able to detect HIV below this level, but the term "undetectable" is still used to describe a viral load at or below this level.

[7] *See Fundamentals of HIV Medicine*, at Ch. 17: Overview of ARV Therapy.

load, sometimes CD4+ T cells and other potential health issues.[8] Increasingly, it is becoming common for physicians to see a well-suppressed, adherent patient once a year.

18. Development of resistance to an ART regimen does not occur randomly. Almost exclusively, resistance occurs because a patient is not adherent to their prescribed medications. One of the important features of the ART regimens used today is that if the virus is suppressed, the development of mutations that lead to resistance becomes impossible. With three or more medications combatting the virus using multiple targets at the same time, the virus is not able to mutate around any of those medications. For patients who develop resistance due to non-adherence, constructing a different regimen to which their virus has not developed resistance and to which they are subsequently adherent will regain viral suppression for that patient.[9] I would not expect a patient to develop viral resistance to medication after abruptly stopping or discontinuing medications. I would expect that someone who stopped taking their medication would continue to have a suppressed viral load for 4–12 weeks.[10] They would not develop symptoms of HIV for several months or years after discontinuing medication.

19. As antiretroviral medications have become increasingly better tolerated over the past 20 years, adherence to ART regimens has grown increasingly easier. Today, most people living with HIV are on a single tablet regimen ("STR")—in which all three or four medications are combined into one pill—that is taken once a day. STRs have few, if any, dietary restrictions and although they contain multiple medications, their side effects are minimal, transient, and

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[8] *See* U.S. Dep't of Health and Human Services, *Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents Living with HIV* (Oct. 25, 2018), https://aidsinfo.nih.gov/guidelines/html/1/adult-and-adolescent-arv/282.
[9] *Fundamentals of HIV Medicine*, at Ch.21: HIV-1 Resistance to Antiretroviral Drugs.
[10] Li JZ et al., *The size of the expressed HIV reservoir predicts timing of viral rebound after treatment interruption*, 30 AIDS 343, 343-53 (2016).

overall well-tolerated. Long gone is the time when persons living with HIV had to plan their lives around their medications and the attendant side effects.

20. A person who is diagnosed with HIV in a timely manner and adheres to their prescribed ART regimen has nearly the same life expectancy as a person who is not living with HIV.[11] The great majority of previous short-term and medium-term adverse effects associated with ART regimens have almost vanished. Gone are the days of persistent nausea, diarrhea, headaches, dizziness, unpleasant dreams, and body-shape-disfiguring lipodystrophy. Today, with near-normal anticipated lifespans, the majority of persons living with HIV enjoy a renewed and welcomed sense of long-term well-being and hope for an almost medically unblemished life. Some reports of higher prevalence of common medical problems such as cardiac disease, kidney disease, and bone demineralization have appeared, but have not been confirmed as being distinct from the effects of normal aging, a new phenomenon for many persons living with HIV.

C. The Transmission of HIV

21. HIV can be transmitted via only specific body fluids—blood, semen, pre-seminal fluid, rectal fluids, vaginal fluids, and breast milk.[12] For transmission to occur, these fluids from a person living with HIV must either come in contact with a mucous membrane or cut or punctured tissue or be directly injected into the bloodstream (with a needle or syringe). Mucous

[11] *See* U.S. Centers for Disease Control and Prevention, *About HIV/AIDS* (Mar. 9, 2019), https://www.cdc.gov/hiv/basics/whatishiv.html.
[12] *See* U.S. Centers for Disease Control and Prevention, *HIV Transmission* (Oct. 31, 2018), https://www.cdc.gov/hiv/basics/transmission.html

membranes are the moist tissues found inside the rectum, vagina, penis, and mouth. HIV is not spread through saliva, sweat, tears, urine, or feces.[13]

22. Most commonly, HIV is transmitted by engaging in sexual activities or sharing needles or syringes. Outside of the contexts of sexual activity and transmission via routes such as sharing of drug-injection equipment, blood transfusion, needle sticks, or perinatal exposure (including breastfeeding), transmission of HIV is rare. For all other activities—including biting, spitting, and throwing of body fluids—the CDC characterizes the risk as "negligible" and further states that "HIV transmission through these exposure routes is technically possible but unlikely and not well-documented."[14] HIV is approximately 10 times less transmissible than hepatitis C and 100 times less transmissible than hepatitis B.[15] In fact, the CDC estimates the chances of HIV transmission via a blood-filled needle puncture at 0.3%.[16]

23. Contrary to popular belief, HIV is not an easily transmitted virus. In the absence of treatment and condom use, the CDC estimates that the per-act risk of transmission for the riskiest sexual activity—receptive anal intercourse—is approximately 1.38% (138 out of 10,000 exposures).[17] The per-act risk of transmission for other sexual activities is between zero and .08%.[18]

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[13] *See Fundamentals of HIV Medicine*, at Ch. 3: Modes of HIV Transmission; *see also* U.S. Centers for Disease Control and Prevention, *HIV Transmission* (Oct. 31, 2018), https://www.cdc.gov/hiv/basics/transmission.html

[14] *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. 4, 2015), www.cdc.gov/hiv/risk/estimates/riskbehaviors.html (hereinafter "CDC Risk Behaviors").

[15] *See* U.S. Centers for Disease Control and Prevention, *Exposure to Blood, What Healthcare Personnel Need to Know* (July 2003), https://www.cdc.gov/hai/pdfs/bbp/exp_to_blood.pdf.

[16] *See* CDC Risk Behaviors.

[17] *See id*.

[18] *See id.*

24. Furthermore, it is now universally accepted by the HIV scientific community that people living with HIV who are virally suppressed or have an undetectable viral load are incapable of transmitting the virus to HIV-negative persons.[19] Advances in our understanding of the transmission-blocking effects of ART have led the CDC to declare that " . . . people who take ART daily as prescribed and achieve and maintain an undetectable viral load have effectively no risk of sexually transmitting the virus to an HIV negative partner."[20] This statement speaks loudly to the high quality of scientific evidence underlying this pronouncement. I personally received this information with great enthusiasm. Having watched this area of research in HIV interpersonal transmission for years, the results of HPTN 052 and the PARTNER 1 and 2 studies tested the question of HIV sexual transmission between MSM (men who have sex with men) as well as heterosexuals with rigorous scientific study design, follow-up, and analysis. The fact that no linked transmissions occurred between any MSM or heterosexual serodiscordant couples after thousands of condomless sex acts provides scientific evidence to confirm the power of ART in preventing HIV transmission. It is not surprising that there have been and will be rare case reports of suspected HIV transmission challenging the CDC's statement (e.g., Case report: Is transmission of HIV-1 in non-viraemic, serodiscordant couples possible?). However, significant limitations in these reports purportedly documenting a new seroconversion frequently invalidates them.

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[19] *See* U.S. Centers for Disease Control and Prevention, *HIV Treatment as Prevention* (Dec. 18, 2018), https://www.cdc.gov/hiv/risk/art

[20] *See* U.S. Centers for Disease Control and Prevention, *Dear Colleague: Information from CDC's Division of HIV/AIDS Prevention* (Sept. 27, 2017), https://www.cdc.gov/hiv/library/dcl/dcl/092717.html; U.S. Centers for Disease Control and Prevention, *Treatment as Prevention* (Dec. 18, 2018), http://www.cdc.gov/hiv/risk/art ("People with HIV who take HIV medicine as prescribed and get and keep an undetectable viral load have effectively no risk of transmitting HIV to their HIV-negative sexual partners.").

25. As further stated in the CDC letter, "Across three different studies, including thousands of couples and many thousands of acts of sex without a condom or pre-exposure prophylaxis (PrEP), no HIV transmissions to an HIV-negative partner were observed when the HIV-positive person was virally suppressed"[21] (i.e., a viral load of fewer than 200 copies/ml).

26. Based on these studies regarding the effect of a suppressed or undetectable viral load on sexual transmission risk, and the extremely low—and possibly only theoretical—risk of transmission via blood splash and other non-injection activities, I am reasonably certain that it is not possible for a person with a suppressed or undetectable viral load to transmit HIV through such exposures.

D. The Risk of Neurocognitive Impairment is Speculative, at Best

27. I understand that in August 2018, at the request of Congress, the Department of Defense ("DoD") submitted a report titled *Department of Defense Personnel Policies Regarding Members of the Armed Forces Infected with Human Immunodeficiency Virus* ("2018 Report").[22] This report provides "[a] description of policies addressing the enlistment or commissioning,

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[21] The cases referenced in the CDC letter: Myron Cohen et al., *Prevention of HIV-1 Infection with Early Antiretroviral Therapy*, 365 New Eng. J. of Med. 493, 493–505 (Aug. 11, 2011) (explaining the results of HIV Prevention Treatment Network Study No. 052); AJ Rodger et al., *Sexual Activity Without Condoms and Risk of HIV Transmission in Serodifferent Couples When the HIV-Positive Partner Is Using Suppressive Antiretroviral Therapy*, 316 J. of the Am. Med. Ass'n 171, 171–181 (2016) (explaining the results of the PARTNER study); Andrew Grulich et al., HIV Transmissions in Male Serodiscordant Couples in Australia, Thailand and Brazil, University of South Wales (Feb 26, 2015), https://www.croiconference.org/sites/default/files/posters-2015/1019LB.pdf (explaining the results of the Opposites Attract study reported at the Conference on Retroviruses and Opportunistic Infections (CROI) in 2015).

[22] 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").

retention, deployment, discharge, and disciplinary policies regarding individuals with this condition [HIV]."[23]

28. The 2018 Report contains a section on "Recent Findings Signifying Impairments Despite Viral Suppression and Asymptomatic HIV."[24] Specifically, the Report suggests that people living with HIV on ART *may* develop certain types of neuro-cognitive impairment (NCI).[25] But the 2018 Report then indicates the "impact of these *potential* NCI on a Service member's readiness, resilience, and/or retention is currently unknown."[26] In other words, it does not appear that the DoD has determined that the development of NCI is likely, much less that it would have any significant impact on the readiness, resilience, or retention of service members living with HIV. Such possible, but not well-documented, side effects that some researchers are *beginning* to believe *may* occur after long-term infection with HIV can and should be dealt with, if they occur, on a case-by-case basis. The occurrence of NCI as a result of an HIV diagnosis and/or HIV treatments is far too rare and speculative to justify a policy that would prevent all people living with HIV from serving in the military. In fact, the 2018 Report states that "HIV positive patients diagnosed and managed early during the course of HIV infection had a low prevalence of NCI. ***This is comparable to matched HIV-uninfected persons***."[27] In short, the DoD's own report says that the prevalence of NCI is "comparable" to the prevalence of NCI in the general population, which is consistent with my experience. A 2013 study found that people living with HIV who had been diagnosed and managed early had a similar prevalence of NCI

[23] *Id.* at 1.
[24] 2018 Report at 20.
[25] *Id.* (emphasis added).
[26] *Id.* at 21 (emphasis added).
[27] *Id.* at 20 (emphasis added).

compared to the individuals without HIV.[28] Another study found that HIV status had less of an effect on cognition than years of education, age, and reading level.[29] Therefore, there does not appear to be any evidence that NCI would be more likely to affect service members with HIV, especially because those service members would be receiving care for their HIV.[30] In fact, the DHHS guidelines only reference NCIs in older people taking ART and do not recommend testing in any population.[31]

29. To the extent that NCI does occur in service members living with HIV, their onset could be addressed under the general retention or deployment standards and/or the specific retention and deployment standards relating to neurodegenerative disorders.

IV. CONCLUSION

I understand HIV is now a relatively easy-to-manage, chronic condition that, when properly treated, presents no cognizable risk to the health or safety of others through occupational exposures, including exposures that could potentially occur during military service.

I declare under penalty of perjury that the foregoing is true and correct.

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[28] Nancy F. Crum-Cianflone et al., *Low Prevalence of Neurocognitive Impairment in Early Diagnosed and Managed HIV-Infected Persons*, 80 Am. Acad. of Neurology 371, 375 (2013).
[29] Richard W. Price, *HIV-Associated Neurocognitive Disorders: Epidemiology, Clinical Manifestations, and Diagnosis*, Wolters Kluwer (last updated Oct. 2018), https://www.uptodate.com/contents/hiv-associated-neurocognitive-disorders-epidemiology-clinical-manifestations-and-diagnosis.
[30] Blaylock Dep. 147:13–148:1; Shell Dep. 301:22–302:19.
[31] *See* U.S. Dep't of Health and Human Services, *Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents Living with HIV* (Oct. 25, 2018), https://aidsinfo.nih.gov/guidelines/html/1/adult-and-adolescent-arv/282.

Executed this 22nd day of March, 2019

W. David Hardy, M.D.

ATTACHMENT 1

Curriculum Vitae
W. David Hardy, M.D.

PERSONAL HISTORY:

Title:	Adjunct Professor of Medicine Division of Infectious Diseases Johns Hopkins University School of Medicine
OFFICE ADDRESS:	4627 47th Street, NW, Washington, DC 20016-4436
Office Phone:	(310) 709-3505
E-MAIL ADDRESS:	wdavidhardymd@gmail.com
Mobile Phone:	(310) 709-3505
PLACE OF BIRTH:	Dallas, Texas
CITIZENSHIP:	U. S. Citizen
PARTNER:	Barry Goldblatt

EDUCATION & TRAINING:

1974-1977	University of Texas at Austin, Texas; (Zoology/Classics) Summa Cum Laude
1977-1981	Baylor College of Medicine, Houston, Texas; Doctor of Medicine with Honors
1981-1982	Internship in Internal Medicine, Department of Medicine, Baylor College of Medicine Affiliated Hospitals, Houston, Texas
1982-1984	Residency in Internal Medicine, Department of Medicine, Harbor-UCLA Medical Center, Torrance, California
1984-1986	Clinical Fellowship in Infectious Diseases and Clinical Immunology (Mentors-Michael S. Gottlieb, MD/Lowell Young, MD), Department of Medicine, University of California - Los Angeles School of Medicine, Los Angeles, CA
1984-1986	Clinical Research Fellowship (Mentor-Michael S. Gottlieb, MD), UCLA AIDS Center, Department of Medicine, University of California – Los Angeles School of Medicine, Los Angeles, California
1998-2002	Laboratory Research Fellowship, Laboratory of Irvin S. Y. Chen, Ph.D., Department of Microbiology, Immunology and Molecular Genetics, David Geffen School of Medicine, UCLA, Los Angeles, CA

LICENSURE:

District of Columbia, #043801
State of California, #C-40623
State of Texas #F-9536

BOARD CERTIFICATION:

1984	Diplomat, American Board of Internal Medicine, Internal Medicine
2015	Diplomat, American Board of Internal Medicine, Infectious Diseases

PROFESSIONAL EXPERIENCE:

1984-1986	Staff Physician, Department of Medicine, UCLA School of Medicine, Los Angeles, California
1986	Visiting Assistant Professor, Division of Clinical Immunology/Allergy, Department of Medicine, University of California-Los Angeles School of Medicine, Los Angeles, California (Full-time Faculty)
1986-1987	Assistant Clinical Professor of Medicine, Division of Infectious Diseases, Department of Medicine, University of California - San Diego School of Medicine, San Diego, California (Full-time Faculty)
1986-1987	Co-Investigator, NIH/ NIAID-sponsored AIDS Clinical Trials Unit (ACTU) University of California - San Diego School of Medicine, San Diego, California
1986-1987	Staff Physician, Owen Clinic (HIV Outpatient Clinical Services), University of California - San Diego School of Medicine, San Diego, California
1987-1993	Assistant Clinical Professor of Medicine, Division of Infectious Diseases, Department of Medicine, University of California - Los Angeles School of Medicine, Los Angeles, California (Full-time Faculty)
1987-1996	Director, Infectious Diseases/Immunology (HIV/AIDS) Clinic, Department of Medicine, UCLA Medical Center, Los Angeles, California
1987-1996	Co-Investigator, NIH/NIAID-sponsored AIDS Clinical Trials Unit (ACTU), University of California – Los Angeles School of Medicine, Los Angeles, California
1988-2010	President and Cofounder, Los Angeles Physicians AIDS Forum (LAPAF), UCLA Center for AIDS Research and Education (CARE; 1988-1996), Independent HIV/AIDS-focused Continuing Medical Education (CME) Provider, Los Angeles, California
1990-1996	Co-Principal Investigator, NIH/NEI-sponsored Studies of the Ocular Complications of AIDS (SOCA), Department of Ophthalmology, University of California - Los Angeles School of Medicine, Los Angeles, California
1993-1996	Associate Clinical Professor of Medicine, Division of Infectious Diseases, Department of Medicine, University of California, Los Angeles, School of Medicine, Los Angeles, California (Accelerated Promotion on Full-time Faculty)

1993-1996	Principal Investigator, NIH/NIAID-sponsored, Multidisciplinary HIV/AIDSTraining Grant (T32AI07388), UCLA AIDS Institute, University of California – Los Angeles School of Medicine, Los Angeles, California
1994-1996	Associate Director for Community Liaison, UCLA Center for AIDS Research (CFAR), UCLA AIDS Institute, University of California - Los Angeles School of Medicine, Los Angeles, California
1994-1996	Program Director, Infectious Diseases Fellowship Training Program, Division of Infectious Diseases, Department of Medicine, University of California – Los Angeles School of Medicine, Los Angeles, California
1996-2002	Clinical Associate Professor of Medicine, Department of Medicine, University of California - Los Angeles School of Medicine, Los Angeles, California (Volunteer Teaching Faculty)
1996-2002	Scientific Director of Research, Research Department, Pacific Oaks Medical Group, Beverly Hills, California
1996-2002	Private Practice Specializing in Infectious Diseases and HIV Medicine, Pacific Oaks Medical Group, Beverly Hills, California
2002-2009	Principal Investigator, NIH/NIAID - K08 AI-49759-01A2, *"Developing Foamy Virus Vectors for HIV-1 Vaccine Applications"*, Cedars-Sinai Medical Center, Los Angeles, California (5-year grant with 2, 1-year no-cost extensions)
2002–2013	Director, Division of Infectious Diseases, Department of Medicine, Cedars-Sinai Medical Center, Los Angeles, California
2002-2012	Associate Professor of Medicine-in-Residence, Division of Infectious Diseases, Department of Medicine, David Geffen School of Medicine, University of California - Los Angeles, Los Angeles, California
2002–2013	Associate Program Director, Cedars-Sinai-UCLA Multi-campus Infectious Diseases Fellowship Training Program (Cedars-Sinai Medical Center, Olive View- UCLA Medical Center, Greater Los Angeles VA Medical Center), Los Angeles, California
2003-2012	Co-Principal Investigator, NIH/ NIAID-funded U01, "*Solid Organ Transplantation in HIV: Multi-site Study,* Departments of Medicine and Surgery, Cedars-Sinai Medical Center, Los Angeles, California
2007-2012	Co-Investigator, NIH/NIMH-funded R01, "*HIV, Aging and Cognition: A Synergism?"*, Department of Psychiatry and Behavioral Medicine, Cedars-Sinai Medical Center, Los Angeles, California
2008-2011	Associate Program Director, NIH/NCRR-sponsored General Clinical Research Center (GCRC), Cedars-Sinai Medical Center, Los Angeles, California

2011–2013 Associate Program Director, NIH/NCATS-sponsored Clinical and Translational Research Center (CTRC), UCLA CTSI, Cedars-Sinai Medical Center site, Los Angeles, California

2012-2015 Clinical Professor of Medicine, Department of Medicine, David Geffen School of Medicine, University of California - Los Angeles, Los Angeles, California [Full-time Faculty (2012-2013), then Volunteer Faculty (2013-2015)]

Medical Officer, State of California Institute of Regenerative Medicine (CIRM)-funded/private (Calimmune) collaborative phase I studies of gene-modified CD4+ T cells and CD34+ hematopoietic stem/progenitor cells to cure HIV infection (NCT01734850).

Chief Medical Officer, State of California Institute for Regenerative Medicine (CIRM)-funded/private (Calimmune) collaborative phase I studies of gene-modified CD4+ T cells and CD34+ hematopoietic stem/progenitor cells to cure HIV infection (NCT01734850).

Senior Director of Evidence-based Practices (Research), Whitman-Walker Health, Washington, DC

ACTG Investigator – Johns Hopkins University CRS, Johns Hopkins University School of Medicine Clinical Trials Unit (CTU), AIDS Clinical Trials Group (ACTG), Baltimore, Maryland

Site Principal Investigator, Multicenter AIDS Cohort Study (MACS), Johns Hopkins University School of Public Health, Baltimore, Maryland (Whitman-Walker – MACS/SHARE expansion site)

Clinical Professor of Medicine, Division of Infectious Diseases, Department of Medicine, George Washington University School of Medicine and Health Sciences, Washington, DC

Investigator and Executive Committee, District of Columbia - Center for AIDS Research (DC CFAR), Washington, DC

Adjunct Professor of Medicine, Johns Hopkins University School of Medicine, Division of Infectious Diseases, Department of Medicine, Baltimore, MA

Investigator, NIH-Martin Delaney HIV Cure Collaboratory- BELIEVE- Multi-site Research HIV Cure Research Project, Washington, DC (P.I.-Doug Nixon, MD, PhD)

PROFESSIONAL ACTIVITIES:

Quality Improvement Committees:

2002 - 2013 Co-Chairman- Pulmonary-Infectious Diseases Performance Improvement Committee, Department of Medicine, Cedars-Sinai Medical Center, Los Angeles, California

22002 – 2013 Member, Department of Medicine Performance Improvement Committee, Cedars-Sinai Medical Center, Los Angeles, California

22002 – 2013 Member, Antibiotic Utilization Review Committee, Pharmacy Department, Cedars-Sinai Medical Center, Los Angeles, California

22008 -- 2013 Member, Hospital-acquired Infection Task Force, Cedars-Sinai Medical Center, Los Angeles, California
Hand Hygiene Working Group
Antibiotic Stewardship

Academic Service Committees

2005 – 2013 Member, Institutional Biosafety Committee (IBC), Burns Research Institute, Cedars-Sinai Medical Center, Los Angeles, California

2006 - 2012 Member, Committee on Academic Appointments and Promotions, Department of Medicine, David Geffen School of Medicine, UCLA, Los Angeles, California

2007 – 2013 Member, Scientific Advisory Committee, General Clinical Research Center, Burns Research Institute, Cedars-Sinai Medical Center, Los Angeles, California

2007 – 2013 Member, Physician Well-Being Committee, Medical Staff Office Cedars-Sinai Medical Center, Los Angeles, California

2009 – 2013 Member, Graduate Medical Education Committee, Academic Affairs,Cedars-Sinai Medical Center, Los Angeles, California

2010 – 2013 Member, Institutional Review Board (IRB), Burns Research Institute,Cedars-Sinai Medical Center, Los Angeles, California

Scientific Committees

1988-1993 NIH/NIAID-AIDS Clinical Trials Group (ACTG) Opportunistic Infection Committee and Protozoan Pathogen Study Group,

1990-1996 NIH/NEI – Steering Committee for Studies of the Ocular Complications of AIDS (SOCA)

1992-2010 Co-Chairman, 2nd, 3rd, 4th, 5th, 6th, 7th, 8th, 9th, 10th ,11th, 12th, 13th, 14th, 17th, 19th and 20th National HIV Clinical Care Options (CCO) for HIV CME Conference.

1993-1996 NIH/NIAID-ACTG Opportunistic Infection Committee – Viral Pathogen Study Group

1993-1996 NIH/NIAID-ACTG Primary Infection, Phase II/III Clinical Trials Working Group

1992, 1994, 2000, 2002 Scientific Organizing Committee, 1st, 2nd, 5th and 6th International Congress on Drug Therapy in HIV Infection, Glasgow, Scotland

2007 *American Academy of HIV Medicine (AAHIVM)/American Heart Association (AHA) Joint Committee on Cardiovascular Complications in HIV-infected Patients, AAHIVM, Washington, DC*
- Prevention strategies for cardiovascular diseases in HIV-infected patients writing subcommittee

2010-present *Centers for Disease Control and Prevention (CDC) Prevention with Positives (PwP) Review Committee and Consultant, CDC, Atlanta, Georgia*

2015-present *Performance Evaluation Committee (PEC), NIH/NIAID-funded AIDS Clinical Trials Group (ACTG)*

2016-present *Investigator-HIV Reservoirs and Viral Eradication (Cure) Transformative Science Group (TSG), NIH/NIAID-funded AIDS Clinical Trials Group (ACTG)*

2017-present Co-chair- ACTG protocol A5370 – "Safety and Immuno-therapeutic Activity of Anti-PD-1 Antibody (REGN2810) in HIV-1-infected Participants on Suppressive cART: A Phase I/II, Double-blind, Placebo-controlled, Multiple Dose Study Ascending Multiple Dose Study"

Community Organization
1989-1996

Community Services Center, Los Angeles, California

1990-1996 Board of Directors, AIDS Project - Los Angeles (APLA), Los Angeles, California

1990-2000 Scientific Advisory Committee, Search Alliance (Community-based clinical research organization), Los Angeles, California

1991-1994 Board of Directors, Southwest Community-based AIDS Trials Group [NIH-sponsored Community Program for Clinical Research on AIDS (CPCRA)], Los Angeles, California

1996 – present Ambassadors Council, AIDS Project - Los Angeles (APLA), Los Angeles, California

1996 - 2007 Medical Advisory Committee, AIDS Healthcare Foundation (AHF; HIV healthcare providing organization), Los Angeles, California

2000 - 2006 Board of Directors, Project Angel Food (home delivery of meals to person with AIDS and other life-threatening illnesses), Los Angeles, California

2008 – 2015	Board of Directors, Aid for AIDS (housing, financial assistance and food for persons and families with AIDS), Los Angeles, California
2012- 2015	Board of Directors, AIDS Research Alliance (community-based, HIV Cure and clinical research organization), Los Angeles, California
2013- 2015	Chairman, Board of Directors, AIDS Research Alliance (community-based, HIV Cure and clinical research organization), Los Angeles, California

PROFESSIONAL ASSOCIATIONS:

1984 – present	American College of Physicians (ACP), Member
1985 – present	American Society for Microbiology (ASM)
1985 – present	Infectious Diseases Society of America (IDSA)
1988 – present	International AIDS Society (IAS)
1988 – 2010	Los Angeles Physicians AIDS Forum (President and Co-founder)
1989 – present	International Society for Antiviral Research
2000 – present	HIV Medicine Association (HIVMA)
2000 – present	American Academy of HIV Medicine (AAHIVM)
2005 – 2010	Board of Directors - California Chapter of the American Academy of HIV Medicine (AAHIVM)
2005 – 2008	Chairman, Board of Directors, California Chapter of the AAHIVM
2005 – present	National Board of Directors, AAHIVM
2008 – present	- Chairman, Education Committee
2008 -- present	- Member, Executive Committee
2010 -- present	HIV Medicine Association (HIVMA) - Research Awards Committee
2011 – 2014	Board of Directors, HIV Medicine Association (HIVMA), Infectious Diseases Representative
2016-2020	Chair-elect (progression to Chair in 2018), Board of Directors, HIV Medicine Association (HIVMA), Infectious Diseases Society of America

HONORS AND SPECIAL AWARDS

1993	Commitment to Service Award from Los Angeles Shanti Foundation (provider of emotional and psychological support for persons with HIV/AIDS; $30,000 Research Award)
2007	Spirit of Hope Award from Being Alive-Empowering People with HIV/AIDS (Community-based HIV/AIDS Service Organization)
2010	Clinical Trial Exceptional Service Award from the Pharmaceutical Researchers and Manufactures Association (PhRMA)

2011 Alliance Humanitarian Award from Alliance for Housing & Healing (Aid for AIDS/Serra Project—provides house and direct financial grants to persons and families with HIV)

2012 Research Achievement Award; AIDS Research Alliance, World AIDS Day Concert Ceremony, Los Angeles, California

RESEARCH GRANTS:

Research Support

NIH-sponsored

2014/04/01 – 2019/03/31
U01 AI035042 Margolick (PI) 2.0 calendar
NIH/NIAID $1,869,107
Subcontract Hardy (PI)
Multicenter AIDS Cohort Study: Natural History Study of HIV-1 in Gay and Bisexual Men

The MACS is an ongoing prospective study of the natural and treated histories of HIV-1 infection in homosexual and bisexual men.

2013/12/01-2020/11/30
UM1AI069465 Flexner/Gupta (PIs) 2.4 calendar
NIH/NIAID

$2,047,780

Subcontract Hardy (PI)
The Johns Hopkins Baltimore-Washington-India Clinical Trials Unit (BWI-CTU)

The goals of this project are to support AIDS research through clinical studies.

2016/07/01-2021/06/30
1UM1AI12661701 (NIAID) $291,076 1.44 calendar
Nixon, Doug (PI)
Subcontract Hardy (PI)
BELIEVE: Bench-to-Bed Enhanced Lymphocyte Infusions to Engineer Viral Eradication
BELIEVE is a new Martin Delaney HIV Cure Collaboratory seeking to create and translate
new technologies aimed at curing HIV infection.
Role: Site PI /Co-Investigator

2017/07/01-2022/06/30

R01DA043089 (Celentano) 0.6 calendar
NIH $429,521
Subcontract Hardy (PI)
Identifying and Engaging Urban HIV-infected and -uninfected Young Black and Latino Men Who Have Sex with Men in Care.

2017/12/01-2022/11/30
UG3AI133669
.42 calendar
NIH (Wirtz) $140,000
Subcontract Hardy (PI)
American Cohort to Study HIV Acquisition among Transgender Women at High Risk

2017/06/01-2018/31/08
5P30Ai117970-03 $12,000
.6 calendar
Greenberg (PI)
Subcontract Hardy (PI)

DC CFAR Membership and Executive Leadership Board

Completed:

2014/04/01-2018/01/10
CDC Foundation
Sustainable Health Center Implementation PrEP Pilot (SHIPP) Study
Subcontract Coleman (PI)
Nationwide study looking at the implementation of PrEP within health centers and adherence.

1. NIH NCATS CTSI – UL1RR033176 (PI-Melmed)
Clinical and Translational Research Institute (CTSI) at UCLA
Clinical and Translational Research Institute (CTSI) is funded by the NIH NCRR to provide an infrastructure to investigators to facilitate their clinical and translational research, in a primarily outpatient and community-based settings and with access to core lab facilities.
Role: Assistant Program Director -
.4 calendar Cost: $72,000 (in salary support)
Duration: 3/01/2011-2/29/16

2. Cedars-Sinai Medical Center Finance Department and Intellectual Property Department, *"East Meets West: In-Vitro Study of Herbal Medicines against Resistant Bacteria"*.
   This project analyzes the antibacterial activity of herbal extracts in *in vitro* experiments alone as well as in combination with synthetic antibiotics against multidrug-resistant(MDR) bacteria. The goal of this research is to identify a specific molecular compound conferring antibacterial properties.
   Role: Principal Investigator – 0.12
   calendar Cost: $391,158
   Duration: 10/1/2009 – 9/30/2010; 10/1/2010 – 9/30/2011; 10/1/2011-9/30/2012,10/1/2012-9/30/2013

3. Gilead Sciences
   Protocol # GS-US-236-0102
   A Phase3, Randomized, Double-Blind Study to Evaluate the Safety and Efficacy of Elvitegravir/Emtricitabine/Tenofovir Disoproxil Fumarate/GS-9350 vs (Efavirenz/Emtricitabine/Tenofovir Disoproxil Fumarate in HIV-1 Infected, Antiretroviral Treatment-Naïve Adults
   The primary objective of this study is to evaluate the safety and efficacy of a regimen containing the quadruple agent co-formulated single tablet of elvitegravir/emtricitabine/tenofovir disoproxil fumarate/cobicistat vs triple agent co-ormulated single tablet of efavirenz/emtricitabine/tenofovir disoproxil fumarate in HIV-1 infected, antiretroviral treatment-naïve adult subjects.
   Role: Principal Investigator
   Cost: $167,400
   Duration: 2/1/2010 – 12/31/2013

4. GSK/ ViiV Healthcare
   GSK- 113086/SPRING2
   A Phase III Randomized, Double-blind Study of the Safety and Efficacy of GSK134957250 mg Once Daily vs Raltegravir 400 mg Twice Daily Both Administered with Fixed-dose Dual Nucleoside Reverse Transcriptase Inhibitor Therapy Over 96 Weeks in HIV-1 Infected Antiretroviral Therapy-naïve Adult Subjects
   The goal of this study is to compare a new investigational integrase inhibitor drug dolutegravir (GSK 1349572) dosed at 50 mg once daily vs raltegravir 400mg twice daily, currently the only FDA-approved integrase inhibitor and thus the current standard-of-care, both with either abacavir/lamivudine or tenofovir DF/emtricitabine, in treatment-naïve, HIV-1-infected subjects.
   Role: Principal Investigator
   Duration: 11/1/2010 – 10/31/2013
   Cost: $57,425

5. GSK/ViiV Healthcare
   GSK-11762/SAILING
   "A Phase III Randomized, Double-blind Study of the Safety and Efficacy of GSK 1349572 50 mg Once Daily vs Raltegravir 400 mg Twice Daily, both Administered with an Investigator-selected Background Regimen Over 48 Weeks in HIV-1 Infected, Integrase Inhibitor-Naïve, Antiretroviral Therapy-Experienced Adults

The goal of this study is to compare the antiviral efficacy of the new investigational integrase inhibitor dolutegravir (GSK 1349572) dosed at 50 mg once daily compared to raltegravir 400 mg twice daily both in combination with a background regimen consisting of one to two fully active agents in HIV-1-infected, integrase inhibitor naïve, therapy-experienced subjects.
Role: Principal Investigator
Duration: 12/6/2010 – 12/5/2013
Cost: $50,088

Gilead Sciences
GS264-0110
"A Phase 3, Randomized, Open-label Study to Evaluate the Safety and Efficacy of a Single Tablet Regimen of Emtricitabine / Rilpivirine / Tenofovir Disoproxil Fumarate Compared with a Single Tablet Regimen of Efavirenz / Emtricitabine / Tenofovir Disoproxil Fumarate in HIV-1 Infected, Antiretroviral Treatment-naïve Adults
The primary objective of this study is to evaluate the efficacy of a single tablet regimen of emtricitabine/rilpivirine/tenofovir disoproxil fumarate (FTC/RPV/TDF) compared with a single tablet regimen of efavirenz/emtricitabine/tenofovir disoproxil fumarate (EFV/FTC/TDF) in HIV-1 infected, antiretroviral treatment-naïve adult subjects.
Role: Principal Investigator
Duration: 3/1/2012 –3/1/2014
Cost: $118,675

P fizer/ViiV A4001095

"A Multicenter, Randomized, Double Blind, Comparative Trial of Maraviroc + Darunavir/Ritonavir versus Emtricitabine/Tenofovir + Darunavir/Ritonavir for Treatment of Antiretorviral-Naive HIV-infected Patients With CCR5 Tropic HIV-1.
The study aims to examine whether or not a once-daily dosing of the new combination of maraviroc (Selzentry®) with darunavir (Prezista®) and ritonavir (Norvir®) will be as safe and effective as another once-daily combination routinely used containing darunavir, ritonavir, and Truvada® (a combination of entricitabine and tenofovir). Maraviroc belongs to a relatively new class of drugs called CCR5 inhibitors which block HIV from entering a target cell.
Role: Principal Investigator
Duration: 12/1/2011-11/30/2013
Cost: $96,000

6. Vertex
VX11-950-115

An Open-Label, Phase 3 Study of Telaprevir in Combination With Peginterferon Alfa-2a (Pegasys®) and Ribavirin (Copegus®) in Subjects Coinfected With Genotype 1 Hepatitis C Virus and Human Immunodeficiency Virus Type 1(HCV/HIV-1).
The proposed study (Vx 11-950-115) is a phase III clinical study to confirm the effectiveness of the new protease inhibitor, telaprevir in HCV treatment in HIV co-infected patients. This study will enroll individuals infected with HIV and HCV genotype 1 who have or have not received prior anti-HCV drug treatment
Role: Principal
Investigator Duration:
3/1/12-2/28/14Cost:
$120,000

7. Gilead
GS 334-0123

*A Phase 3, Open-label Study to Investigate the Efficacy and Safety of GS-7977 (sofosbuvir) plus Ribavirin for 12 Weeks in Chronic Genotype 1, 2 and 3 Hepatitis C Virus (*HCV) and Human Immunodeficiency Virus (HIV) Co-Infected Subjects.*
This is a phase III clinical study to investigate the effectiveness and safety of a new HCV drug, GS-7977 plus Ribavirin for 12 weeks or 24 weeks for HCV treatment in HIV-HCV co-infected patients.
Role: Principal
Investigator Duration:
9/1/12-8/31/2014 Cost:
$130, 000

NIH/NIAID - K08 AI-49759-01A2 (PI-Hardy)
Number: PA-00-003
"*Developing Foamy Virus Vectors for HIV-1 Vaccine Applications*"
The goals of the study are to develop and optimize recombinant HIV-1/Foamy Virus vectors. KO8 Mentored Clinical Scientist Development Award.
Role: Principal Investigator; 75% Effort
Total Direct Costs: $515,000
Duration: 08/01/02 – 04/30/09 (no cost extensions)

NIH/NIAID - 1 U01 AI052748-01A1 (PI-Stock)
"Solid Organ Transplantation in HIV; Multi-Site Study"
The primary aim of this study is to evaluate the safety and efficacy of solid organ transplantation in people with HIV disease by conducting a prospective, multi-center cohort study of HIV-positive (+) patients who undergo kidney or liver transplantation.
Role: Site Co-PI - .012 calendar
Annual Direct Cost: $120,000
Duration: 08/15/03 – 01/31/10; 2/1/2010 – 7/31/2013

NIH/NIMH – 5R01MH058532-10 (PI-Goodkin)
"HIV, Aging and Cognition: A Synergism?"
The goal of this project is to determine if age interacts with HIV infection to result in a higher prevalence and more rapid progression of cognitive-motor impairment, decreases in functional status, decreases in CD4+ cell count, increases in viral load,

progression of CDC stage, and decreased survival time.
Role: Co-investigator – 0.12 calendar
Annual Direct Cost: $436,665
Duration: 01/26/2007 – 11/30/2008; 12/1/2008 – 12/31/2012

NIH/NCRR – M01-RR00425 (PI-Melmed)

General Clinical Research Center

The General Clinical Research Center is funded by the NIH NCRR to provide an infrastructure to investigators to facilitate their clinical research, in a primarily outpatient setting and with access to core lab facilities.
Role: Assistant Program Director - .4 calendar
Cost: $72,000 (in salary support)
Duration: 11/30/2008 – 12/01/2011

UCLA AIDS Institute/Pendelton Trust Seed Grant

"Foamy Virus Vectors for Gene Therapy and Vaccine Studies

The purpose of this study is to optimize foamy virus vectors for future use as HIV vaccine and potential gene therapy applications.
Role: Principal Investigator –
Cost: $50,000
Duration: 05/01/2004 – 04/30/2006

Gilead Sciences

Protocol #GS-US-236-0103

"*A Phase 3, Randomized, Double-Blind Study to Evaluate the Safety and Efficacy of Elvitegravir/Emtricitabine/Tenofovir Disoproxil Fumarate/cobicistat vs. Ritonavir-boostedAtazanavir Plus Emitricitabine/Tenofovir Disoproxil Fumarate in HIV-1 Infected, Antiretroviral Treatment-Naïve Adults"*

The primary objective of this study is to evaluate the safety and efficacy of a regimen containing the quadruple agent co-formulated single tablet of elvitegravir/emtricitabine/tenofovir disoproxil fumarate/cobicistat vs ritonavir-boosted atazanavir plus emitricitabine/tenofovir disoproxil fumarate in HIV-1 infected, antiretroviral treatment-naïve adult subjects
Role: Principal Investigator
Duration: 2/1/2010 – 1/31/2013
Cost: $20,125

Bionor Immuno AS

Protocol CT-BI Vacc-4x2007/1: A Phase II, Randomized, Double-Blind, Multicenter, Immunogenicity Study of Vacc-4x versus Placebo in Patients Infected with HIV-1 Who Have Maintained an Adequate Response to ART"

The primary purpose of this study is to evaluate the effect of Vacc-4x immunization versus placebo on CD4+ cell counts, T-cell function and T-cell proliferation, response to treatment interruption of antiretroviral therapy and the proportion of subjects restarting treatment within 24 weeks after stopping ART).

Role: Principal Investigator
05/19/2008 – 04/18/2012
Cost: $108,328

Merck - CSRI #200387; IRB #4066-01
Clinical Trial V520-022 – A phase II, multi-center, double-blind, randomized, placebo-controlled probe study with an additional open-label control arm to evaluate the safety and immunogenicity of a 3-dose regimen of the MRKAd5 HIV-1 gag vaccine in subject with chronic hepatitis C virus infection
Role: Principal Investigator - .06 calendar
Cost: $15,750
Duration: 05/014/04 – 9/30/2005

Boehringer Ingelheim
Protocol No. 1182.12) Phase III, Open-label, Randomized, Parallel Group Pharmacokinetics Trial of Tipranavir (TPV/RTV), Alone or in Combination with Saquinavir (SQV), Amprenavir (APV) or Lopinavir (LPV), Plus an Optimized Background Regimen, in Multiple Antiretroviral (ARV) Experienced Patients.
Role: Principal Investigator
Cost: $51,110
Duration: 6/14/04 – 1/31/07

Boehringer Ingelheim
Clinical Trial 1182.17 - A Long-term Open-label Rollover Trial Assessing the Safety and Tolerability of Combination Tipranavir and Ritonavir use in HIV-1Infected Subjects.
Role: Principal Investigator
Cost: $13,814
Duration: 9/01/04 – 8/31/08

Pfizer, Inc.
Protocol 1029: "A Multi-center, Randomized, Double-blind, Placebo-controlled Trial of a Novel CCR5 Antagonist, UK-427,857, in Combination with Optimized Background Therapy versus Optimized Background Therapy Alone for the Treatment of Antiretroviral- Experienced, non-CCR5-tropic HIV-1 Infected Subjects"
The purpose of this study is to determine wheter the new study drug, UK-427, 857 has effective anti-HIV activity in treatment-experienced patients with few remaining treatment options, who have either mixed tropic (both CCR5 and CXCR4) and non CCR- 5 tropic HIV.
Role: Principal Investigator - .06 calendar
Cost: $12,500
Duration: 01/01/2005 – 12/31/06

International Antiviral Therapy Evaluation Consortium (IATEC)
Protocol #05-IAT-0110: "A Randomized, Controlled, Open-label, 48-week Study to Assess Differences in Changes in Plasma Lipid Profile between Patients on

Saquinavir/Ritonavir or Atazanavir/Ritonavir in Combination with Tenofovir Disoproxil Fumarate and Emtricitabine as a First-line Regimen.
The purpose of this study is to compare several outcomes to two different once-daily protease inhibitor PI-based + Truvada® anti-HIV treatment medication regimens.
Role: Principal Investigator - .012 calendar
Cost: $46,067
Duration: 10/01/2006 – 09/30/2007; 10/01/2007 – 09/30/2009

9. GlaxoSmithKline
GRZ107460): "A Phase 2a, Multicenter, Randomized, Parallel, Double-Blind, Dose Ranging, Placebo-Controlled Study to Compare Antiviral Effect, Safety, Tolerability and Pharmacokinetics of GSK364735 Monotherapy Versus Placebo Over 10 days in HIV-1 Infected Adults"
This study is to evaluate GSK364735 (an integrase inhibitor) for the treatment of HIV infection. Integrase inhibitors are a new class of anti-HIV medications. For HIV to reproduce, its genetic make-up must be spliced into the genetic make-up of the human T-cell (a type of immune cell attacked by HIV). This study is the first of its kind being done in HIV + persons to see if this investigational drug is safe and effective.
Role: Principal Investigator - .06 calendar
Cost: $26,559
Duration: 12/15/06 – 12/15/2007

Pfizer *Protocol #A4001050: "A multi-center, open label, expanded access trial of Maraviroc"* This is an expanded access protocol for Pfizer's investigational anti-HIV medication, maraviroc which makes the drug available to persons needing new treatment options for their HIV infection. Maraviroc is currently in Phase III clinical trials as a new anti-HIV treatment for HIV infection. The study will make maraviroc available for free to HIV+ persons needing treatment and collecting safety and efficacy data..
Role: Principal Investigator - .06 calendar
Cost: $17,580
Duration: 02/01/2007 – 01/30/2008

Tibotec Pharmaceuticals
"A Randomized, Controlled, Open-label Trial to Make TMC114/RTV Available to HIV+ Patients with Limited Treatment Options"
The purpose of this study is to look at the long term safety, tolerability, and effectiveness of TMC114 combined with a low dose of Ritonavir (RTV) compared to Kaletra (the current gold-standard protease inhibitor for HIV treatment) when used in subjects with HIV infection.
Role: Principal Investigator - 1% effort
Cost: $25,350
Duration: 11/11/05 – 12/11/07; 12/12/2007 – 06/11/2008

Pfizer *Protocol 1026: A Multi-center, Randomized, Double-blind, Comparative Trial of a Novel CCR5 Antagonist, UK-427,857, in Combination with Zidovudine/Lamivudine versus Efavirenz in Combination with Zidovudine / Lamivudine for the Treatment of Antiretroviral-naïve HIV-1 Infected Subjects"*

The purpose of this study is to determine the anti-HIV effectiveness of the new anti-HIV drug, UK 427,857 in combination with other anti-HIV medications against HIV infection in HIV+ patients who have never taken HIV medications and whose HIV is CCR5 tropic"

Role: Principal Investigator - .06 calendar
Cost: $43,483
Duration: 01/01/2005 – 09/10/2010

Pfizer, Inc.

Protocol # A400-1078: Phase IIb, Pilot Study of Novel Combination of Maraviroc + Atazanavir/Ritonavir vs Atazanavir/Ritonavir + Tenofovir/Emtricitabine for the Treatment of Naïve HIV-Infected Patients with R5 HIV-1

Role: Principal Investigator
Duration: 4/3/2009 – 4/02/2012
Cost: $32,290

Pfizer

Protocol 1027: A Multi-center, Randomized, Double-blind, Placebo-controlled Trial of a Novel CCR5 Antagonist, Maraviroc, in Combination with Optimized Background Therapy Versus Optimized Background Therapy Alone for the Treatment of Antiretroviral-experienced HIV-1 Infected Subjects

The purpose of this study is to determine the effectiveness of the new anti-HIV drug maraviroc in combination with other anti-HIV medications against HIV infection in treatment-experienced patients whose HIV is CCR5 tropic).
Role: Principal Investigator - .012 calendar
Cost: $142,901
Duration: 01/01/2005 – 12/31/07; 1/01/2008 – 12/31/2010

INVITED LECTURES: (since returning to academic medicine in March 2002)

1. Grand Rounds, Division of Pulmonary/Critical Care Medicine, Department of Medicine, Cedars-Sinai Medical Center, "Update on HIV Research", Cedars-Sinai Medical Center, Los Angeles, CA, August 27, 2002

2. Grand Rounds, Division of Pulmonary/Critical Care Medicine, Department of Medicine, Cedars-Sinai Medical Center, "Update from the XVth World AIDS Conference" Cedars- Sinai Medical Center, Los Angeles, CA, August 18, 2004

3. Second Annual Tough Decisions Made Easier: Clinical Management of Treatment- experienced HIV + Patients, UCLA Center for AIDS Research & Education (CARE), UCLA-Bradley International Hall, Los Angeles, CA, October 22, 2004

4. Grand Rounds, Division of Infectious Diseases, Department of Medicine, Feinberg School of Medicine, Northwestern University "Management of Neurologic Complications in the HAART Era", Chicago, Illinois, October 27, 2004

5. Post ICAAC/Glasgow Conferences Review: "Update on Antiretrovirals Therapy", AIDS Clinical Research Initiative of America (ACRIA), Plaza Hotel, New York, NY, December 2, 2004

6. Los Angeles Gay & Lesbian Center Visiting Faculty Program: "HIV Protease Inhibitor Update", Los Angeles, CA, March 4, 2005

7. Department of Medicine House Staff Noon Conference: "Methicillin-resistant *Staphylococcus aureus*", Department of Graduate Medical Education, Cedars-Sinai Medical Center, Los Angeles, CA, March 28, 2005

8. Grand Rounds, Divisions of Infectious Diseases, Department of Medicine, and Department of Pediatrics, University of Texas at Dallas School of Medicine "Treatment of HIV Infection: New Strategies, New Agents", Dallas, TX, April 8 and 9, 2005.
   (two separate lectures; one emphasizing treatment for adult patients, one for pediatric patients) Grand Rounds, Division of Maternal-Child Health, Department of Pediatrics, Keck School of Medicine, University of Southern California (USC), "Update of HIV Antiretroviral Therapy with Emphasis on Prevention of Mother-to-Child Transmission of HIV", USC School of Medicine/LAC-USC Medical Center, Los Angeles, CA, April 26, 2005

9. Grand Rounds, Department of Psychiatry and Behavioral Sciences, Cedars-Sinai Medical Center, "Update on HIV Treatment and Drug-Drug Interactions", Los Angeles, CA, April 28, 2005

10. Grand Rounds, Genitourinary and HIV Medicine Department, Royal Free Hospital," HIV Treatment Guidelines: An American Perspective", London, UK, August 25, 2005

11. Grand Rounds, Department of Medicine, Royal Free Hospital, "Novel Approach to HIV Vaccine Development", UK, August 29, 2005

12. European AIDS Clinical Society (EACS) Advanced Course on HIV, " "HIV Vaccine Development", Montpelier University, Montpelier, France, August 26-27, 2005

13. Grand Rounds, Department of Medicine, Cedars-Sinai Medical Center "HIV/AIDS: The Global and National Pandemic", Los Angeles, CA, September 16, 2005

14. Grand Rounds, Division of Infectious Diseases, Department of Pediatrics, Keck School of Medicine, University School of Medicine, "HIV as a Chronic Disease and Associated Complications ", Children's Hospital, Los Angeles, CA, October 25, 2005

15. Grand Rounds, Division of Pulmonary/Critical Care Medicine, Department of Medicine, Cedars-Sinai Medical Center, "Progress in HIV Research", Cedars-Sinai Medical Center, Los Angeles, CA, October 26, 2005

16. Didactic Lecture: "HIV Treatment Guidelines", ID Combined Conference, GLAVAMC, Los Angeles, CA, February 14, 2006

17. Los Angeles Physicians AIDS Forum: "Post 13th Conference on Retrovirus & Opportunistic Infections Update", March 7, 2006, Le Meridian Hotel, Los Angeles, CA

18. ID Combined Conference: "Post 13th Conference on Retrovirus & Opportunistic Infections Update", WVAHCS, Los Angeles, CA, March 7, 2006

19. "HIV Treatment: Recent Progress", Physicians from the California Men's Colony at San Luis Obispo, CA, May 30, 2006

20. Invited Lecture for Symposium on Advances in HIV Therapy, "HIV Tropism: Biology of Both Viral and Human Determinants and Therapeutic Applications", Paulista Congress of Infectology, Sao Paulo, Brazil, August 25, 2006

21. Los Angeles Physicians AIDS Forum: "Update from 2006 International AIDS Conference, Hyatt Regency Century Plaza, Los Angeles, CA, September 9, 2006

22. ICAAC Satellite Symposium: Consult with the HIV Experts: "Optimizing HIV Therapy for Treatment-experienced Patients, Moscone Center, San Francisco, CA, September 29, 2006

23. IDSA Satellite Symposium: Emerging Therapies in the Blockade of HIV Binding: "Early Inhibitors: Clinical Progress Thus Far", Sheraton Centre Toronto Hotel, Ontario, Canada, October 11, 2006

24. Continuing Medical Education Program: "Initiating HIV Therapy", Ecotrust Conference Center, Portland, OR, October 24, 2006

25. Infectious Diseases Noon Conference: "New Therapies for HIV Infection", El Rio Community Health Center, Tucson, AZ, February 2, 2007

26. Grand Rounds, Division of Infectious Diseases, Department of Pediatrics, Keck School of Medicine, University of Southern California,, "Long Term Safety & Efficacy of Tenofovir-based Regimens Compared to Thymidine-analog Containing Regimens", Children's Hospital Los Angeles, CA, March 27, 2007.

27. Annual Investigators' Meeting of the NIH-sponsored Multi-Site Solid Organ Transplantation Study in HIV+ Patients, "Novel Therapies for HIV Infection: Use in Solid Organ Transplant Patients", Washington, DC, April 29, 2007

28. Grand Rounds, Division of Infectious Diseases, Department of Medicine, Harbor-UCLA Medical Center, "New Classes of Antiretrovirals: The Potential Clinical Role of Integrase Inhibitors and Entry Inhibitors", Torrance, CA, July 17, 2007

29. CME Dinner Program: "Current Perspectives on HIV-associated Metabolic and Morphologic Abnormalities", Boston, MA, August 17, 2007

30. National Minority AIDS Council (NMAC) Annual Conference, Seminar: Special Issues in HIV Care: "New Therapies and Treatments", Palm Springs, CA, November 8, 2007

31. HIV Grand Rounds, Howard Brown Health Center, "A New Class, A New Option: Understanding CCR5 Antagonists and Maraviroc" , Chicago, IL, January 10, 2008

32. Grand Rounds, Department of Medicine, City of Hope Medical Center, "Strategies for Treatment-Naïve Patients with HIV Infection: When and What to Start?, Duarte, CA, February 19, 2008

33. Grand Rounds, Division of Pediatric Infectious Diseases, University of Nevada School of Medicine, "Optimizing Antiretroviral Therapy for the Treatment-Experienced Patient: A Case-based Approach", Reno, NV, February 21, 2008

34. Los Angeles Physicians AIDS Forum: "Update from the 15th Conference on Retroviruses and Opportunistic Infections (CROI)", InterContinental Hotel, Century City, CA, March 11, 2008

35. HIV Grand Rounds, University Medical Center Wellness Clinic, "Rising to the Challenge: CCR5 Antagonists in Treatment-experienced Patients", Las Vegas, NV, March 21, 2008

36. HIV Conference Program: "CCR5 Antagonists - A New Era in Patient Management", Orange County Public Health, Santa Ana, CA, April 2, 2008

37. Grand Rounds, Division of Infectious Diseases, Department of Medicine, Keck School of Medicine, University of Southern California, "Progress in Antiretroviral Therapy", LAC/USC Medical Center, Los Angeles, CA, May 8, 2008

38. Scientific Meeting on New Trends and New Perspectives for HIV Treatment, Federal University of Rio de Janeiro, "Efficacy and Safety of Maraviroc in HIV+ Patients", Rio de Janeiro, May, 12 2008

39. 16th Annual State of Texas, Department of HIV/STD Conference, "Protease Inhibitor-based HAART: Predictive Factors for Treatment Success", Austin, TX, May 18, 2008

40. HIV Minifellowship Program: Current Challenges in the Clinical Management of HAART: "Side Effect Issues and Management Strategies", Hollywood Roosevelt Hotel, Los Angeles, CA, June 7, 2009

41. Grand Rounds, USC Communicable Diseases Grand Rounds: "HIV in Young Adults: An Often Overlooked Epidemic", USC Medical Center, Los Angeles, July 11, 2008

42. Grand Rounds, Division of Infectious Diseases, Department of Medicine, "A New Era in Patient HIV Treatment", Olive View Medical Center, Sylmar, CA, August 15, 2008

43. UCLA Center for AIDS Research and Education (CARE), 6th Annual HIV Symposium – Tough Decisions Made Easier: "Antiretroviral Therapy in the Current Era: Case-Based Panel Discussion", Renaissance Hotel, Hollywood, CA, October 17, 2008

44. Los Angeles Physicians AIDS Forum, "HIV Highlights of the 2008 ICAAC/IDSA Annual Meeting", InterContinental Hotel, Los Angeles, CA December 2, 2008

45. Infectious Diseases Grand Rounds, "Post CROI Update: Best Practices in HIV Therapy, Kaiser West Los Angeles, CA, March 26, 2009

46. Grand Rounds, Infectious Diseases Section, Sunnybrook Hospital, "HIV-1 Tropism: How We Can Use it to Treat Human Infection", Toronto, Canada, March 30, 2009

47. HIV Rounds Noon Lecture: "Viral Tropism: Epidemiology, Natural History, and Therapeutics", St Michael's Hospital, Toronto, Canada, March 31, 2009

48. Infectious Diseases Morning Rounds, McMaster University School of Medicine, "Progress in Treating HIV Infection: Using Laboratory Technology to Make Therapeutic Decisions", McMaster University, Toronto, Canada, April 1, 2009

49. Ottawa HIV Physicians' Community Consortium, "HIV-1 Tropism: How We Can Use It To Treat Human Infection", Ottawa, Canada, April 1, 2009

50. The New York Course: HIV Management 2009: "HIV Prevention in Clinical Practice", Hudson Theatre, New York, May 15, 2009

51. Cedars-Sinai Department of Pharmacy Conference: "Centers for Disease Control STD Treatment Guidelines", Cedars-Sinai Medical Center, May 27, 2009

52. Grand Rounds, Division of Infectious Diseases, Department of Medicine, SUNY Downstate Medical Center, "A New Era in HIV Patient Management", Brooklyn, NY, June 24, 2009

53. Grand Rounds, Infectious Diseases Section, Department of Medicine, Beth Israel Medical Center, "Rising to the Challenge: CCR5 Antagonists in Treatment-experienced HIV+ Patients", Peter Kruger Clinic, New York, NY, June 25, 2009

54. Grand Rounds, Division of Infectious Diseases and HIV Medicine, New York Hospital of Queens, "Viral Tropism and How it can be Used as Treatment for HIV Infection", Queens, NY, June 26, 2009

55. Grand Rounds, Infectious Diseases Section, Department of Medicine, US Naval Medical Center at Balboa, "Current Considerations for the Management of Patients with HIV Infection", San Diego, CA, August 14, 2009

56. Plenary Session, Session 1, Basic Science, "HIV Infection: An Inflammatory Disease?", HIV Congress 2010, Mumbai, India, January 8, 2010

57. Plenary Session, Session 2, Future Therapies, "Stem Cell Therapy for Treatment of HIV Infection", HIV Congress 2010, Mumbai, India, January 9, 2010

58. Grand Rounds, Division of Infectious Diseases, Department of Medicine, Cedars-Sinai Medical Center, "HIV Infection is an Inflammatory Disease", Cedars-Sinai Medical Center, February 9, 2010

59. 20th Annual Clinical Care Options for HIV Symposium: Current Opportunities and Continuing Challenges in HIV Care: "Missed Opportunities: Practical Strategies for Enhancing Early HIV Diagnosis and Timely Treatment" - Sheraton Wild Horse Pass, Phoenix, AZ – April 8, 2010.

60. Satellite Symposium, XVIII International AIDS Society (IAS) Conference, "The Art of Orchestration: Achieving Treatment Harmony in HIV Patients- Cardiovascular Disease in HIV Infection", Vienna Austria, July 18, 2010.

61. Satellite Symposium, ICAAC-2010, "Asked and Answered: Frontline Providers Challenge the Experts on HIV Management Strategies, Boston, MA, September, 13, 2010.

62. Satellite Symposium, ICAAC-2010, "HIV: Assessing the Long-term Consequences of Therapy and Infection", Boston, MA, September 14, 2010.

63. Seventh Annual St Bernadine Infectious Disease Symposium: "HIV/AIDS: Three Decades of Medical Progress", St Bernadine Medical Center, San Bernardino, CA, March 26, 2011.

64. 20th Annual HIV/AIDS-On the Front Line: "Challenges of Diagnosing and Treating HIV Infection among Latinos", University of California at Irvine School of Medicine, Orange, CA, April 27, 2011.

65. Miami Community HIV Physician Forum, "The Overlooked Epidemic: Beyond the Basics: Meeting the Challenges of Caring for Women with HIV Infection", Miami Beach, FL, September 7, 2011.

66. Los Angeles InterCity HIV Rounds: "Current Clinical Controversies in the Treatment of HIV/AIDS", Hollywood Presbyterian Medical Center, Los Angeles, CA, February 1, 2012

67. Plenary Session: Current Research Questions: "Is HIV Infection a Cardiovascular Disease Risk Equivalent?", International HIV Congress 2012, Mumbai, India, March 15-18, 2012.

68. Plenary Session: HIV Clinical Care: Renal Disease in HIV+ Persons-Diagnosis and Treatment", International HIV Congress 2012, Mumbai, India, March 15-18, 2012.

69. Department of Medicine Grand Rounds: "Emerging Issues in the Management of HIV Infection", WVA Medical Center, Los Angeles, CA, June 6, 2012.

70. Third Annual HIV Latina Forum: "Treating Beyond HIV", Renaissance Sao Paulo Hotel, Sao Paulo, Brazil, June 21 – 23, 2012.

71. Grand Rounds: "Post IAC 2012 Update: Assessing Best Practices in HIV/AIDS Therapy", Health Care Agency of Orange County, Santa Ana, CA, August 15, 2012

72. Department of Medicine Grand Rounds: "Prevention of HIV Infection-Current Research Progress", Cedars-Sinai Medical Center, Los Angeles, CA, September 7, 2012.

73. Department of Medicine Grand Rounds: "Curing HIV Infection: Is It Possible?", Cedars-Sinai Medical Center, Los Angeles, CA, March 29, 2013.

74. Puerto Rico HIV Physician Forum, "HIV Treatment in Latino Persons: Differences in Adherence, Virologic and Immunologic Response to ART?", San Juan, Puerto Rico, April 19, 2013.

75. Official Satellite Symposium of 7th International AIDS Society (IAS) Conference on HIV Pathogenesis, Treatment and Prevention, "Emerging Issues of Aging HIV-seropositive Persons", Kuala Lumpur, Malaysia, June 28, 2013.

CME-ACCREDITED PROGRAMS:

76. Foundation for Better Healthcare CME Program: "Fusion Inhibitors: Optimizing Response in Treatment-experienced HIV-infected Patients", Seattle, WA, January 13, 2004

77. CME Activity: "A New Class, A New Option: Understanding CCR5 Antagonists", Howard Brown Health Center, Chicago, IL, January 10, 2008

78. CME Activity: "A New Generation of Targets" Understanding Co-Receptor Antagonists", Milwaukee, WI, January 11, 2008

79. CME Activity for AdvanceMed: HIV Resistance Workshop, Renaissance New York Times Square Hotel, New York, NY, January 25, 2008

80. CME Activity for AdvanceMed: HIV Resistance Workshop, San Francisco, CA, February 22, 2008

81. CME Program: "Current Clinical Controversies in the Treatment of HIV/AIDS"; Case Discussion on Treatment-Experienced Patients: "How many Drugs Does a Patient Need?, Rancho Las Palmas, Rancho Mirage, CA, May 2, 2008

82. CME Program: "Novel Agents for Treatment-Experienced Patients" Faculty Mentoring for Managing Challenging Cases", Rancho Las Palmas, Rancho Mirage, CA, May 3, 2008

83. CME Program: Simply Speaking HIV – An Expert Educators CME Lecture Series: "Current Clinical Controversies in the Treatment of HIV/AIDS", Silver Fox, Dallas, TX, May 15, 2008

84. CME Dinner Program: "A New Era in Patient Management", Simon LA, Los Angeles, CA, May 20, 2008

85. CME Certified Symposium: New Insights into the Use of Protease Inhibitors Across the Treatment Spectrum: Case Scenarios: Participant Polling with Panel Discussion, Inter-Continental Hotel, Los Angeles, CA, June 12, 2008

86. Web-based CME Program: HIV Knowledge Network Study Group, XVII International AIDS Conference: "Highlights of the 2008 IAS", Moderator, August 21, 2008

87. First Care Forums in HIV: "Best Practices Workshops for the Treatment Team", Millennium UN Plaza Hotel, New York, NY, September 6, 2008.

88. CCO CME-Certified Expert Recap from the 17th International AIDS Conference, Mexico City, August 3-8, 2008: "Update on Timing and Choice of First-Line Therapy", October 3, 2008

89. CME Dinner Program: Profiles in HIV: In-Depth Analyses and Case Studies of Unique Populations Living with HIV, Los Angeles, CA, January 15, 2009

90. CME Program: First Care Forums in HIV: Best Practices Workshops for the Treatment Team, Madison Hotel, Washington, DC, January 17, 2009

91. CME Program Simply Speaking HIV, Post ICAAC/IDSA 2008 CME Update: "Assessing Best Practices in HIV/AIDS Therapy", Hollywood Presbyterian Medical Center, Hollywood, CA, January 21, 2009

92. CCO CME Program: Panel Discussion on Management of Antiretroviral Naïve Patients, Loews Hotel Vogue, Montreal, Canada, February 11, 2009

93. CME Program: The HIV Treatment Debate, Renaissance Hotel, Hollywood, CA, March 3, 2009

94. CME Program: "Integrating Resistance Testing into Clinical Practice", Los Angeles, CA, March 18, 2009

95. CCO CME/CE-Certified Video Module: "Planning and Strategizing for Long-term Success With Antiretroviral Therapy", April 6, 2009

96. CCO CME/CE-Certified Treatment Update Video Module: CCO HIV: Stay Tuned Evolving Concepts in Antiretroviral Therapy: "Stem Cell Therapy, SWITCHMRK, and HIV-Associated Inflammation", June 2009

97. CME Harkness Roundtable Program: Current challenges in HIV: Maximizing outcomes Through Case-Based Discussions, West Hollywood, CA, June 17, 2009

98. 5th IAS 2009 Preview from CCO Faculty Experts Audio Preview: "The Impact of Home-Based Compared with Facility-Based HIV Care on Virologic Failure and Mortality: A Cluster Randomized Trial", July 20, 2009

99. 2009 International AIDS Society (IAS) Conference on HIV Pathogenesis, Treatment and Prevention, "Highlights and Overview of Progress in Antiretroviral Therapy, July 19, 2009.

100. CME Dinner Program: "The Graying of an Epidemic: Clinical Considerations of HIV and Aging", San Francisco, CA, October 20, 2009

101. CME Dinner Program: "Effect of Resistance and Resistance Barriers on ARV Therapy Efficacy", Beverly Hills, CA, October 21, 2009

102. CME Dinner Program: "The Graying of an Epidemic: Clinical Considerations of HIV and Aging", New York, NY, October 22, 2009.

CEDARS-SINAI MEDICAL CENTER CME CONFERENCES - CHAIRMAN & SPEAKER

103. 5th Annual CSMC World AIDS Day Conference: A Promising Future - Chairman, Cedars-Sinai Medical Center, Hotel Sofitel, Los Angeles, CA, December 4, 2003

104. 6th Annual CSMC HIV/AIDS Update Conference: A Multidisciplinary Approach – Chairman, Cedars-Sinai Medical Center, Le Meridian Hotel, Los Angeles, CA, March 11, 2005

105. 1St CSMC Crystal Methamphetamine Medical Conference (Co-Chair, Organizer & Speaker): "Treatment Options", Cedars-Sinai Medical Center, Los Angeles, CA, June 23, 2006

106. 7th Annual CSMC HIV/AIDS Medical Update Conference: 25 Years of Old Standards and New Frontiers-A Multidisciplinary Approach - Chairman, Cedars-Sinai Medical Center, Le Meridian Hotel, Los Angeles, CA, September 19, 2006

107. 8th Annual CSMC HIV/AIDS Medical Update Conference: Emerging Issues and Challenges - Chairman, InterContinental Hotel-Century City, Los Angeles, CA, September 28, 2007

108. 9th Annual CSMC HIV/AIDS Conference: "New Therapies, New Patient Populations, and New Global Challenges", September 26, 2008.

109. 10th Annual CSMC HIV/AIDS Conference: "HIV Infections – Inflammation, Prevention and Sex Workers", September 25, 2009.

110. 11th Annual HIV/AIDS Conference: Primary Care and ART Optimization in a Changing Healthcare System, Intercontinental Hotel, Los Angeles, CA, September 24, 2010

111. 12th Annual HIV/ AIDS Conference: Hepatitis C Co-infection, Cardiovascular Disease and Promising Gene Therapies", SLS Hotel, Los Angeles, CA, September 23, 2011.

112. 13th Annual HIV/AIDS Conference: "Comparing First-line Antiretroviral Options, Update on Hepatitis C Treatment, Screening for HIV-associated Neurocognitive Disorders, and Prospects for Curing HIV", SLS Hotel, Los Angeles, CA, September 28, 2012

PUBLICATIONS / BIBLIOGRAPHY

A. RESEARCH PAPERS (Peer Reviewed)

1. Ahmed RA, Kaplan RP**, Hardy WD**, Feldman E, Pitt H. Bullous pemphigoid and ulcerative colitis. Int J Dermatol 21:594-598, 1982.

2. Holland GN, Sakamoto MJ, **Hardy WD**, Sidikaro Y, Krieger AE, Frenkel LM. Treatment of cytomegalovirus retinopathy in patients with acquired immunodeficiency syndrome – Use of the experimental drug 9-(2-hydroxyl-1 (hydroxymethyl) ethoxymethyl) guanine (DHPG). Arch Ophthalmol 104:1794-1800, 1986.

3. Holland GN, Sidikaro Y, Kreiger AE, **Hardy WD**, Sakamoto MJ, Frenkel LM, Winston DJ, Gottlieb MS, Bryson YJ, Champlin RE, Ho WG, Winters RE, Wolfe PR, Cherry JD. Treatment of cytomegalovirus retinopathy with ganciclovir. Ophthalmology 94:815-823, 1987.

4. Fay MT, Freeman WR, Wiley CA, **Hardy WD**, Bozzette S. Atypical retinitis in patients with the acquired immunodeficiency syndrome. Am J Ophthalmol 105:483-490, 1988.

5. Fischl MA, Richman DD, Causey DM, Grieco MH and the **AZT Collaborative Working Group-Hardy, WD**. Prolonged zidovudine therapy in patients with AIDS and advanced AIDS-related complex. JAMA 262:2405-2410, 1989.

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2. Phase I/II Safety, Immunogenicity and Feasibility Study of a Dual Anti-HIV Gene Transfer Construct to Treat HIV-1 Infection Using and Adaptive Design of Busulfan Pre-conditioning in Viremic HIV-1-Seropositive Persons (NCT01734850): What This Study Teaches the Field of HIV Cure Research.

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ATTACHMENT 2

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EXHIBIT 21

Expert Report of Trevor Hoppe, MPH, Ph.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 TREVOR HOPPE, MPH, Ph.D

I. INTRODUCTION

1. My name is Trevor Hoppe, MPH, Ph.D. I have been retained by counsel for Plaintiffs in the above-captioned case.

2. I have been asked to provide an expert opinion regarding the history of stigma and discrimination against people living with HIV in the United States, as well as the use of the public health system and criminal laws to modify or control the behavior of such persons.

3. Except where otherwise stated, I have actual knowledge of the matters stated and would so testify if called as a witness.

4. The opinions I express are my own and do not reflect the official policy of any organization with which I am affiliated.

5. I am knowledgeable about the matters set forth below based upon my own knowledge and experience, as well as my review of various materials that are cited herein.

A. Professional Background & Qualifications

6. I am an assistant professor of sociology at the University of North Carolina at Greensboro. My research examines the rise and application of criminal laws related to HIV and other infectious diseases in the United States. I received my doctoral degree from the University of Michigan in 2014 in Sociology and Women's Studies. I also earned a Master's in Public Health in Health Behavior and Health Education from the University of Michigan in 2011. After my doctoral training, I was awarded a postdoctoral fellowship at the University of California at Irvine in the Department of Criminology, Law and Society. I subsequently joined the sociology faculty at the University at Albany, SUNY, where I taught for three years before joining the sociology faculty at UNC Greensboro.

7. I am an active participant in the global HIV research community, having participated in two International AIDS Conferences. In 2011, the Centers for Disease Control

and Prevention ("CDC") awarded me the "Young Innovator Award" at its national HIV prevention conference. I have published seven peer-reviewed scientific journal articles on HIV and infectious disease more broadly, including a recently published article in the prestigious *American Journal of Public Health*. In addition to journal articles, my book analyzing the rise and application of HIV-specific criminal laws in the United States, *Punishing Disease: HIV and the Criminalization of Sickness*, was published in 2018 by University of California Press and has won several awards. I consider myself to be an expert in the social dimensions of HIV and infectious disease control, permitting me to give the following expert opinion.

8. A true and accurate copy of my curriculum vitae is attached hereto as Exhibit A, and provides a complete overview of my education, training, and work experience, and a full list of my publications.

9. I have not testified as an expert at trial or by deposition in the past four years.

B. Information Considered

10. This report is based on an analysis of the academic literature on HIV stigma, as well as an original analysis of the legal and social response to the HIV epidemic that provides the basis for my book, *Punishing Disease: HIV and the Criminalization of Sickness*. In addition, this report reviews key findings in HIV polling data from the past 30 years to analyze changes in public knowledge and attitudes about the epidemic.

C. Compensation

11. I am being compensated: $150 per hour for work other than testimony at deposition, hearing, or trial; $1,000 per day for any travel time and attendance at a deposition, hearing, or trial; and reimbursement for reasonable out-of-pocket travel expenses (hotel, flight, airport transportation, and food) incurred for any deposition, hearing, or trial.

II. STIGMA AND DISCRIMINATION AGAINST PEOPLE LIVING WITH HIV WERE AND STILL ARE PERVASIVE AND SUBSTANTIAL TO SEVERE

A. History of HIV Stigma and Discrimination

12. In June 1981, the CDC first reported cases of a strange new form of *Pneumocystis pneumonia* that appeared to be killing otherwise healthy young patients. Health authorities did not understand what was causing so many patients—hundreds at first, but quickly thousands—to become sick and die. Medical authorities officially labeled the disease acquired immune deficiency syndrome ("AIDS") in 1982. Scientists would not discover the cause of this illness until the discovery of the human immunodeficiency virus ("HIV") in 1984, and a test for the virus would not become publicly available until 1985—after thousands of Americans had already died.

13. Apart from medical patients and hemophiliacs exposed through tainted blood products, the HIV epidemic disproportionately has historically impacted marginalized and stigmatized communities. Between 1981 and 1987, 65 percent of newly diagnosed patients were gay and bisexual men, also referred to in most public health literature as "men who have sex with men" ("MSM"). Following MSM, the second most disproportionately impacted population during this time was injection drug users (17 percent).[1] These epidemiological trends led some social critics to collectively and derisively refer to people with AIDS as the "4-H club" (homosexuals, heroin users, Haitians, and hemophiliacs).[2]

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[1] James W. Curran et al., *Epidemiology of HIV Infection and AIDS in the United States*, 239 Science (Issue 4840) 610 (1988).

[2] *Current Trends Prevention of Acquired Immune Deficiency Syndrome (AIDS): Report of Inter-Agency Recommendations*, CENTERS FOR DISEASE CONTROL, https://www.cdc.gov/mmwr/preview/mmwrhtml/00001257.htm (March 4, 1983); AVERT, ORIGIN OF HIV & AIDS, https://www.avert.org/professionals/history-hiv-aids/origin (last visited March 22, 2019).

14. Even when untreated, the per-contact risk of sexually transmitting HIV is relatively low.[3] Nonetheless, many Americans not only feared contracting HIV via exposures it had been established presented no risk, such as kissing or sharing a drinking glass, but also as a result of highly improbable scenarios spread through urban legends (such as tainted pins planted in movie theater seat cushions).[4] For example, beginning in the 1980s—and even in recent years—polling firms have consistently found that a substantial portion of Americans mistakenly believe that kissing can transmit HIV.[5]

15. The outbreak of AIDS coincided with the election of Ronald Reagan and the ascendance of the New Right, a coalition of conservative politicians and evangelical Christians which would become a formidable force in American politics. The unique combination of stigmatizing attitudes against those infected with HIV, along with widespread fear and ignorance about the disease, proved to be fertile ground for the New Right. Conservatives heralded AIDS as a symbol of America's moral decline. Medical authorities originally called the disease "G.R.I.D." (gay-related immunodeficiency), a misstep that facilitated the New Right's characterization of the disease as a "Gay Plague"–divine retribution for sexual sin, or in the words of the televangelist Jerry Falwell, "the wrath of a just God against homosexuals."[6] A 1987

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[3] *HIV Risk Behaviors*, Centers for Disease and Prevention, https://www.cdc.gov/hiv/risk/estimates/riskbehaviors.html (last updated Dec. 4, 2015).
[4] Timothy C. Correll, *'You Know about Needle Boy, Right?': Variation in Rumors and Legends about Attacks with HIV-Infected Needles*, 67 Western Folklore (Issue 1) 59 (2008).
[5] Gregory H. Herek et al., *HIV-Related Stigma and Knowledge in the United States: Prevalence and Trends, 1991–1999,* 92 American Journal of Public Health (Issue 3) 371 (2002).
[6] Clarence Page, *The Rise and Fall of Jerry Falwell,* Chi. Trib., May 20, 2007, http://articles.chicagotribune.com/2007-05-20/news/0705190543_1_thomas-road-baptist-church-lynchburg-baptist-nation-of-islam-minister.

Gallup Poll found that 43 percent of Americans believed AIDS to be a form of punishment for moral decline, reflecting the efforts of conservatives such as Falwell.[7]

16. People living with HIV faced frequent discrimination and heightened stigma. Doctors turned away HIV-positive patients. Funeral homes refused to bury people who had died of AIDS-related complications. Even children living with the disease were cast out, as 13-year-old Ryan White experienced in Kokomo, Indiana in 1984. A hemophiliac, Ryan contracted the disease from tainted blood products. Parents at Ryan's school successfully petitioned the school board to expel him from the school based on his diagnosis. Although his expulsion was perhaps the most widely publicized case of its kind at the time, it was not isolated. When a Florida couple successfully sued the De Soto County School District in 1987 to allow their three hemophiliac, HIV-positive sons to attend school, they found their house had been burned down, forcing them to leave town.[8]

17. Americans' fear and ignorance of HIV transmission, coupled with the intense stigma against communities disproportionately impacted by HIV, led to strident calls for invasive measures to control the epidemic. Conservative commentator William F. Buckley famously called for all newly-diagnosed patients to be tattooed with the words "HIV-positive," but there were countless other leaders who called for public health departments to institute quarantine procedures and to criminalize people living with HIV who they viewed as a threat to society.[9]

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[7] *HIV/AIDS at 30: A Public Opinion Perspective* (Kaiser Family Foundation, Jun. 1, 2011), https://kaiserfamilyfoundation.files.wordpress.com/2013/07/8186-hiv-survey-report_final.pdf.
[8] Mike Thomas, *Arson Cause of Fire at Rays – Boys Start School Today*, Orlando Sentinel, Sep. 23, 1987, https://www.orlandosentinel.com/news/os-xpm-1987-09-23-0150050182-story.html.
[9] Gregory H. Herek & Eric K. Glunt, *An Epidemic of Stigma: Public Reactions to AIDS*, 43 American Psychologist (Issue 11) 886 (1988).

18. The military was not immune from these pressures. In 1996, President Clinton publicly struggled over his decision to sign into law the National Defense Authorization Act for Fiscal Year 1996 as it included a controversial provision that required the military to discharge servicemembers living with HIV within six months. The architect behind the provision, Representative Robert Dornan, fiercely resisted President Clinton's efforts in 1993 to repeal the ban on people living with HIV entering the United States; Rep. Dornan also fought to enact a ban on gay servicemembers.[10] Although President Clinton ultimately signed the reauthorization bill with the HIV ban provision, the president directed the Attorney General not to enforce the law while his administration was pushing for repeal of the ban in Congress. Those efforts were ultimately successful, and by April 1996, both houses of Congress approved the repeal of the ban on HIV-positive service members.[11]

19. AIDS activists fiercely resisted calls to crack down on people living with HIV by arguing that the deeply negative response to AIDS necessitated that public health authorities take special care to protect people with the disease from the harms of stigma. Advocates were particularly concerned that any state-managed database that included the names of people diagnosed with HIV (a practice called names-based reporting) would raise serious privacy risks and potentially discourage people from testing for HIV. These concerns were not without merit; for example, in 1996, a Florida health department staff member was accused of using a health department list of more than 4,000 people living with HIV as a tool for screening potential

[10] Jonathan S. Landay, *Congress Jumps into Military Social Fray Debate This Week to Focus on Gay Rights, Abortion More than Pentagon Spending*, Christian Science Monitor, July 18, 1996, at 4.

[11] Chrystanthe Gussis, *The Constitution, the White House, and the Military HIV Ban: A New Threshold for Presidential Non-Defense of Statutes*, 30 University of Michigan Journal of Law Reform (Issue 2) 591 (1997).

sexual partners.[12] For these reasons, advocates lobbied for special protections for tracking and monitoring HIV that were different from other public health problems—a view that became known as "AIDS exceptionalism." Although AIDS activists did not convince public health authorities to abandon names-based reporting procedures, health authorities did begin offering anonymous HIV testing services nationwide. HIV remains the only infectious disease for which such a service is legally mandated to be offered by state and local health departments.

B. Criminal Laws Used to Control People Living with HIV

20. HIV stigma has informed the legal response to the epidemic. Beginning in the mid-1980s, lawmakers in 45 states introduced legislation that imposed criminal sanctions specifically targeting the behavior of people living with HIV. Rather than misdemeanor or civil penalties, most HIV-specific criminal legislation enacted in the United States featured felony penalties that carried stiff prison sentences, ranging from two to three years to life in prison. According to a 2014 report co-authored by staff from the CDC and the Department of Justice ("DOJ"), 33 states enacted criminal legislation specifically targeting people living with HIV.[13] Although the federal and state governments do not compile official statistics regarding these prosecutions, research has revealed thousands of criminal cases involving people living with HIV who have been prosecuted under HIV-based criminal laws.[14]

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[12] Reuters, *Theft of AIDS Database Prompts New Effort to Guard Information*, Washington Times, Oct. 14, 1996, at A8.

[13] J. Stan Lehman et al. *Prevalence and Public Health Implications of State Laws That Criminalize Potential HIV Exposure in the United States*, 18 AIDS and Behavior (Issue 6) 997 (2014).

[14] Amira Hasenbush, *HIV Criminalization in Georgia: Penal Implications for People Living with HIV* (The Williams Institute, 2018), https://williamsinstitute.law.ucla.edu/wp-content/uploads/HIV-Criminalization-Georgia-Jan-2018-1.pdf; Trevor Hoppe, *Punishing Disease: HIV and the Criminalization of Sickness* (U. of Cal. Press, 1st ed. 2018); Dini Harsono et al., *Criminalization of HIV Exposure: A Review of Empirical Studies in the United States*, 21 AIDS and Behavior 27 (2017); Amira Hasenbush et al., *HIV Criminalization in California:*

21. Most statutes are construed broadly without regard to transmission or even the risk of transmission from the specific activity in question. In most states with such laws, the crime is defined as failing to disclose one's HIV-positive status before engaging in a range of behaviors—typically, sexual contact; however, some states also prohibit needle sharing and even spitting, biting, or other nonsexual exposures, which involve no real risk of transmission. In the sexual context, use of a condom or other preventive measures is generally irrelevant. In Michigan, for example, the law prohibits people living with HIV from engaging in "sexual penetration" without first disclosing their HIV status. The law defines sexual penetration as "sexual intercourse, cunnilingus, fellatio, anal intercourse, or any other intrusion, however slight, of any part of a person's body or of any object into the genital or anal openings of another person's body."[15] Such imprecise statutory language has facilitated the criminalization of a wide range of practices, including those that are unlikely to transmit the disease and also those that could not conceivably transmit HIV. For example, in a case I review in my book, *Punishing Disease*, a Tennessee man who was admitted to the hospital after attempting suicide was charged and convicted in 2010 under that state's HIV exposure law after he bit a hospital attendant.[16] Biting has never been definitively established as a route of HIV transmission; nonetheless, the defendant was sentenced to three years in prison.

22. Lengthy prison sentences are common in these cases. In a study I conducted analyzing 431 prosecutions in six U.S. states between 1992 and 2010, I found that more than three-quarters of defendants convicted under HIV-specific criminal laws were sentenced to jail

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Penal Implications for People Living with HIV, (The Williams Institute, 2015), https://williamsinstitute.law.ucla.edu/wp-content/uploads/HIV-Criminalization-California-Updated-June-2016.pdf.

[15] MCL § 333.5131 (2017).

[16] *See* Trevor Hoppe*, supra* n. 11, 150-151.

or prison; of those incarcerated, the average prison term was 92 months (nearly eight years).[17] In 2012, an Iowa man, Nick Rhoades, was accused of engaging in a one-time sexual encounter in which he used a condom; he had an undetectable viral load, which the CDC has recently confirmed reduces the risk of transmission effectively to zero; there was (of course) no transmission; after he pleaded guilty, Mr. Rhoades was sentenced to 25 years in prison.[18]

23. No disease in American history has ever been met with a similarly punitive response from lawmakers. While laws targeting syphilis were enacted in many states during World War I, these laws were primarily used as part of a wider crackdown on prostitution that was spearheaded by the U.S. military; while still on the books in many states, these misdemeanor "venereal disease" statutes have rarely been used since the mid-20th century.[19] The only comparable contemporary case of criminalization is hepatitis C virus ("HCV"), a viral infection transmitted through blood-to-blood contact (typically needle-sharing) that has been the subject of criminal legislation enacted in a handful of states. Even in the much smaller number of states with HCV-specific laws, however, few cases have ever been prosecuted—perhaps because most people who could plausibly file charges are unlikely to do so, as it would require reporting criminal drug-using behavior to the police.

24. Other diseases that can cause serious health complications and even death have not faced similar criminal penalties. For example, human papillomavirus ("HPV") is a highly contagious, sexually transmitted infection that can cause lesions on the skin. Studies now show

[17] *See id*., ch. 6.
[18] Brian Cox, *Turning the Tide: The Future of HIV Criminalization after Rhoades v. State and Legislative Reform in Iowa*, 11 Northwestern J. of Law and Soc. Policy 28 (2016).
[19] Trevor Hoppe, *supra* note 11, ch. 1.

that it can also cause cervical cancer—sometimes fatal—many years after initial infection.[20] There have never been campaigns to criminalize HPV exposure. In part, the lack of a punitive response to HPV can be credited to two characteristics of the disease that stand in stark contrast to HIV. First, the high prevalence of HPV in adult Americans (in the years preceding the introduction of an HPV vaccine, estimates suggest that more than 50 percent of U.S. women aged 20–24 had an HPV infection[21]) makes criminal sanctions targeting HPV a costly and impractical policy response. Second, the epidemic is considered to be generalized to the entire adult population, in contrast to the concentrated HIV epidemic that disproportionately impacts highly stigmatized communities already viewed as potentially criminal.

C. Continuing Stigma and Discrimination Rooted in Misconceptions About HIV Treatment, Prognosis, and Transmission

25. Since the first cases of AIDS were reported in the 1980s, scientific advances have transformed the medical significance of an HIV-positive diagnosis. Today, most newly diagnosed patients are prescribed a pill-a-day treatment regimen that carries few side effects. These advances have been credited with both improving the quality of life of people living with HIV and preventing the spread of this disease. To the first point, life expectancy studies have shown a significant narrowing in the life expectancy gap between HIV-positive and HIV-negative individuals; while a recent study found lingering disparities in people living with HIV generally, when analyzing gay men living with HIV specifically, researchers estimated that a 20-

[20] Guglielmo Ronco et al., *Efficacy of HPV-Based Screening for Prevention of Invasive Cervical Cancer: Follow-up of Four European Randomised Controlled Trials*, 383 The Lancet (Issue 9916) 524 (2014).
[21] Catherine L. Satterwhite et al., *Sexually Transmitting Infections among US Women and Men: Prevalence and Incidence Estimates, 2008*, 40 Sexually Transmitted Diseases (Issue 3) 187 (2013).

year-old gay man diagnosed as HIV-positive today and prescribed treatment is expected to live several years longer than men in the general population.[22] To the second point, studies now show that treatment is also an effective form of HIV prevention. Treatment's preventative effects are credited to the fact that HIV medications reduce the amount of virus in a person's bodily fluids to extremely low levels, reducing the risk of transmission to effectively zero. In 2017, the CDC endorsed this science in its prevention strategies and materials, issuing a statement that having a low amount of virus in your bodily fluids "prevents sexual HIV transmission."[23]

26. Although the science of living with HIV has changed dramatically over the past four decades, the social response to the disease has not similarly improved. Ignorance remains pervasive, particularly regarding how HIV is transmitted and the methods for preventing its spread. In 1985, for example, a *New York Times*-CBS poll found that 32 percent of Americans believed that kissing could transmit HIV.[24] In 2001, a Kaiser Family Foundation poll found a remarkably similar proportion (31 percent) of Americans held this belief.[25] A 2017 Kaiser Family Foundation survey of young adults aged 18–30 found that 58 percent of respondents believed HIV could be transmitted though kissing and that 38 percent believed it could be transmitted through casual contact with everyday items such as toilet bowls.[26] These findings

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[22] Hasina Samji et al., *Closing the Gap: Increases in Life Expectancy among Treated HIV-Positive Individuals in the United States and Canada*, 8 PLoS ONE (Issue 12) e81355 (2013), https://doi.org/10.1371/journal.pone.0081355.

[23] Eugene McCray, MD, & Jonathan H. Mermin, MD, MPH, *Dear Colleague: September 27, 2017*, CDC (Sep. 27, 2017), https://www.cdc.gov/hiv/library/dcl/dcl/092717.html.

[24] Erik Eckholm, *Poll Finds Many AIDS Fears That the Experts Say Are Groundless*, N.Y. Times, Sep. 12, 1985, https://www.nytimes.com/1985/09/12/us/poll-finds-many-aids-fears-that-the-experts-say-are-groundless.html.

[25] *The AIDS Epidemic at 20 Years: The View from America* (Kaiser Family Foundation, 2001), https://kaiserfamilyfoundation.files.wordpress.com/2013/01/the-aids-epidemic-at-20-years-the-view-from-america-survey.pdf.

[26] *National Survey of Young Adults on HIV/AIDS* (Kaiser Family Foundation, 2017), http://files.kff.org/attachment/Report-National-Survey-of-Young-Adults-on-HIV/AIDS.

suggest that Americans may be even less knowledgeable about HIV today than they were in 1985.

27. Stigma toward the disease and those living with it has remained similarly persistent. In the previously cited survey of young adults aged 18–30 published in 2017, the Kaiser Family Foundation found that 51 percent would be uncomfortable having a roommate who was living with HIV, while 58 percent reported being uncomfortable with the idea of having someone living with HIV prepare their food.[27] In addition, many Americans continue to blame those who contract HIV for their illness. The most recent national survey of Americans by the Kaiser Family Foundation found that nearly a third of Americans believed that "it's people's own fault if they get AIDS"—although that proportion had declined slightly from 40 percent since 2002.[28]

28. HIV stigma continues to manifest in violence and discrimination against people living with the disease. Nationally, a 2012 Kaiser Family Foundation review of polling data between 2000 and 2012 suggests modest improvement in the social landscape for people living with HIV. Among a nationally representative sample of Americans, 40 percent of respondents indicated that they perceive that people living with HIV experience "a lot" of prejudice and discrimination; that proportion is down slightly from 51 percent in 2000. However, reports from around the country reveal persistent bias. For example, in 2014, a Michigan woman was ticketed by a police officer after she disclosed her HIV status during a routine traffic stop; in a video recording of the encounter, the officer explicitly informed her that he was issuing a ticket

[27] *Id*.
[28] *2012 Survey Of Americans On HIV/AIDS* (Kaiser Family Foundation, 2012), https://www.kff.org/hivaids/poll-finding/2012-survey-of-americans-on-hivaids/.

because she was HIV-positive and he was "pissed" that he might contract the disease.[29] Other reports reveal the dangers involved when people disclose that they are HIV-positive to partners—especially for women. In 2012, for example, a Texas man killed a woman he was having an affair with after she disclosed to him that she was living with HIV; Larry Dunn testified at trial that he "wanted to make her pay."[30] In 2015, another Texas man, Justin Welch, pleaded guilty to charges he murdered a woman after she disclosed her HIV status.[31]

29. After the first six years of the epidemic, AIDS advocacy organizations were able to mobilize political responses to instances of violence and discrimination such as those mentioned in the previous section. The AIDS Coalition to Unleash Power ("ACT UP") was a well-known direct-action political organization that successfully pressured federal agencies and raised awareness about AIDS in the late 1980s and early 1990s.[32] Over time, however, explicitly political AIDS organizations have disbanded or shifted their focus away from political advocacy and towards providing medical care and clinical services—especially as the focus of HIV prevention shifted away from promoting safer sex practices towards people not yet diagnosed as HIV-positive and towards promoting treatment adherence for people living with HIV.[33] To that

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[29] Niraj Warikoo, *Detroit Woman with HIV Gets $40K Settlement from Dearborn*, Detroit Free Press, Sep. 15, 2015, https://www.freep.com/story/news/local/michigan/wayne/2015/09/21/dearborn-hiv-settlement-police/72564850/.

[30] Jennifer Emily, *Man who Admitted Killing HIV-Positive Girlfriend: 'I Wanted to Make Her Pay'*, Dallas News, Oct. 29, 2013, https://www.dallasnews.com/news/crime/2013/10/29/man-who-admitted-killing-hiv-positive-girlfriend-i-wanted-to-make-her-pay.

[31] Morénike Giwa Onaiwu & Venita Ray, *When Ignorance Kills, Nobody Wins: Advocates Reflect on an HIV-Related Murder Case*, The Body, Jan. 20, 2015, http://www.thebody.com/content/75444/when-ignorance-kills-nobody-wins-advocates-reflect.html.

[32] Steven Epstein, *Impure Science: AIDS, Activism, and the Politics of Knowledge* (U. of Cal. Press, 1st ed. 1998).

[33] Roy Cain, *Community-Based AIDS Services: Formalization and Depoliticization*, 23 International Journal of Health Services (Issue 4) 665 (1993); Peter Aggleton & Richard Parker,

point, none of the several dozen chapters of ACT UP remain active in the United States and extremely few AIDS service organizations dedicate substantial resources to political advocacy.

30. Reports of violence and discrimination contribute to a chilling climate for people living with HIV who face complicated decisions about whether to reveal that information to friends, co-workers, and partners.[34] While the gay and lesbian rights movement placed significant emphasis on the importance of publicly "coming out" as a sexual minority, there has not been a similar push for people living with HIV to do the same. While same-sex desire and HIV infection are both the subject of tremendous social stigma, norms around medical privacy complicate any effort to promote publicly acknowledging one's HIV-positive status (to that point, a popular magazine for people living with HIV, *POZ*, advises readers to "be selective" and emphasizes the relevant health privacy protections that restrict most employers from asking).[35]

31. Reactions to the *Harrison v. Shanahan* and the *Roe v. Shanahan* lawsuits reflect the persistence of HIV stigma described above. For the purposes of this report, I reviewed public comments on electronic news stories reporting on various stages of the litigation (from the lawsuit's filing in 2018 to the issuance of the preliminary injunction in 2019).[36] A total of 709 comments were downloaded from ten articles reporting on the lawsuit. As this is not a representative sample of Americans, caution should be taken in assigning too much weight to

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Moving Beyond Biomedicalization in the HIV Response: Implications for Community Involvement and Community Leadership Among Men Who Have Sex with Men and Transgender People, 105 Am. J. of Pub. Health (Issue 8) 1552 (2015); Trevor Hoppe, *supra* n. 11, ch. 2.

[34] Carla M. Obermeyer et al., *Facilitating HIV Disclosure Across Diverse Settings: A Review*, 101 Am. J. of Pub. Health (Issue 6) 1011 (2011).

[35] *See Living with HIV: Disclosure*, POZ, https://www.poz.com/basics/hiv-basics/disclosure (last reviewed Feb. 27, 2018).

[36] Articles selected for this analysis were identified using Google and Google News, with keywords "HIV," "military," and "Harrison." Electronic articles that did not include a comment feature or for which there either zero or one comment posted were excluded (which includes numerous outlets such as *The New York Times*).

these comments. Nonetheless, statements by readers about the lawsuit reflect two themes raised previously in this analysis.

32. First, many readers describe HIV in outdated terms that better reflect its status in the 1980s. A commenter posting to an article published in *The Hill* asks: "How does the military deal with servicemen who are infected with incurable deadly diseases spread by blood and bodily fluids? HIV is still an incurable deadly disease."[37] Another reader on that site follows up by asking "So will the military now require soldiers and medics to don haz-mat suits when providing aid to injured soldiers with HIV?" A user on Military.com posted a similarly inflammatory comment. "HIV is a deadly and highly contagious [sic] disorder. We cannot allow this disease to contaminate and decimate out [sic] military."[38]

33. Second, many readers made a direct connection between their opposition to servicemembers living with HIV and their association of HIV with homosexuality. For example, a user on *The Hill* laments that: "Once again gays endanger our Troops while sucking up our tax dollars." Another user asks "Is the military being forced to make an exception to that rule because of the Gay Mafia?" Yet another user connects the Obama-era end to "Don't Ask, Don't Tell" policies with a spike in sexually transmitted disease in the military. "Since Obama forced the open service of gays, morale dropped 50% between 2008–2016… STDs [in the military] have exploded with 90% of syphilis and 80% of new HIV cases being gay men." These

[37] Morgan Gstalter, *Federal Judge Temporarily Blocks Military from Discharging HIV-Positive Airmen*, The Hill, Feb. 16, 2019, https://thehill.com/homenews/administration/430330-federal-judge-temporarily-blocks-military-from-discharging-hiv#bottom-story-socials.
[38] Oriana Pawlyk, *Airmen Sue Defense Department over Discharges for HIV Status*, Military.com, December 20, 2018, https://www.military.com/daily-news/2018/12/20/airmen-sue-defense-department-over-discharges-hiv-status.html.

comments mirror how anti-gay bias has frequently tainted calls for punitive policies ostensibly enacted in the name of public health.

34. In conclusion, HIV stigma remains recalcitrant in American society. Despite significant medical advances that have transformed HIV into a chronic, manageable illness, public attitudes remain in many ways unchanged since the 1980s. Because of its association with marginalized communities, the HIV epidemic has produced a particularly noxious form of stigma that is imbued with homophobia and deep-seated anxieties about sex and injection drug use more broadly. This stigma manifests in violence, discrimination, and exclusion in American life that is unique to this disease and stands apart in modern American history.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on: 03/21/2019

Respectfully,

Trevor Hoppe, MPH, PhD

Exhibit A

Trevor Alexander Hoppe

tahoppe@uncg.edu | http://www.trevorhoppe.com

EMPLOYMENT

Assistant Professor, University of North Carolina at Greensboro — Greensboro, NC
Department of Sociology (2018 – Present)

Assistant Professor, University at Albany, SUNY — Albany, NY
Department of Sociology (2015-2018)

Postdoctoral Fellow, University of California at Irvine — Irvine, CA
Department of Criminology, Law and Society (2014-2015)

EDUCATION

Ph.D. University of Michigan (2014) — Ann Arbor, MI
Sociology and Women's Studies
Dissertation: *From Sickness to Badness: Michigan HIV Law as a Site of Social Control*
Committee: Renee Anspach & David Halperin (Co-Chairs), Sarah Burgard, Sandra Levitsky
- WINNER: American Sociological Association (ASA), Martin P. Levine Dissertation Fellowship
- WINNER: ASA, Medical Sociology Section, Roberta G. Simmons Outstanding Dissertation Award

M.P.H University of Michigan (2011) — Ann Arbor, MI
Health Behavior and Health Education, School of Public Health

M.A. San Francisco State University (2007) — San Francisco, CA
Human Sexuality Studies

B.A. University of North Carolina at Chapel Hill (2005) — Chapel Hill, NC

PUBLICATIONS

Books:

2018. *Punishing disease: HIV and the criminalization of sickness.* University of California Press.
- WINNER: 2018 Lambda Literary Award for LGBTQ Studies
- WINNER: 2018 *POZ* Magazine Award for Best in Literature, Fiction, and Non-Fiction

2017. Hoppe, Trevor and David Halperin (Eds.). *The war on sex*. Duke University Press
- FINALIST: 2018 Lambda Literary Award for LGBTQ Studies

Journal articles:

Rebeca Herrero Saenz*, and **Trevor Hoppe**, "Disease on trial: Medical risk and molecular responsibility in HIV exposure and disclosure jury trials (1994–2015)." Forthcoming in *Current Sociology*.

"'Spanish flu': When infectious disease names blur origins and stigmatize those infected." *American Journal of Public Health*, 2018, 108(11):1462-1464.

"Punishing sex: Sex offenders and the missing punitive turn in sexuality studies." *Law & Social Inquiry*, 2016, 41(3): 573-94.

"Cruel intentions? HIV prevalence and criminalization during an age of mass incarceration, U.S. 1999-2012." Second author, with Bryan Sykes and Kristen Maziarka. *Medicine*, 2016, 95(16):1-9.

"Social science perspectives on pre-exposure prophylaxis for HIV (PrEP)." Second author, with Judith Auerbach. *Journal of the International AIDS Society,* 2015, 18(S3):19983.

"Disparate risks of conviction under Michigan's felony HIV disclosure law: An observational analysis of convictions and HIV diagnoses, 1992-2010." *Punishment & Society*, 2015. 17:73-93.

- Featured in *Ebony, The Nation, TheBody.com*

"From sickness to badness: The criminalization of HIV in Michigan." *Social Science & Medicine*, 2014, 101: 139-147.

"Controlling sex in the name of 'public health': Social control and Michigan HIV law." *Social Problems*, 2013, 60: 27-49.

- ASA, Sexualities Section, Best Graduate Student Paper, 2014
- ASA, Sociology of Law Section, Best Graduate Student Paper, 2013
- University of Michigan, Department of Sociology, Mark Chesler Paper Award, 2013

"Circuits of power, circuits of pleasure: Sexual scripting in gay men's bottom narratives." *Sexualities*, 2011, 14: 193-217.

- Sociologist AIDS Network Martin Levine Student Essay Award, 2009

Book chapters:

Hoppe, Trevor. "Queer and punishment: Sexual social control and the legacy of 'nuts, sluts and preverts'" (Book chapter). Forthcoming in Schilt, Kristen, Tey Meadow, and D'Lane Compton (eds.), *Other, Please Specify:_____: Queer Methods in Sociology*. Berkeley, CA: University of California Press.

Manuscripts in progress or under review:

Hoppe, Trevor, Bryan Sykes, and Kyle Maksuta* "Sexual threat: Using group threat theory to explain the rise and spread of American sex offender registries."

Hoppe, Trevor, and Renee Anspach. "Towards a critical sociology of public health."

*Authors denoted with an asterisk * are graduate students*

Reviews:

Hoppe, Trevor. Forthcoming. "Review of *Sex Offenders, Stigma, and Social Control*, by Diana Rickard," *Contemporary Sociology.*

Hoppe, Trevor. 2017. "Review of *The Straight Line: How the Fringe Science of Ex-Gay Therapy Reoriented Sexuality*, by Tom Waidzunas," *American Journal of Sociology*, 123(1):312-314.

Hoppe, Trevor. 2011. "Review of *Unlimited Intimacy: Reflections on the Subculture of Barebacking*, by Tim Dean." *Journal of Sex Research*, 48: 506-8.

Hoppe, Trevor. 2009. "Review of *Sexual Inequalities & Social Justice*, N. Teunis & G. Herdt (Eds.), and *The Health of Sexual Minorities,* I. Meyer & M. Northridge (Eds)." *Culture, Health and Sexuality,* 11: 107-10.

Other publications and media appearances:

Interview. 2018, March 26. "How state laws criminalize people with HIV." *The Crime Report.* https://thecrimereport.org/2018/03/26/how-state-laws-criminalize-hiv-sufferers/

Interview and Book Review. 2018, March 2. "Creating criminals: The misguided crackdown on HIV/AIDS." *Undark.* https://undark.org/article/book-review-hoppe-punishing-disease/

Interview. 2018, February 6. "Hepatitis C exposure is a crime in some states; is this the new HIV criminalization?" *The Body*. http://www.thebody.com/content/80840/hepatitis-c-exposure-is-a-crime-in-some-states-is-.html

Interview. 2017, December 12. "What's the future of HIV criminalization activism? An interview with Trevor Hoppe." *The Body*. http://www.thebody.com/content/80680/whats-the-future-of-hiv-criminalization-activism-a.html

Interview. 2017, December 8. "Are we punishing diseases or punishing people? An interview with Trevor Hoppe." *The Body*. http://www.thebody.com/content/80668/are-we-punishing-diseases-or-punishing-people-an-i.html

Hoppe, Trevor. 2017, November 20. "Should we punish the sick?" *Washington Blade*. http://www.washingtonblade.com/2017/11/20/should-we-punish-the-sick/

Interview. 2017, August 14. "Fear and ignorance criminalized HIV. Can science and wisdom undo that?" *Undark*. https://undark.org/article/hiv-criminalization-laws-aids/

Hoppe, Trevor. "Are sex offender registries reinforcing inequality?" *The Conversation*. 2017, August 8. https://theconversation.com/are-sex-offender-registries-reinforcing-inequality-79818

- Reposted in *Newsweek, San Francisco Chronicle*

Hoppe, Trevor, and David Halperin. 2017, June 26. "Two years after SCOTUS gay marriage ruling, the road to sexual freedom remains long." *The Hill*. http://thehill.com/blogs/pundits-blog/civil-rights/337079-two-years-after-scotus-gay-marriage-ruling-long-road-to

Hoppe, Trevor. 2017, May 19. "Lawmakers: Don't give in to the 'stealthing' moral panic." *Advocate*. https://www.advocate.com/commentary/2017/5/19/lawmakers-dont-give-stealthing-moral-panic

Interview. 2016, May 25. "The war on sex offenders is the new war on drugs, which means its about race." *Inverse*. https://www.inverse.com/article/16109-the-war-on-sex-offenders-is-the-new-war-on-drugs-which-means-it-s-about-race

Interview. 2016, April 5. *Stateside*. National Public Radio. http://michiganradio.org/post/stateside-tuesday-april-5-2016

Hoppe, Trevor. 2016, April 3. "The County in Michigan Where HIV is a Crime." *Huffington Post*. http://www.huffingtonpost.com/trevor-hoppe/the-county-in-michigan-wh_b_9602758.html

Hoppe, Trevor. 2015, November 17. "Let's Not Treat Charlie Sheen Like a Criminal." *Huffington Post.* http://www.huffingtonpost.com/trevor-hoppe/lets-not-treat-charlie-sh_b_8583710.html

Interview. 2015, May 29. "The reckless prosecution of 'Tiger Mandingo.' *The Nation*. https://www.thenation.com/article/reckless-prosecution-tiger-mandingo/

Interview. 2013. *More Harm than Good: How Overly Broad HIV Criminalisation is Hurting Public Health*. Documentary Film. Directed by Edwin Bernard, HIV Justice Network. http://www.hivjustice.net/moreharm/

Interview. 2013, March 23. *Strange Fruit*. *89.3 WFPL*. http://wfpl.org/strange-fruit-rob-portman-marriage-equality-trevor-hoppe-criminalization-hiv-0/

AWARDS, GRANTS, SCHOLARSHIPS, AND FELLOWSHIPS

2018 Lambda Literary Award for LGBTQ Studies, Lambda Literary Foundation

2018 Lavender Award for Excellence in LGBTQ+ Scholarship, University at Albany, SUNY

2018 Faculty Research Award Program (FRAP), University at Albany, SUNY ($9850)

2016 Individual Development Award, Campus Professional Development Committee, SUNY-Albany

2015 College of Arts and Sciences Conference Travel Fund Program, SUNY-Albany

2014 American Sociological Association, Sexualities Section, Best Graduate Student Paper

2014 American Sociological Association, Medical Sociology Section, Roberta G. Simmons Outstanding Dissertation Award

2013 American Sociological Association, Sociology of Law Section, Best Graduate Student Paper

2013 University of Michigan Department of Sociology, Mark Chesler Paper Award

2013 Seed Grant, Center for Public Policy in Diverse Societies, Gerald R. Ford School of Public Policy, University of Michigan

2013 American Sociological Association Student Forum, Travel Grant

2013 Lee Student Support Fund Travel Award, Society for the Study of Social Problems

2013 Scholarship, 2nd International Conference for the Social Sciences and Humanities in HIV, Paris, France.

2012 ASA, Martin P. Levine Memorial Dissertation Fellowship

2012 University of Michigan Rackham Predoctoral Fellowship

2012 Scholarship, American Sociological Association Section on Sexualities Mini-Conference

2012 Scholarship, International AIDS Conference, Washington, DC.

2011 Centers for Disease Control and Prevention, Young Innovator Award

2011 Sociologist AIDS Network, Scholarly Activity Award

2011 Community of Scholars Fellowship, Institute for Research on Women and Gender, University of Michigan

2011 Rackham Graduate Student Candidacy Research Grant, University of Michigan

2011 Dissertation Research Grant, Department of Sociology, University of Michigan

2011 Student Research Grant, Center for Education of Women, University of Michigan

2010 Social Science Research Council, Dissertation Proposal Development Fellowship

2009 Sociologist AIDS Network Martin Levine Student Essay Award

2009 Dean's Scholarship, School of Public Health, University of Michigan (Declined)

2008 Rackham Graduate Student Pre-Candidacy Research Grant, University of Michigan

2007 Herbert E. Boynton Scholarship, University of Michigan

2006 SFSU University Scholarship, San Francisco State University

2006 Jim Brogan Teaching Scholarship, San Francisco State University

INVITED LECTURES AND PRESENTATIONS

"Punishing disease: HIV and the criminalization of sickness"

- Women and Gender Studies Department, Sonoma State University, April 2019, Sonoma, CA
- Department of Women's Studies, University of Michigan, March 2019, Ann Arbor, MI
- Department of Sociology, University of South Carolina, November 2018, Columbia, SC

- Saint Louis University, April 2018, St Louis, MO
- Washington University in St. Louis, April 2018, St Louis, MO
- Middlebury College, April 2018, Middlebury, VT
- Concordia University, March 2018, Montreal, QC, Canada
- Muskegon Community College, March 2018, Muskegon, MI
- Harvard Law School, January 2018, Cambridge, MA
- University of Arizona, January 2018, Tucson, AZ
- HIV is Not a Crime II National Training Academy, May 2016, Huntsville, AL
- HIV Criminalization Working Group, Yale University, April 2016, New Haven, CT
- Department of Sociology, Grand Valley State University, April 2016, Grand Rapids, MI
- Department of Sociomedical Sciences, UCSF, March 2016, San Francisco, CA
- Department of Sociology, UCLA, November 2015, Los Angeles, CA

"Queer and punishment: Sexual social control and the legacy of 'nuts, sluts and preverts," Queer Methods in Sociology Conference, Harvard University, April 2016, Cambridge, MA.

"Punishing sex: Sex offenders and the missing punitive turn in sexuality studies," The Sexualities Project at Northwestern (SPAN) Annual Workshop, April 2015, Chicago, IL

"Surveying the criminalization of HIV in the United States: Preliminary findings." The Williams Institute, University of California at Los Angeles, October 2013, Los Angeles, CA.

"Making sense of disparate outcomes in Michigan trial court HIV nondisclosure convictions: The modifying impact of the partner's gender." York University, April 2013, Toronto, ON.

"The criminalization of HIV." Invited Lecture, WS 212, "Global HIV/AIDS Epidemic." April 2013, Ann Arbor, MI.

"HIV criminalization in Michigan: Criminal justice and public health in contest." Wayne State University, March 2013, Detroit, MI

"The criminalization of HIV/AIDS." Wayne State University, November 2012, Detroit, MI

"'Equal time': Gays, media, and the myth of equality." Invited panelist, Indiana University, April 2012, Bloomington, IN

"The criminalization of HIV." Invited lecture, "Global HIV/AIDS Epidemic." March 2012, Ann Arbor, MI.

"HIV disclosure laws in the United States: Theory, practice, and politics." Summer Institute on Sexuality, San Francisco State University, June 2011, San Francisco, CA.

"Using sociological theory to understand pleasure and power: Bottom identity among gay men as a case study." Summer Institute on Sexuality, San Francisco State University, June 2011, San Francisco, CA.

"Historical mobilizations of 'public health' against public sex venues." Summer Institute on Sexuality, San Francisco State University, June 2010, San Francisco, CA.

"Remembering Eric Rofes." Against Health Conference, University of Michigan, October 2006.

CONFERENCE PRESENTATIONS

"Victim impact: Analyzing disparities by race, gender, and sexuality under state HIV exposure and disclosure laws,"

- American Sociological Association Annual Meeting, August 2017, Montreal, CA.
- International AIDS Conference [Poster presentation], July 2017, Paris, France.

"One million and counting? How policy levers will impact the future of sex offender registries in the United States," Law & Society Association Annual Meeting, June 2017, Mexico City, MX.

"Punishing HIV: Does race impact sentencing under criminal HIV exposure and disclosure laws in the United States?" [Poster presentation] International AIDS Conference, July 2016, Durban, ZA.

"Punishing disease: HIV and the criminalization of sickness"

- International Sociological Forum, July 2016, Vienna, Austria
- Law and Society Association, June 2016, New Orleans, LA
- American Sociological Association Annual Meeting, August 2015, Chicago, IL

"Punishing sex: Sex offenders and the missing punitive turn in sexuality studies."

- After Marriage Conference at CUNY, October 2016, New York, NY
- American Sociological Association, August 2016, Seattle, WA
- American Society of Criminology, November 2015, Washington, DC
- Law & Society Association Annual Meeting, May 2015, Seattle, WA
- Pacific Sociological Association Annual Meeting, April 2015, Long Beach, CA

"HIV stops with me: The repolarization of post-AIDS HIV prevention."

- Association for the Social Sciences and Humanities in HIV, July 2015 Cape Town, ZA
- American Sociological Association Annual Meeting, August 2014, San Francisco, CA.

"Controlling the criminally sick: A systematic analysis of HIV disclosure trial court cases in Michigan."

- American Sociological Association Annual Meeting, August 2013, New York, NY
- Society for the Study of Social Problems Annual Meeting, August 2013, New York, NY
- 2nd International HIV Social Science and Humanities Conference, July 2013, Paris, France
- 17th Annual Sørensen Memorial Conference, Columbia University, April 2013, New York, NY
- Western Society of Criminology, February 2013, Berkeley, CA
- National Women's Studies Association Annual Meeting, November 2012, Oakland, CA
- American Sociological Association Section on Sexualities Mini-Conference, August 2012, Denver, CO
- International AIDS Conference, August 2012, Washington, DC

"From sickness to badness: Towards a theory of medical social control beyond medicalization."

- American Sociology Association Annual Meeting, August 2012, Denver, CO
- Gendered Borders and Queer Frontiers Conference, Madison, WI, March 2012

"Controlling sex in the name of 'public health': Social control and Michigan's HIV disclosure law."

- Making (In)Appropriate Bodies Conference, Vienna, Austria, December 2011
- American Sociological Association Annual Meeting, Las Vegas, NV, August 2011
- National HIV Prevention Conference, Atlanta, GA, August 2011
- Law & Society Association Annual Meeting, San Francisco, CA, June 2011
- Midwest Sociological Society Annual Meeting, St. Louis, MO, March 2011
- Doing Queer Studies Now: A Graduate Conference, Ann Arbor, MI, October 2010
- Midwest Law & Society Retreat, Madison, WI, October 2010.

"Circuits of Power, Circuits of Pleasure: Sexual Scripting in Gay Men's Bottom Narratives"

- American Sociological Association Annual Meeting, San Francisco, CA, August 2009
- National Gay Men's Health Summit, Seattle, WA, October 2008

"Resisting Public Health: Working within the Gay Men's Health Movement to Produce Change." LumpenCity: Marginalizing Discourses | Discourses of Marginalization, Toronto, ON, Canada, March 2009.

"Being Gay Post-HAART: Young Gay Men Negotiating Desire, Risk, and Heternormativity."

- AIDS in Culture IV, Mexico City, Mexico, December 2007
- LGBTI Health Summit, Philadelphia, PA, March 2007.

PUBLIC LECTURES AND READINGS

"Punishing disease: HIV and the criminalization of sickness"

- Flyleaf Books, Chapel Hill, NC, March 2018
- LGBT Center of Raleigh, Raleigh, NC, March 2018
- Center on Halsted, Chicago, IL, February 2018
- West Hollywood Library, Los Angeles, CA, January 2018
- Bluestockings, New York, NY, December 2017
- William Way LGBT Center, Philadelphia, PA, November 2017
- Red Emma's Bookstore, Baltimore, MD, November 2017

"Reframing HIV: From 'prevention' to 'management.'" National Gay Men's Health Summit, August 2010, Fort Lauderdale, FL.

"Power and rethinking risk." Gay Men's Health Summit, October 2009, Seattle, WA

"Bus stops, billboards and you: campaigning for queer health." San Francisco Lesbian, Gay, Bisexual, and Transgender Community Center, July 2008, San Francisco, CA.

TEACHING EXPERIENCE

Assistant Professor, Department of Sociology, UNC-Greensboro 2018 - Present

- "Global Deviance," Fall 2018
- "Law and Society," Fall 2018

Assistant Professor, Department of Sociology, University at Albany, SUNY 2015 - 2018

- "Sociology of Deviant Behavior," Fall 2015, Fall 2016, Spring 2017, Fall 2017, Spring 2018
- "Sociology of Sexualities," Spring 2018
- "The Global HIV/AIDS Epidemic," Fall 2016
- "The Sociology of Law" (Graduate Seminar), Spring 2017

Primary Instructor, University of Michigan 2009, 2014

- "Sociological Analysis of Deviance" (SOC 488), Spring 2014
- "Sociology of Sexuality" (SOC 345), Spring 2009

Graduate Student Instructor, University of Michigan 2008 – 2014

- "Introduction to Sociology" (SOC 100), Fall 2008, Fall 2010, Winter 2011
- "Sociology of Marriage & The Family" (SOC 344), Winter 2009
- "The Global HIV/AIDS Epidemic" (WOMENSTD / ANTHRO 212), Winter 2012, Fall 2013
- "History of Sexuality" (HIST 369), Winter 2010
- "Men's Health" (WOMENSTD 300), Fall 2009

Teaching Assistant, San Francisco State University 2006 – 2007

- "Variations in Human Sexuality" (SOC 400), Spring 2006, Fall 2006, Spring 2006

REVIEWER FOR THE FOLLOWING PUBLICATIONS

Social Problems, Sociological Forum, Sexualities, Law & Social Inquiry, PLOS One, Theoretical Criminology, Contemporary Sociology, Culture, Health & Sexuality, Men and Masculinities, AIDS & Behavior, Journal of Homosexuality, Archives of Sexual Behavior, Sexuality Research & Social Policy, Women's Studies Quarterly, Studies in Law, Politics & Society, Oxford Bibliographies

PROFESSIONAL SERVICE

2018 – 2021	Council Member-Elect, American Sociological Association Section on Sociology of Law
2018 – 2021	Editorial Board, *Social Problems*
2016 – 2019	Council Member-Elect, American Sociological Association Section on Sexualities
2017 – 2018	Member, Undergraduate Committee, University at Albany Department of Sociology
2017	Member, Distinguished Book Award Committee, ASA Section on Sex and Gender
2016 – 2017	Member, Executive Committee, University at Albany Department of Sociology
2016 – 2017	Chair, Advancement Committee, University at Albany Department of Sociology
2015 – 2016	Member, Advancement Committee, University at Albany Department of Sociology
2014 – 2015	Member, Selection Committee, Roberta G. Simmons Outstanding Dissertation Award, American Sociology Association Section on Medical Sociology
2014 – 2015	Member, Selection Committee, Best Graduate Student Paper Award, American Sociology Association Section on Sexualities
2013 – 2014	Member, Nominations Committee, American Sociology Association Section on Sex and Gender
2013 –	Member, Criminalization of HIV Transmission and Exposure Working Group Law, Policy and Ethics (LPE) Core, Center for Interdisciplinary Research on AIDS (CIRA), Yale University
2013	Co-chair with Eric Mykhalovskiy of "Social Science, Criminal Law and HIV Transmission Risks: Novel Research" and "Viral Politics: HIV Criminalization & Social Inquiry" Panels, 2nd International HIV Social Sciences and Humanities Conference
2012 –	Invited Abstract Reviewer, International AIDS Conference
2012	"Sex and Justice" Thematic Panel Organizer, American Sociological Association Section on Sexualities Mini-Conference
2012	Roundtable Discussant, American Sociological Association Section on Sexualities Mini-Conference
2011 –	Martin Levine Paper Prize Committee, Sociologist AIDS Network
2011 – 2012	Graduate Student Representative-Elect, Section on Sexualities, American Sociological Association
2011 – 2012	Organizer, "Sex and Justice" Conference, University of Michigan
2011 – 2012	Graduate Admissions Committee, Department of Sociology, University of Michigan
2010 – 2011	Personnel Committee, Department of Sociology, University of Michigan
2010	Martin Levine Paper Prize Committee, Sociologist AIDS Network

2009 – 2010 Search Committee, HIV/AIDS Cluster Hire, Department of Women's Studies, University of Michigan

2009 – 2010 HIV/AIDS Survey Course Development Committee, Department of Women's Studies, University of Michigan

2009 – 2010 Organizer, "Doing Queer Studies Now" Graduate Conference, University of Michigan

PROFESSIONAL AFFILIATIONS

Member, American Sociological Association (ASA)
- Sections: Medical Sociology; Crime, Law and Deviance; Sex and Gender; Sexualities; Sociology of Law

Member, American Sociology of Criminology (ASC)

Member, Law and Society Association (LSA)

Member, Society for the Study of Social Problems (SSSP)

Member, International AIDS Society (IAS)

Exhibit B

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EXHIBIT 22

Excerpts from the July 31, 2019 Deposition of Col. Patrick Danaher

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
ALEXANDRIA DIVISION

RICHARD ROE, et al.	§	
	§	
VS.	§	NO. 1:18-CV-01565
	§	
MARK T. ESPER, et al.	§	

ORAL AND VIDEOTAPED DEPOSITION OF COLONEL PATRICK DANAHER
JULY 31, 2019

ORAL AND VIDEOTAPED DEPOSITION OF COLONEL PATRICK DANAHER, produced as a witness at the instance of the Plaintiff and duly sworn, was taken in the above styled and numbered cause on Wednesday, July 31, 2019, from 10:03 a.m. to 11:51 a.m., before JANALYN ELKINS, CSR, in and for the State of Texas, reported by computerized stenotype machine, at the offices of Hoffman Reporting, 206 E. Locust, San Antonio, Texas, pursuant to the Federal Rules of Civil Procedure and any provisions stated on the record herein.

MR. NORWAY: Objection, form, foundation.

Q. (BY MR. SOMMER) Is that a "yes"?

A. Yes.

Q. Okay. And are airman with asymptomatic HIV, from a purely medical standpoint, fit to deploy into austere environments?

A. Yes.

MR. NORWAY: Objection, form and foundation.

Q. (BY MR. SOMMER) Based on your medical experience, after an individual is stable on oral medication, how often does that person need to see a doctor for the HIV?

A. So based on current guidelines, it's between every three to six months. And that's based on CDC and DDHS guidelines.

Q. Can it ever be a year?

A. In individual patient circumstances, absolutely.

Q. And what would those circumstances be?

A. So someone who has been well controlled on the medication, stable on it for a long period of time, it would be reasonable to push those visits to once a year.

Q. And when you refer to a long period of time, how much time are you thinking?

A. So typically several years. You'd like to see stability for several years of time and then going to once a year would be reasonable.

Q. Are you familiar with the treatment regimen for people living with HIV?

A. Yes.

Q. And can you please describe that treatment regimen, like if someone were to present to you with an initial case of an HIV diagnosis, what does that regimen look like and how does it progress?

A. So it's typically now the first line regimens recommended by the CDC are once-a-day regimens. The regimens, each one of those individual pills contain three separate medications that are co-formulated and the way I explain it to patients is that we never treat HIV, much like tuberculosis, you don't treat it with a single drug, you treat it with multiple medications so that in the event that the virus develops resistance to it you have other medications onboard that would be effective. The one pill once-a-day regimen that we have now are very well tolerated and that's usually what we're starting people on.

The recommendations that we typically start everyone at the time of diagnosis on a one pill, once-a-day regimen.

And I -- I counsel people that they can expect life expectancy now is about the same for those with HIV as without HIV, so I go through that data with them. We walk through kind of some of the common side effects with the medications and typically prescribe initially a one month supply of the medication with the follow-up appointment around that time to assess tolerability and efficacy and then if they're tolerating it well we go to a three month supply of the medication with several refills.

Q. From a medical standpoint, were there any limitations that you perceived regarding airmen with asymptomatic HIV in their ability to complete their terms of service?

MR. NORWAY: Objection, form, foundation.

THE WITNESS: How do you mean to complete their terms of service?

Q. (BY MR. SOMMER) Well, let's say an enlisted airman has a several year contract. You wouldn't expect someone with asymptomatic HIV -- let me rephrase the question.

Airmen will enlist with a contract period, correct?

A. Yes.

Q. And do you have any medical reason to believe

that an airman that was diagnosed and had well controlled HIV would be unable, because of the HIV, to complete their service?

MR. NORWAY: Objection, foundation.

THE WITNESS: In most circumstances that would propose no area for them not completing their service medically.

Q. (BY MR. SOMMER) Sir, did there ever come a time that you thought that the Air Force was discriminating against airmen with asymptomatic HIV?

MR. NORWAY: Objection, form.

THE WITNESS: I wouldn't use that term. As I mentioned, I thought that the policies were being applied incorrectly, interpreted incorrectly and applied incorrectly.

Q. (BY MR. SOMMER) And why is that?

A. I had -- from 2000 when I started practicing infectious diseases in the Air Force as a fellow, I had occasion to see airmen living with HIV back in my clinic longitudinally over time. And in my experience up through around 2015 I had not seen the personnel office separate anyone for purposes of asymptomatic HIV. My experience was they were routinely returned to duty.

So in 2015, sometime around 2015, 2016, it came to my attention that some airmen were being

Q. (BY MR. SOMMER) You mentioned a waivers to deploy to certain theaters. Are you aware of any waivers being granted for deployments to CENTCOM?

MR. NORWAY: Objection, form.

THE WITNESS: No.

Q. (BY MR. SOMMER) Not for people living with HIV?

A. Not for people living with HIV, no, I'm not aware of that.

Q. Were you aware of any -- well, let me rephrase the question.

Based on your experience, were waivers available for people living with HIV to deploy to CENTCOM?

A. So a -- a waiver is available. You can fill out a waiver, waiver paperwork in a package and submit it anywhere you want to submit it. The question is, is it approved and who is the approving official and will they approve it.

I was never involved with submitting a waiver for someone to deploy to CENTCOM nor am I aware of one being submitted or granted or rejected. I don't know if that happened or didn't happen.

Q. From a medical perspective, does an airman with asymptomatic HIV need any special food during

deployment?

A. No.

Q. From a medical perspective, does an airman with asymptomatic HIV need any special housing during deployment?

A. No.

Q. From a medical perspective, does an airman living with asymptomatic HIV need any special medical attention during a deployment?

A. No.

Q. And finally, does an airman with asymptomatic HIV need any special medical equipment during a deployment?

A. No.

Q. At any point in time, did you have an understanding that people living with HIV would be precluded from deploying to CENTCOM?

MR. NORWAY: Objection, foundation.

THE WITNESS: Yes. I've read the CENTCOM reporting instructions which state something to the effect that you must -- I don't know if it said the CENTCOM commander or the SG, I don't know who was the approving official, but they spelled out very clearly that you could not select somebody living with HIV to deploy to CENTCOM without getting prior approval for

that.

Q. (BY MR. SOMMER) Based on your medical experience, do you believe that that prohibition on deployment to CENTCOM is irrational?

A. I don't think it's got any basis in medical decision-making, no.

Q. So I'm going to just show you some documents and then ask you some questions about the documents.

A. I'm going to the grab my reading glasses.

Q. Oh sure, absolutely.

MR. SOMMER: Why don't we go off the record.

VIDEOGRAPHER: Off the record 10:33.

(Discussion off the record.)

VIDEOGRAPHER: Back on the record at 10:34.

Q. (BY MR. SOMMER) So I'm going to start handing you some documents and we'll do these one at a time. I'd read some numbers into the record just so that they can be identified and then I'll ask you some questions based on that.

A. Okay.

MR. SOMMER: So the first one, and we'll call this Exhibit 1, is US 00021184 underscore 0001 to underscore 0014.

(Exhibit No. 1 was marked.)

EXHIBIT 23

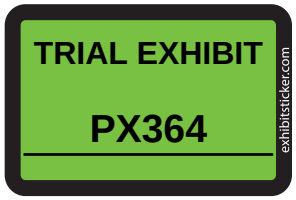
Harrison Defendants' Objections and Responses to Plaintiffs' First Set of Interrogatories to Defendants (Nos. 1-23)

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
Alexandria Division

NICHOLAS HARRISON, *et al.*,	)	
	)	
Plaintiffs,	)	No. 1:18-cv-641-LMB-IDD
	)	
v.	)	
	)	
JAMES N. MATTIS, *et al.*,	)	
	)	
Defendants.	)	

DEFENDANTS' OBJECTIONS AND RESPONSES TO PLAINTIFFS' FIRST SET OF INTERROGATORIES TO DEFENDANTS (NOS. 1-23)

Pursuant to Local Rule 26(C) and Federal Rule of Civil Procedure 33, Defendants, through undersigned counsel, provide the following objections and responses to Plaintiffs' Interrogatories (Nos. 1-23). Defendants reserve the right to supplement, clarify, revise, or correct all or part of these Responses. Defendants' investigation and search for responsive information is continuing. Defendants expressly reserve the right to rely on subsequently discovered information and produce additional responsive documents or information. The information provided in these responses is submitted in accordance with Federal Rule 26(b)(1), which permits the discovery of any non-privileged information that is relevant to a party's claim or defense and proportional to the needs of the case. Accordingly, Defendants do not, by providing such information, waive any objection to its admissibility on the grounds of relevance, materiality, or other appropriate grounds. These responses have been generated after a reasonable, good-faith search for information and records at the Department of Defense ("DoD") and the United States Army.



Additionally, Defendants hereby reaffirm that the Administrative Procedure Act provides the proper vehicle for Plaintiffs' constitutional challenges to agency action, including agency policies, and therefore Plaintiffs' claims should be reviewed by the Court on an administrative record and discovery should not be permitted. *See* 5 U.S.C. § 706.

OBJECTIONS APPLICABLE TO PLAINTIFFS' INSTRUCTIONS THAT PLAINTIFFS STATE WILL APPLY TO EACH INTERROGATORY

1. Defendants object to Plaintiffs' interrogatories to the extent they seek information protected by the attorney-client privilege, the attorney work-product privilege, or the deliberative process privilege.

2. Defendants object to Plaintiffs' Definition No. 3 to the extent it seeks information in the custody of the U.S. Navy, U.S. Marine Corps, U.S. Air Force, or U.S. Coast Guard. Plaintiff Harrison, who is a soldier in the U.S. Army, is the only Plaintiff to have alleged an injury in this case, which stems only from application of Department of Defense Instruction ("DoDI") 6485.01 § 3(a) to the commissioning of Service members who are HIV positive. *See* Defs.' Opp. to Pls.' Mot. For Prelim. Inj. and Mem. in Supp. of Mot. to Dismiss at 20-21, ECF No. 43. Information in the custody and control of Military Departments to which Plaintiff Harrison does not belong have no bearing on this case and responding to requests for that information would impose a significant burden on these Military Departments.

3. Defendants object to Plaintiffs' Definition No. 4 to the extent it seeks information in the custody of the U.S. Navy, U.S. Marine Corps, U.S. Air Force, or U.S. Coast Guard. Plaintiff Harrison, who is a soldier in the U.S. Army, is the only Plaintiff to have alleged an injury in this case, which stems only from application of Department of Defense

Instruction ("DoDI") 6485.01 § 3(a)to the commissioning of Service members who are HIV positive. *See* Defs.' Opp. to Pls.' Mot. For Prelim. Inj. and Mem. in Supp. of Mot. to Dismiss at 20-21, ECF No. 43. Information in the custody and control of Military Departments to which Plaintiff Harrison does not belong have no bearing on this case and responding to requests for that information would impose a significant burden on these Military Departments.

4. Defendants object to Definition No. 10 to the extent it seeks drafts or any other information or documents that are protected by the deliberative process privilege, as is inherent in the phrase "prior versions or amendments thereof." Defendants further object to Definition 10 to the extent it seeks versions of policy documents that have been superseded and therefore have no bearing on the claims in this case.

5. Defendants object to Definition No. 11 to the extent it seeks drafts or any other information or documents that are protected by the deliberative process privilege, as is inherent in the phrase "prior versions or amendments thereof." Defendants further object to Definition 11 to the extent it seeks versions of policy documents that have been superseded and therefore have no bearing on the claims in this case.

6. Defendants object to Definition No. 12 to the extent it seeks drafts or any other information or documents that are protected by the deliberative process privilege, as is inherent in the phrase "prior versions or amendments thereof." Defendants further object to Definition 12 to the extent it seeks versions of policy documents that have been superseded and therefore have no bearing on the claims in this case.

7. Defendants object to Definition No. 13 to the extent it seeks drafts or any other information or documents that are protected by the deliberative process privilege, as is

inherent in the phrase "prior versions or amendments thereof." Defendants further object to Definition 13 to the extent it seeks versions of policy documents that have been superseded and therefore have no bearing on the claims in this case.

8. Defendants object to Definition No. 14 to the extent it seeks drafts or any other information or documents that are protected by the deliberative process privilege, as is inherent in the phrase "prior versions or amendments thereof." Defendants further object to Definition 14 to the extent it seeks versions of policy documents that have been superseded and therefore have no bearing on the claims in this case.

9. Defendants object to Definition No. 17 to the extent it seeks information that is protected by the deliberative process privilege, as is inherent in the inclusion of "thoughts," "ideas," "drafts," "notes," "memoranda to file," and "any conversation or meeting between one or more individuals and another, whether such contact was by chance or prearranged or not, formal or informal." Defendants also object to this definition on the ground that the category of information it seeks is overly broad and unduly burdensome given the size of the organizations identified by Plaintiffs and the time period encompassed by the interrogatories.

10. Defendants object to Definition No. 20, including its five subparts, to the extent it seeks to require Defendants to create or otherwise produce documents not already in existence. *See* Fed. R. Civ. P. 34.

11. Defendants object to Definition No. 22 to the extent it seeks information that is protected by the deliberative process privilege, as is inherent in "reflecting," "discussing," "commenting on," and "memorializing."

OBJECTIONS TO SPECIFIC INTERROGATORIES

The parties have agreed that Plaintiffs' interrogatories shall be counted as being served in the following order: 1-11; 16-23, 13, 15, 12, and 14. *See* Dec. 12, 2018 Letter from J. Harding at 3. Defendants will respond to Plaintiffs' interrogatories in this order based on the parties' agreement.

INTERROGATORY NO. 1

Identify by name, title, and rank all individuals who reviewed, contributed, or reached a determination regarding Plaintiff Nicholas Harrison's request for a medical waiver under AR 40-501 and/or DoDI 6130.03, and identify all Documents or Communications generated as part of that process.

OBJECTIONS: Defendants object to this interrogatory on the basis that it is overly broad and unduly burdensome because Plaintiffs' claims should properly be reviewed on an administrative record and discovery should not be permitted. Recognizing, however, that discovery has been ordered in this case, *see* Scheduling Order (ECF No. 68), Defendants object to the extent this interrogatory seeks information that is protected by the attorney-client privilege, attorney work product, and/or deliberative process privilege.

Defendants also object to the extent that this interrogatory contains multiple, discrete subparts, and thus Plaintiffs have exceeded the number of interrogatories, inclusive of discrete subparts, that they may serve under Federal Rule of Civil Procedure 33(a)(1). Specifically, Plaintiffs request identification of both the individuals who "reviewed, contributed, or reached a determination regarding" Plaintiff Harrison's request for a medical waiver and identification of all documents and communications generated by that process. Thus, this interrogatory contains at least two distinct subparts,

and Plaintiffs have served more than the allowed 30 interrogatories. *See Smith v. Café Asia*, 256 F.R.D. 247, 254 (D.D.C. 2009) (explaining that "each interrogatory that seeks identification of documents in addition to an answer will be counted as two interrogatories.").

Furthermore, because the answer to this interrogatory can be derived from documents that Defendants have produced or will produce to Plaintiffs, the burden of deriving or ascertaining the answer is substantially the same for both parties and the Plaintiffs cannot shift the cost of doing so to the Defendants. *See* Fed. R. Civ. P. 33(d).

Defendants further object to this interrogatory's use of the term "medical waiver" as vague and ambiguous.

RESPONSE: Subject to and without waiving the foregoing objections and construing this interrogatory as (1) a request to identify of individuals involved in the processing of the request for an accession waiver from Sgt. Harrison that was disapproved on December 30, 2014, and (2) a separate request to identify documents associated with the Training Support-Material Army-wide Tracking System (TS-MATS) record of Sgt. Harrison's request for a medical accessions waiver as well as the documents associated with that request in the custody of the Office of the Chief Surgeon of the National Guard Bureau, Defendants respond that information concerning individuals connected to the disapproval of Sgt. Harrison's request for an accession waiver was included in the Memorandum for the Adjutant General, District of Columbia, dated December 30, 2014, which is Bates numbered US00003219. Specifically, Lt. Col. Paul D. Tumminello signed the disapproval for Col. Eric D. Morgan, who was Chief Surgeon, Army National Guard. The records list Messrs. Kinney Simpkins, John Fano-

Schultz, and Randy Dodson as administrative points of contact who reviewed the accession waiver, and Lt. Col. Tumminello and Lt. Col. Edith Fraley, the delegate waiver authority, as clinical points of contact. In addition, Captain Nicole Ono and Sgt.1st Cl. Scott M. Lichtsinn submitted Sgt. Harrison's request for an accession waiver to the National Guard Bureau.

Documents associated with the TS-MATS record of Sgt. Harrison's request for a medical accessions waiver as well as documents associated with that request in the custody of the Office of the Chief Surgeon of the National Guard Bureau are Bates numbered US0003219 through US0003257.

INTERROGATORY NO. 2

Identify by name, title, and rank all individuals who reviewed, contributed, or reached a determination regarding Plaintiff Nicholas Harrison's request for an exception to the policy under AR 600-110 and/or DoDI 6485.01, and identify all Documents or Communications generated as part of that process.

OBJECTIONS: Defendants object to this interrogatory on the basis that it is overly broad and unduly burdensome because Plaintiffs' claims should properly be reviewed on an administrative record and discovery should not be permitted. Recognizing, however, that discovery has been ordered in this case, *see* Scheduling Order (ECF No. 68), Defendants object to the extent this interrogatory seeks information that is protected by the attorney-client privilege, attorney work product, and/or deliberative process privilege.

Defendants also object to the extent that this interrogatory contains multiple, discrete subparts, and thus Plaintiffs have exceeded the number of interrogatories,

inclusive of discrete subparts, that they may serve under Federal Rule of Civil Procedure 33(a)(1). Specifically, Plaintiffs request identification of both the individuals who "reviewed, contributed, or reached a determination regarding" Plaintiff Harrison's request for an exception to the policy and identification of all documents and communications generated by that process. Thus, this interrogatory contains at least two distinct subparts, and Plaintiffs have served more than the allowed 30 interrogatories. *See Smith*, 256 F.R.D at 254 ("each interrogatory that seeks identification of documents in addition to an answer will be counted as two interrogatories.").

Defendants further object to this interrogatory's use of the term "request for an exception to the policy" as vague and ambiguous. Plaintiff Harrison made several separate requests and this interrogatory does not specify to which request it refers. Moreover, if this interrogatory refers to more than one request for an exception, it contains additional discrete subparts and Plaintiffs have exceeded the number of interrogatories, inclusive of discrete subparts, that they may serve under Federal Rule of Civil Procedure 33(a)(1), as described above. Defendants also object to this interrogatory on the basis that that the phrase "reviewed, contributed, or reached a determination" is vague, ambiguous, and unduly burdensome.

Furthermore, because the answer to this interrogatory can be derived from documents that Defendants have produced or will produce to Plaintiffs, the burden of deriving or ascertaining the answer is substantially the same for both parties and the Plaintiffs cannot shift the cost of doing so to the Defendants. *See* Fed. R. Civ. P. 33(d).

RESPONSE: Subject to and without waiving the foregoing objections and construing this interrogatory as (1) a request to identify individuals within the Army who

had an official duty to review Plaintiff Harrison's requests for exceptions to policy directed to the Army Deputy Chief of Staff, G-1; the Assistant Secretary of the Army, Manpower & Reserve Affairs; the Secretary of the Army; and the Secretary of Defense, as well as the identity of the DoD official who reviewed Sgt. Harrison's request for an exception to policy under DoDI 6485.01, and (2) a separate request to identify the official records of those requests in the custody of the Health Promotion Officer, Office of the Deputy Chief of Staff, G-1, the Army responds that information responsive to this interrogatory may be derived from documents that have been produced to Plaintiffs in this case, and the burden of deriving the answer is substantially the same for both Plaintiffs and the Defendants. The individuals within the Army who had an official duty to review Plaintiff Harrison's requests for exceptions to policy may be derived from the four staffing forms provided in Defendants' document production on October 24, 2018, located at Bates numbers US00001057 through US00001058, US00002236 through US00002238, US00001123 through US00001124, and US00002233 through US00002235.

DoD responds that the DoD authority who reviewed Sgt. Harrison's request for an exception to policy under DoDI 6485.01 was Ms. Stephanie Barna, Principal Deputy Assistant Secretary of Defense for Manpower and Reserve Affairs.

The Army further responds that the records of Sgt. Harrison's requests for exceptions to policy in the custody of the Health Promotion Officer, Office of the Deputy Chief of Staff, G-1, are Bates numbered US00000649 through US00000824, US00000991 through US00001966, and US00001968 through US00003135.

INTERROGATORY NO. 3

Identify the three individuals who made the most substantive contributions to the preparation of the DoD 2018 Report to Congress, as well as any Documents considered by such persons.

OBJECTIONS: Defendants object to this interrogatory on the basis that it is overly broad and unduly burdensome because Plaintiffs' claims should properly be reviewed on an administrative record and discovery should not be permitted. Recognizing, however, that discovery has been ordered in this case, *see* Scheduling Order (ECF No. 68), Defendants object to the extent this interrogatory seeks information that is protected by the attorney-client privilege, attorney work product, and/or deliberative process privilege.

To the extent it could be construed as a contention interrogatory, pursuant to Fed. R. Civ. P. 33(a)(2), defendants object to this interrogatory on the grounds that it is premature in light of the present stage of discovery.

Defendants also object to the extent that this interrogatory contains multiple, discrete subparts, and thus Plaintiffs have exceeded the number of interrogatories, inclusive of discrete subparts, that they may serve under Federal Rule of Civil Procedure 33(a)(1). Specifically, Plaintiffs request identification of both the individuals who contributed to the preparation of the DoD 2018 Report to Congress and identification of any documents considered by those individuals. Thus, this interrogatory contains at least two distinct subparts, and Plaintiffs have served more than the allowed 30 interrogatories. *See Smith*, 256 F.R.D at 254 ("each interrogatory that seeks identification of documents in addition to an answer will be counted as two interrogatories.").

Defendants further object to this interrogatory on the basis that it is overly broad and unduly burdensome as to "any Documents considered by such persons" and therefore does not seek information that is both (1) relevant to any party's claim or defense and (2) proportional to the needs of the case. *See* Fed. R. Civ. P. 26(b)(1). Plaintiffs' interrogatory does not limit its request for documents to any specified time period or to any particular matter involving the individuals to be identified and therefore is not limited to relevant documents or proportional to the needs of the case.

Additionally, Defendants object to this interrogatory on the basis that the phrase "most substantive contribution" is not defined by the interrogatories and is vague and ambiguous.

RESPONSE: Subject to and without waiving the foregoing objections and construing this interrogatory as (1) a request to identify three individuals involved in the preparation of the 2018 report to Congress, and (2) a separate request to identify documents in the custody of the Office of the Assistant Secretary of Defense for Health Affairs (OASD(HA)), Defendants respond that the individual with primary responsibility for drafting the August 2018 Report to Congress was Dr. Donald Shell, M.D., M.A., Director, Disease Prevention, Disease Management and Population, Health Policy and Oversight. He was informed and advised by U.S. Army Lieutenant Colonel Jason M. Blaylock, M.D. FACP, FIDSA; U.S. Air Force Lieutenant Colonel Jason F. Okulicz, M.D.; and U.S. Navy Commander Todd D. Gleeson, M.D., M.P.H.

Documents from the files of OASD(HA) are Bates numbered US00003465 through US00005339, and documents from Dr. Shell's official email account are Bates numbered US00010744 through US00011921.

INTERROGATORY NO. 4

Identify the three individuals who made the most substantive contributions to the creation, promulgation, reconsideration, and revision of DoDI 6130.03, Section 5.23 (Systemic Conditions) (a) and DoDI 6130.03, Section 5.23 (Systemic Conditions) (b), the role that each person identified played, as well as any Documents considered by such persons.

OBJECTIONS: Defendants object to this interrogatory on the basis that it is overly broad and unduly burdensome because Plaintiffs' claims should properly be reviewed on an administrative record and discovery should not be permitted. Recognizing, however, that discovery has been ordered in this case Scheduling Order (ECF No. 68), Defendants object to the extent this interrogatory seeks information that is protected by the attorney-client privilege, attorney work product, and/or deliberative process privilege.

To the extent it could be construed as a contention interrogatory, pursuant to Fed. R. Civ. P. 33(a)(2), defendants object to this interrogatory on the grounds that it is premature in light of the present stage of discovery.

Defendants also object to the extent that this interrogatory contains multiple, discrete subparts, and thus Plaintiffs have exceeded the number of interrogatories, inclusive of discrete subparts, that they may serve under Federal Rule of Civil Procedure 33(a)(1). Specifically, Plaintiffs request identification of the individuals who contributed to the "creation, promulgation, reconsideration, and revision" of both DoDI 6130.03, Section 5.23(a) and DoDI 6130.03, Section 5.23(b). *See Mezu v. Morgan State Univ.*, 269 F.R.D. 565, 572-73 (D. Md. 2010) ("[D]iscrete or separate questions should be

counted as separate interrogatories notwithstanding they…may be related." (omission in original) (quoting *Kendall v. GES Expositions Servs.*, 174 F.R.D. 684, 685-86 (D. Nev. 1997)). Additionally, Plaintiffs request identification of both the individuals who participated in the creation, promulgation, reconsideration, and revision of both DoDI 6130.03, Section 5.23(a) and DoDI 6130.03, Section 5.23(b) and identification of any documents considered by those individuals. Thus, this interrogatory contains at least four distinct subparts per version of each regulation, and Plaintiffs have served more than the allowed 30 interrogatories. *See Smith*, 256 F.R.D at 254 ("each interrogatory that seeks identification of documents in addition to an answer will be counted as two interrogatories.").

Defendants further object to this interrogatory on the basis that it is overly broad and unduly burdensome as to "any Documents considered by such persons" and therefore does not seek information that is both (1) relevant to any party's claim or defense and (2) proportional to the needs of the case. *See* Fed. R. Civ. P. 26(b)(1). Plaintiffs' interrogatory does not limit its request for documents to any specified time period or to any particular matter involving the individuals to be identified and therefore is not limited to relevant documents or proportional to the needs of the case.

Additionally, Defendants object to this interrogatory on the basis that the phrase "most substantive contribution" is not defined by the interrogatories and is vague and ambiguous.

RESPONSE: Subject to and without waiving the foregoing objections and construing this interrogatory as (1) a request to identify the organizations responsible for the most recent revision of DoDI 6130.03, and (2) a separate request to identify

documents in the custody of the Accession Policy Directorate (AP directorate) of the Office of the Deputy Assistant Secretary of Defense for Military Personnel Policy (ODASD(MPP)) concerning the most recent revision of DoDI 6130.03, Defendants respond that the most recent revisions to DoDI 6130.03 were a cooperative endeavor between the AP directorate and the Office of the Assistant Secretary of Defense for Health Affairs (HA) after a review by the Accessions Medical Standards Working Group (AMSWG). The current co-chairs of the AMSWG are Dr. Paul Ciminera, M.D., M.P.H, and U.S. Army Lieutenant Colonel Peggy J. Urbano. Prior to Lieutenant Colonel Peggy J. Urbano's arrival to the AP directorate and appointment to the AMSWG, the AP directorate representative to the AMSWG was U.S. Army Lieutenant Colonel Gary W. Brown. The HA representative during the AMSWG review of this section was Dr. Jules Delaune.

Documents in the custody of the Accession Policy Directorate (AP directorate) of the Office of the Deputy Assistant Secretary of Defense for Military Personnel Policy (ODASD(MPP)) concerning the most recent revision of Section 5.23(a) and Section 5.23(b) of DoDI 6130.03 are Bates numbered US00006129 through US00006135, and documents from Dr. Ciminera's official email account are Bates numbered US00005764 through US00006128.

INTERROGATORY NO. 5

Identify the three individuals who made the most substantive contributions to the creation, promulgation, reconsideration and revision of DoDI 6485.01, the role that each person identified played, as well as any Documents considered by such persons.

OBJECTIONS: Defendants object to this interrogatory on the basis that it is overly broad and unduly burdensome because Plaintiffs' claims should properly be reviewed on an administrative record and discovery should not be permitted. Recognizing, however, that discovery has been ordered in this case, *see* Scheduling Order (ECF No. 68), Defendants object to the extent this interrogatory seeks information that is protected by the attorney-client privilege, attorney work product, and/or deliberative process privilege.

To the extent it could be construed as a contention interrogatory, pursuant to Fed. R. Civ. P. 33(a)(2), defendants object to this interrogatory on the grounds that it is premature in light of the present stage of discovery.

Defendants also object to the extent that this interrogatory contains multiple, discrete subparts, and thus Plaintiffs have exceeded the number of interrogatories, inclusive of discrete subparts, that they may serve under Federal Rule of Civil Procedure 33(a)(1). Specifically, Plaintiffs request identification of both the individuals who contributed to the "creation, promulgation, reconsideration, and revision of DoDI 6485.01," and identification of any documents considered by those individuals. Thus, this interrogatory contains at least two distinct subparts per version of this regulation, and Plaintiffs have served more than the allowed 30 interrogatories. *See Smith*, 256 F.R.D at 254 ("each interrogatory that seeks identification of documents in addition to an answer will be counted as two interrogatories.").

Defendants further object to this interrogatory on the basis that it is overly broad and unduly burdensome as to "any Documents considered by such persons" and therefore does not seek information that is both (1) relevant to any party's claim or defense and (2) proportional to the needs of the case. *See* Fed. R. Civ. P. 26(b)(1).

Plaintiffs' interrogatory does not limit its request for documents to any specified time period or to any particular matter involving the individuals to be identified and therefore is not limited to relevant documents or proportional to the needs of the case.

Additionally, Defendants object to this interrogatory on the basis that the phrase "most substantive contribution" is not defined by the interrogatories and is vague and ambiguous.

RESPONSE: Subject to and without waiving the foregoing objections and construing this interrogatory as (1) a request to identify three individuals involved in the most recent revision of DoDI 6485.01, and (2) a separate request to identify documents in the custody of OASD(HA) concerning the most recent revision of DoDI 6485.01, Defendants respond that the most recent version of DoDI 6485.01 was enacted in June 7, 2013. The office responsible for promulgation of this DoDI is HA. The individual within that office that was responsible for DoDI 6485.01 at the time it was released has retired. The individual with primary responsibility for this DoDI within HA is currently Dr. Donald Shell, M.D., M.A., Director, Disease Prevention, Disease Management and Population, Health Policy and Oversight. Dr. Shell's supervisor is Dr. Terry Adirim, M.D., M.P.H., M.B.A., Deputy Assistant Secretary of Defense for Health Services Policy and Oversight. Dr. Adirim's supervisor is Mr. Thomas McCaffery, Principal Deputy Assistant Secretary of Defense for Health Affairs.

Documents from the files of OASD(HA) are Bates numbered US00003465 through US00005339, and documents from Dr. Shell's official email account are Bates numbered US00010744 through US00011921.

INTERROGATORY NO. 6

Identify the three individuals who made the most substantive contributions to the creation, promulgation, reconsideration, and revision of DoDI 6490.07, Enclosure 3 ("Medical Conditions Usually Precluding Contingency Deployment"), section (e) ("Infectious Diseases"), the role that each person identified played, as well as any Documents considered by such persons.

OBJECTIONS: Defendants object to this interrogatory on the basis that it is overly broad and unduly burdensome because Plaintiffs' claims should properly be reviewed on an administrative record and discovery should not be permitted. Recognizing, however, that discovery has been ordered in this case, *see* Scheduling Order (ECF No. 68), Defendants object to the extent this interrogatory seeks information that is protected by the attorney-client privilege, attorney work product, and/or deliberative process privilege.

To the extent it could be construed as a contention interrogatory, pursuant to Fed. R. Civ. P. 33(a)(2), defendants object to this interrogatory on the grounds that it is premature in light of the present stage of discovery.

Defendants also object to the extent that this interrogatory contains multiple, discrete subparts, and thus Plaintiffs have exceeded the number of interrogatories, inclusive of discrete subparts, that they may serve under Federal Rule of Civil Procedure 33(a)(1). Specifically, Plaintiffs request identification of both the individuals who contributed to the "creation, promulgation, reconsideration, and revision" of DoDI 6490.07, Enclosure 3, section (e), and identification of any documents considered by those individuals. Thus, this interrogatory contains at least two distinct subparts per version of this regulation, and Plaintiffs have served more than the allowed 30

interrogatories. *See Smith*, 256 F.R.D at 254 ("each interrogatory that seeks identification of documents in addition to an answer will be counted as two interrogatories.").

Defendants further object to this interrogatory on the basis that it is overly broad and unduly burdensome as to "any Documents considered by such persons" and therefore does not seek information that is both (1) relevant to any party's claim or defense and (2) proportional to the needs of the case. *See* Fed. R. Civ. P. 26(b)(1). Plaintiffs' interrogatory does not limit its request for documents to any specified time period or to any particular matter involving the individuals to be identified and therefore is not limited to relevant documents or proportional to the needs of the case.

Additionally, Defendants object to this interrogatory on the basis that the phrase "most substantive contribution" is not defined by the interrogatories and is vague and ambiguous.

RESPONSE: Subject to and without waiving the foregoing objections and construing this interrogatory as (1) a request to identify individuals responsible for the revision of DoDI 6490.07, and (2) a separate request to identify documents in the custody of HA concerning the most recent revision of DoDI 6490.07, Defendants respond that the most recent version of DoDI 6490.07 was enacted on February 5, 2010. The office responsible for promulgation of this DoDI is HA. The individual within that office that was responsible for DoDI 6490.07 at the time it was released has retired. The individual responsible for this DoDI within HA is currently U.S. Army Colonel Andrew Wiesen, M.D., M.P.H., Director of Preventive Medicine, Office of the Deputy Assistant Secretary of Defense for Health Affairs. His supervisor is Dr. Terry M. Rauch, Acting

Deputy Assistant Secretary of Defense for Health Readiness Policy and Oversight. Dr. Rauch's supervisor is Mr. Thomas McCaffery, Principal Deputy Assistant Secretary of Defense for Health Affairs.

Documents concerning the most recent revision of DoDI 6490.07, if any, will be produced by Defendants on or before December 28, 2018.

INTERROGATORY NO. 7

Identify the three individuals who made the most substantive contributions to the creation and promulgation of the DOGO Instruction (*i.e.*, DoDI 1332.45), the role that each person identified played, as well as any Documents considered by such persons.

OBJECTIONS: Defendants object to this interrogatory on the basis that it is overly broad and unduly burdensome because Plaintiffs' claims should properly be reviewed on an administrative record and discovery should not be permitted. Recognizing, however, that discovery has been ordered in this case, *see* Scheduling Order (ECF No. 68), Defendants object to the extent this interrogatory seeks information that is protected by the attorney-client privilege, attorney work product, and/or deliberative process privilege.

To the extent it could be construed as a contention interrogatory, pursuant to Fed. R. Civ. P. 33(a)(2), defendants object to this interrogatory on the grounds that it is premature in light of the present stage of discovery.

Defendants also object to the extent that this interrogatory contains multiple, discrete subparts, and thus Plaintiffs have exceeded the number of interrogatories, inclusive of discrete subparts, that they may serve under Federal Rule of Civil Procedure 33(a)(1). Specifically, Plaintiffs request identification of both the individuals who

contributed to the "creation and promulgation of the DOGO Instruction (*i.e.*, DoDI 1332.45)," and identification of any documents considered by those individuals. Thus, this interrogatory contains at least two distinct subparts per version of this regulation, and Plaintiffs have served more than the allowed 30 interrogatories. *See Smith*, 256 F.R.D at 254 ("each interrogatory that seeks identification of documents in addition to an answer will be counted as two interrogatories.").

Defendants further object to this interrogatory on the basis that it is overly broad and unduly burdensome as to "any Documents considered by such persons" and therefore does not seek information that is both (1) relevant to any party's claim or defense and (2) proportional to the needs of the case. *See* Fed. R. Civ. P. 26(b)(1). Plaintiffs' interrogatory does not limit its request for documents to any specified time period or to any particular matter involving the individuals to be identified and therefore is not limited to relevant documents or proportional to the needs of the case.

Additionally, Defendants object to this interrogatory on the basis that the phrase "most substantive contribution" is not defined by the interrogatories and is vague and ambiguous.

RESPONSE: Subject to and without waiving the foregoing objections and construing this interrogatory as (1) a request to identify individuals responsible for the promulgation of DoDI 1332.45, and (2) a separate request to identify documents in the custody of the Officer and Enlisted Personnel Management Directorate (OEPM directorate) of ODASD(MPP) concerning the promulgation of DoDI 1332.45, Defendants respond that the office responsible for promulgation of DoDI 1332.45 is the OEPM directorate of ODASD(MPP). The individual responsible for this DoDI within

OEPM directorate is currently Mr. Michael Melillo, Deputy Director, Force Management, Officer and Enlisted Personnel Management. His supervisor is Ms. Patricia Mulcahy, Director, Officer and Enlisted Personnel Management. Ms. Mulcahy's supervisor is Mr. Lernes Hebert, Acting Deputy Assistant Secretary of Defense for Military Personnel Policy.

Documents in the custody of the Officer and Enlisted Personnel Management Directorate (OEPM directorate) of ODASD(MPP) concerning the promulgation of DoDI 1332.45 are Bates number US00006509 through US00006850.

INTERROGATORY NO. 8

Identify the three individuals who made the most substantive contributions to the creation and promulgation of the DOGO Policy, the role that each person identified played, as well as any Documents considered by such persons.

OBJECTIONS: Defendants object to this interrogatory on the basis that it is overly broad and unduly burdensome because Plaintiffs' claims should properly be reviewed on an administrative record and discovery should not be permitted. Recognizing, however, that discovery has been ordered in this case, *see* Scheduling Order (ECF No. 68), Defendants object to the extent this interrogatory seeks information that is protected by the attorney-client privilege, attorney work product, and/or deliberative process privilege.

To the extent it could be construed as a contention interrogatory, pursuant to Fed. R. Civ. P. 33(a)(2), defendants object to this interrogatory on the grounds that it is premature in light of the present stage of discovery.

Defendants also object to the extent that this interrogatory contains multiple, discrete subparts, and thus Plaintiffs have exceeded the number of interrogatories, inclusive of discrete subparts, that they may serve under Federal Rule of Civil Procedure 33(a)(1). Specifically, Plaintiffs request identification of both the individuals who contributed to the "creation and promulgation of the DOGO Policy," and identification of any documents considered by those individuals. Thus, this interrogatory contains at least two distinct subparts per version of this regulation, and Plaintiffs have served more than the allowed 30 interrogatories. *See Smith*, 256 F.R.D at 254 ("each interrogatory that seeks identification of documents in addition to an answer will be counted as two interrogatories.").

Defendants further object to this interrogatory on the basis that it is overly broad and unduly burdensome as to "any Documents considered by such persons" and therefore does not seek information that is both (1) relevant to any party's claim or defense and (2) proportional to the needs of the case. *See* Fed. R. Civ. P. 26(b)(1). Plaintiffs' interrogatory does not limit its request for documents to any specified time period or to any particular matter involving the individuals to be identified and therefore is not limited to relevant documents or proportional to the needs of the case.

Additionally, Defendants object to this interrogatory on the basis that the phrase "most substantive contribution" is not defined by the interrogatories and is vague and ambiguous.

RESPONSE: Subject to and without waiving the foregoing objections and construing this interrogatory as (1) a request to identify the individuals responsible for promulgating the Memorandum for Secretaries of the Military Departments, Chairman of

the Joint Chiefs of Staff, Under Secretaries of Defense, Deputy Chief Management Officer; Chief, National Guard Bureau; Director of Cost Assessment and Program Evaluation regarding "DoD Retention Policy for Non-Deployable Service Members" (Feb. 14, 2018), and (2) a separate request to identify documents in the custody of HA concerning the promulgation of that memorandum, Defendants respond that the office responsible for promulgation of the policy memorialized in DoDI 1332.45 is the OEPM directorate. The individual responsible for this DoDI within OEPM directorate is currently Mr. Michael Melillo, Deputy Director, Force Management, Officer and Enlisted Personnel Management. His supervisor is Ms. Patricia Mulcahy, Director, Officer and Enlisted Personnel Management. Ms. Mulcahy's supervisor is Mr. Lernes Hebert, Acting Deputy Assistant Secretary of Defense for Military Personnel Policy.

Documents in the custody of the OEPM directorate concerning the promulgation of the memorandum are Bates number US00006509 through US00006850.

INTERROGATORY NO. 9

Identify the three individuals who made the most substantive contributions to the creation, promulgation, and reconsideration of AR 600-110, the role that each person identified played, as well as any Documents considered by such persons.

OBJECTIONS: Defendants object to this interrogatory on the basis that it is overly broad and unduly burdensome because Plaintiffs' claims should properly be reviewed on an administrative record and discovery should not be permitted. Recognizing, however, that discovery has been ordered in this case, *see* Scheduling Order (ECF No. 68),

Defendants object to the extent this interrogatory seeks information that is protected by the attorney-client privilege, attorney work product, and/or deliberative process privilege.

To the extent it could be construed as a contention interrogatory, pursuant to Fed. R. Civ. P. 33(a)(2), defendants object to this interrogatory on the grounds that it is premature in light of the present stage of discovery.

Defendants also object to the extent that this interrogatory contains multiple, discrete subparts, and thus Plaintiffs have exceeded the number of interrogatories, inclusive of discrete subparts, that they may serve under Federal Rule of Civil Procedure 33(a)(1). Specifically, Plaintiffs request identification of both the individuals who contributed to the "creation, promulgation, and reconsideration of AR 600-110," and identification of any documents considered by those individuals. Thus, this interrogatory contains at least two distinct subparts per version of this regulation, and Plaintiffs have served more than the allowed 30 interrogatories. *See Smith*, 256 F.R.D at 254 ("each interrogatory that seeks identification of documents in addition to an answer will be counted as two interrogatories.").

Defendants further object to this interrogatory on the basis that it is overly broad and unduly burdensome as to "any Documents considered by such persons" and therefore does not seek information that is both (1) relevant to any party's claim or defense and (2) proportional to the needs of the case. *See* Fed. R. Civ. P. 26(b)(1). Plaintiffs' interrogatory does not limit its request for documents to any specified time period or to any particular matter involving the individuals to be identified and therefore is not limited to relevant documents or proportional to the needs of the case.

Additionally, Defendants object to this interrogatory on the basis that the phrase "most substantive contribution" is not defined by the interrogatories and is vague and ambiguous.

RESPONSE: Subject to and without waiving the foregoing objections and construing this interrogatory as (1) a request for the three primary contributing sources for developing HIV policy within the Department of the Army, including the promulgation of AR 600-110, and (2) a separate request to identify the materials relied upon when promulgating AR 600-110 in the custody of the Health Promotion Officer, Office of the Deputy Chief of Staff, G-1, the official staff proponent for promulgating AR 600-110, Defendants respond that the three primary contributing sources for developing HIV policy within the Department of the Army are:

- The Health Promotion Division, Army Resiliency Directorate, Office of the Deputy Chief of Staff, G-1;
- The Disease Epidemiology Division, Army Institute of Public Health, Army Public Health Center;
- The Infectious Disease Service, Walter Reed National Military Medical Center.

The general nature of the responsibilities for the contributors listed above regarding their duties and participation in the promulgation of AR 600-110 correspond to the responsibilities and duties of the offices to which they are assigned.

Publications relied on, cited in, or related to AR 600-110 are identified in Appendix A of that regulation. Additional materials in the custody of the Health Promotion Officer, Office of the Deputy Chief of Staff, G-1, including those relied on

when promulgating the current version of AR 600-110, were previously produced to Plaintiffs as Bates numbers US00000991 through US00001966.

INTERROGATORY NO. 10

Identify the three individuals who made the most substantive contributions in the promulgation and reconsideration of AR 40-501, Section 2-30 ("Systemic diseases") (a) and AR 40-501, Section 3-7 ("Blood and blood-forming tissues diseases") (h), Section 4-5 ("Blood and blood-forming tissue diseases") (b), Section 4-33 ("Medical standards for ATC personnel") (8), Section 5–14 ("Medical fitness standards for deployment and certain geographical areas") (12) and (17), the role the persons identified played, as well as any Documents considered by such persons.

OBJECTIONS: Defendants object to this interrogatory on the basis that it is overly broad and unduly burdensome because Plaintiffs' claims should properly be reviewed on an administrative record and discovery should not be permitted. Recognizing, however, that discovery has been ordered in this case, *see* Scheduling Order (ECF No. 68), Defendants object to the extent this interrogatory seeks information that is protected by the attorney-client privilege, attorney work product, and/or deliberative process privilege.

To the extent it could be construed as a contention interrogatory, pursuant to Fed. R. Civ. P. 33(a)(2), defendants object to this interrogatory on the grounds that it is premature in light of the present stage of discovery.

Defendants also object to the extent that this interrogatory contains multiple, discrete subparts, and thus Plaintiffs have exceeded the number of interrogatories, inclusive of discrete subparts, that they may serve under Federal Rule of Civil Procedure

33(a)(1). Specifically, Plaintiffs request identification of the individuals who contributed to the "promulgation and reconsideration" of AR 40-501, Section 2-30(a), AR 40-501, Section 3-7(h), AR 40-501, Section 4-5(b), AR 40-501, Section 4-33(8), AR 40-501, Section 5-14(12), and AR 40-501, Section 5-14(17). *See Mezu*, 269 F.R.D. at 572-73 ("[D]iscrete or separate questions should be counted as separate interrogatories notwithstanding they…may be related."). Additionally, Plaintiffs request identification of both the individuals who participated in the promulgation and reconsideration of these various sections and identification of any documents considered by those individuals. Thus, this interrogatory contains at least two distinct subparts per version of each of these six regulations, and Plaintiffs have served more than the allowed 30 interrogatories. *See Smith*, 256 F.R.D at 254 ("each interrogatory that seeks identification of documents in addition to an answer will be counted as two interrogatories.").

Defendants further object to this interrogatory on the basis that it is overly broad and unduly burdensome as to "any Documents considered by such persons" and therefore does not seek information that is both (1) relevant to any party's claim or defense and (2) proportional to the needs of the case. *See* Fed. R. Civ. P. 26(b)(1). Plaintiffs' interrogatory does not limit its request for documents to any specified time period or to any particular matter involving the individuals to be identified and therefore is not limited to relevant documents or proportional to the needs of the case.

Additionally, Defendants object to this interrogatory on the basis that the phrase "most substantive contribution" is not defined by the interrogatories and is vague and ambiguous.

RESPONSE: Subject to and without waiving the foregoing objections and construing this interrogatory as (1) a request for the three primary contributing sources for promulgating the policies within AR 40-501 concerning HIV, and (2) a separate request to identify the materials relied upon when promulgating AR 40-501 in the custody of the Office of the Surgeon General of the Army, the official staff proponent for promulgating AR 40-501, Defendants respond that the three primary contributing sources for promulgating the policies within AR 40-501 within the Department of the Army are:

- The Health Promotion Division, Army Resiliency Directorate, Office of the Deputy Chief of Staff, G-1;
- The Disease Epidemiology Division, Army Institute of Public Health, Army Public Health Center;
- The G-37 Medical Readiness Division, Healthcare Operations, Army Office of the Surgeon General.

The general nature of the responsibilities for the contributors listed above regarding their duties and participation in the promulgation of AR 40-501 correspond to the responsibilities and duties of the offices to which they are assigned.

Publications relied on, cited in, or related to AR 40-501 are identified in Appendix A of that regulation.

INTERROGATORY NO. 11

Identify the current members of the Accession Medical Standards Working Group and all Documents reviewed or relied upon, either directly or indirectly, by the

Accession Medical Standards Working Group concerning DoD's medical accession standards for individuals living with HIV.

OBJECTIONS: Defendants object to this interrogatory on the basis that it is overly broad and unduly burdensome because Plaintiffs' claims should properly be reviewed on an administrative record and discovery should not be permitted. Recognizing, however, that discovery has been ordered in this case, *see* Scheduling Order (ECF No. 68), Defendants object to the extent this interrogatory seeks information that is protected by the attorney-client privilege, attorney work product, and/or deliberative process privilege.

Defendants also object to the extent that this interrogatory contains multiple, discrete subparts, and thus Plaintiffs have exceeded the number of interrogatories, inclusive of discrete subparts, that they may serve under Federal Rule of Civil Procedure 33(a)(1). Specifically, Plaintiffs request identification of both the individuals who are current members of the Accession Medical Standards Working Group and identification of "all Documents reviewed or relied upon, either directly or indirectly" by the Working Group concerning "medical accession standards for individuals living with HIV." Thus, this interrogatory contains at least two distinct subparts, and Plaintiffs have served more than the allowed 30 interrogatories. *See Smith*, 256 F.R.D at 254 ("each interrogatory that seeks identification of documents in addition to an answer will be counted as two interrogatories.").

Defendants further object to this interrogatory the extent it seeks information that the Working Group "reviewed but did not rely on concerning DoD's medical accession standards for individuals living with HIV" because such information is not (1) relevant to any party's claim or defense or (2) proportional to the needs of the case. *See* Fed. R. Civ.

P. 26(b)(1). Additionally, the phrase "reviewed or relied upon…indirectly" is problematic to the extent that it could be construed to apply to documents with mere peripheral connections to the claims and defenses of this case, and identifying all such documents would be excessively burdensome and disproportionate to the needs of the case.

Defendants further object to this interrogatory's use of "individuals living with HIV" because that phrase is vague and inconsistent with the applicable regulations, which apply once there laboratory evidence of HIV infection. Defendants also object to this interrogatory because "DoD's medical accession standards" is vague and ambiguous.

RESPONSE: Subject to and without waiving the foregoing objections and construing this interrogatory as (1) a request to identify the organizations with representatives on the Accessions Medical Standards Working Group (AMSWG), and (2) a separate request to identify documents in the custody of the AP directorate of ODASD(MPP) concerning the most recent revision of DoDI 6130.03, Defendants respond that the AMSWG is currently comprised of representatives from the following offices:

Voting Members:

- DASD (MPP) - Co-chair
- PDASD (HA)- Co-chair
- Manpower and Reserve Affairs, Army
- Manpower and Reserve Affairs, Navy
- Manpower and Reserve Affairs, Air Force
- Manpower and Reserve Affairs, Marine Corps
- Director of Reserve and Military Personnel, Coast Guard

Non-Voting Advisory Members:

- Joint Staff Surgeon
- Surgeon General of the Army

- Surgeon General of the Navy
- Surgeon General of the Air Force
- Chief Medical Officer, U.S. Coast Guard
- Joint Surgeon, National Guard Bureau
- Director, Manpower and Personnel, Joint Staff (J-1)
- Deputy Chief of Staff for Personnel Army
- Deputy Chief of Staff for Personnel Navy
- Deputy Chief of Staff for Personnel Air Force
- Deputy Chief of Staff for Personnel Marine Corps
- National Guard Bureau (J-1)

Documents in the custody of the AP directorate of ODASD(MPP), including those concerning the most recent revision of DoDI 6130.03, are Bates numbered US00006129 through US00006135, and documents from Dr. Ciminera's official email account are Bates numbered US00005764 through US00006128.

INTERROGATORY NO. 16

Identify any individuals or groups of individuals who have been allowed to deploy even though they cannot donate blood (e.g., individuals who recently completed treatment for malaria; individuals who recently received tattoos in states that do not regulate tattoo facilities; sexually active gay or bisexual men).

OBJECTIONS: Defendants object to this interrogatory on the basis that it is overly broad and unduly burdensome because Plaintiffs' claims should properly be reviewed on an administrative record and discovery should not be permitted. Recognizing, however, that discovery has been ordered in this case, *see* Scheduling Order (ECF No. 68), Defendants object to the extent this interrogatory seeks information that is protected by the attorney-client privilege, attorney work product, and/or deliberative process privilege.

Defendants further object on the grounds that this interrogatory is overbroad, unduly burdensome, and disproportionate to the needs of this case. This interrogatory

places no time limits whatsoever on the information it seeks and therefore calls for a substantial amount of information that is neither relevant to any party's claims or defenses nor proportional to the needs of this case. *See* Fed. R. Civ. P. 26(b)(1). Additionally, this interrogatory places no limits whatsoever on the deploying agency or type of deployment, and therefore calls for a substantial amount of information that is neither relevant to any party's claims or defenses nor proportional to the needs of this case.

Defendants further object to this interrogatory to the extent it seeks information regarding individuals other than Plaintiff Harrison that is covered by the Privacy Act, 5 U.S.C. § 552(a), or by other medical privacy laws such as HIPAA, P.L. 104-191, 100 Stat. 2548.

Defendants further object to this interrogatory on the ground that Plaintiffs have exceeded the number of interrogatories, inclusive of discrete subparts, that they may serve under Federal Rule of Civil Procedure 33(a)(1).

RESPONSE: Subject to and without waiving the foregoing objections and construing this interrogatory as a single request directed to the Armed Services Blood Program ("ASBPO") to identify categories of Service members who have been allowed to serve during a contingency deployment, as defined in DoDI 6490.07, and who are not eligible to donate blood, Defendants respond that DoD does not maintain a list of categories of individuals who have been permitted to deploy even though they cannot donate blood due to the variables presented in the donation of blood.

The ASBPO is chartered by the DoD to coordinate the provisions of blood products throughout the Services to meet medical requirements during national

emergencies and overseas military operations. ASBP Blood Program Letters (BPLs) are issued by ASBPO on items that affect one or multiple components of the ASBP. Addressed within the BPLs are updates to the Standardized Donor Deferral Lists, which are used to determine donor eligibility. While the BPLs address several areas including tattoos, foreign travel, medication, and medical conditions, they do not expressly address deployment in support of contingency or combat operations.

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.

OBJECTIONS: Defendants object to this interrogatory on the basis that it is overly broad and unduly burdensome because Plaintiffs' claims should properly be reviewed on an administrative record and discovery should not be permitted. Recognizing, however, that discovery has been ordered in this case, *see* Scheduling Order (ECF No. 68), Defendants object to the extent this interrogatory seeks information that is protected by the attorney-client privilege, attorney work product, and/or deliberative process privilege.

Pursuant to Fed. R. Civ. P. 33(a)(2), defendants object to this interrogatory on the grounds that it is premature in light of the present stage of discovery. Defendants expect to receive further documents through discovery that will concern and provide responsive information. Because Fed. R. Civ. P. 26 imposes a duty of supplementation, complying

with such interrogatories would require defendants to continually supplement their responses each time they receive an additional document or information concerning the subject or contention on which the interrogatory seeks information. Doing so would cause defendants to suffer unnecessary burden and expense and would not serve to narrow the issues that are in dispute. Accordingly, Defendants will provide a response encompassing the current state of their knowledge, belief, and understanding, but reserve the right to supplement their interrogatory response pursuant to Fed. R. Civ. P. 26 at the conclusion of discovery, both as to the merits of this action and with respect to experts designated to testify at trial.

Defendants further object on the grounds that this interrogatory is overbroad, unduly burdensome, and disproportionate to the needs of this case. Specifically, the only injury alleged by Plaintiffs in this case is that of Plaintiff Harrison, who was precluded from becoming a commissioned officer in the Army, not from enlisting or being inducted into the Army or any of the other Military Services identified by Plaintiffs in their First Set of Interrogatories. Requests for this substantial amount of unrelated information from the Army and the other four services identified are neither relevant to any party's claims or defenses nor proportional to the needs of this case. *See* Fed. R. Civ. P. 26(b)(1).

Defendants further object to this interrogatory's use of "HIV-positive persons" because that phrase is vague and inconsistent with the applicable regulations, which apply once there laboratory evidence of HIV infection. Defendants also object to this interrogatory because it's use of "DoD's policies" and "*inter alia*" are vague, undefined, overly broad and unduly burdensome.

Subject to Defendants' construction of this request, as stated in the response below, Defendants withdraw their objection that this interrogatory contains distinct subparts, but continue to object to this interrogatory on the ground that Plaintiffs have exceeded the number of interrogatories, inclusive of discrete subparts, that they may serve under Federal Rule of Civil Procedure 33(a)(1).

RESPONSE: Subject to and without waiving the foregoing objections and construing this interrogatory as a single request to identify DoD's rationale for the enlisted and officer medical accession policies for individuals with laboratory evidence of HIV contained in DoDI 6485.01 and DoDI 6130.03, Defendants respond that DoD set forth it's complete reasoning underlying the policies on the prohibition of persons with laboratory evidence of HIV from enlisting in the Military Services, being inducted into the Military Services, or being appointed as an officer in the Military Services in the 2014 and 2018 reports to Congress. The 2014 report to Congress is publically available at: https://health.mil/Reference-Center/Reports/2014/09/22/DoD-Personnel-Policies-Regarding-Members-of-the-Armed-Forces-with-HIV-or-Hepatitis-B. H.R. 3304, NDAA for FY 2014, Sec. 572. The 2018 report to Congress is publically available at: https://www.health.mil/Reference-Center/Congressional-Testimonies/2018/08/27/Personnel-Policies-Regarding-Members-of-the-Armed-Forces-Infected-with-HIV. H.R. 2810, HASC Report for FY 2018, 115-200, Pg. 148-149.

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 6480.07.

OBJECTIONS: Defendants object to this interrogatory on the basis that it is overly broad and unduly burdensome because Plaintiffs' claims should properly be reviewed on an administrative record and discovery should not be permitted. Recognizing, however, that discovery has been ordered in this case, *see* Scheduling Order (ECF No. 68), Defendants object to the extent this interrogatory seeks information that is protected by the attorney-client privilege, attorney work product, and/or deliberative process privilege.

Pursuant to Fed. R. Civ. P. 33(a)(2), defendants object to this interrogatory on the grounds that it is premature in light of the present stage of discovery. Defendants expect to receive further documents through discovery that will concern and provide responsive information. Because Fed. R. Civ. P. 26 imposes a duty of supplementation, complying with such interrogatories would require defendants to continually supplement their responses each time they receive an additional document or information concerning the subject or contention on which the interrogatory seeks information. Doing so would cause defendants to suffer unnecessary burden and expense and would not serve to narrow the issues that are in dispute. Accordingly, Defendants will provide a response encompassing the current state of their knowledge, belief, and understanding, but reserve the right to supplement their interrogatory response pursuant to Fed. R. Civ. P. 26 at the conclusion of discovery, both as to the merits of this action and with respect to experts designated to testify at trial.

Defendants object to this interrogatory's use of "regular deployment" and "contingency deployment" which are vague and ambiguous. Defendants further object to

this interrogatory's use of "HIV-positive persons" because that phrase is vague and undefined. Defendants also object to this interrogatory because "DoD's policies" and "*inter alia*" are vague and ambiguous, and also because those phrases are overly broad and unduly burdensome.

Subject to Defendants' construction of this request, as stated in the response below, Defendants withdraw their objection that this interrogatory contains distinct subparts, but continue to object to this interrogatory on the ground that Plaintiffs have exceeded the number of interrogatories, inclusive of discrete subparts, that they may serve under Federal Rule of Civil Procedure 33(a)(1).

RESPONSE: Subject to and without waiving the foregoing objections and construing this interrogatory as a single request to identify DoD's rationale for the policies governing the availability of Service members to serve during a contingency deployment, as defined in DoDI 6490.07, Defendants respond that DoD set forth it's complete reasoning underlying it's policies in the 2014 and 2018 reports to Congress. The 2014 report to Congress is publically available at: https://health.mil/Reference-Center/Reports/2014/09/22/DoD-Personnel-Policies-Regarding-Members-of-the-Armed-Forces-with-HIV-or-Hepatitis-B. H.R. 3304, NDAA for FY 2014, Sec. 572. The 2018 report to Congress is publically available at: https://www.health.mil/Reference-Center/Congressional-Testimonies/2018/08/27/Personnel-Policies-Regarding-Members-of-the-Armed-Forces-Infected-with-HIV. H.R. 2810, HASC Report for FY 2018, 115-200, Pg. 148-149.

INTERROGATORY NO. 19

State all facts and identify any Documents that support your contention that "Defendants' policies are rationally related to their legitimate government interest in ensuring that every Service member is fit and capable of performing his or her job." Defs.' Answer at ¶3, ECF No. 62.

OBJECTIONS: Defendants object to this interrogatory on the basis that it is overly broad and unduly burdensome because Plaintiffs' claims should properly be reviewed on an administrative record and discovery should not be permitted. Recognizing, however, that discovery has been ordered in this case, *see* Scheduling Order (ECF No. 68), Defendants object to the extent this interrogatory seeks information that is protected by the attorney-client privilege, attorney work product, and/or deliberative process privilege.

Pursuant to Fed. R. Civ. P. 33(a)(2), defendants object to this interrogatory on the grounds that it is premature in light of the present stage of discovery. Defendants expect to receive further documents through discovery that will concern and provide responsive information. Because Fed. R. Civ. P. 26 imposes a duty of supplementation, complying with such interrogatories would require defendants to continually supplement their responses each time they receive an additional document or information concerning the subject or contention on which the interrogatory seeks information. Doing so would cause defendants to suffer unnecessary burden and expense and would not serve to narrow the issues that are in dispute. Accordingly, Defendants will provide a response encompassing the current state of their knowledge, belief, and understanding, but reserve the right to supplement their interrogatory response pursuant to Fed. R. Civ. P. 26 at the

conclusion of discovery, both as to the merits of this action and with respect to experts designated to testify at trial.

Defendants further object to this interrogatory to the extent that it is properly the subject of expert testimony. Defendants will disclose and permit discovery in connection with the opinions of the experts that they intend to call at trial only as required by the schedule established by the Court and in accordance with Rule 26 of the Federal Rules of Civil Procedure. Defendants' investigation and search for responsive information is continuing. Defendants expressly reserve the right to rely on subsequently discovered information and produce additional responsive information.

Defendants further object on the grounds that this interrogatory is overbroad, unduly burdensome, and disproportionate to the needs of this case. Specifically, Plaintiffs' interrogatory does not limit its request to any particular policies of the defendant, whereas the Plaintiffs' statement to which the Defendants were responding in ¶ 3 of their answer is limited to DoD and the Army's "bar to enlistment and appointment of people living with HIV, as well as the restrictions on deployment." Compl. ¶ 3, (ECF No.1). Therefore this interrogatory requests information that is neither relevant to the claims or defenses of either party nor proportional to the needs of the case. *See* Fed. R. Civ. P. 26(b)(1).

Subject to Defendants' construction of this request, as stated in the response below, Defendants withdraw their objection that this interrogatory contains distinct subparts, but continue to object to this interrogatory on the ground that Plaintiffs have exceeded the number of interrogatories, inclusive of discrete subparts, that they may serve under Federal Rule of Civil Procedure 33(a)(1).

RESPONSE: Subject to and without waiving the foregoing objections and construing this interrogatory as a single request to identify DoD's rationale for the policies governing Service members who have laboratory evidence of HIV, Defendants respond that DoD set forth it's complete reasoning underlying it's policies in the 2014 and 2018 reports to Congress. The 2014 report to Congress is publically available at: https://health.mil/Reference-Center/Reports/2014/09/22/DoD-Personnel-Policies-Regarding-Members-of-the-Armed-Forces-with-HIV-or-Hepatitis-B. H.R. 3304, NDAA for FY 2014, Sec. 572. The 2018 report to Congress is publically available at: https://www.health.mil/Reference-Center/Congressional-Testimonies/2018/08/27/Personnel-Policies-Regarding-Members-of-the-Armed-Forces-Infected-with-HIV. H.R. 2810, HASC Report for FY 2018, 115-200, Pg. 148-149.

INTERROGATORY NO. 20

Identify all medical conditions other than HIV that require taking medication on a regular basis but do not inhibit or restrict a service member's ability to deploy.

OBJECTIONS: Defendants object to this interrogatory on the basis that it is overly broad and unduly burdensome because Plaintiffs' claims should properly be reviewed on an administrative record and discovery should not be permitted. Recognizing, however, that discovery has been ordered in this case, *see* Scheduling Order (ECF No. 68), Defendants object to the extent this interrogatory seeks information that is protected by the attorney-client privilege, attorney work product, and/or deliberative process privilege.

To the extent it could be construed as a contention interrogatory, pursuant to Fed. R. Civ. P. 33(a)(2), defendants object to this interrogatory on the grounds that it is

premature in light of the present stage of discovery. Defendants' investigation and search for responsive information is continuing. Defendants expressly reserve the right to rely on subsequently discovered information and produce additional responsive information.

Defendants further object on the grounds that this interrogatory is overbroad, unduly burdensome, and disproportionate to the needs of this case. Specifically, the only injury alleged by Plaintiffs in this case is that of Plaintiff Harrison, who is subject only to deployment restrictions applicable to members of the United States Army. Requests for this information from the other four services identified are neither relevant to any party's claims or defenses nor proportional to the needs of this case. *See* Fed. R. Civ. P. 26(b)(1). Furthermore, because the answer to this interrogatory can be derived from publicly available regulations and policies, or documents that Defendants have produced or will produce to Plaintiffs, the burden of deriving or ascertaining the answer is substantially the same for both parties and the Plaintiffs cannot shift the cost of doing so to the Defendants. *See* Fed. R. Civ. P. 33(d).

Defendants further object to this interrogatory on the ground that Plaintiffs have exceeded the number of interrogatories, inclusive of discrete subparts, that they may serve under Federal Rule of Civil Procedure 33(a)(1).

Defendants further object to this interrogatory on the ground that the terms "regular basis," "inhibit or restrict," and "ability to deploy" are undefined, vague, ambiguous, overly broad, and unduly burdensome.

RESPONSE: Subject to and without waiving the foregoing objections and construing this interrogatory as a single request to identify medical conditions that usually preclude service during contingency deployments, as defined in DoDI 6490.07,

Defendants respond that Enclosure 3 to DoDI 6490.07 sets forth a non-exhaustive list of medical conditions that usually preclude contingency deployment. As stated in that document, "[a] list of all possible diagnoses and their severity that may cause an individual to be potentially non-deployable, pending further evaluation, would be too extensive. Medical evaluators must consider climate, altitude, rations, housing, duty assignment, and medical services available in theater when deciding whether an individual with a specific medical condition is deployable. In general, individuals with the conditions in paragraphs a. through h. of this enclosure, based upon a medical assessment as described in Enclosure 2 and Reference (l), shall not deploy unless a waiver is granted."

INTERROGATORY NO. 21

Identify all medical conditions other than HIV that require medical monitoring through a visit with a healthcare provider one or more times a year but do not inhibit or restrict a service member's ability to deploy.

OBJECTIONS: Defendants object to this interrogatory on the basis that it is overly broad and unduly burdensome because Plaintiffs' claims should properly be reviewed on an administrative record and discovery should not be permitted. Recognizing, however, that discovery has been ordered in this case, *see* Scheduling Order (ECF No. 68), Defendants object to the extent this interrogatory seeks information that is protected by the attorney-client privilege, attorney work product, and/or deliberative process privilege.

To the extent it could be construed as a contention interrogatory, pursuant to Fed. R. Civ. P. 33(a)(2), defendants object to this interrogatory on the grounds that it is premature in light of the present stage of discovery.

Defendants further object on the grounds that this interrogatory is overbroad, unduly burdensome, and disproportionate to the needs of this case. Specifically, the only injury alleged by Plaintiffs in this case is that of Plaintiff Harrison, who is subject only to deployment restrictions applicable to members of the United States Army. Requests for this information from the other four services identified are neither relevant to any party's claims or defenses nor proportional to the needs of this case. *See* Fed. R. Civ. P. 26(b)(1). Furthermore, because the answer to this interrogatory can be derived from publicly available regulations and policies, or documents that Defendants have produced or will produce to Plaintiffs, the burden of deriving or ascertaining the answer is substantially the same for both parties and the Plaintiffs cannot shift the cost of doing so to the Defendants. *See* Fed. R. Civ. P. 33(d).

Defendants further object to this interrogatory on the ground that Plaintiffs have exceeded the number of interrogatories, inclusive of discrete subparts, that they may serve under Federal Rule of Civil Procedure 33(a)(1).

RESPONSE: Subject to and without waiving the foregoing objections and construing this interrogatory as a single request to identify medical conditions that do not usually preclude service during contingency deployments, as defined in DoDI 6490.07, Defendants respond that it is not possible to identify all medical conditions that require medical monitoring through a visit with a healthcare provider one or more times a year due to the individualized nature of healthcare. Enclosure 3 to DoDI 6490.07 enumerates

the conditions that preclude deployment without a waiver from the Service and the Combatant Command to which the service member will deploy.

INTERROGATORY NO. 22

Identify all medical conditions other than HIV that require medical monitoring through blood testing one or more times a year but do not inhibit or restrict a service member's ability to deploy.

OBJECTIONS: Defendants object to this interrogatory on the basis that it is overly broad and unduly burdensome because Plaintiffs' claims should properly be reviewed on an administrative record and discovery should not be permitted. Recognizing, however, that discovery has been ordered in this case, *see* Scheduling Order (ECF No. 68), Defendants object to the extent this interrogatory seeks information that is protected by the attorney-client privilege, attorney work product, and/or deliberative process privilege.

To the extent it could be construed as a contention interrogatory, pursuant to Fed. R. Civ. P. 33(a)(2), defendants object to this interrogatory on the grounds that it is premature in light of the present stage of discovery. Defendants' investigation and search for responsive information is continuing. Defendants expressly reserve the right to rely on subsequently discovered information and produce additional responsive information.

Defendants further object on the grounds that this interrogatory is overbroad, unduly burdensome, and disproportionate to the needs of this case. Specifically, the only injury alleged by Plaintiffs in this case is that of Plaintiff Harrison, who is subject only to deployment restrictions applicable to members of the United States Army. Requests for this information from the other four services identified are neither relevant to any party's

claims or defenses nor proportional to the needs of this case. *See* Fed. R. Civ. P. 26(b)(1). Furthermore, because the answer to this interrogatory can be derived from publicly available regulations and policies, or documents that Defendants have produced or will produce to Plaintiffs, the burden of deriving or ascertaining the answer is substantially the same for both parties and the Plaintiffs cannot shift the cost of doing so to the Defendants. *See* Fed. R. Civ. P. 33(d).

Defendants further object to this interrogatory on the ground that Plaintiffs have exceeded the number of interrogatories, inclusive of discrete subparts, that they may serve under Federal Rule of Civil Procedure 33(a)(1).

RESPONSE: Subject to and without waiving the foregoing objections and construing this interrogatory as a single request to identify medical conditions that require blood testing and that do not usually preclude service during contingency deployments, as defined in DoDI 6490.07, Defendants respond that it is not possible to categorically state that any particular medical condition requiring medical monitoring through blood testing one or more times a year does not inhibit or restrict a service member's ability to deploy. Based on an individual's diagnosis and treatment for their medical condition(s), blood testing may be required one or more times a year to monitor the status of an acute or chronic disease state, and or for medication treatment adverse drug reactions. Determinations of deployability are made by trained DoD health-care providers based on information obtained in the medical assessment described in section 1 of Enclosure 2 of DoDI 6490.07. 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. Enclosure 3

to DoDI 6490.07 sets forth a non-exhaustive list of medical conditions that preclude deployment in support or a contingency or combat operation.

INTERROGATORY NO. 23

Identify any changes to any military regulations that were considered, implemented, or rejected based on the medical consensus that a person with well-controlled HIV has essentially no risk of transmitting HIV sexually.

OBJECTIONS: Defendants object to this interrogatory on the basis that it is overly broad and unduly burdensome because Plaintiffs' claims should properly be reviewed on an administrative record and discovery should not be permitted. Recognizing, however, that discovery has been ordered in this case, *see* Scheduling Order (ECF No. 68), Defendants object to the extent this interrogatory seeks information that is protected by the attorney-client privilege, attorney work product, and/or deliberative process privilege.

Defendants further object to this interrogatory on the ground that "any changes to any military regulations" and "considered" are vague, overly broad, and unduly burdensome. Consequently this interrogatory seeks information that is neither relevant to any party's claims or defenses nor proportional to the needs of this case. *See* Fed. R. Civ. P. 26(b)(1).

Defendants further object to this interrogatory on the ground that Plaintiffs have exceeded the number of interrogatories, inclusive of discrete subparts, that they may serve under Federal Rule of Civil Procedure 33(a)(1).

Defendants further object on the grounds that this interrogatory is overbroad, unduly burdensome, and disproportionate to the needs of this case. This interrogatory

places no time limits whatsoever on the information it seeks and therefore calls for a substantial amount of information that is neither relevant to any party's claims or defenses nor proportional to the needs of this case. *See* Fed. R. Civ. P. 26(b)(1). Defendants object to this interrogatory on the basis that the phrase "any changes" is vague, undefined, and is not limited to information that is relevant to any party's claims or defenses. Defendants further object to this interrogatory on the basis that the phrase "military regulation" is vague, undefined, and overly broad. Defendants object to this interrogatory on the basis that the phrase "considered, implemented, or rejected" is overly broad and unduly burdensome, and because that phrase is directed to information that is protected from disclosure by the deliberative process privilege. Defendants object to this interrogatory on the basis that the phrase "medical consensus" is vague, ambiguous, and undefined by Plaintiffs. Defendants object further to this interrogatory on the basis that the phrase "well-controlled" is vague, ambiguous, and undefined by Plaintiffs.

RESPONSE: Subject to and without waiving the foregoing objections and construing this interrogatory as a single request to identify changes to DoD policy, Defendants respond that there have been no changes in policy contemplated by the DoD based on the risk of transmitting HIV sexually.

INTERROGATORY NO. 13

For each year since 2000, identify for each branch of the Military Services: (a) the number of service members living with HIV; (b) the number of those individuals who were granted or denied a waiver for a regular deployment; the number of those

individuals who were granted or denied a waiver for a contingency deployment; and (c) the number of those individuals who were involuntarily separated after a determination they were unfit for duty based primarily on their HIV-diagnosis.

OBJECTIONS: Defendants object to this interrogatory on the basis that it is overly broad and unduly burdensome because Plaintiffs' claims should properly be reviewed on an administrative record and discovery should not be permitted. Recognizing, however, that discovery has been ordered in this case, *see* Scheduling Order (ECF No. 68), Defendants object to the extent this interrogatory seeks information that is protected by the attorney-client privilege, attorney work product, and/or deliberative process privilege.

Defendants also object to the extent that this interrogatory contains multiple, discrete subparts, and thus Plaintiffs have exceeded the number of interrogatories, inclusive of discrete subparts, that they may serve under Federal Rule of Civil Procedure 33(a)(1). Specifically, Plaintiffs request identification of four separate and independent categories of information, including HIV status of service members, the status of those members' waivers for regular deployment, the status of those members' waivers for contingency deployment, and those members' involuntary separation records based on HIV diagnosis, for each of the five Military Services defined by Plaintiffs' First Set of Interrogatories for each of the preceding 18 years. Thus, this interrogatory contains at least 20 distinct subparts, and Plaintiffs have served more than the allowed 30 interrogatories. *See Mezu*, 269 F.R.D. at 572-73 ("[D]iscrete or separate questions should be counted as separate interrogatories notwithstanding they…may be related.").

Defendants further object on the grounds that this interrogatory is overbroad, unduly burdensome, and disproportionate to the needs of this case. Specifically, Plaintiff

Harrison is the only individual alleged to have been injured by Defendants' regulations and policies, and he is subject to those regulations and policies only as a member of the United States Army. Plaintiff OutServe-SLDN has not alleged any injuries to its own interests. Requests for this substantial amount of information are neither relevant to any party's claims or defenses nor proportional to the needs of this case. *See* Fed. R. Civ. P. 26(b)(1). Furthermore, Plaintiffs request for records spanning 18 years of operations across all Military Services is neither relevant to any claims or defenses nor proportional to the needs of the case.

Defendants further object to this interrogatory to the extent it seeks information regarding individuals other than Plaintiff Harrison that is covered by the Privacy Act, 5 U.S.C. § 552(a), or by other medical privacy laws such as HIPAA, P.L. 104-191, 100 Stat. 2548.

Defendants further object to this interrogatory's use of "individuals living with HIV" because that phrase is vague and inconsistent with the applicable regulations, which apply once there laboratory evidence of HIV infection. Defendants also object to this interrogatory's use of "regular deployment" and "contingency deployment" which are vague and ambiguous.

RESPONSE: Defendants stand on their objections and have withheld information pursuant to those objections.

INTERROGATORY NO. 15

Identify for each of the Military Services: (a) the number of service members who received blood transfusions while deployed since 2000, broken down on a yearly basis;

(b) the number of such transfusions that involved "fresh whole blood" collected from other service members (e.g., from a "walking blood bank" program); and (c) the number of such transfusions that involved blood that did not undergo rapid infectious disease testing.

OBJECTIONS: Defendants object to this interrogatory on the basis that it is overly broad and unduly burdensome because Plaintiffs' claims should properly be reviewed on an administrative record and discovery should not be permitted. Recognizing, however, that discovery has been ordered in this case, *see* Scheduling Order (ECF No. 68), Defendants object to the extent this interrogatory seeks information that is protected by the attorney-client privilege, attorney work product, and/or deliberative process privilege.

Defendants also object to the extent that this interrogatory contains multiple, discrete subparts, and thus Plaintiffs have exceeded the number of interrogatories, inclusive of discrete subparts, that they may serve under Federal Rule of Civil Procedure 33(a)(1). Specifically, Plaintiffs request identification of three separate and independent categories of blood transfusion information for each of the five Military Services defined by their First Set of Interrogatories for each of the preceding 18 years. Thus, this interrogatory contains at least 15 distinct subparts, and Plaintiffs have served more than the allowed 30 interrogatories. *See Mezu*, 269 F.R.D. at 572-73 ("[D]iscrete or separate questions should be counted as separate interrogatories notwithstanding they…may be related.").

Defendants further object on the grounds that this interrogatory is overbroad, unduly burdensome, and disproportionate to the needs of this case. Specifically, Plaintiff Harrison is the only individual alleged to have been injured by Defendants' regulations

and policies, and he is subject to those regulations and policies only as a member of the United States Army. Plaintiff OutServe-SLDN has not alleged any injuries to its own interests. Requests for this substantial amount of information from the other four services identified is neither relevant to any party's claims or defenses nor proportional to the needs of this case. *See* Fed. R. Civ. P. 26(b)(1). Furthermore, Plaintiffs request for records spanning 18 years of operations across all Military Services is neither relevant to any claims or defenses nor proportional to the needs of the case.

Defendants further object to this interrogatory to the extent it seeks information regarding individuals other than Plaintiff Harrison that is covered by the Privacy Act, 5 U.S.C. § 552(a), or by other medical privacy laws such as HIPAA, P.L. 104-191, 100 Stat. 2548.

Defendants further object to this interrogatory's use of "while deployed" as vague and ambiguous.

RESPONSE: Defendants stand on their objections and have withheld information pursuant to those objections.

INTERROGATORY NO. 12

For each year since 2000, identify for each of the Military Services: (a) the total number of applicants for each of the Military Services on a yearly basis since 2000; (b) the number of applicants who did not meet the standards under DoDI 6130.03, segregated by the specific disqualifying conditions; and (c) the number of applicants who were granted medical waivers, segregated by the specific conditions for which waivers were granted.

OBJECTIONS: Defendants object to this interrogatory on the basis that it is overly broad and unduly burdensome because Plaintiffs' claims should properly be reviewed on an administrative record and discovery should not be permitted. Recognizing, however, that discovery has been ordered in this case, *see* Scheduling Order (ECF No. 68), Defendants object to the extent this interrogatory seeks information that is protected by the attorney-client privilege, attorney work product, and/or deliberative process privilege.

Defendants also object to the extent that this interrogatory contains multiple, discrete subparts, and thus Plaintiffs have exceeded the number of interrogatories, inclusive of discrete subparts, that they may serve under Federal Rule of Civil Procedure 33(a)(1). Specifically, Plaintiffs request identification of three separate and independent categories of application information for each of the five Military Services defined by their First Set of Interrogatories for each of the preceding 18 years. Thus, this interrogatory contains at least 15 distinct subparts, and Plaintiffs have served more than the allowed 30 interrogatories. *See Mezu*, 269 F.R.D. at 572-73 ("[D]iscrete or separate questions should be counted as separate interrogatories notwithstanding they…may be related.").

Defendants further object on the grounds that this interrogatory is overbroad, unduly burdensome, and disproportionate to the needs of this case. Specifically, Plaintiff Harrison is the only individual alleged to have been injured by Defendants' regulations and policies, and he is subject to those regulations and policies only as a member of the United States Army. Plaintiff OutServe-SLDN has not alleged any injuries to its own interests. Requests for this substantial amount of information are neither relevant to any party's claims or defenses nor proportional to the needs of this case. *See* Fed. R. Civ. P.

26(b)(1). Furthermore, Plaintiffs request for records spanning 18 years of operations across all Military Services is neither relevant to any claims or defenses nor proportional to the needs of the case.

Defendants further object to this interrogatory to the extent it seeks information regarding individuals other than Plaintiff Harrison that is covered by the Privacy Act, 5 U.S.C. § 552(a), or by other medical privacy laws such as HIPAA, P.L. 104-191, 100 Stat. 2548.

RESPONSE: Defendants stand on their objections and have withheld information pursuant to those objections.

INTERROGATORY NO. 14

Identify for each of the Military Services: (a) the number of service members living with deployment-limiting medical conditions, including but not limited to HIV, diabetes, hepatitis C, hypertension, and asthma, on a yearly basis since 2000, segregated by condition; (b) the number of those individuals who were granted or denied a waiver to deploy; and (c) the number of those individuals who were involuntarily separated after a determination they were unfit for further duty.

OBJECTIONS: Defendants object to this interrogatory on the basis that it is overly broad and unduly burdensome because Plaintiffs' claims should properly be reviewed on an administrative record and discovery should not be permitted. Recognizing, however, that discovery has been ordered in this case, *see* Scheduling Order (ECF No. 68), Defendants object to the extent this interrogatory seeks information that is protected by the attorney-client privilege, attorney work product, and/or deliberative process privilege.

Defendants also object to the extent that this interrogatory contains multiple, discrete subparts, and thus Plaintiffs have exceeded the number of interrogatories, inclusive of discrete subparts, that they may serve under Federal Rule of Civil Procedure 33(a)(1). Specifically, Plaintiffs request identification of three separate and independent categories of information including, medical condition status of service members, deployment waiver status of those service members, and those members' involuntary separation records, for each of at least five conditions, for each of the five Military Services defined by Plaintiffs' First Set of Interrogatories, for each of the preceding 18 years. Thus, this interrogatory contains at least 75 distinct subparts, and Plaintiffs have served more than the allowed 30 interrogatories. *See Mezu*, 269 F.R.D. at 572-73 ("[D]iscrete or separate questions should be counted as separate interrogatories notwithstanding they…may be related.").

Defendants further object on the grounds that this interrogatory is overbroad, unduly burdensome, and disproportionate to the needs of this case. Specifically, Plaintiff Harrison is the only individual alleged to have been injured by Defendants' regulations and policies, and he is subject to those regulations and policies only as a member of the United States Army. Plaintiff OutServe-SLDN has not alleged any injuries to its own interests. Requests for this substantial amount of information are neither relevant to any party's claims or defenses nor proportional to the needs of this case. *See* Fed. R. Civ. P. 26(b)(1). Furthermore, Plaintiffs request for records spanning 18 years of operations across all Military Services is neither relevant to any claims or defenses nor proportional to the needs of the case. Additionally, Plaintiff's request for involuntary separation records for individuals with deployment-limiting medical conditions encompasses

determinations that those members were "unfit for further duty" for any reason. This information is not relevant to any party's claims or defenses nor proportional to the needs of this case.

Defendants further object to this interrogatory to the extent it seeks information regarding individuals other than Plaintiff Harrison that is covered by the Privacy Act, 5 U.S.C. § 552(a), or by other medical privacy laws such as HIPAA, P.L. 104-191, 100 Stat. 2548.

Defendants further object to this interrogatory's use of "waiver to deploy" as vague and ambiguous.

RESPONSE: Defendants stand on their objections and have withheld information pursuant to those objections.

As to responses to the interrogatories, see Attachment A.

As to objections:

DATE: December 17, 2018

Respectfully submitted,

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CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and correct copy of the above document was served on December 17, 2018, to the following counsel of record via electronic mail:

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/s/ Robert M. Norway

VERIFICATION

Based on information that I obtained in the course of my official duties, I declare under penalty of perjury that the substance of the responses to Interrogatory No. 6, Interrogatory No. 20, Interrogatory No. 21, and Interrogatory No. 22 are true and correct to the best of my knowledge and belief.

Date: 20181218

Signature: Andrew R. Wiesen, MD

Dr. ANDREW R. WIESEN

VERIFICATION

Based on information that I obtained in the course of my official duties, I declare under penalty of perjury that the substance of the response to Interrogatory No. 1 is true and correct to the best of my knowledge and belief.

Date: 20181214

Signature: MAJOR

STEVEN F. NELSON, Major, U.S. Army
Medical Standards Officer
Office of Chief Surgeon
National Guard Bureau

VERIFICATION

Based on information that I obtained in the course of my official duties, I declare under penalty of perjury that the substance of the Army's responses to Interrogatory No. 2 and Interrogatory No. 9 are true and correct to the best of my knowledge and belief.

Date: 17Dec2018

Signature: Carrie Shult

Carrie Shult

VERIFICATION

Based on information that I obtained in the course of my official duties, I declare under penalty of perjury that the substance of the response to Interrogatory No. 10 is true and correct to the best of my knowledge and belief.

Date:_17 DEC 2018_

Signature: PITNEY.AARON.CHRISTOPHER.1144144917 Digitally signed by PITNEY.AARON.CHRISTOPHER.1144144917 Date: 2018.12.17 12:40:14 -05'00'

AARON C. PITNEY
Colonel, MC
G-37, Medical Readiness

VERIFICATION

Based on information that I obtained in the course of my official duties, I declare under penalty of perjury that the substance of DoD's response to Interrogatory No. 2 is true and correct to the best of my knowledge and belief.

Date: 12/17/2018

Signature: Stephanie P. Miller

STEPHANIE P. MILLER

VERIFICATION

Based on information that I obtained in the course of my official duties, I declare under penalty of perjury that the substance of the responses to Interrogatory No. 3, Interrogatory No. 5, Interrogatory No. 17, Interrogatory No. 18, Interrogatory No. 19, and Interrogatory No. 23 are true and correct to the best of my knowledge and belief.

Date: December 17, 2018 Signature: *Donald Shell, MD, MA*

Dr. DONALD SHELL

VERIFICATION

Based on information that I obtained in the course of my official duties, I declare under penalty of perjury that the substance of the responses to Interrogatory No. 4 and Interrogatory No. 11 are true and correct to the best of my knowledge and belief.

Date: Dec 17, 2018

Signature: 

Dr. PAUL CIMINERA

VERIFICATION

Based on information that I obtained in the course of my official duties, I declare under penalty of perjury that the substance of the responses to Interrogatory No. 7 and Interrogatory No. 8 are true and correct to the best of my knowledge and belief.

Date: 12/17/2018

Signature: M. Melillo

MICHAEL R. MELILLO

VERIFICATION

Based on information that I obtained in the course of my official duties, I declare under penalty of perjury that the substance of the response to Interrogatory No. 16 is true and correct to the best of my knowledge and belief.

Date: 17 December 2018

Signature: _____

AUDRA L. TAYLOR

EXHIBIT 24

Excerpts from the February 22, 2019 Deposition of Andrew Wiesen

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
ALEXANDRIA DIVISION

NICHOLAS HARRISON and OUTSERVE-SLDN, INC.,	Plaintiffs,	
vs.		No. 1:18-cv-00641
JAMES N. MATTIS, In His 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.	LMB-IDD
RICHARD ROE, VICTOR VOE, and and OUTSERVE-SLDN, INC.,	Plaintiffs,	
vs.		No. 1:18-cv-01565
JAMES N. MATTIS, In His Official Capacity As Secretary of Defense; HEATHER A. WILSON, In Her Official Capacity as Secretary of the AIR FORCE; and the UNITED STATES DEPARTMENT OF DEFENSE,	Defendants.	

VIDEOTAPED 30(b)(6) DEPOSITION OF DEFENDANTS
GIVEN BY ANDREW WIESEN

DATE: Friday, February 22, 2019
TIME: 9:14 a.m.
LOCATION: Winston & Strawn
1700 K Street, N.W.
Washington, D.C.

spitting at someone?

A It has not ever been shown that saliva itself is a -- carries viable HIV that could result in a transmission to another person.

Q You spoke earlier about blood splash. Has there been a documented transmission of HIV via blood splash?

A I am not aware that that has been documented. However, it may well have occurred. If a blood splash occurred onto a mucous membrane, the possibility for transmission from an HIV-positive individual to someone who is not HIV-positive is possible.

Procedures would be that that person would receive prophylaxis, so the absence of documentation of transmission does not mean that transmission is not possible.

Q And the other factors would come into play at that point, the amount of the infected bodily fluid --

A Yes.

Q -- to which there was exposure, the viral load of the individual?

A Yes.

MS. BERMAN: Objection. Compound and

loads means that we cannot detect the -- any copies of it -- of HIV in the blood, so it's below the detection limit of the best tests that we have. So undetectable will continue to get smaller as the tests we have get better.

Q And -- so are you aware of the studies that have shown that a person living with HIV who is adhering to their HIV medications has -- the studies that have shown that there have been no link to transmissions from such a person?

A I am aware of the studies.

Q And do you know what those studies consider the demarcation point below which the viral load will no longer be capable of transmitting HIV sexually?

MS. BERMAN: Objection. Vague.

Go ahead.

THE WITNESS: So the problem with the question is that we don't -- we can't prove a negative. So while we have not seen transmission at levels that are undetectable, it doesn't mean that it's not still possible. So the way your question is phrased is what number would mean it's not possible, and I can't provide an accurate answer to that.

absolutely no risk of transmission -- the studies simply are not large enough for that to be a certainty.

So what you're asking me to tell you is, is it certain that 200, or whatever number they pick, would not result -- could not result in transmission? And what I'm telling you is that we could never make that statement, that any level of viral copies in blood, that viable virus in blood theoretically can transmit the disease. There is no level that would be considered to be absolutely safe.

BY MR. SCHOETTES:

Q And I -- I think my question was a little different because I was asking what the studies were testing for, not what they had shown. But setting that aside, are you aware that the CDC issued a statement in September of 2017 saying that a person who had an undetectable viral load had essentially no risk of transmitting HIV sexually?

A I am aware of that statement.

Q When did you become aware of that?

A I can't recall exactly when. It probably was around the time it came out, since that's part

know -- I mean, I don't want to pin myself down to an actual number, but it's certainly going to be something greater than, you know, I don't know, maybe one in a hundred.

Q So 1 percent?

A Perhaps. Again, this is -- it's difficult to pin that down. But, yes, if somebody had a 1 percent chance of transmitting a disease within a year, that would be -- that could be considered to be likely.

Q Well, but the standard isn't "likely." It's "probably," correct?

A This is -- the standard is vague.

Q But "probably" in this case doesn't mean more likely than not?

A No, it does not.

Q That's one definition of "probably" that could be used, correct?

A It could be used.

Q But that's not how the definition is -- of "probably" is being used here?

A In public health, we would not use "probably" to mean more likely than not.

Q Do service members with HIV probably endanger the health of other personnel?

A It depends.
Q What does it depend on?
A It would depend on the individual's activity and primarily if an individual had HIV, whether they were controlled or not in terms of taking medication and what their sexual activity was, and if they were having sexual activity with other personnel.
Q Setting aside sexual activity, would a service member with HIV probably endanger the health of other personnel?
MS. BERMAN: Objection. Calls for speculation.
THE WITNESS: Under certain circumstances, it is possible that they could endanger, whether willingly or not -- if a person had HIV and didn't know it or didn't disclose it to a health care provider, it's possible that infection could be transmitted.
It's possible under certain circumstances, should they need to donate blood in a manner which has not gone through the screening mechanisms that we would normally associate with blood transfusion, or even if it were and they happened to be in a period where it couldn't be

detected by normal methods, that could pose a risk to others.

BY MR. SCHOETTES:

Q And so now I want to narrow us to people who have been diagnosed with HIV, not people who don't know that they're HIV-positive. What activities in which that person engaged would probably endanger the health of other personnel?

A A person diagnosed with HIV, again, depending on whether they were taking medications or what their viral load was, the primary activities that could endanger other personnel would be sharing of needles, sharing of any other bodily fluids and sexual activity, and potentially donation of blood if that blood was given to another individual and it was not picked up in screening.

Q So I understand -- well, maybe I don't. Can you explain to me what you mean by sharing of needles?

A So if an individual uses a needle to inject something into their body and then they provide that needle to another individual, that the likelihood of transmission of HIV from that is certainly possible.

follow-up rates for HIV-infected individuals who are on treatment is on the order of three or four times a year of follow-up visits with their providers which, at most, would account for maybe, you know, 8 to 16 hours out of a 2,000-hour work week which would not be even 1 percent, so...

BY MR. SCHOETTES:

Q So if a person living with HIV is in treatment and has a suppressed viral load, I hear you saying that they would not require excessive time lost from duty for the treatment of HIV or hospitalization?

MS. BERMAN: Objection. Calls for speculation.

THE WITNESS: An individual without complications who is not -- who is routinely being monitored and does not need multiple revisits for any exigencies for complications of their treatment would not meet the standard of excessive time.

BY MR. SCHOETTES:

Q And you talked about needing care up to three or four times a year, follow-up evaluation as a person living with HIV in treatment, that that did not -- would not constitute excessive

They have not.

Q I'm going to go on to the next criteria, and that is, "medically capable of performing duties without aggravation of existing physical defects or medical conditions."

Are HIV-positive service members with well-controlled HIV medically capable of performing duties without aggravation of existing physical defects or medical conditions?

MS. BERMAN: Objection. Calls for speculation.

BY MR. SCHOETTES:

Q Actually, let me restate that. Are HIV-positive service members medically capable of performing duties without aggravation of their HIV?

A Under certain circumstances. And what I mean by that is that the circumstance would necessitate they be able to take their medication continuously over the period of this military duty. So if they were not able to, for whatever reason, take their medication, that would exacerbate their condition, and that is known that interrupting HIV suppressive therapy can lead to untoward effects for the individual, including

resistance to the drugs and a rebound of the infection.

Q Beside [sic] for treatment interruption, would there be any reason that a person -- service member with HIV would not be medically capable of performing their duties without aggravation of their HIV?

A There could be other reasons. I can't speak that there could not be any other reason why they wouldn't be able to.

Q But in evaluating this criteria for a service member living with HIV, would you base your decision, on other things that -- yeah. Would the decision be based on anything else or would it be based on the possibility of treatment interruption?

A If you assumed that the individual did not undergo a treatment interruption, then the question of would they be medically capable of performing duties without aggravating the medical condition of HIV, they would not. If they did not have treatment interruption, then the conditions they would need to perform should not aggravate the condition itself of HIV.

Q And we'll talk more about treatment

A So again, it depends how many, for how long, what were you taking, what was your load before and, you know, what was the resistance pattern before. It's not good to miss any doses. So the fewer doses missed, the better for that individual.

Q Once -- if an HIV-positive service member begins experiencing a treatment interruption, how long does it take on average for their immune system to become compromised as a result?

A So again, it would depend, again, on what their immune system was prior to the interruption. If the assumption you're making is that they were completely suppressed and that their immune system was relatively normal, on an individual basis, it could be as short as perhaps a month or two to as long as -- it could be much longer than that. It's an individualized response, but don't develop immunocompromise immediately once you interrupt medication.

Q So you could go for a month, I think you said, was the smallest amount of time you said, before there would be any type of compromise of the immune system as a result of treatment interruption; is that correct?

person was on and it is not that the virus goes into certain reservoirs where the medications are not actually getting to the virus?

A It's possible that, again, there are rests or areas where the drug penetration is less, that the virus could potentially survive. But again, the -- the patterns of resistance we see are that it's dangerous to stop drugs because it does allow -- the ones that have survived are generally more resistant to the drugs we're using than others. And so they tend to be less effective and, after an interruption has occurred and they've been reinitiated, they tend to work less well.

Q Which then could require a switch in medication for that individual?

A If one is available and tolerable by the patient, yes.

Q And the treatments today that are used most frequently by people who are naive to treatment are -- have fewer side effects and are more tolerable than the medications even from ten years ago, correct?

A The medications today are better than the medications even ten years ago and they are

generally well tolerated.

Q And they have fewer side effects?

A In general, yes.

Q In this statement on page 2, it talks about military risks that could lead to illness exacerbations. Can you explain what military risks could lead to illness exacerbation for an HIV-positive service member?

A Again, I think these would fall into the order of difficulty with either water, food, environment, or just general stress of, you know, 24/7 operations. There are a lot of psychological stressors in these military environments. And so those may exacerbate HIV or any other disease based on those -- the extreme stressors.

Q So that's something -- the things you described are applicable to many different conditions?

A Yes.

Q And even someone without a medical condition --

A Yes.

Q -- could be -- could have those military risks affect their well-being, correct?

A Yes.

I think we've talked about some of these things, but I just want to make sure that the definitions are the same in this context. So what aspect of the nature of HIV would influence the deployment waiver decision?

A Well, I -- so the nature of HIV is it's an infectious disease as opposed to some other physical limitation. So it's an infectious disease. So the nature of that is what is the risk of the infectious disease itself, first to that individual of worsening or causing a problem, and then secondly to, as we talked about earlier, transmission to others or risk to others.

Q And just in the language of this particular provision, how would a deployment put a service member with HIV at an increased risk of injury or illness?

A So again, as we discussed before, in the contingency environment, there are environmental and other stressors which may cause the disease to worsen. The interruption in treatment is a factor to consider, as well as the inability to receive normal food rations or rations that one is accustomed to, access to water, prolonged operations, psychological trauma, many other

things where those could all increase the stress on the individual and on someone taking medications already -- I guess we had already mentioned they may have to take additional medications for prevention, prophylactic purposes against malaria, may need other immunizations. There are other stressors that are going to be applied to them.

And so all of those together could cause an individual with this condition to worsen.

Q And just so I've got these categories right, there's treatment interruption, correct?

A Correct.

Q There are stressors --

A Correct.

Q -- which includes lack of food or limited rations or --

A Dehydration.

Q -- not having access to water, dehydration --

A Loss of sleep.

Q Those are all in the stressors category?

A Sure.

Q Psychological stressors, I think you said. And then there are potential drug

interactions with additional meds?

A Correct.

Q Do you have a scientific basis on which you're relying or documents or studies for how these stressors would result in a worsening of HIV?

A I don't have scientific basis to say they would or would not. What I say is that having a medical condition makes you more susceptible to any stressor. So when I add stressors to what stressor you already have, the likelihood of you having an adverse event is increased.

Q And as we discussed before, we don't know how much it's increased?

A We do not.

Q It's your assertion that it's increased by some incremental amount, at least?

MS. BERMAN: Objection. Mischaracterizes the testimony.

Go ahead.

THE WITNESS: It may be increased, that having a disease in the beginning would make you more susceptible to environmental stressors in general.

BY MR. SCHOETTES:

Q So it may not be increased. That's possible, too?

A It is possible.

Q And on the potential interactions or problems caused by the interactions, what's the scientific basis for that? Are there studies? Is there anything supporting the concerns specifically with respect to HIV and antimalarial medications or the other vaccinations or immunizations you discussed?

MS. BERMAN: Objection. Vague and compound.

You can answer.

THE WITNESS: So there are some. Specifically I would say that one of the force protection measures is a live virus vaccine for vaccinia, smallpox virus, which would not be administered to an individual with the HIV even if they were fully suppressed. That's a contraindication. However, we do have other people with valid reasons to not take that vaccine as well.

There are limited studies on the interactions of antimalarial medications with anti-HIV medications. As you had stated earlier,

there are many people in the world, especially in Africa, that live with both of these conditions. The medications that we typically use for antimalarial prophylaxis, I did not see a great deal of study on, but what I had seen noted that there was a generally minimum interaction between the HIV medications and the two that we use most commonly, doxycycline and Malarone, atovaquone/proguanil. That's a trade name -- Malarone is the trade name.

BY MR. SCHOETTES:

Q So I want to make sure I've got this right. There could be interactions between antimalarial drugs and HIV medications. The ones that the -- the antimalarials that the military uses most commonly, though, have minimal interaction problems with HIV medications; is that right?

A The studies I've seen have shown that they have generally minimal interactions.

Q And have -- do other antimalarial medications have a greater problem in terms of interactions with HIV medications?

A Yes. There are certain antimalarial medications that are not indicated to be taken

with HIV agents.

Q But the military does not use those?

A The military -- it's not the first-line agent for the military.

Q The folks who can't take the live virus vaccine for other reasons -- first of all, can you give me examples of what those other reasons might be?

A The simplest example for smallpox is history of eczema. So --

Q History of?

A Eczema.

Q Okay.

A E-C-Z-E-M-A, which is just a skin condition, irritable skin condition that the smallpox virus, the current one we use right now, just causes that to flare up and can be quite serious.

Q Anything else that pops into your mind?

A There are a variety of conditions, but eczema is known to occur in maybe up to 10 percent of the population, so it's fairly common and a fairly common reason for people to not get the smallpox vaccine.

Q So what do you do with those folks who

have a history of eczema in terms of deploying?

A So they're not prohibited from deploying. They simply receive a medical reason for not receiving that particular force protection measure.

Q And they don't take some other substitute or take other measures to prevent whatever the vaccine is intended to prevent?

A So, yeah, we don't have -- at this point, we don't have an alternative smallpox vaccine. It's the same one we've used since the 1940s. So, no, there isn't an alternative. I mean, we have other countermeasures in terms of, you know, using mask and, you know, our chemical protective gear, but it's more effective to use the vaccine since it's much less obtrusive.

Q So do you ask service members who have not had the vaccine because they have eczema, a history of eczema, to use those other countermeasures?

A So those other countermeasures would be used in the event of an actual smallpox attack or usage, biologic weapons usage, but there is no naturally-occurring smallpox in the world right now. So they would have to have them, but

everybody has to have those for these deployments.

Q So everybody would use those. The other folks would be protected by the vaccine as well, and these individuals with the history of eczema would be relying solely on the protective gear?

A Yes. That's correct.

Q Can you say in what deployed environment HIV is likely to significantly worsen? Or in what deployment environment is HIV likely to significantly worsen, if any?

MS. BERMAN: Objection. Calls for speculation.

Go ahead.

THE WITNESS: So the more stressors that are placed on the individual, the more likelihood that any condition will exacerbate, including HIV. So the most stressful situations that one could be deployed in would be a combination of environmental and other physical stressor factors.

So a contingency deployment in an undeveloped theater where there's limited access to the things that we normally want -- food, medicine, water, shelter -- where you're required to wear all your protective gear at all times so you're subject to heat stress and weight stress

sometimes they -- the combatant commander may delegate, may delegate, that authority to their component combatant commander. But per this regulation, yes, it would be the combatant commander themselves.

Q Now, according to this, special operations forces have a somewhat different procedure; is that correct?

A They are listed separately from DOD to personnel in the fact that their requests go through a slightly different channel because they're -- while they're uniform -- like, I work for DOD too. So I'm not considered an Army asset, but I'm owned by the Army for some administrative purposes.

So special forces personnel still have to get waivers. They just go through a slightly separate channel.

Q Got it. And that channel is the CDRUSSOCOM?

A Yeah. So that's the commander, U.S. special operations command, is what that stands for.

Q Thank you.

A And so that is simply their commander.

So because they deploy in small numbers for irregular durations at all times, they just have a slightly separate channel to put those requests through. And then they still have to go to the combatant commander; it's just it goes through the USSOC commander.

THE REPORTER: It goes through the...

THE WITNESS: Commander of the U.S. special operations command. USSOCOM is what they list this as here. USSOCOM.

BY MR. SCHOETTES:

Q So this next paragraph talks about the fact that a request for a waiver shall include a summary of a detailed medical evaluation or consultation concerning the medical condition. It then -- it talks about the maximization of mission accomplishment and the protection of the health of personnel are the ultimate goals. I want to focus on this next part: The "justification shall include statements indicating service experience."

So tell me what that means, service experience.

A So I believe what this is getting at is that you may have an individual who has got unique qualifications due to extensive experience, that

they may be one of very few individuals who can do a job. And so if you're asking for a waiver, the rationale would say, I have no one else but this person to do it because of their unique experience. And so that's why they wanted that addressed.

Q Okay. I'm going to jump to the next -- to one further down, which is "the benefit expected to accrue from the waiver," because it sounds to me like that would be connected to what you just referred to.

A So the benefit here would have to be to the unit. An individual would never achieve a benefit by deploying. I mean, I guess that you get more pay if you deploy, or some patch or something, but a benefit -- normally what we would think, that this benefit would be accruing to a unit that I need this person and that's why I wanted to bring them in, and so I'm asking for a waiver.

Q Right. So that's how I feel like it's connected to --

A Yes.

Q -- that service experience piece. So service experience isn't just referring to they've

A So for them to manifest outward signs and symptoms of a progression of HIV, the likelihood of them needing to be without meds for that to occur would be, at a minimum, I would say, at least a month, but could be much longer than that. The average time would probably be much longer than that, six or longer months.

The untoward effects that they might experience in terms of increased susceptibility to resistant strains of HIV when they restart their medications, that could occur earlier. The exact timing on that I -- I can't say. It's not my specialty area.

Q And for how long would a person with HIV need to be without their medication before there was likely to be a grave medical outcome as a result?

A So untreated HIV, the life expectancy in the early '90s -- it's what we really had -- was about seven years. But they typically suffered from opportunistic infections much before then. So it would be on the order of years before they would have a grave medical outcome without medications, in general.

Q Was life expectancy seven years during

A So this is where it gets a little different. So deployed service members are normally given 180-day supplies of maintenance medication. 180-day supply was chosen because it is anticipated that resupply should be available within 180 days but may not be available prior to 180 days.

The individual is then responsible for that medication and the care of that medication and proper taking of the medication until they can achieve a resupply.

Q And when are they permitted to initiate the refill, if you will, of their medication while deployed? So after 120 days, can they put in to get that medication resupplied? After 150 days? How far down do they have to be on their current supply before they can start the process of getting it refilled?

MS. BERMAN: Objection. Form.

You can answer.

THE WITNESS: So in a deployed environment, obviously things are a little bit different. The individual is going to know when and how urgent it is that they get that medication. And their individual circumstances

A So again, I don't have the accession standards in front of me, but my best recollection is that asthma had to occur after age 12 and had to be documented in some way, shape or form. So asthma or use of inhaler. And then the question would be for the examiner as to what -- they would have to elucidate whether that was truly asthma or whether somebody just gave them an inhaler because they thought it was asthma.

But I don't know how specific it gets into what's required for a waiver, because there are tests that can be done to determine whether you actually have the diagnosis.

Q So for -- what is the deployment policy for individuals with asthma who -- well, yeah, I'll just leave it right there.

A So since it's in front of me, I'm going to take a look and see if it's mentioned specifically --

Q Please do.

A -- because I don't remember. I see pulmonary disorders. So it says here under -- this is on page 11, subparagraph (d) of enclosure 3: Asthma that has a forced expiratory volume (FEV-1) of less than or equal to 60 percent

of predicted, despite appropriate therapy, and that has required hospitalization at least two times in the last 12 months or requires daily systemic steroids would require a waiver.

So that would be at least moderate asthma -- moderate to severe asthma would require a waiver.

Q So asthma below that level would not require a waiver?

A For deployment, if it didn't meet those criteria, then presumably you could deploy without a waiver.

Q And then anything that is at this level or worse would require a waiver?

A Yes.

Q How are individuals with diabetes supplied with their treatments during deployment?

MS. BERMAN: You mean asthma?

MR. SCHOETTES: Yes, I do.

BY MR. SCHOETTES:

Q How are individuals with asthma supplied with their treatments during deployment?

A The same way that we've covered before.

Q And if a person with diabetes -- I'm sorry, asthma -- was -- lost -- their treatment

was lost, stolen or destroyed while deployed, would they be resupplied with their treatment modalities in the same manner as you have described previously?

A Yes.

Q Is the urgency of the need for treatment for asthma different from the urgency of the need for treatment for HIV?

MS. BERMAN: Objection. Vague.

You can answer.

THE WITNESS: So it could be under certain circumstances. Severe asthma exacerbation could result in sudden death. So -- and as we've discussed before, HIV is a chronic disease and so unlikely to cause sudden incapacitation or sudden deterioration in health.

BY MR. SCHOETTES:

Q So imagine a person with even moderate asthma who, for whatever reason, doesn't have access to their inhaler is having an attack. That could impact their ability to perform right away.

MS. BERMAN: Objection. Calls for speculation.

But you can answer.

THE WITNESS: Yes, it could.

BY MR. SCHOETTES:

Q They have shortness of breath, they're, you know, coughing, all the things that we described, or any of those things, could potentially impact their ability to perform immediately.

MS. BERMAN: Same objection.

Go ahead.

THE WITNESS: Yes.

BY MR. SCHOETTES:

Q But a person living with HIV who doesn't take their medication one day, it has no real effect on their ability to perform their duties, does it?

MS. BERMAN: Same objection.

Go ahead.

THE WITNESS: It would be unlikely that a person with HIV who missed their meds for one day would have a deterioration of their ability to do their normal duties.

BY MR. SCHOETTES:

Q Would it be more than unlikely? Would it, in fact, be not possible?

MS. BERMAN: Same objection.

Go ahead.

destroying their glasses or losing their glasses. They would need to make more. So they do bring the capability in forward deployed medical assets to make glasses.

Q Can you explain to me -- I think I have an idea of what this is -- but the mask inserts. What is that?

A So there's just a special set of lenses that go inside your protective mask, which is for chemical or biological hazards, that you might have to put on and so -- that's so you can see properly through that mask because glasses in general aren't compatible with the mask because the temples of the glasses themselves would interfere with the proper seal on the mask.

Q So glasses, I think, are another example of a -- a durable device that, if you didn't have in the moment, could hinder performance of your duties. Is that accurate to say?

A It is. Glasses are considered a special class of devices which is why you have to bring two.

Q But if you were out doing your job and you lost, destroyed your glasses, it could seriously impact in the moment your ability to do

your job?

A Yes, it could.

Q Are you aware of any other medical conditions other than those that we have discussed that require daily medication or treatment to control that -- with which individuals are nonetheless allowed to deploy?

A So let me make sure I understand. Are you asking are there any other medical conditions requiring daily medications in which people can deploy?

Q Yes.

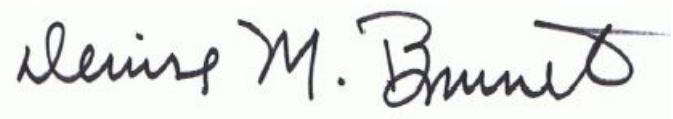
A So, yes, there are. There's a lot of them. And I couldn't name them all because there are just too many medical conditions that exist.

Q Would you be able to supply us with a list or refer us to a list of those conditions?

A I don't know that conditions like that are, you know, listed out in a manner in which you phrased the question. I mean, I -- you know, for example, if I say I have, you know, chronic back pain and I take Motrin, you know, once a day for that back pain and it seems to help me, that's a chronic condition that requires medication. I mean, there's just too many medical conditions

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 25

Excerpts from the February 27, 2019
Deposition of Dr. Jason Blaylock

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
UNITED STATES ARMY
GIVEN BY JASON BLAYLOCK

DATE: Wednesday, February 27, 2019
TIME: 9:04 a.m.
LOCATION: Winston & Strawn
1700 K Street, N.W.
Washington, D.C.
REPORTED BY: Denise M. Brunet, RPR
Reporter/Notary

Veritext Legal Solutions
1250 Eye Street, N.W., Suite 350
Washington, D.C. 20005

their oral pharynx somewhere that was bleeding.

Q Has there ever been a documented case of HIV transmission via biting?

A I have not reviewed the literature recently on that, so I wouldn't be able to tell you definitively.

Q What is the risk of transmission of HIV via blood splash?

A Again, assuming an intact mucosal surface, it's negligible.

Q And actually, will you define blood splash for us?

A When I -- my definition of blood splash is if blood or -- splashed onto a person who -- let's say it was a health care provider caring for a patient, and the blood landed on intact skin, then that's a negligible risk of transmission.

Q Has there ever been a documented case of transmission via blood splash?

A Not to my knowledge, but I have not reviewed the literature on that recently.

Q How is HIV treated?

MS. BERMAN: Objection. Vague.

BY MR. SCHOETTES:

Q What is the common treatment for HIV?

serodiscordant relationships and they found no direct transmission of HIV virus between serodiscordant couples. They did find a handful of transmissions, I think about 11, that were outside of the relationship between those serodiscordant couples so they couldn't account for the viral load status of those other infecting partners.

BY MR. SCHOETTES:

Q So --

A So --

Q And that's --

A So I was just going to say that the CDC made that statement based on that one large clinical trial.

Q And you don't think the CDC took into account all of the literature around HIV or the reported transmissions in the context of viral suppression in making that statement?

MS. BERMAN: Objection. Mischaracterizes the testimony.

You can answer.

THE WITNESS: Again, I don't know what the CDC looked at. I would venture, no, that they looked at the entirety of the medical literature,

but that's why they said approximately zero and effectively zero. They never said absolutely zero.

BY MR. SCHOETTES:

Q And did -- you referred to one study. Do you remember the name of that study?

A I don't remember the exact name. It's a pretty long name, but it was in the New England Journal of Medicine.

Q Does HPTN 052 ring a bell?

A It does. I don't know as relates to that exact study, but -- I'd have to see it in front of me.

Q And you say they looked at that one study and came up with this statement about effectively zero risk. Were they looking at other studies at the same time?

MS. BERMAN: Objection. Vague and mischaracterizes the testimony.

Go ahead.

THE WITNESS: I don't know what exactly they were looking at. I know that their statement came out after the results of this study.

BY MR. SCHOETTES:

Q Are you familiar with the partners study?

witness being offered to speak specifically about this report. But to the extent that your question is asking about the Army's interpretation of 6130.03, that is the only item to which this witness is offering 30(b)(6) testimony.

MR. SCHOETTES: Thank you.

BY MR. SCHOETTES:

Q So how does the Army interpret "probably" in the context of this criterion?

A "Probably" is typically interpreted as more likely will endanger.

Q More likely than not?

A Uh-huh. Right.

Q Do soldiers with HIV probably endanger the health of other personnel?

A Not more likely than not, no.

Q How probable would you say it is that circumstances would arise for a soldier living with HIV that would endanger the health of other personnel?

A It's fairly unlikely.

Q Would you describe that risk as negligible?

A It's hard to say. Negligible means, like, almost zero risk. In the appropriate

service members.

Q And would the time that it takes to take those medications be considered time lost at all from duties?

A Physically taking those medications, no.

Q What parts of a person's HIV treatment would potentially create time lost from duty?

A So in the Army, HIV-infected service members are required to go to -- every six months they meet with an infectious disease provider in a clinic appointment visit, obtain a lot of blood work, obtain a 45-minute to 60-minute appointment with that physician to discuss how they're doing on their medications and a lot of different aspects related to their infectious disease -- disease.

They also have to travel to these appointments a lot of times because we only have, you know, infectious disease specialists at certain military treatment facilities around the United States. And so they have to -- typically, it's -- for somebody who lives away from a military treatment facility that has an infectious disease specialist, they have to travel. So that is typically a day or two away from their unit at

their home duty station.

Q So you referred to appointments every six months --

A Correct.

Q -- at which an evaluation is done and blood is drawn?

A Uh-huh.

Q Would the time that is required for that care in theater be considered excessive time lost?

A When you say "in theater," mean in a deployed setting?

Q Yes. Within a theater of operations.

A So currently, in a theater of operations, we don't have access to care at a military treatment facility that would include an infectious disease specialist and all of the laboratory testing required that would need to be obtained for somebody's biannual visit with HIV.

Q And where -- sorry.

Is an infectious disease specialist required to provide the follow-up evaluation for an individual living with HIV in a deployed setting?

A So again, in a deployed setting, we -- there's no precedent for that. We don't have

Q -- in order to make it viable for the kind of test that's going to be performed?

A Correct.

Q And are you saying that, for HIV, there are currently not the capabilities to do those types of preservation of the specimen within theater?

A At most levels of care within theater. So if I -- can I explain to you --

Q Sure.

A -- the different roles of care for patients in theater?

Q Yes.

A So we have role one capabilities, which is our most minimal capability for care, which is usually at the front line where the unit is in -- very near to combat operations. So that essentially is what we typically call it as a battalion aid station. It's a tented facility that really is designed for acute trauma care, life -- lifesaving care to get them to the next level of care. So it's run by, most of the time, a PA, sometimes a medical physician, and a handful of medics, to sometimes include, like, a senior medic. So there's that level of care which really

typically has little to no lab testing capability at all.

So the next level of care --

Q I'm sorry. Follow-up question there.

A Yes.

Q You said lab testing capability.

A Correct.

Q Is that differentiated from the actual draw of the blood?

A They kind of go hand in hand because you wouldn't draw somebody's blood if you weren't going to be able to test it from there.

Q So that's part of my question, is can --

A Oh, you're saying --

Q Can blood be shipped -- can a specimen be shipped to a different location?

A Yes, but you would need to know -- you would need to be able to process that blood at that role one facility. And those capabilities are typically not in place.

Q The processing capabilities --

A Correct.

Q -- for the draw?

A Yes.

Q Okay. Go ahead. You were going to talk

about, I think, role two.

A Okay. But if I could also clarify. So processing -- typically what it involves is spinning down the blood to separate it out between -- there's different, you know, compartments of the blood. There's plasma, serum, and there's actually whole, you know, red blood cells. So they separate that out. Then they typically need to freeze it, particularly for HIV testing. They freeze it to minus 20 degrees Celsius. And that capability is not present at role one facilities.

BY MR. SCHOETTES:

Q Thank you. Let's talk about the next level of care.

A Sure. So the next level of care is role two facilities. That is typically run by a medical company, which could be anywhere from, you know, 30 to as many as, like, a hundred personnel in that medical company. It includes essentially the capability maybe to hold somebody for a 24 to maybe 48-hour period, depending on the type of environment you're working in. We also include our forward surgical teams as kind of a role two facility. And that's -- they provide acute

surgical care fairly close to the front line. And so they're considered, just because of their surgical capabilities, a role two level of care.

Again, at role two facilities, very limited laboratory services as well. Maybe chemistries, like checking somebody's electrolytes or -- I -- I can't speak to the exact lab assets at the role two, but they're fairly limited and -- your more, like, benign, day-to-day lab testing capabilities.

Q And then -- so they also would not have the capability of processing the blood, spinning it down, as you say?

A For the most part. Again, it probably depends on what assets they decide to deploy with in a given circumstance, but typically not.

Q Can you talk about the next level of care?

A So role three is the next level of care, and that's your combat support hospitals, which are -- in the deployed setting, they're usually at major hubs of military bases in the deployed setting. So, for example, in our current theater in Afghanistan, we've got role three facilities in Bagram and I think also in Kandahar. And that's

where, you know, you get your more, you know, typical hospital assets as far as being able to draw blood and process it appropriately, store it appropriately, and then send it, particularly for HIV diagnostics, to send it out of theater to get tested.

Q So an individual living with HIV who was able to get to a combat support hospital would be able to obtain the necessary blood testing required for one of these six-month evaluations, correct?

MS. BERMAN: Objection. Mischaracterizes the testimony.

You can go ahead.

THE WITNESS: That is correct. The turnaround time for that -- the blood results is another issue, though, that would pose some -- it would not be the same as getting a blood draw in the United States at one of our labs in the United States, in one of our clinics.

BY MR. SCHOETTES:

Q Approximately how long would the turnaround be from a role three?

A So again, that -- a lot of variables at play. It depends on what's going on in that

medication, that it would be important to get that individual back on their medication.

A Yes.

Q And that would not be reliant upon the -- getting the test results from that patient, correct?

A Correct.

Q So I want to know what the effect would be on the doctor's ability to provide the type of monitoring and care that the doctor is being asked to provide if they got the labs back 30 days later, 45 days later?

MS. BERMAN: Same objections and asked and answered.

You can answer.

THE WITNESS: I don't see an effect to the doctor managing the patient in that setting.

BY MR. SCHOETTES:

Q You talked about -- would it likely result in excessive time lost from duty for an individual with HIV to get to a role three medical facility twice a year?

A So again, I think you're mixing up -- so a role three medical facility in our current Army policy does not have an infectious disease

specialist there. So they would never go to a -- a role three facility, that's only what we talk about in the deployed setting.

In the United States, we have role four facilities, which include all of our major medical treatment facilities where, at the -- most of them infectious disease specialists reside.

Q Can you tell -- can you describe a role four medical facility?

A Yeah. So I can use -- Walter Reed, where I work, for example, is a role four military treatment facility. Has, you know, robust services that you would expect in any other civilian hospital in the United States, great laboratory capabilities, radiology capabilities, primary care and subspecialty care capabilities.

Q So does the Army believe that an individual living with HIV must return to the United States from a deployed setting in order to get their six-month follow-up evaluation?

A Currently, yes.

Q And I understand that that's the current policy, but what I'm asking is, is there any reason why an individual living with HIV would not be able to get the kind of follow-up care they

that could be deemed an excessive loss of time for that unit.

BY MR. SCHOETTES:

Q Are soldiers with HIV medically capable of satisfactorily completing required training?

MS. BERMAN: Objection. Calls for speculation.

You can answer.

THE WITNESS: Yes. Assuming they are well controlled and otherwise asymptomatic HIV-infected service members, yes.

BY MR. SCHOETTES:

Q Are HIV-positive soldiers -- I'm sorry. Yes. Is an HIV-positive soldier adaptable to the military environment without the necessity of geographic area limitations?

MS. BERMAN: Objection. Calls for speculation.

THE WITNESS: Currently, no.

BY MR. SCHOETTES:

Q And why is that?

A Currently, because we do not deploy service members into combat operations or contingency operations. They are -- for the various variables that we've already discussed, it

depends on the austerity of the environment, the access to laboratory capabilities and medical service capabilities, the access to pharmacy capabilities should that service member require refills of his medications or lose his medications.

And I would also add the confidentiality issue that we had already discussed as well.

Q So we already talked about the access to care and we talked about the confidentiality provision. Let's talk about the austerity of the environment. What factors influence an individual living with HIV in terms of the austerity of the environment?

MS. BERMAN: Objection. Vague.

THE WITNESS: So when we talk about austere environments, so -- it depends on, you know, again, the austerity in the environment kind of goes hand in hand with what capabilities are available in that environment.

If all -- I guess I'll -- I can use an example from personal experience. Being deployed in the middle of the desert in Afghanistan only next to a role one facility that has essentially no diagnostic laboratory capabilities and no

access to pharmaceuticals for treatment of HIV infection at that role one, outside of a short supply of antiretrovirals for use as PEP if needed -- so that's a pretty austere environment where there's a lot of variables that could come into play where an HIV-infected service member might need care at that role one and not be able to receive it.

BY MR. SCHOETTES:

Q So that's what I -- I -- what I want to know about is what those factors are. So I understand -- and I want to set aside access to care and access to medication. We're going to talk about that in a moment. And I just want to know what the austere environment factors, environmental factors, are that would create a need for more immediate care.

MS. BERMAN: Objection. Vague.

You can answer.

THE WITNESS: I guess -- I mean, that's -- I kind of lump all of this access to austerity, if you get what I'm saying. Are you talking about, like, extremes in temperature, extremes in the -- you know, just maybe staying up for 48 hours straight without sleep?

BY MR. SCHOETTES:

Q Right, I want to know how those things --

A I mean, that's kind of more combat operations, kind of op tempo, I guess is what I think of that as, not really the austerity of an environment.

Q Okay. So you're defining austerity as being about access to medical care?

A Yes. In a remote location where you're not -- you don't have ready access to medical care.

Q Okay. Then, what -- are you talking about those more environmental factors, temperature, lack of access to water, or limited access to water -- what would you call those, if not part of the austerity of the environment?

A You could call that austerity, if you want. I don't know what I would --

Q I just want something to be able to it because -- so whatever they're called, I want to ask you about those.

A Okay.

Q So describe for me what those factors are and whether -- and what influence they have on a person living with HIV.

A I mean, in particular, for somebody living with HIV is not -- I mean, I would hope that folks would have access to water to take your medications, would be the most important reason to have access to water, somebody with HIV. But typically our units do a good job of keeping water around for that reason, or for hydration purposes.

With -- there -- I don't know how familiar you are with, like, HIV-associated neurocognitive disease, but there's a lot of medical literature that is looking at personnel with HIV, even though they are -- may have an undetectable viral load and do a great job at, you know, taking their medication, that there still may be some effects of either the HIV virus itself or the medication that they're taking that affects their central nervous system and affects their able to concentrate, their ability to remember stuff, their ability just -- as far as just psycho-motor functioning, their ability to do their job.

So there is a body of literature that -- and there's an ongoing, you know, study that we're doing in the military called the HAND study where we're continuing to evaluate this disorder.

Q Is that HAN or HAND?

A HAND, HIV-associated neurocognitive disorder.

So what I'm getting at is somebody who with well-controlled, you know, apparently asymptomatic HIV-infected disease, or HIV infection, if they were in extremes of environmental temperatures or not sleeping for 48 hours at a time, that that might exacerbate HIV-associated neurocognitive disorder.

Q Anything else that you feel like the environmental factors -- I guess I will call them to differentiate them from what you're calling austerity -- that have an effect on the health of a person living with HIV?

A So we also know that environmental stressors can affect someone's immune system. So it can affect an HIV-infected service member's CD4 count. And by affecting your immune system, you're affecting your body's ability to also keep the HIV virus suppressed in addition to you taking your medication. So that can cause fluctuations in an HIV viral load.

Q Stress even in the context of an effective treatment regimen?

A Uh-huh.
Q You're saying affects the viral load?
A It very well potentially could affect the viral load.
Q And do you -- for what are you relying upon that statement?
MS. BERMAN: Objection. Form.
Go ahead.
THE WITNESS: Just knowing how HIV affects -- or how the body's immune system is, with our CD4 counts in particular, are -- the goal is to keep as robust of a CD4 count as possible to help with suppression of the HIV virus. And then fluctuations in that CD4 count, which we know occur with concomitant viral illnesses, other environmental stressors could be, you know, anything from extreme sunlight to extreme fatigue, lack of sleep, how that affects the immune system.
BY MR. SCHOETTES:
Q And those would affect an individual who wasn't living with HIV as well, correct?
A Certainly. Yeah.
Q Do you know -- can you tell me what the difference is between how they would affect a person who does not have HIV versus a person who

has HIV?

MS. BERMAN: Objection. Vague. Calls for speculation.

Go ahead.

THE WITNESS: I mean, I think that there's a lot that we don't know about the effects, particularly as relates to HAND, HIV neurocognitive disorder. There's certainly a lot of ongoing research and literature in that realm, but, you know, there's still a lot of unknowns, what environmental stressors and -- impact is on HIV infection, so...

BY MR. SCHOETTES:

Q Setting aside neurocognitive impairments, is there any literature about -- that would tell us the difference between how these environmental factors would affect a person living with HIV versus a person who did not have HIV?

A Not to my knowledge, no.

Q Are the geographical limitations that are placed upon an individual soldier living with HIV -- scratch that question.

The fifth criteria here is medically capable of performing duties without aggravation of existing physical defects or medical

conditions. Are HIV-positive soldiers medically capable of performing their duties without aggravation of existing physical defects or medical conditions?

MS. BERMAN: Objection. Calls for speculation.

THE WITNESS: Outside of what we just talked about with potential being in an austere environment and based on what exactly their duties are in a deployed setting, let's say, other than that, they are able to perform their duties without aggravating their medical condition.

BY MR. SCHOETTES:

Q So the report talks about -- that a waiver maybe be recommended on a case-by-case basis after review of the individual service member's health and consideration of factors, including the climate, altitude, rations, housing, nature of the duty assignment proposed and medical services available in the location. And then there's a second part of that which I'll come back to. But are these the environmental factors to which you were -- we've been referring: Climate, altitude, rations, housing, nature of the duty assignment?

Q Okay. That's all right. Other than the things that we have already talked about, is there anything else -- let me ask a different question.

A Okay.

MR. SCHOETTES: I would like to take a small break if you don't mind.

THE VIDEOGRAPHER: The time is 11:29 a.m. This completes media unit number 2. We are now off the record.

(Whereupon, a short recess was taken.)

THE VIDEOGRAPHER: The time is 11:41 a.m. This begins media unit number 3. We are now on the record. Please proceed, Counsel.

BY MR. SCHOETTES:

Q So I'm going to ask some questions about topic 21, which is the process by which service members requiring daily medication are provided with that medication.

How are maintenance medications provided to soldiers stationed in the continental United States?

A So typically, in the continental U.S., if a soldier is seen at a military treatment facility, usually their medications are able to be procured at the local -- the military pharmacy

that's -- where they're being seen for care.

Depending on certain medications, they may have to access it from -- through the TRICARE network, but from a local pharmacy if it's not readily available right at the military treatment facility.

Q Do any service members utilize a mail-in pharmacy program?

A Yes. Express Scripts is utilized.

Q How many days of medication are supplied at one time?

A It depends on the medication that you're talking about. Certain medications have stipulations on numbers of days that they're authorized at one time.

Q What is the maximum number of days that -- let's just talk about HIV. What is the maximum number of days supplied at one time for an HIV medication?

A Most HIV medications, the maximum number is 90, so a three months' supply with three refills, typically.

Q If a soldier's medications are lost, stolen or destroyed while they're located here in the United States, how are they provided with a

replacement supply?

A They usually contact their provider, the ordering provider, and the provider will put a new prescription in for them to pick up.

Q And how long would it generally take for that replacement supply to reach the solder in the United States?

A In the United States, it depends on what pharmacy they're going to pick it up at. There are certain pharmacies that have, like, a 72-hour turnaround, but if somebody was going without their HIV medications and they knew they had no more, they would put the script in at a local pharmacy that had the capability to fill that, if needed.

Q Are the answers any different if we're talking about soldiers stationed in Alaska, Hawaii or Puerto Rico, answers to the last series of questions under topic 21?

A No.

Q How are maintenance medications provided to deployed soldiers?

A In a lot of cases, they are provided via Express Scripts to deployed soldiers. Sometimes there's capability at, depending on what role of a

facility the soldier is next to, to actually get the medication from that role or -- role three facility, if, for example, a soldier is stationed right next to one.

Typically, at role one facilities, either the service member goes with the amount of medication they know they need for that entire deployment or it's procured through Express Scripts.

Q Does -- is it common for a service member to spend their entire deployment in a unit with only a role one medical facility?

A It's fairly common, yes.

Q And you said that individual would often be sent with a full supply for the length of their deployment?

MS. BERMAN: Objection. Mischaracterizes the testimony.

You can answer.

THE WITNESS: Yes.

BY MR. SCHOETTES:

Q If -- what's the maximum number of days' supply that a soldier would be provided with maintenance medication?

MS. BERMAN: Objection. Vague.

You can answer.

THE WITNESS: To clarify, this is assuming on a deployment?

BY MR. SCHOETTES:

Q Yes, I'm sorry.

A If -- on a deployment, the service member would be given whatever number of medications they needed to span that deployment, in most cases.

Q How long are the longest deployments?

A The longest deployments currently are slated as nine-month deployments, but it varies based on combat operations.

Q So for a nine-month deployment, the soldier would be given 270 days' worth of medication, approximately?

A Yes.

Q If a deployed soldier's medications were lost, stolen or destroyed, how would they be provided with a replacement supply?

A That depends on the scenario and where they're located in -- in theater.

Q Can we do it for each -- for someone with a role one, someone with a -- a soldier with a role two and then a soldier near a role three?

A Sure.

Q Okay.

A So at a role one facility, there would be no pharmaceutical capability to immediately replenish that medication supply. The role one provider would probably reach out to a role three facility, the closest role three, and ask for their capability to supply an immediate course of that medication until that service member can actually order it through TRICARE Express Scripts and have that new shipment sent out to him.

Q How long would it likely take for the supply at the role three to reach a soldier at a role one?

A Again, that completely depends on combat operations at the time, whether there's no-fly restrictions, what that unit is doing. If they're out in the field somewhere and not even going back to that role one battalion aid station for a week or so, then it might span anywhere from 48 hours to get that supply to them out to a couple of weeks to a month, depending on what they're doing.

Q Are there currently any HIV medications that are stocked or on the formulary within theaters of operations?

MS. BERMAN: Objection. Vague.

service member. So -- I mean, it could be outwards of a month to -- I can't put a top end range to it.

BY MR. SCHOETTES:

Q It could be more than two months?

A Sure.

Q It could be more than three months?

A Potentially. Unlikely, but potentially.

Q So would three months be a top-end range?

MS. BERMAN: Objection. Mischaracterizes the testimony.

THE WITNESS: I can't definitively give you a top-end range because I don't know -- I can't account for every variable that could occur in that setting.

BY MR. SCHOETTES:

Q But more than three months is unlikely?

A Correct.

Q Is more than two months unlikely?

A Less likely than more than three months. Less unlikely than more than three months.

Q Do antiretroviral medications have any storage or handling restrictions?

A So all medications that are FDA-approved come with a package insert that lists storage

requirements. And antiretrovirals are no exclusion to that.

Q Are they -- do HIV antiretroviral medications have any special storage or handling restrictions that are not -- that are out of the ordinary in some way?

MS. BERMAN: Objection. Vague.

You can answer.

THE WITNESS: Not to my knowledge.

BY MR. SCHOETTES:

Q Do they tolerate -- do any of them require refrigeration?

A Not any of the commonly used regimens that we use today.

Q Do they tolerate heat relatively well?

MS. BERMAN: Objection. Vague.

You can answer.

THE WITNESS: As well as antimalarials or other medications we take in a deployed setting.

BY MR. SCHOETTES:

Q Do they tolerate cold very well?

MS. BERMAN: Same objection.

THE WITNESS: Same response.

BY MR. SCHOETTES:

Q I'm going to move on to topics 24 and 25.

You described earlier concerns over transmission via the blood supply. Are soldiers who have been diagnosed with HIV told that they are not to donate blood?

A Yes.

Q Given that soldiers are told not to donate blood, what are the concerns with transmission via a donation from a soldier living with HIV?

A So the biggest concern that we've seen actually has been concerns for the soldier breaching confidentiality of his HIV status to fellow service members. And we have seen cases -- at least one case that I am aware of -- of a service member who attempted to donate blood within the United States who knew he was HIV-infected and was flagged by the blood bank, because we have very good blood testing capabilities for HIV infection in the United States. And that was brought to the attention of the Army public health -- or the -- I believe this was a marine soldier, so it was a -- whatever public -- the public health service for -- that governs them. And it was also brought to the soldier's attention too. They notified the

bank?

A So there are attempts to test for hepatitis B, hepatitis C and HIV in those settings. Those tests are not always run reliably before blood is transfused in the activation of a walking blood bank.

Q And can -- why is that?

A It's based on the emergence of the need for blood. So each of those tests take approximately 15 minutes to run, to get results, and sometimes you don't have 15 minutes before you need to give somebody blood.

Q Now, anyone who is participating in the walking blood bank is presumably asked to consent to giving blood, correct?

MS. BERMAN: Objection. Calls for speculation.

You can answer.

THE WITNESS: To my knowledge, there's no written consent when a walking blood bank is activated.

BY MR. SCHOETTES:

Q No soldier is asked to donate blood against his will?

A No.

Q Are there soldiers that potentially could have some of those reasons?

MS. BERMAN: Objection. Vague.

You can answer.

THE WITNESS: In a deployed setting? In a deployed setting, it would be very rare that a soldier would have another disease process that would prohibit them from transfusing blood, and not to the extent of the potential transmissibility of somebody with HIV.

BY MR. SCHOETTES:

Q Does the Army collect and use the blood of men who have sex with men?

A The Army follows the same standards that the American Red Cross does for blood donation, and I believe that is if you have had sex with a man within 12 months, then you are not to donate blood.

Q So soldiers who have -- male soldiers who have had sex with another man within the past 12 months would not be allowed to donate blood as a part of the walking blood bank?

MS. BERMAN: Objection. Mischaracterizes the testimony.

You can answer.

THE WITNESS: Yes.
BY MR. SCHOETTES:
Q And they potentially would be outing themselves as gay if they followed that prohibition on blood donation, correct?
MS. BERMAN: Objection. Calls for speculation.
You can answer.
THE WITNESS: Yes.
BY MR. SCHOETTES:
Q Does the Army have a system of tags that indicate blood type or ability to donate blood or allergies? Is there any type of medical information provided on a tag in a soldier?
MS. BERMAN: Objection. Compound.
BY MR. SCHOETTES:
Q Let me just ask the last question. Is there medical information that is provided on a soldier's dog tags?
A Yes. There is. It's -- your blood type is the medical information that's provided on every dog tag.
Q When it comes to HIV, isn't the primary concern in terms of transmission via blood donation undiagnosed HIV?

transmit HIV infection in that setting even with an undetectable viral load.

BY MR. SCHOETTES:

Q I'm asking a slightly different question, which is not what would be the risk of transmission if there was a donation, but rather whether the risk of HIV-infected blood getting into the blood supply is actually greater as a result of people who are undiagnosed than it is of people who have already been diagnosed?

MS. BERMAN: Objection. Form and vague.

You can answer if you understood the question.

THE WITNESS: I mean, I would purely be speculating, to be honest, that, yes, if there were an undiagnosed patient with HIV in theater and they did unknowingly, because they didn't know their diagnosis, donate blood, that would pose a very significant risk to the...

BY MR. SCHOETTES:

Q The HIV-positive soldier donating blood, that would be a direct violation of an order, correct?

A Correct.

Q The soldier who donated blood and did not

know they were diagnosed with HIV, that would not be a violation of an order, correct?

A Correct.

Q You expect your soldiers do follow orders, correct?

A Correct.

Q Okay.

A Sometimes they don't.

Q Let's talk about the concerns over battlefield transmission. Can you -- as differentiated from donation -- transmission via blood donation, can you describe what a battlefield transmission is?

A So a battlefield transmission is -- would be any potential exposure to blood or bodily fluids in a combat setting. There's various examples that people have used, whether you're -- somebody gets shot and you're plugging a chest wound or you're plugging an artery in somebody's abdominal contents in somebody's abdomen, whether you're a medic or just a first responder -- I mean, we always talk about using, you know, standard precautions, putting on gloves, but obviously in the combat setting, that's not -- you know, oftentimes not possible.

So -- but again, that battlefield transmission is negligible, assuming there's no break in that person's skin as well or there's no -- you need to, you know, mix blood or body fluids, potentially.

Q So it's negligible risk from a battlefield transmission, which you described earlier as almost zero, correct?

MS. BERMAN: Objection. Mischaracterizes the testimony.

THE WITNESS: It is a negligible risk.

BY MR. SCHOETTES:

Q And I'm pretty sure it's in the transcript, but -- and you said negligible earlier was almost zero, correct?

A Yes.

Q And I think you just described that there would need to be some type of break in the skin of the individual providing the aid, correct?

A Correct.

Q So even in the absence of the precautionary measures, there would still need to be some trauma to the individual providing the aid before there was going to be a concern of transmission?

A Correct. The other caveat is -- so mucosal surfaces also would include, like, the conjunctiva. So if it were a significant blood exposure with, you know, a lot of blood going into the eye, then that does increase the transmission risk.

Q And that would require a significant amount of blood going into the eye of the HIV-negative person, correct?

A Correct.

Q Chances of that are pretty low, yes?

A Correct.

Q Has there ever been a documented instance of HIV transmission on the battlefield?

A To my knowledge, no.

Q So in theory, it's possible that there could be a transmission, but we don't have proof that one has ever occurred in that manner?

MS. BERMAN: Asked and answered.

You can answer.

THE WITNESS: Correct.

BY MR. SCHOETTES:

Q I'm going to hand you what we will mark as Exhibit 3.

(Blaylock Deposition Exhibit Number 3 was

So those -- those types of training where you are physically having altercations with another service member.

Q How did you resolve the inquiry here?

MS. BERMAN: Objection. This is beyond the scope of what this witness is being offered to testify about.

But you can answer.

THE WITNESS: So this is something that we were looking at in revisions to Army regulation because this particular topic is not addressed in the current Army regulation. So it is something that we are addressing.

BY MR. SCHOETTES:

Q Do you think there is a significant risk of transmission via combatives?

MS. BERMAN: Objection.

BY MR. SCHOETTES:

Q I'm sorry, significant HIV transmission via combatives?

MS. BERMAN: Sorry. This is beyond the scope of what he's being offered to testify about.

But you can testify your personal opinion.

THE WITNESS: My personal opinion is

there's negligible risk to a service member with HIV engaging in combatives.

BY MR. SCHOETTES:

Q I'm sorry. Sticking with Exhibit 3 for one moment, the section that is redacted on page 1, can you tell me if it refers to potential changes related to combatives in AR 600-110?

MS. BERMAN: Objection. The items that are redacted in this exhibit are protected under the deliberative process privilege. And I'm going to instruct the witness not to answer about the substance of any of the redacted portions, if he even knows.

BY MR. SCHOETTES:

Q So I guess I'm trying to phrase it -- come up with a question that will allow me to be able to set aside and not be concerned about this document anymore.

So if it is about combatives, given the information that I just received -- the answer I just received about that being a negligible risk, and this is about changes regarding combatives, then I'm not so concerned about what it actually says. And that's why I'm asking if the discussion there is related to -- I'm not asking what it says

A Yes. That's what I'm saying.
Q Okay. I think I'm good there. You can put that document aside. Give me a second. I need to find this document to do this part of my outline.
(Pause.)
BY MR. SCHOETTES:
Q We're going to continue on and I will come back to this after we've taken a break.
I'm going to talk about topic 23 which is accessions and deployment policies for other conditions requiring daily medication. Are you familiar with the medical condition of dyslipidemia?
A Yes, I am.
Q What kind of treatment does dyslipidemia generally require?
A Generally, it requires a cholesterol-lowering medication, typically from a class we call statins.
Q Taken daily?
A Yes.
Q Generally one pill?
A Yes.
Q Once a day?

A Yes.

Q What is the accession policy for individuals with dyslipidemia?

A I don't believe it specifically mentions dyslipidemia as a limiting restriction to joining the military.

Q And if it's not listed specifically, then it would not be a bar to enlisting or commissioning?

A I believe there's a line in our accessions policy that says every medication can be looked at on an individual basis for consideration for whether it merits accessioning or not.

MS. BERMAN: Counsel, I just want to reiterate that this witness is here to provide medical testimony as it applies to these questions. We did offer someone to talk about accessions in a more policy-specific way. And deployment as well.

MR. SCHOETTES: Okay.

MS. BERMAN: But you --

MR. SCHOETTES: I just want to try to understand what portion of the topic -- I mean, I don't want to waste our time if he's not

testifying on the topic. So...

MS. BERMAN: As we discussed earlier, it's just -- he's going to talk about these conditions and how they might be different than HIV, might be treated same or different than HIV. But I think it's fine. You can --

MR. SCHOETTES: Okay.

MS. BERMAN: -- continue your questioning.

BY MR. SCHOETTES:

Q All right. So if a soldier is diagnosed with dyslipidemia after enlisting or commissioning, are they discharged?

A No.

Q If a soldier is required to start taking daily medication for dyslipidemia, are they discharged?

A No.

Q What is the deployment policy for individuals with dyslipidemia?

A So I don't know exactly what the deployment policy is with [sic] somebody with dyslipidemia, but if it is very well controlled on a once-daily statin regimen, they would be allowed to deploy.

Q And are individuals with dyslipidemia supplied with their medication during deployment -- well, let me go back.

How are individuals living with dyslipidemia supplied with their medication during deployment?

A So if they don't already bring a 270-day or whatever duration their deployment is, supply with them, they can sign up via TRICARE Express Scripts to have it mailed to them throughout their deployment.

Q If they go with 180-day supply on a 270-day deployment, how long into their deployment before they can request a refill of their prescription?

A I don't know the exact time frame that TRICARE would -- mandates for you before you can get a refill of a medication.

Q Would it take into account the fact that it might take some time for that refill to get to the individual who is deployed?

A I would hope so, but I can't tell you definitively.

Q And if the medication of a person with dyslipidemia was lost, stolen or destroyed while

deployed, would they be resupplied in the manner that we discussed earlier for all of their medications?

A Yes.

Q Besides for [sic] receiving treatment, are soldiers handled -- are soldiers with dyslipidemia handled differently in any respect?

MS. BERMAN: Objection. Vague.

BY MR. SCHOETTES:

Q I can ask a more specific question. Are individuals living with dyslipidemia referred into the DES under 1332.18?

A I don't know -- I don't know how to exactly address that, because I would imagine it would -- if they have very uncontrolled dyslipidemia that -- despite being on appropriate statins or other agents to reduce cholesterol, then they very well may be referred to the DES.

Q And to clarify, the DES is the Disability Evaluation System?

A Correct.

MS. BERMAN: And I want to reiterate that this witness is not being offered to talk about retentions, so...

MR. SCHOETTES: Right.

hypothyroidism?

A So if it goes untreated, then you develop -- in many cases, you can develop symptomatic hypothyroidism which is manifested by a number of symptoms to include extreme fatigue, weight gain, cold intolerance, constipation.

Q All things that could affect one's ability to perform one's duties as a soldier, correct?

A Correct.

Q What is the accession policy for individuals with hypothyroidism?

A Individuals with hypothyroidism are, if it's well controlled, are allowed to accession.

Q And if a service member is diagnosed with hypothyroidism after enlisting or commissioning, are they discharged?

A No.

Q If they're required to start taking daily medication for their hypothyroidism, are they discharged?

A No.

Q Do you know what the deployment policy is for individuals with hypothyroidism?

A As long as it's well controlled, then

deployment in terms of vision?

A Again, I would defer to AR 40-501 for exact details of that. I know that service members deploy with glasses and contact -- well, you're not supposed to deploy with contacts.

Q Okay. Are you saying you know that sometimes people do deploy with contacts?

A I don't know.

Q If a person were to lose or have their glasses destroyed, that could impact their ability to perform their duties, correct?

A Correct.

Q Then it would be pretty immediate, right?

A Correct.

Q Are you aware of other medical conditions other than those we've already discussed, that require daily medication or treatment to control that nonetheless people are allowed to access or deploy with?

A Off the top of my head, I can't think of anything in particular.

Q If you come up with anything, you'll let me know.

A Okay.

MR. SCHOETTES: I think I want to take a

maybe had not gotten all the way back down to suppressed at that point, in which case what do you do?

A We would still --

MS. BERMAN: Objection. Form.

THE WITNESS: We -- can I still answer?

MS. BERMAN: Yes.

THE WITNESS: We would still want to check a genotype because it might give us a glimpse into a new resistance panel and it may prompt us to switch that regimen.

BY MR. SCHOETTES:

Q But that would require at least a thousand copies if you used the one test?

A Right, 1,000 to 2,000 copies, yes.

Q Okay. What concerns, if any, is there around -- well, I guess we were just talking about this. Do you know what the likelihood is of resistance after treatment interruption?

MS. BERMAN: Objection. Vague and calls for speculation.

You can answer.

THE WITNESS: Yeah. I mean, it depends on a lot of different variables. So it's -- you are more likely to acquire resistance if you're

intermittently taking your medications. So one thing that we always try to couch [sic] our patients about is when you're -- sometimes what our patients do -- because, for various reasons, they may not come back in to get refills of their medications or run out of their meds -- sometimes what they do is they start spacing out the dosing of their medication. So they'll say, oh, I'll take it every other day or every third day to make it last longer. That's exactly how you develop resistance. So it's actually better to stop it cold turkey and then restart it up later. That's your best option for not developing resistance.

So it depends on if somebody is taking their meds intermittently to space them to -- or stops it altogether.

BY MR. SCHOETTES:

Q So in the context of lost medication, and it's a sustained stop, that would be less likely to develop resistance than someone intermittently taking their medication?

A Correct. The other thing that you have to take into account is the half life of the particular drug in the body. So there's different antiretroviral regimens that have longer half

lives or shorter half lives. So missing one or two medications of one drug might be not as -- might be less forgiving than missing one or two days of another drug.

Q And that's more of a concern in that intermittent drug-taking scenario --

A Yes.

Q -- than it would be in a full stop?

A Yes.

Q Because the half life on all of them is going to sort of run out relatively quickly and then there won't be anything that the virus could mutate around, because there's only one of the medications left, right?

A Correct.

MR. SCHOETTES: I think I'm done.

MS. BERMAN: Okay. I think we want to talk for a minute about whether I have any follow-up questions. And -- so if we want to go off the record for a minute, I may have a few more.

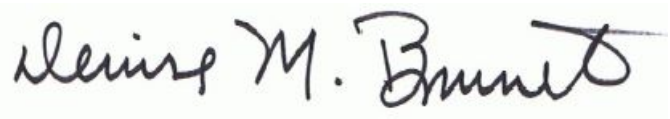
MR. SCHOETTES: Sounds good.

THE VIDEOGRAPHER: The time is 3:28 p.m. We are going off the record.

(Whereupon, a short recess was taken.)

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 26

DODI 6485.01 (1991 version): Human Immunodeficiency Virus (HIV) in Military Service Members

Department of Defense

DIRECTIVE

NUMBER 6485.1

March 19, 1991

Incorporating Change 1, August 10, 1992

ASD(HA)

SUBJECT: Human Immunodeficiency Virus-1 (HIV-1)

References: (a) Deputy Secretary of Defense Memorandum, "Policy on Identification, Surveillance, and Administration of Personnel Infected with Human Immunodeficiency Virus (HIV)," August 4, 1988 (hereby canceled)
(b) Deputy Secretary of Defense Memorandum "Recommendations for Revision of DoD Human Immunodeficiency Virus (HIV) Policies," March 8, 1988 (hereby canceled)
(c) Assistant Secretary of Defense (Health Affairs) Memorandum, "Policy on Clinical Evaluation, Staging and Disease Coding of Military Personnel Infected with Human Immunodeficiency Virus (HIV)," September 11, 1987 (hereby canceled)
(d) Assistant Secretary of Defense (Health Affairs) Memorandum, "The DoD HTLV-III Testing Program," December 5, 1985 (hereby canceled)
(e) through (p), see enclosure 1

1. PURPOSE

This Directive supersedes references (a) through (f) to update policy, responsibilities, and procedures on identification, surveillance, and administration of civilian and military personnel infected with HIV-1.

2. APPLICABILITY

This Directive applies to the Office of the Secretary of Defense, the Military Departments (including their Reserve components), the Chairman of the Joint Chiefs of Staff and the Joint Staff, the Unified and Specified Commands, and the Defense Agencies (hereafter referred to collectively as "the DoD Components"). The term "Military Services," as used herein, refers to the Army, the Navy, the Air Force, and the Marine Corps.

3. DEFINITIONS

3.1. Human Immunodeficiency Virus-1 (HIV-1). The virus most commonly associated with the Acquired Immune Deficiency Syndrome (AIDS) in the United States.

3.2. HIV-1 and/or AIDS Education Program. Any combination of information, education, and behavior-change strategies designed to facilitate behavioral alteration that will improve or protect health. Included are those activities intended to support or influence individuals in managing their own health through lifestyle decisions and self-care. Operationally, such programs include community, worksite, and clinical aspects using appropriate public health education methodologies.

3.3. Serologic Evidence of HIV-1 Infection. A reactive result given by a Food and Drug Administration (FDA)-approved enzyme-linked immunosorbent assay (ELISA) serologic test that is confirmed by a reactive and diagnostic immunoelectrophoresis test (Western blot (WB)) test on two separate samples.

3.4. Host Nation. A foreign nation to which DoD U.S. civilian employees are assigned to perform their official duties.

3.5. DoD Civilian Employees. Current and prospective DoD U.S. civilian employees, including appropriated and nonappropriated fund personnel. This does not include members of the family of DoD civilian employees, employees of, or applicants for, positions with contractors performing work for the Department of Defense, or their families.

3.6. Epidemiological Assessment. The process by which personal and confidential information on the possible modes of transmission of HIV-1 are obtained from an HIV-1 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-1 and to prevent further transmission of HIV-1.

4. POLICY

It is DoD policy to:

4.1. Deny eligibility for appointment or enlistment for Military Service to individuals with serologic evidence of HIV-1 infection.

4.2. Screen active duty (AD) and Reserve component military personnel periodically for serologic evidence of HIV-1 infection.

4.3. Refer AD personnel with serologic evidence of HIV-1 infection for a medical evaluation of fitness for continued service in the same manner as personnel with other progressive illnesses, as specified in DoD Directive 1332.18 (reference (g)). Medical evaluation shall be conducted in accordance with the standard clinical protocol, as described in enclosure 2. Individuals with serologic evidence of HIV-1 infection who are fit for duty shall not be retired or separated solely on the basis of serologic evidence of HIV-1 infection. AD personnel with serological evidence of HIV-1 infection or who are ELISA repeatedly reactive, but WB negative or indeterminate, shall be advised to refrain from donating blood.

4.4. Deny eligibility for extended AD (duty for a period of more than 30 days) to those Reserve component members with serologic evidence of HIV-1 infection (except under conditions of mobilization and on the decision of the Secretary of the Military Department concerned). Reserve component members who are not on extended AD or who are not on extended full-time National Guard duty, and who show serologic evidence of HIV-1 infection, shall be transferred involuntarily to the Standby Reserve only if they cannot be utilized in the Selected Reserve.

4.5. Retire or separate AD or Reserve Service members infected with HIV-1 who are determined to be unfit for further duty, as implemented in reference (g).

4.6. Ensure the safety of the blood supply through policies of the Armed Services Blood Program Office, the FDA guidelines, and the accreditation requirements of the American Association of Blood Banks.

4.7. Comply with applicable statutory limitations on the use of the information obtained from a Service member during, or as a result of, an epidemiological assessment interview and the results obtained from laboratory tests for HIV-1, as provided in this Directive. (See enclosure 3.)

4.8. Control transmission of HIV-1 through an aggressive disease surveillance and health education program.

4.9. Provide education and voluntary HIV-1 serologic screening for DoD healthcare beneficiaries (other than Service members).

4.10. Comply with host-nation requirements for HIV-1 screening of DoD civilian employees, as described in enclosure 8.

5. RESPONSIBILITIES

5.1. The Assistant Secretary of Defense (Health Affairs), in coordination with the Assistant Secretary of Defense (Force Management and Personnel) (ASD(FM&P)), the General Counsel of the Department of Defense (GC, DoD), and the Assistant Secretary of Defense (Reserve Affairs), is responsible for establishing policies, procedures, and standards for the identification, surveillance, and administration of personnel infected with HIV-1. The Assistant Secretary of Defense (Health Affairs) (ASD(HA)) shall provide overall policy guidance and approval for the HIV-1 and/or AIDS education and information efforts and shall establish the HIV-1 and/or AIDS Information and Education Coordinating Committee.

5.2. The Secretaries of the Military Departments shall establish Service policies, procedures, and standards for the identification, surveillance, education, and administration of personnel infected with HIV-1, based on and consistent with all sections of this Directive.

5.3. The Assistant Secretary of Defense (Force Management and Personnel) shall establish and revise policies governing HIV-1 screening of DoD civilian employees assigned to, performing official travel in, or deployed on ships with ports of call at host nations, in coordination with the ASD(HA), the Assistant Secretary of Defense (International Security Affairs), and the GC, DoD.

5.4. The Assistant Secretary of Defense (International Security Affairs) shall identify or confirm host-nation HIV-1 screening requirements for DoD civilians, transmit this information to the ASD(FM&P), and coordinate requests for screening with the Department of State.

5.5. The Heads of the DoD Components shall implement HIV-1 screening policies and procedures for DoD civilian employees identified in paragraph 5.3., above, and shall take the following actions:

5.5.1. Report newly established host-nation HIV-1 screening requirements to the ASD(FM&P) and provide sufficient background information to support a decision. This reporting requirement is exempt from licensing, in accordance with DoD 7750.5-M, subparagraph 5.4.2. (reference (h)).

5.5.2. Develop and distribute policy implementing instructions.

5.5.3. Establish procedures to notify individuals who are evaluated as HIV-1 seropositive and provide initial counseling to them.

6. PROCEDURES

6.1. Applicants for Military Service and, periodically, AD and Reserve component military personnel shall be screened for serologic evidence of HIV-1 infection. Testing and interpretation of results shall be in accordance with the procedures in enclosure 4. Test results shall be reported to the Reportable Disease Database, as described in the ASD(HA) Memorandum (reference (i)).

6.2. Applicants for enlisted service shall be screened at the Military Entrance Processing Stations or the initial point of entry to Military Service. Applicants who enlist under a delayed enlistment program, but before entry on AD and who exhibit serologic evidence of HIV-1 infection, may be discharged due to erroneous enlistment.

6.3. Officer candidates shall be screened during their preappointment and/or pre-contracting physical examination. The disposition of officer applicants who are ineligible for appointment due to serologic evidence of HIV-1 infection shall be in accordance with the procedures in enclosure 5.

6.4. Applicants for Reserve components shall be screened during the normal entry physical examinations or in the pre-appointment programs established for officers. Those individuals with serologic evidence of HIV-1 infection who are required to meet accession medical fitness standards to enlist, or be appointed, are not eligible for Military Service with the Reserve components.

6.5. Initial testing and periodic retesting of AD and Reserve component personnel shall be accomplished in the priority listed in enclosure 6.

6.6. AD personnel (including Active Guard and/or Reserve) who exhibit serologic evidence of HIV-1 infection shall receive a medical evaluation in accordance with the procedures in enclosures 2, 6, and 7. Guard and Reserve personnel, not on extended AD, must obtain a medical evaluation from a civilian physician.

6.7. The Head of each Military Service shall appoint an HIV-1 and/or AIDS education program coordinator to serve as the focal point for all HIV-1 and/or AIDS education program issues and to integrate the educational activities of the medical and personnel departments.

6.8. An HIV-1 and/or AIDS Information and Education Coordinating Committee shall be established to enhance communication among the Military Services, recommend joint education policy and program actions, review education program implementation, and recommend methodologies and procedures for program evaluation. That committee shall be chaired by a representative of the ASD(HA). Members shall include two representatives from the Office of the ASD(FM&P) and the HIV-1 and/or AIDS education program coordinator from each Military Service. Additional members shall represent the Armed Services Blood Program Office and, on an ad hoc basis, the OASD(HA). Policy and program proposals shall be coordinated with the Secretaries of the Military Departments.

6.9. The Head of each Military Service shall prepare a plan for the implementation of a comprehensive HIV-1 and/or AIDS education program that includes specific objectives with measurable action steps. The plan shall address information, education, and behavior-change strategies, as described in enclosure 6.

6.10. Civilians may not be mandatorily tested for serologic evidence of HIV-1 infection except as necessary to comply with valid host-nation requirements for screening of DoD employees. Procedures for mandatory screening of DoD civilians shall be in accordance with enclosure 8.

6.11. The medical assessment of each exposure to, and/or case of, HIV-1 infection seen at a military medical treatment facility (MTF) shall include an epidemiological assessment of the potential transmission of HIV-1 to other persons at risk of infection, including sexual and other intimate contacts and family of the patient, and transfusion history. The occurrence of HIV-1 infection or serologic evidence of HIV-1 infection may not be used as a basis for any disciplinary action against an individual, except as described in enclosure 3.

6.12. Each military medical service shall conduct an ongoing clinical evaluation of each AD Service member with serologic evidence of HIV-1 infection at least annually. CD4 lymphocyte percentages or counts shall be monitored at least every 6 months. Appropriate preventive medicine counseling shall also be provided to all individual patients and public health education materials shall be made available to that medical services' beneficiary population. Each military medical service shall conduct longitudinal clinical evaluations of AD Service members with serologic evidence of HIV-1 infection and shall prepare internal reports to facilitate timely review and reassessment of current policy guidelines.

6.13. All military MTFs shall notify promptly the cognizant military health authority, when there is clinical or laboratory evidence indicative of infection with HIV-1 in accordance with enclosure 9.

6.14. The Secretary of each Military Department shall ensure that a mechanism is established to gather data on the epidemiology of HIV-1 infection of its members. Such epidemiological research shall be accomplished to ensure appropriate protection of information given by the Service member on the means of transmission.

6.15. The Department of the Army, as the Lead Agency for infectious disease research within the Department of Defense, shall budget for and fund tri-Military Department DoD HIV-1 research efforts, in accordance with guidance provided by the ASD(HA). The research program shall focus on the epidemiology and natural history of HIV-1 infections in military and military associated populations; on improving the methods for rapid diagnosis and patient evaluation; and on studies of the immune response to HIV-1 infection, including the potential for increased risk in the military operational environment.

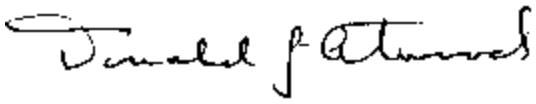
6.16. Service members with serologic evidence of HIV-1 infection shall be assigned within the United States, including Alaska, Hawaii, and Puerto Rico, due to the high priority assigned to the continued medical evaluation of military personnel. The Secretaries of the Military Departments may restrict such individuals to non-deployable units or positions for purposes of force readiness. To protect the health and safety of Service members with serologic evidence of HIV-1 infection and of other Service members (and for no other reason), the Secretaries of the Military Departments may, on *the basis of an evaluation consistent with established Service procedures for other medical conditions*, limit assignment of HIV-1-infected individuals on the nature and location of the duties performed in accordance with operational requirements.

6.17. AD and Reserve component personnel with serologic evidence of HIV-1 infection shall be retained or separated in accordance with enclosure 10.

6.18. The ASD(HA), in coordination with the Heads of the Military Services, shall revise enclosures 2, 4, 6, and 7, as appropriate. The ASD(FM&P) shall revise enclosure 8, as appropriate. Revisions under this paragraph shall be coordinated with GC, DoD. *The ASD(HA) shall issue policy guidance on the prevention of HIV-1 transmission to patients during exposure-prone invasive procedures.*

7. EFFECTIVE DATE AND IMPLEMENTATION

This Directive is effective immediately. Forward two copies of implementing documents to the Assistant Secretary of Defense (Health Affairs) within 90 days.



Donald J. Atwood
Deputy Secretary of Defense

Enclosures - 10

E1. References, continued
E2. Standard Clinical Protocol
E3. Limitations on the Use of Information
E4. HIV-1 Testing and Interpretation of Results
E5. Administration of Officer Applicants
E6. Disease Surveillance and Health Education
E7. Procedure for Evaluating T-Helper Cell Count
E8. HIV-1 Testing of DoD Civilian Employees
E9. Personnel Notification and Epidemiological Investigation
E10. Retention and Separation

E1. ENCLOSURE 1

REFERENCES, continued

(e) Assistant Secretary of Defense (Health Affairs) Memorandum, "Military Implementation of Public Health Service Provisional Recommendations Concerning Testing Blood and Plasma for Antibodies to HTLV-III," July 17, 1985 (hereby canceled)

(f) DoD Instruction 1438.4, "Compliance with Host Nation Human Immunodeficiency Virus (HIV) Screening Requirements for DoD Civilian Employees," December 5, 1988 (hereby canceled)

(g) DoD Directive 1332.18, "Separation from the Military Service by Reason of Physical Disability," February 25, 1986

(h) DoD 7750.5-M, "DoD Procedures for Management of Information Requirements," November 1986

(i) Assistant Secretary of Defense (Health Affairs) Memorandum, "DoD Reportable Disease Database," December 30, 1985

(j) Chapter 47 of title 10, United States Code, "Uniform Code of Military Justice (UCMJ)"

(k) Assistant Secretary of Defense (Force Management and Personnel) Memorandum, "Information and Guidance on Human Immunodeficiency Virus (HIV)," January 22, 1988

(l) Federal Personnel Manual Bulletin 792-42, "AIDS in the Workplace, March 24, 1988

(m) Section 794 of title 29, United States Code, "Section 504 of the Rehabilitation Act of 1973," as amended

(n) DoD Directive 5400.11, "Department of Defense Privacy Program," June 9, 1982

(o) Assistant Secretary of Defense (Health Affairs) Memorandum, "HIV Testing and Look Back Guidelines for Homologous Blood Donations," January 11, 1989

(p) Public Law 93-579, "Privacy Act of 1974," December 31, 1974 (5 U.S.C. 552a)

E2. ENCLOSURE 2

STANDARD CLINICAL PROTOCOL

E2.1. MEDICAL EVALUATION

E2.1.1. A complete medical evaluation shall be accomplished, at least annually, and T-cell subset evaluation at least every 6 months, on military personnel with serologic evidence of HIV-1 infection. This medical evaluation shall be documented in a manner consistent with the Head of the Medical Evaluation Board requirements of each Service.

E2.1.2. Minimally, the medical workup shall include the following:

E2.1.2.1. An epidemiological assessment.

E2.1.2.2. History and physical examination, to include a neurological and neuropsychiatric evaluation.

E2.1.2.3. Complete blood count with differential, platelet count, red blood cell indices, and erythrocyte sedimentation rate.

E2.1.2.4. Total lymphocyte count, total T-lymphocyte cell count, and absolute CD4 and CD8 levels.

E2.1.2.5. Intradermal skin tests (intermediate purified protein derivative standard tuberculin units, mumps 40 colony forming units (CFU) per milliliter (ml), trichophyton 1:30, candida 1:10, and tetanus 1:10).

E2.1.2.6. HIV-1 ELISA and confirmation test.

E2.1.2.7. Chest x-ray (posterior-anterior and lateral) on the initial evaluation. Subsequent chest x-rays shall be ordered when clinically indicated.

E2.1.3. Because of the strong association of HIV-1 infection with other sexually transmitted diseases, the workup minimally shall include evaluative tests for syphilis, hepatitis, urethritis, cervicitis, or proctitis.

E2.1.4. The Surgeon General of each Military Department shall designate DoD Component military MTFs, which are to be used to evaluate and treat individuals with serologic evidence of HIV-1 infection. The initial evaluation and annual reevaluation of Service members with serologic evidence of HIV-1 infection shall ordinarily be

accomplished within the individual's respective Military Department. In the case of symptomatic individuals, subsequent hospitalizations or continuation of care following the initial evaluation may be at any designated MTF within the Department of Defense.

E2.1.5. A frozen blood specimen on all HIV-1-positive individuals shall be maintained for at least 3 years at -70 Celsius. The Military Departments shall maintain central serum banks.

E2.1.6. A mental health assessment and social history shall be elicited that includes current emotional and social support, depression, interpersonal relationships, and work adjustment. Sociodemographic and psychosocial risk factors relating to suicide, drug and alcohol abuse, and major mental illness shall be emphasized. Subtle signs of dementia shall also be sought.

E2.1.6.1. The mental health evaluation may be performed by a psychiatric nurse, psychiatric social worker, psychologist, trained nonpsychiatric physician, or psychiatrist, depending on local MTF resources.

E2.1.6.2. Specific diagnostic and treatment modalities shall depend on clinical and research resources at each site, but may include psychiatric rating scales and behavioral intervention strategies. Examples of testing methods that shall be employed include the following: Beck Depression Index, Michigan Alcohol Screening Test, Perceived Social Support Questionnaire, Symptom Check List 90-Revised, Wechsler Memory Scale-Revised, Halstead-Reitan, and Trailmaking B.

E2.1.6.3. Psychiatric consultation shall be sought for further evaluation, if concerns exist for fitness for duty, or if this screening evaluation suggests that more detailed psychiatric evaluation is needed. If the patient has persistent evidence of diminished intellectual skills, personality changes, and motor impairment, the patient shall require specialized studies (neurologic studies, computed tomography or magnet resonance imaging, lumbar puncture, psychiatric examination, and neuropsychologic testing) to evaluate the possible presence of a HIV-1-related mental or neurological syndrome.

E2.2. ARMED FORCES HIV-1 DISEASE CLASSIFICATION

E2.2.1. All patients with either serologic evidence of HIV-1 infection or a positive virus isolation shall be staged according to the following scheme:

Stage	HIV-1 Antibody and/or Virus Isolation	Chronic Lymph-adenopathy	T-Helper Cells per Cubic Millimeter (mm^3)	Delayed Hyper-sensitivity	Thrush	Opportunistic Infection
1	+	-	GT400	WNL		
2	+	+	GT400	WNL		
3	+	+/-	LT400	WNL		
4	+	+/-	LT400	P		
5	+	+/-	LT400	P/C	+	
6	+	+/-	LT400	P/C	+/-	+

(GT = greater than, LT = less than)

E2.2.2. Because of the natural variability of the number of T-helper cells, classification of HIV-1 infections shall not be based on a single T-helper cell determination. A second count at an interval of at least 1 month is required if the initial CD4 absolute number is less than 400 cells per mm^3. The higher of the two counts shall be used for staging. All HIV-1-infected personnel shall have CD4 lymphocyte percentages or counts monitored at least every 6 months.

E2.2.3. There are a small number of patients who cannot be readily staged using the scheme in section E2.2. of this enclosure, above. When a patient falls between two stages the lower stage shall be selected; e.g., select stage 4, if patient falls between stages 4 and 5.

E2.2.4. Stages 1 through 6 require demonstration of the presence of HIV-1antibody to structural proteins and/or HIV-1 virus isolation.

E2.2.5. An individual will occasionally be found with at least 400 T-helper cells per mm^3 who demonstrates partial or complete cutaneous anergy. In staging, if the CD4 number is 400 cells per mm^3, or greater, the individual shall be placed in stage 1 or 2.

E2.2.6. Stage 5 is defined by the occurrence of either complete anergy, or thrush, microscopically confirmed in a patient with less than 400 CD4 cells per mm^3.

E2.2.7. The presence of symptoms is denoted by the addition of the letter B after the stage; e.g., stage 5B. Symptoms are defined as fever greater than 100.5 Fahrenheit

for 3 weeks, unexplained weight loss of greater than 10 percent of body weight over 3 months, night sweats for at least 3 weeks, or chronic diarrhea for at least 1 month. Many of these patients can be documented to have an occult opportunistic infection (OI) by a careful and complete reevaluation.

E2.2.8. Kaposi's sarcoma is designated by adding the letter K after the appropriate class; e.g., stage 4K. Current evidence suggests that this neoplastic process is not dependent on severe T-helper cell depletion.

E2.2.9. The occurrence of other neoplasms is designated by adding the letter N after the appropriate class; e.g., stage 4N.

E2.2.10. Central nervous system (CNS) HIV-1 is neurologic disease or secondary psychiatric disease (demyelinating disease, encephalopathy, and/or neuropathy) as a result of infection of the nervous system by HIV-1 and is designated by adding CNS after the appropriate stage; e.g., stage 4CNS. An abnormal cerebrospinal fluid (e.g., pleocytosis, increased cerebrospinal fluid protein, increased cerebrospinal fluid IgG, viral isolation, or oligoclonal bands) does not alone warrant this designation.

E2.2.11. HIV-1 antibody is defined as the presence of antibody to the structural proteins of HIV-1, as determined by WB techniques or supplemental tests. (See enclosure 4, subparagraph E4.4.4.1.) HIV-1 virus isolation also fulfills criteria to document infection.

E2.2.12. Chronic lymphadenopathy is defined as two or more extrainguinal sites with lymph nodes greater than, or equal to, 1 centimeter in diameter that persist for more than 3 months.

E2.2.13. T-helper cells are expressed as cells per mm^3. Quantitative depletion must be persistent for at least 1 month to be placed in stage 3 or a higher stage.

E2.2.14. Delayed hypersensitivity is defined as within normal limits (WNL) when an intact cutaneous response (mean diameter of induration greater than, or equal to, 5 millimeters) to at least two of the following four intradermal test antigens is observed: tetanus 1:10, trichophyton 1:30, mumps 40 CFU per ml, and candida 1:10. A partial response is defined as an intact cutaneous response to only one of those four antigens. The letter "C" represents complete cutaneous anergy to all four test antigens.

E2.2.15. Thrush is defined as clinical oral candidiasis including a positive potassium hydroxide (KOH) preparation or yeast seen on gram stain.

E2.2.16. OI is present when infections such as pneumocystis carinii pneumonia, CNS or disseminated toxoplasmosis, chronic cryptosporidiosis, candida esophagitis, disseminated histoplasmosis, CNS or disseminated cryptococcosis, disseminated atypical mycobacterial disease, extrapulmonary tuberculosis, disseminated nocardiosis, disseminated cytomegalovirus, or chronic mucocutaneous herpes simplex occur. Other disseminated or chronic nonself-limited infections with agents in which cellular immunity plays a pivotal role in host defense (i.e., viral, parasitic, fungal, mycobacterial, or certain other bacterial agents) should be anticipated to cause opportunistic disease in patients with stages 5 and 6. Kaposi's sarcoma solely does not fulfill staging criteria for stage 6.

E2.3. MEDICAL RECORD CODING OF HIV-1 INFECTIONS

The MTFs shall use both the 042-044 and 795.8 codes from the International Classification of Disease, 9th Revision, Clinical Modification (ICD-9-CM). The code extenders 795.8--1 to 795.8--9 were developed to support the DoD classification system to indicate staging. The appropriate 795.8 code shall be used when an individual is evaluated by a MTF. Per DoD disease and procedure classification ICD-9-CM coding guidelines, they can be used alone, following the initial screening process, or in conjunction with the 042-044 codes. The following 042-044 codes describe the site of infection and are compatible with civilian practice:

E2.3.1. These codes shall be used only on inpatient records:

CODE	DESCRIPTION
042.0	HIV-1 infection with specified infections
042.1	HIV-1 infection causing other specified infections
042.2	HIV-1 infection with specified malignant neoplasms
042.9	AIDS unspecified
043.0	HIV-1 infection causing lymphadenopathy
043.1	HIV-1 infection causing specified diseases of CNS
043.2	HIV-1 infection causing other disorders of immune mechanism
043.3	HIV-1 infection causing other specified conditions
043.9	AIDS-related complex with or without other conditions
044.0	HIV-1 infection causing specific acute infections
044.9	HIV-1 infection unspecified
795.8-1	HIV-1 (HIV-1 antibody positive stage 1 of infection)
795.8-2	As above, stage 2 of infection
795.8-3	As above, stage 3 of infection
795.8-4	As above, stage 4 of infection
795.8-5	As above, stage 5 of infection
795.8-6	As above, stage 6 of infection
795.8-9	HIV-1 antibody positive, stage of infection unspecified

E2.3.2. The following codes are no longer authorized for use, having been replaced by the 759.8 code with extenders, as in paragraph E2.3.1. of this enclosure, above. Records should be updated by replacing the following with the current approved code:

V73.71	HIV-1 antibody positive, stage 1 of infection
V73.72	As above, stage 2 of infection
V73.73	As above, stage 3 of infection
V73.74	As above, stage 4 of infection
V73.75	As above, stage 5 of infection
V73.76	As above, stage 6 of infection
V73.79	As above, stage of infection unspecified

E2.3.3. The following codes shall be used only on outpatient records:

V72.60	Serologic test only - HIV-1 antibody negative (ELISA or comparable screening test negative), a single positive ELISA that is negative and on repeat ELISA testing that is negative
V72.61	Serologic test only - HIV-1 antibody unconfirmed (repeatedly reactive ELISA with negative WB)
V72.62	Serologic test only - HIV-1 antibody positive (WB or comparable antibody assay positive)
V72.69	Other laboratory examination

E2.4. DISPOSITION OF INDIVIDUALS INFECTED

E2.4.1. Fitness for duty determinations shall be in accordance with DoD Directive 1332.18 (reference (g)). The fitness for duty determination shall not be based solely on the Armed Forces HIV-1 disease classification.

E2.4.2. Service members infected with HIV-1 shall be referred to a Medical Evaluation Board, regardless of the clinical stage of the disease, if the Service member shows signs of immunological deficiency or a progressive illness. Signs of immunological deficiency include persistent reduction in the level of T-helper lymphocytes below 300 cells per mm^3 for greater than 1 month without other demonstrable cause; reduced or absent delayed hyper-sensitivity, 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. Signs of a progressive clinical illness include development of neurological manifestations; Kaposi's sarcoma; other lymphoreticular malignancies; thrombocytopenia; diffuse, persistent lymphadenopathy; or unexplained weight loss, diarrhea, anorexia, fever, malaise, or fatigue. The Walter Reed staging system may not be the sole criterion for evaluations of fitness for duty in Medical Evaluation Board reports.

E3. ENCLOSURE 3

LIMITATIONS ON THE USE OF INFORMATION

E3.1. LIMITATIONS OF RESULTS

E3.1.1. Results obtained from laboratory tests performed under this Directive may not be used as the sole basis for separation of a Service member. Those results may be used to support a separation based on physical disability or as specifically authorized by any section in this Directive. This paragraph shall not preclude use of such laboratory test results in any other manner consistent with law or regulation.

E3.1.2. Laboratory test results confirming the serologic evidence of HIV-1 infection may not be used as an independent basis for any adverse administrative action or any disciplinary action, including punitive actions under the UCMJ (10 U.S.C. 47, reference (j)). However, such results may be used for other purposes including, but not limited to, the following:

E3.1.2.1. Separation under the accession testing program.

E3.1.2.2. Voluntary separation for the convenience of the Government.

E3.1.2.3. Other administrative separation action authorized by DoD policy.

E3.1.2.4. In conducting authorized Armed Services Blood Program Look Back activities.

E3.1.2.5. Other purposes (such as rebuttal or impeachment) consistent with law or regulation (e.g., the Federal or Military Rules of Evidence or the rules of evidence of a State), including to establish the HIV-1 seropositivity of a Service member when:

E3.1.2.5.1. The Service 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.

E3.1.2.5.2. HIV-1 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 (reference (j)), or under the code of a State or the United States).

E3.1.2.5.3. HIV-1 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-1 positive Service member is convicted of an act of rape committed after being informed that he is HIV-1 positive).

E3.2. LIMITATIONS ON THE USE OF INFORMATION OBTAINED IN THE EPIDEMIOLOGICAL ASSESSMENT INTERVIEW

E3.2.1. Information obtained from a Service member during, or as a result of, an epidemiological assessment interview may not be used against the Service member in the following:

E3.2.1.1. A court-martial.

E3.2.1.2. Line of duty determination.

E3.2.1.3. Nonjudicial punishment.

E3.2.1.4. Involuntary separation (other than for medical reasons).

E3.2.1.5. Administrative or punitive reduction-in-grade.

E3.2.1.6. Denial of promotion.

E3.2.1.7. An unfavorable entry in a personnel record.

E3.2.1.8. A bar to reenlistment.

E3.2.1.9. Any other action considered by the Secretary of the Military Department concerned to be an adverse personnel action.

E3.2.2. The limitations in paragraph E3.2.1. of this enclosure, above, 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 Service member or to disciplinary or other action based on independently derived evidence.

E3.2.3. The limitations in paragraph E3.2.1. of this enclosure, above, do not apply to, *the basis of an evaluation consistent with established Service procedures for other medical conditions*, non-adverse personnel actions, such as:

E3.2.3.1. Reassignment.

E3.2.3.2. Disqualification (temporary or permanent) from a personnel reliability program.

E3.2.3.3. Denial, suspension, or revocation of a security clearance.

E3.2.3.4. Suspension or termination of access to classified information.

E3.2.3.5. 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.

E3.3. GENERAL

Except as authorized by this Directive, if any such personnel actions are taken because of, or are supported by, serologic evidence of HIV-1 infection or information described in section E3.1. of this enclosure, above, 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 that an individual has serologic or other evidence of infection with HIV-1 is not an unfavorable entry in a personnel record.

E4. ENCLOSURE 4

HIV-1 TESTING AND INTERPERTATION OF RESULTS

E4.1. LABORATORIES

E4.1.1. Either in-house or contract laboratories shall be used to perform the initial screening test on specimens collected from Service members.

E4.1.2. Confirmatory testing shall be limited to as few laboratories per Service as possible, since the confirmatory test is subjective and tight controls must be maintained on both the procedure and interpretation of results.

E4.1.3. After awarding a contract, final approval of the laboratory shall be contingent on an inspection by the appropriate Military Service. The laboratory must correctly identify 95 percent of the samples in an open panel (20 specimens) provided by a DoD reference laboratory. The inspection shall focus on the laboratory facilities, standard operation procedure manuals, training of technicians, specimen handling procedures, reporting capabilities, and internal quality control procedures.

E4.1.4. The Heads of the Military Services shall ensure the conduct of a semiannual quality assurance inspection of each contract laboratory.

E4.1.5. All specimens positive on the confirmatory test shall be stored frozen in the Services' central serum bank.

E4.2. SPECIMEN COLLECTION AND HANDLING

E4.2.1. Blood samples shall be collected using appropriate vacutainer tubes.

E4.2.2. Minimally, each sample shall have a label containing the individual's social security number, the date and time of collection, and a laboratory assigned number.

E4.2.3. Samples shall be centrifuged and serum separated within 6 hours of collection.

E4.2.4. Specimens shall be refrigerated before the initial test. If the initial test is not conducted within 7 days, or the date at which the sample was collected is unknown, the specimen shall be frozen.

E4.2.5. Cold packs shall be used to maintain specimens at refrigerated temperatures during transit between laboratories.

E4.3. INITIAL TEST

E4.3.1. The initial test shall be conducted using an FDA-approved ELISA test kit and results interpreted according to the manufacturer's package insert.

E4.3.2. The laboratory shall establish an internal quality control program that includes a minimum total of 10 percent quality control samples per batch (e.g., standards, negatives, positive controls, and blind samples).

E4.3.3. All controls and blinds shall be 100-percent correct before the entire batch results are considered acceptable.

E4.4. CONFIRMATORY TEST

E4.4.1. Each laboratory performing the WB test shall conduct the test using a FDA-approved procedure.

E4.4.2. Minimally, the laboratory shall validate its procedure using a protocol that establishes the accuracy, precision, and reproducibility of the method.

E4.4.3. The internal quality control program shall include a minimum total of 20-percent quality control samples (e.g., standards, negatives, positive controls, or blind samples).

E4.4.4. WB test results shall be interpreted, as follows:

E4.4.4.1. Positive, when it exhibits at least two of three bands at p24, gp41, and gp120 and/or 160.

E4.4.4.2. Negative, when it exhibits no bands.

E4.4.4.3. An indeterminate shall be resolved using nondiagnostic tests of a different technology. The following scheme shall be used to report results when supplemental testing is conducted to resolve nondiagnostic WB results:

Lab Test	Result						
First ELISA	-	+	+	+	+	+	+
Second and/or third ELISA	-	+	+	+	+	+	
WB		-	+	+/-	+/-	+/-	
Supplemental				-	+	+/-	
Laboratory Report	-	-	-	+	-	+	-

+ = positive
= negative
+/- = nondiagnostic

E4.5. REFERENCE LABORATORY AND EXTERNAL PROFICIENCY TESTING

E4.5.1. The Secretaries of the Military Departments shall establish a reference laboratory to provide panels of specimens to its blood banks conducting ELISA testing, to its contract laboratories conducting WB testing, and to the reference laboratories of the other Services.

E4.5.2. The open panels shall consist of 20 specimens containing approximately 50-percent negatives and 50-percent positives.

E4.5.3. The panels shall be provided at least quarterly. Each laboratory shall report correctly 95 percent of the samples.

E4.5.4. The Secretaries of the Military Departments shall retain the responsibility to interpret all confirmatory results on specimens analyzed by contract laboratories.

E4.5.5. The specific requirements, determined by each Military Department, for the external proficiency testing program (number of blind and open samples, frequency criteria for acceptable performance, etc.) shall depend on the workload of each laboratory doing confirmatory testing.

E5. ENCLOSURE 5

ADMINISTRATION OF OFFICER APPLICANTS

Administration of officer applicants who are ineligible for appointment, due to serologic evidence of HIV-1 infection, shall be in accordance with the following provisions:

E5.1.1. Enlisted members who are candidates for appointment through Officer Candidate School (OCS) or Officer Training School (OTS) programs shall be disenrolled immediately from the program. If OCS and/or OTS is the individual's initial entry training, the individual shall be discharged. If the sole basis for discharge is serologic evidence of HIV-1 infection, an honorable or entry-level discharge, as appropriate, shall be issued. 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 regulations for enlisted personnel.

E5.1.2. Individuals in pre-appointment programs, such as Reserve Officer Training Corps (ROTC) and Health Professions Scholarship Program participants, shall be disenrolled from the program. However, the Head of the Military Service concerned, or the designated representative, may delay disenrollment to the end of the academic term (i.e., semester, quarter, or similar period) in which serologic evidence of HIV-1 infection is confirmed. Disenrolled participants shall be permitted to retain any financial support through the end of the academic term in which the disenrollment is effected. Financial assistance received in these programs is not subject to recoupment, if the sole basis for disenrollment is serologic evidence of HIV-1 infection.

E5.1.3. Service academy cadets, midshipmen, and personnel attending the Uniformed Services University of the Health Sciences (USUHS) shall be separated from the respective Service academy or USUHS and discharged. The Head of the Military Service concerned, or the designated representative, may delay separation to the end of the current academic year. A cadet or midshipman granted such a delay in the final academic year, who is otherwise qualified, may be graduated without commission and, thereafter, discharged. If the sole basis for discharge is serologic evidence of HIV-1 infection, an honorable discharge shall be issued.

E5.1.4. Commissioned officers in DoD-sponsored professional education programs leading to appointment in a professional military specialty (including, but not limited to, medical, dental, chaplain, and legal and/or judge advocate) shall be disenrolled from the program at the end of the academic term in which serologic

evidence of HIV-1 infection is confirmed. Disenrolled officers shall be administered in accordance with Service regulations. Except as specifically prohibited by statute, any additional Service obligation incurred by participation in such programs shall be waived, and financial assistance received in these programs shall not be subject to recoupment. Periods spent by such officers in these programs shall be applied fully toward satisfaction of any preexisting Service obligation.

E5.1.5. All personnel disenrolled from officer programs who are to be separated shall be given appropriate counseling, to include preventive medicine counseling and advice to seek treatment from a civilian physician.

E6. ENCLOSURE 6

DISEASE SURVEILLANCE AND HEALTH EDUCATION

E6.1. GENERAL

Prevention of harm to personnel with serologic evidence of HIV-1 infection and control of transmission of HIV-1, a communicable disease, are dependent on an aggressive disease surveillance and health education program. Those persons whose behaviors put them and others at high risk of infection, followed by those who are infected, shall receive the highest priority for information, education, and behavior change programs.

E6.2. DISEASE SURVEILLANCE

E6.2.1. Periodic retesting of military personnel shall be accomplished in the following priority order:

E6.2.1.1. Military personnel serving in, or subject to deployment on short notice to, areas of the world with a high risk of endemic disease or with minimal existing medical capability.

E6.2.1.2. Military personnel serving in, or pending assignment to, all other overseas permanent duty stations.

E6.2.1.3. Military personnel serving in units subject to deployment overseas.

E6.2.1.4. Other military personnel or units deemed appropriate by the respective Military Department, such as medical personnel involved in the care of HIV-1 infected patients, patients being treated for sexually transmitted diseases or presenting at sexually transmitted disease clinics, patients being treated for alcohol and drug abuse or admitted to alcohol and drug rehabilitation units, and patients at prenatal clinics.

E6.2.1.5. All remaining military personnel in conjunction with routinely scheduled periodic physical examinations.

E6.2.2. AD personnel (to include Active Guard and/or Reserve and/or Selected Reserve) with serologic evidence of HIV-1 infection shall receive a medical evaluation to determine the status of their potential infection and the potential adverse consequences to the individual of serving in a particular geographic region. The standard clinical protocol in enclosure 2 shall be used to ensure consistent evaluation and classification of patients at all military MTFs. Documentation of the medical evaluation shall be equivalent to the medical board component of the Physical Evaluation Board process.

E6.2.3. Reserve component members not on extended AD are ineligible for medical evaluation (beyond initial testing and counseling) in military MTFs. Therefore, those Reserve component individuals shall be counseled on the significance of a positive HIV-1 antibody test and referred to their private physicians for medical care and counseling.

E6.2.4. The surveillance of military personnel for HIV-1 infection is being accomplished for force readiness reasons. It is also essential that all reasonable efforts be made to afford protection and education to our other healthcare beneficiaries on effective means to contain this disease.

E6.2.5. For medical and public health purposes, an appropriate and vigorous HIV-1 and/or AIDS education program and voluntary HIV-1 serologic screening program shall be offered to all beneficiaries of the military healthcare system, in accordance with published recommendations of the United States Public Health Service and as indicated by standard medical practice. HIV-1 serologic screening shall be offered to beneficiaries presenting with sexually transmitted diseases, at sexually transmitted disease clinics, with alcohol and drug abuse problems, at alcohol and drug rehabilitation units, at prenatal clinics, and when clinically indicated.

E6.2.6. Medical healthcare beneficiaries who are concerned about whether they have been exposed to HIV-1 should consult with local DoD medical personnel. As is the procedure for other medical problems (such as other sexually transmitted diseases, cardiovascular disease, breast cancer, and hepatitis), the beneficiary may obtain an appointment to discuss his or her concerns directly with the physician. The appropriate supporting tests, including laboratory evaluation, shall be determined by the physician.

E6.3. HEALTH EDUCATION

Health education shall be accomplished within the following program framework:

DoD HIV-1 AND/OR AIDS INFORMATION AND EDUCATION PROGRAM FRAMEWORK

1. Goal	Verification	Assumptions
Reduction in occurrence of HIV-1 infection in military peronnel and other DoD beneficiaries.	Statistics, as available, resulting from testing done by Services.	All AD tested periodically.
2. Objectives		
a. Provide information, education, and behavior-change programs on the prevention of AIDS.	DoD survey measuring knowledge and attitudes about high-risk behavior. Identified programs targeting recruits at point of entry; commmanders and supervisors; personnel overseas, alcohol and drug orientations, the ROTC, and Services academies.	Information, education, and behavior-change programs promote behavioral risk reduction; DoD survey shall continue. Mass media resources including print, radio and television (TV) are essential components of a comprehensive program.
b. Implement program to provide information on the prevention of HIV-1 infection and AIDS to students in DoD schools.	Survey measuring knowledge and attitudes about HIV-1 infection and AIDS. Curriculum includes the prevention of HIV-1 infection.	
c. Provide information, education, and motivation programs to those persons infected or whose behavior put them at high risk of infection (to include those who must not give blood), targeting patients in sexually transmitted disease clinics, drug and alcohol treatment programs, family planning clinics, and blood banks.	Annual Service-wide assessment of program availability, accessibility, and utilization.	Requires strong involvement of medical, nursing, drug and alcohol, and dental personnel.
d. Provide information and education programs for healthcare personnel on HIV-1 and AIDS, addressing the needs of patients and staff.	Evaluation by Military Services of the extent to which appropriate healthcare providers are integrated in the prevention efforts.	Key to changing attitudes and/or behaviors is the provision of factural information from persons in whom the receipient has confidence.

DoD HIV-1 AND/OR AIDS INFORMATION AND EDUCATION PROGRAM FRAMEWORK, continued

2. Objectives	Verification	Assumptions
	Assessment of knowledge and program implementation by physicians, nurses, dentists, and other healthcare providers.	Healthcare providers have current information about the disease. Infection control training is required.
	Identified programs targeting healthcare personnel, drug and alcohol counselors, and emergency response personnel.	
Activities		
Information, education, and behavior change programs and resources targeting:		
a. Person-to-Person		
(1) Persons infected or at increased risk (including family members).		
(2) Patients seen in sexually transmitted disease clinics, drug and alcohol treatment programs, prenatal clinics, clinical laboratories blood banks, family planning clinics, and other appropriate group clinics or classes.		
(3) Occupational health program patients, particularly at-risk occupational groups.		

DoD HIV-1 AND/OR AIDS INFORMATION AND EDUCATION PROGRAM FRAMEWORK, continued

Activities

b. Groups

Department of Defense Dependents Schools' teachers and students; healthcare personnel; commanders and supervisors; drug and alcohol counselors; emergency personnel: police, fire, security, etc.; healthcare beneficiaries overseas; recruits at points of entry into the Services; drug and alcohol orientation and Service treatment programs; chaplains; parent, family, and youth support programs; ROTC and Service academies; family and community service centers; and child care providers.

c. Mass Media

Print media: newspapers journals, and posters printed under DoD sponsorship

Radio and TV.

E7. ENCLOSURE 7

PROCEDURE FOR EVALUATING T-HELPER CELL COUNT

E7.1. ANALYTICAL PROCEDURE

E7.1.1. Each laboratory performing T-helper cell counts shall maintain 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 positive lymphocytes) and the absolute lymphocyte level. The percentage of CD4 positive lymphocytes is determined by immunophenotyping blood cells using flow cytometry instrumentation. The absolute lymphocyte count is determined using hematology instrumentation.

E7.1.2. Flow cytometry instruments shall be equipped for two-color fluoro-chrome analysis with an electronic compensator to offset the spectral overlap of the most commonly used fluorochromes, fluorescein, and phycoerythrin. Additionally, equipment shall have logarithmic scale capability with a minimum measured output of 3 decades and shall provide simultaneous 4-parameter analysis including right-angle light scatter, forward-angle light scatter, green fluorescence, and red fluorescence.

E7.1.3. Flow cytometry analysis shall be capable of distinguishing between the following cell surface phenotypic expressions: CD2, CD3, CD4, CD8, CD14, CD45, and a B lymphocyte marker of either CD19 or CD20 specificity. All monoclonal antibody reagents shall be conjugated with either fluorescein isothiocyanate or phycoerythrin. Due to the ready availability of directly conjugated monoclonal reagents, no indirect staining procedures shall be used for the above lymphocyte markers. A monoclonal antibody that does not universally identify CD4 cells in all specimens shall not be used for the determination of CD4 lymphocytes. Only reagents with specificity to CD2, CD3, CD4, CD8, CD14, CD19, CD20, and CD45 are acceptable under this procedure.

E7.1.4. Blood specimens for the absolute lymphocyte count and lymphocyte immunophenotype shall be drawn during the same venipuncture between 0600 and 0900 hours. The absolute lymphocyte count shall be performed on an ethylenediamine tetraacetate anticoagulated whole blood specimen within 4 hours of specimen collection. The absolute lymphocyte count shall be determined on an automated hematology instrument with a locally verified interrun and intrarun coefficient of variation of less than 5 percent. The whole blood lysate procedure shall be used for flow cytometry cell preparations. Flow cytometry specimens shall be stained and lysed within a time period that has been locally demonstrated to yield an overall cell viability

greater than the 90 percent. Blood specimens shall be stained and lysed by a standard method that shall be detailed in the director of the laboratory's standard operating procedure manual. All blood specimens for cell surface phenotyping shall be analyzed for nonspecific binding with vendor-matched, isotype-matched, and conjugate-matched control antibody reagents for each test antibody used. As this standard applies to lymphocyte immunophenotyping, lymphocyte populations shall be defined by those cells gated on forward- and right-angle light scatter that are at least 95-percent positive for CD45 (the brightest CD45 population that is specific for lymphocytes) and no more than 5-percent positive for CD14.

E7.2. INTERNAL QUALITY CONTROL PROGRAM

E7.2.1. Each laboratory shall maintain a comprehensive internal quality control program. Minimally, on each day of operation the following flow cytometry procedures or reagents shall be monitored:

E7.2.1.1. Optical focusing and alignment of all lenses and light paths for forward-angle light scatter, right-angle light scatter, red fluorescence, and green fluorescence.

E7.2.1.2. Fluorescent intensity beads, particles, or cells with fluorescence in the range of biological samples.

E7.2.1.3. Fluorescent compensation beads, particles, or cells with fluorescence in the range of biological samples.

E7.2.1.4. A human blood control sample.

E7.2.2. Each laboratory shall establish tolerance limits for each of the procedures or reagents in subparagraphs E7.2.1.1. through E7.2.1.4. of this enclosure, above. Appropriate corrective action shall be taken and documented when any quality control reagent exceeds established tolerance limits. Routine maintenance and function verification checks shall be accomplished expediently. The laboratory director shall review corrective and quality control records regularly.

E7.3. EXTERNAL QUALITY CONTROL PROGRAM

The Army is responsible for establishing and operating an external quality control program to evaluate the results reported by the flow cytometry laboratories. The external quality control program shall include 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.

E7.4. RECORDING AND REPORTING DATA

The laboratory director shall review and verify the reported results. The laboratory report shall contain 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 shall maintain permanent files of reports, internal and external quality control records, and instrument maintenance and performance verification checks.

E7.5. PERSONNEL QUALIFICATIONS

E7.5.1. The importance of accurate flow cytometry determinations requires that all personnel involved with the flow cytometry instrumentation be properly trained.

E7.5.2. The director of the flow cytometry laboratory shall hold a doctoral degree in a biologic science or be a physician, and shall possess experience in immunology or cell biology.

E7.5.3. A laboratory supervisor, if applicable, shall hold a bachelor's degree in a biological science and have at least 2 years of experience in flow cytometry.

E7.6. SAFETY

All laboratories shall comply with the biosafety level 2 standards established by the Centers for Disease Control. 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 shall be treated as infectious throughout all procedures. All material generated in the processing and evaluation of blood specimens shall be decontaminated and disposed of according to established hazardous waste disposal policies.

E8. ENCLOSURE 8

HIV-1 TESTING OF DoD CIVILIAN EMPLOYEES

E8.1.1. Requests for authority to screen DoD civilian employees for HIV-1 shall be directed to the ASD(FM&P). Only requests that are based on a host-nation HIV-1 screening requirement shall be accepted. Requests based on other concerns, such as sensitive foreign policy or medical healthcare issues, shall not be considered under this Directive. Approvals shall be provided in writing by the ASD(FM&P). Approvals shall apply to all the DoD Components that may have activities located in the host nation.

E8.1.2. Specific HIV-1 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-1 screening shall be considered as 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. The Department of Defense has made no official commitment, for positions located in host nations with HIV-1 screening requirements, to those individuals who refuse to cooperate with the screening requirement or to those who cooperate and are diagnosed as HIV-1 seropositive.

E8.1.3. DoD civilian employees who refuse to cooperate with the screening requirement shall be treated, as follows:

E8.1.3.1. Those who volunteered for the assignment, whether permanent or temporary, shall be 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 regulation.

E8.1.3.2. 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.

E8.1.3.3. Host-nation screening requirements, which apply to DoD civilian employees currently located in that country, also must be observed. Appropriate personnel actions may be taken, without prejudice to employee rights and privileges, to comply with the requirements.

E8.1.4. Individuals who are not employed in the host nation, who accept the screening, and who are evaluated as HIV-1 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 ASD(FM&P) Memorandum and FPM Bulletin 792-42 (references (k) and (l)), and for employees in the United States (29 U.S.C. 794, reference (m)). Non-DoD employees should be referred to appropriate support service organizations.

E8.1.5. Some host nations may not bar entry to HIV-1-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-1 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-1 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.

E8.1.6. A positive confirmatory test by WB must be accomplished on an individual if the screening test (ELISA) is positive. A civilian employee may not be identified as HIV-1 antibody positive, unless the confirmatory test (WB) is positive. The clinical standards in this Directive shall be observed during initial and confirmatory testing.

E8.1.7. Procedures shall be established by the DoD Components to protect the confidentiality of test results for all individuals, consistent with the ASD(FM&P) Memorandum and DoD Directive 5400.11 (references (k) and (n)).

E8.1.8. Tests shall be provided by the DoD Components at no cost to the DoD civilian employees, including applicants.

E8.1.9. DoD civilian employees infected with HIV-1 shall be counseled appropriately.

E9. ENCLOSURE 9

PERSONNEL NOTIFICATION AND EPIDEMIOLOGICAL INVESTIGATION

E9.1. PERSONNEL NOTIFICATION

E9.1.1. On notification by a medical health authority of an individual with serologic or other laboratory or clinical evidence of HIV-1 infection, the cognizant military health authority shall undertake preventive medicine intervention, including counseling of the individual and others at risk of infection, such as his or her sexual contacts (who are military healthcare beneficiaries), on transmission of the virus. The cognizant military health authority shall coordinate with the military and civilian blood bank organizations and preventive medicine authorities to trace back possible exposure through blood transfusion or donation of infected blood (ASD(HA) Memorandum, reference (o)) and refer appropriate case-contact information to the appropriate military or civilian health authority.

E9.1.2. All individuals with serologic evidence of HIV-1 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 of that virus, 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 sexual partners of their infection. Women shall be advised of the risk of perinatal transmission during past, current, and future pregnancies. The infected individuals shall be informed that they are ineligible to donate blood and shall be placed on a permanent donor deferral list.

E9.1.3. Service members identified to be at risk shall be counseled and tested for serologic evidence of HIV-1 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 provided to civilian health authorities in the local area where the index case is identified, unless prohibited by the appropriate State or host-nation civilian health authority. Such notification shall comply with the "Privacy Act of 1974" (Pub. L. No. 93-579 (1974), reference (p)). Anonymity of the HIV-1 index case shall be maintained, unless reporting is required by civil authorities.

E9.1.4. Blood donors who demonstrate repeatedly reactive ELISA tests for HIV-1, but for whom WB or other confirmatory test is negative or indeterminate, and who cannot be reentered into the blood donor pool shall be appropriately counseled.

E9.2. EPIDEMIOLOGICAL INVESTIGATION

E9.2.1. Epidemiological investigation shall attempt to determine potential contacts of patients who have serologic or other laboratory or clinical evidence of HIV-1 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-1. Individuals at risk of infection include sexual contacts (male and female); children born to infected mothers; recipients of blood, blood products, organs, tissues, or sperm; and users of contaminated intravenous drug paraphernalia. Those individuals determined to be at risk who are identified and who are eligible for healthcare in the military medical system shall be notified. Additionally, the Secretaries of the Military Departments shall provide for the notification, either through local public health authorities or by DoD healthcare professionals, of the spouses of Reserve component members found to be HIV-1-infected. Such notifications shall comply with the "Privacy Act of 1974" (Pub. L. No. 93-579 (1974), reference (p)). The Secretaries of the Military Departments shall designate all spouses (regardless of the Service affiliation of the HIV-1-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.

E9.2.2. Communicable disease reporting procedures of civil authorities shall be followed to the extent consistent with this Directive through liaison between the military public health authorities and the appropriate local, State, territorial, Federal, or host-nation health jurisdiction.

E10. ENCLOSURE 10

RETENTION AND SEPARATION

E10.1. RETENTION

E10.1.1. AD Service members with serologic evidence of HIV-1 infection shall be referred for a medical evaluation for documentation of fitness for continued service in the same manner as personnel with other progressive illnesses. Evaluation shall be conducted in accordance with the standard clinical protocol, as described in enclosure 2. Service members with serologic evidence of HIV-1 infection who are evaluated as physically fit for duty may not be separated solely on the basis of serologic evidence of HIV-1 infection.

E10.1.2. Reserve component members with serologic evidence of HIV-1 infection are ineligible for extended AD (for a period of more than 30 days) except under conditions of mobilization. Reserve component members who are not on extended AD or who are not on extended full-time National Guard duty, and who show serologic evidence of HIV-1 infection, may be transferred involuntarily to the Standby Reserve only if they cannot be utilized in the Selected Reserve, as determined under paragraph 6.16. of the main body of this Directive, above.

E10.2. SEPARATION

E10.2.1. AD Service members who are infected with HIV-1 and are determined to be physically unfit for further duty shall be retired or separated in accordance with the policies in DoD Directive 1332.18 (reference (g)).

E10.2.2. AD Service members with serologic evidence of HIV-1 infection who are found not to have complied with lawfully ordered preventive medicine procedures for individual patients are subject to appropriate administrative and disciplinary action, which may include separation.

E10.2.3. Separation of AD Service members with serologic evidence of HIV-1 infection under the plenary authority of the Secretary of the Military Department concerned, if requested by the Service member, is permitted.

E10.2.4. Reserve members with serologic evidence of HIV-1 infection may be transferred to the Standby Reserve or separated when they fail to provide from their civilian physician an evaluation conforming to the protocol described in enclosure 2.

Transfer or separation may occur only after the Service member has been allowed a reasonable period of time, as determined by the Secretary of the Military Department, to respond to such requests. If separated, the characterization of service shall never be less than that warranted by the Service member's service record.

E10.2.5. AD Service members determined to have been infected with HIV-1 at the time of enlistment are subject to discharge for erroneous enlistment.

EXHIBIT 27

DODI 6485.01 (2006 version): Human Immunodeficiency Virus (HIV) in Military Service Members

Department of Defense
INSTRUCTION

NUMBER 6485.01
October 17, 2006

USD(P&R)

SUBJECT: Human Immunodeficiency Virus

References: (a) DoD Directive 6485.1, "Human Immunodeficiency Virus-1 (HIV-1)," March 19, 1991 (hereby canceled)
(b) Acting Deputy Secretary of Defense Memorandum, "DoD Directives Review – Phase II," July 13, 2005
(c) DoD Directive 5124.02, "Under Secretary of Defense, Personnel and Readiness," February 11, 2006
(d) DoD Directive 6130.3, "Physical Standards for Appointment, Enlistment, or Induction," December 15, 2000
(e) through (h), see Enclosure 1

1. PURPOSE

This Instruction:

1.1. Reissues Reference (a) as a DoD Instruction in accordance with the guidance in Reference (b) and pursuant to Reference (c).

1.2. Updates policy for the identification, surveillance, and management of military personnel infected with the Human Immunodeficiency Virus (HIV) and for prevention activities to control transmission of HIV.

2. APPLICABILITY

This Instruction applies to the Office of the Secretary of Defense, the Military Departments, the Chairman of the Joint Chiefs of Staff, the Combatant Commands, the Office of the Inspector General of the Department of Defense, the Defense Agencies, the DoD Field Activities, and all other organizational entities in the Department of Defense (hereafter referred to collectively as the "DoD Components").

3. DEFINITIONS

3.1. Adverse Personnel Action. A court-martial, non-judicial punishment, involuntary separation for other than medical reasons, administrative or punitive reduction in grade, denial of promotion, an unfavorable entry in a personnel record (other than an accurate entry concerning an action that is not an adverse personnel action), or a bar to reenlistment other than for medical reasons.

3.2. Epidemiologic Assessment Interview. Questioning of a member of the Armed Forces who has been confirmed by the Department of Defense to have serologic evidence of HIV infection for purposes of medical treatment or counseling or for epidemiologic or statistical purposes.

3.3. HIV. The virus(es) associated with the Acquired Immune Deficiency Syndrome (commonly referred to as "AIDS").

3.4. Serologic evidence of HIV infection. A reactive and confirmed result for HIV infection given by and according to a Food and Drug Administration-approved test.

4. POLICY

It is DoD policy to:

4.1. Deny eligibility for Military Service to individuals with serologic evidence of HIV infection for appointment, enlistment, pre-appointment, or initial entry training for Military Service according to DoD Directive 6130.3 (Reference (d)).

4.2. Periodically screen the Armed Forces for HIV infection.

5. RESPONSIBILITIES

5.1. The Assistant Secretary of Defense for Health Affairs (ASD(HA)), under the Under Secretary of Defense for Personnel and Readiness (USD(P&R)), shall provide overall policy implementation guidance for the medical management of individuals with serological evidence of HIV infection and for health education programs to prevent the transmission of HIV.

5.2. The Principal Deputy Under Secretary of Defense for Personnel and Readiness (PDUSD(P&R)), under the USD(P&R), shall provide overall policy implementation guidance for:

5.2.1. The personnel management of members of the Armed Forces with serologic evidence of HIV infection.

5.2.2. Compliance with host-nation requirements for screening and related matters for civilian employees of the Department of Defense.

5.3. The Assistant Secretary of Defense for International Security Affairs, under the Under Secretary of Defense for Policy, shall identify or confirm host-nation HIV screening and other related requirements, transmit this information to the PDUSD(P&R), and coordinate matters involving host-nation requirements with the Department of State.

5.4. The Secretaries of the Military Departments shall:

5.4.1. Implement this Instruction and any implementing guidance issued under the authority of this Instruction and comply with the policy in paragraph 4.

5.4.2. Support recommendations of the DoD-wide Sexually Transmitted Disease Prevention Committee.

5.4.3. Report HIV test results to the Defense Medical Surveillance System according to DoD Directive 6490.2 (Reference (e)).

5.4.4. Ensure personnel providing medical care follow the recommendations of the Centers for Disease Control and Prevention for preventing HIV transmission in health-care settings.

6. PROCEDURES

6.1. Testing and Screening

6.1.1. Applicants for U.S. Service Academies, Reserve Officer Training Corps scholarship programs, and the Uniformed Services University of the Health Sciences shall be tested for serologic evidence of HIV within 72 hours of arrival to the programs and denied entry if such test is positive.

6.1.2. All members of the Armed Forces shall be screened periodically for serologic evidence of HIV infection.

6.1.2.1. Active duty (AD) personnel shall be screened no more or less than approximately every 2 years unless clinically indicated.

6.1.2.2. Reserve component (RC) personnel shall be screened when called to a period of active duty greater than 30 days if they have not received an HIV test within the last 2 years. Members of the Selected Reserves (SELRES) shall be screened at least once every 5 years.

6.1.2.3. A serum sample from all HIV force screenings shall be forwarded to the Armed Forces Serum Repository as directed by Reference (e).

6.2. Referral. Refer military personnel with serologic evidence of HIV infection for appropriate treatment and a medical evaluation of fitness for continued service in the same manner as personnel with other progressive illnesses according to Reference (d).

6.2.1. Clinical management of individuals with serologic evidence of HIV infection shall be conducted according to nationally accepted, standard HIV clinical protocols and guidelines.

6.2.2. Members with serologic evidence of HIV infection shall not be retired or separated solely on the basis of serologic evidence of HIV infection.

6.2.3. AD members with serologic evidence of HIV infection determined to be fit for duty shall be allowed to serve in a manner that ensures access to appropriate medical care.

6.2.4. AD and RC personnel with serologic evidence of HIV infection who are determined to be unfit for further duty shall be separated or retired according to Reference (d).

6.2.5. Eligibility for extended AD (duty for a period of more than 30 days) shall be denied to those RC members with serologic evidence of HIV infection (except under conditions of mobilization and on the decision of the Secretary of the Military Department concerned). RC members who are not on extended AD or who are not on full-time National Guard duty, and who show serologic evidence of HIV infection, shall be transferred involuntarily to the Standby Reserve only if they cannot be used in the Selected Reserve.

6.3. Transmission Control. Control transmission of HIV through aggressive disease surveillance and health education programs for Service members. Military personnel with serologic evidence of HIV infection shall receive training on the prevention of further transmission of HIV infection to others and the legal consequences of exposing others to HIV infection.

6.4. Screening Compliance. Comply with host-nation requirements for screening for HIV infection for military or DoD civilian personnel and for assignment or deployment to the host nation.

6.5. Adverse Personnel Action. Do not use information obtained during or primarily as a result of an epidemiologic assessment interview to support any adverse personnel action against the member according to section 705(c) of Public Law 99-661 (Reference (f)). This prohibition does not apply to the use of such information for otherwise authorized rebuttal or impeachment purposes.

6.6. Privacy. Protect the privacy of individuals with serologic evidence of HIV infection, according to DoD 5400.11-R and DoD 6025.18-R (References (g) and (h)).

7. EFFECTIVE DATE

This Instruction is effective immediately.

David S. C. Chu
Under Secretary of Defense
Personnel and Readiness

Enclosures – 1
E1. References, continued

E1. ENCLOSURE 1

REFERENCES, continued

(e) DoD Directive 6490.2, "Comprehensive Health Surveillance," October 21, 2004
(f) Section 705(c) of Public Law 99-661, "National Defense Authorization Act for Fiscal Year 1987," November 14, 1986 (section 1074a note of title 10, United States Code)
(g) DoD 5400.11-R, "Department of Defense Privacy Program," August 1983
(h) DoD 6025.18-R, "DoD Health Information Privacy Regulation," January 2003

EXHIBIT 28

DODI 6485.01 (current version): Human Immunodeficiency Virus (HIV) in Military Service Members

Department of Defense
INSTRUCTION

NUMBER 6485.01
June 7, 2013

USD(P&R)

SUBJECT: Human Immunodeficiency Virus (HIV) in Military Service Members

References: See Enclosure 1

1. PURPOSE. In accordance with the authority in DoD Directive (DoDD) 5124.02 (Reference (a)), this instruction reissues DoD Instruction (DoDI) 6485.01 (Reference (b)) to establish policy, assign responsibilities, and prescribe procedures for the identification, surveillance, and management of members of the Military Services infected with HIV and for prevention activities to control transmission of HIV.

2. APPLICABILITY. This instruction applies to OSD, the Military Departments, the Office of the Chairman of the Joint Chiefs of Staff and the Joint Staff, the Combatant Commands, the Office of the Inspector General of the Department of Defense, the Defense Agencies, the DoD Field Activities, and all other organizational entities within the DoD.

3. POLICY. It is DoD policy to:

a. Deny eligibility for military service to persons with laboratory evidence of HIV infection for appointment, enlistment, pre-appointment, or initial entry training for military service pursuant to DoDI 6130.03 (Reference (c)).

b. Periodically screen Service members for HIV infection.

4. RESPONSIBILITIES. See Enclosure 2.

5. PROCEDURES. See Enclosure 3.

6. RELEASABILITY. **Unlimited**. This instruction is approved for public release and is available on the Internet from the DoD Issuances Website at http://www.dtic.mil/whs/directives.

7. EFFECTIVE DATE. This instruction:

a. Is effective June 7, 2013.

b. Must be reissued, cancelled, or certified current within 5 years of its publication in accordance with DoDI 5025.01 (Reference (d)). If not, it will expire effective June 7, 2023 and be removed from the DoD Issuances Website.

Jessica L. Wright
Acting Under Secretary of Defense for Personnel and Readiness

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ENCLOSURE 1

REFERENCES

(a) DoD Directive 5124.02, "Under Secretary of Defense for Personnel and Readiness (USD(P&R))," June 23, 2008
(b) DoD Instruction 6485.01, "Human Immunodeficiency Virus," October 17, 2006 (hereby cancelled)
(c) DoD Instruction 6130.03, "Medical Standards for Appointment, Enlistment, or Induction in the Military Services," April 28, 2010, as amended
(d) DoD Instruction 5025.01, "DoD Directives Program," September 26, 2012
(e) DoD Directive 6490.02E, "Comprehensive Health Surveillance," February 8, 2012
(f) DoD Instruction 6025.19, "Individual Medical Readiness (IMR)," January 3, 2006
(g) DoD Instruction 6490.03, "Deployment Health," August 11, 2006
(h) DoD Instruction 6025.13, "Medical Quality Assurance (MQA) and Clinical Quality Management in the Military Health System (MHS)," February 17, 2011
(i) DoD 6025.13-R, "Military Health System (MHS) Clinical Quality Assurance Program (CQA) Regulation," June 11, 2004
(j) DoD Instruction 6490.07, "Deployment-Limiting Medical Conditions for Service Members and DoD Civilian Employees," February 5, 2010
(k) DoD Instruction 1332.38, "Physical Disability Evaluation," November 14, 1996, as amended
(l) Section 705(c) of Public Law 99-661, "National Defense Authorization Act for Fiscal Year 1987," November 14, 1986
(m) DoD 5400.11-R, "Department of Defense Privacy Program," May 14, 2007
(n) DoD 6025.18-R, "DoD Health Information Privacy Regulation," January 24, 2003

ENCLOSURE 2

RESPONSIBILITIES

1. UNDER SECRETARY OF DEFENSE FOR PERSONNEL AND READINESS (USD(P&R)). The USD(P&R) provides overall policy implementation guidance for:

a. The personnel management of Service members with laboratory evidence of HIV infection.

b. Compliance with host-nation requirements for screening and related matters for Service members.

2. ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS (ASD(HA)). Under the authority, direction, and control of the USD(P&R), the ASD(HA) provides overall policy implementation guidance for the medical management of Service members with laboratory evidence of HIV infection and for health education programs to prevent the transmission of HIV.

3. UNDER SECRETARY OF DEFENSE FOR POLICY (USD(P)). The USD(P):

a. Identifies or confirms host-nation HIV screening and other related requirements and transmits this information to the USD(P&R).

b. Coordinates matters involving host-nation screening and other related requirements with the Department of State.

4. SECRETARIES OF THE MILITARY DEPARTMENTS. The Secretaries of the Military Departments:

a. Implement this instruction and any guidance issued under the authority of this instruction.

b. Report HIV test results to the Defense Medical Surveillance System pursuant to DoDD 6490.02E (Reference (e)).

c. Direct health care personnel providing medical care to follow the recommendations of the Centers for Disease Control and Prevention for preventing HIV transmission in health-care settings.

ENCLOSURE 3

PROCEDURES

1. TESTING AND SCREENING

a. Applicants for appointment, enlistment, or individuals being inducted into the Military Services will be screened for laboratory evidence of HIV infection in accordance with Reference (c).

b. Applicants to the U.S. Service Academies, the Uniformed Services University of the Health Sciences, and other officer candidate programs will be tested for laboratory evidence of HIV within 72 hours of arrival to the program and denied entry to the program if such test is positive. Reserve Officer Training Corps program cadets and midshipmen must be tested for laboratory evidence of HIV not later than during their commissioning physical examination, and denied a commission if they test positive.

c. All Service members will be screened periodically for laboratory evidence of HIV infection.

(1) Active duty (AD) and Reserve Component (RC) Selected Reserve (SELRES) personnel will be routinely screened every 2 years unless more frequent screenings are clinically indicated.

(2) Members of the SELRES will be screened at least once every 2 years. 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.

(3) Testing for laboratory evidence of HIV for pre- and post-deployment must be conducted in accordance with DoDI 6025.19 (Reference (f)) and DoDI 6490.03 (Reference (g)).

d. A serum sample from all HIV force screenings will be forwarded to the DoD Serum Repository as directed by Reference (e).

2. MANAGEMENT

a. Clinical management of an AD Service member and an RC Service member on AD for a period of more than 30 days with laboratory evidence of HIV infection will be conducted consistent with standard of care, evidence-based HIV clinical practice standards, and medical management guidelines, as described in DoDI 6025.13 and DoD 6025.13-R (References (h) and (i)).

b. In accordance with DoDI 6490.07 (Reference (j)), the cognizant Combatant Command surgeon will be consulted in all instances of HIV seropositivity before medical clearance for deployment.

c. An AD Service member with laboratory evidence of HIV infection will be referred for appropriate treatment and a medical evaluation of fitness for continued service in the same manner as a Service member with other chronic or progressive illnesses in accordance with DoDI 1332.38 (Reference (k)). An AD Service member with laboratory evidence of HIV infection determined to be fit for duty will be allowed to serve in a manner that ensures access to appropriate medical care.

d. An RC Service member with laboratory evidence of HIV infection will be referred for a medical evaluation of fitness for continued service in accordance with Service regulations, and in the same manner as an RC Service member with other chronic or progressive illnesses. Eligibility for active duty for a period of more than 30 days will be denied to those RC Service members with laboratory evidence of HIV infection (except under conditions of mobilization and on the decision of the Secretary of the Military Department concerned). RC Service members who are not on active duty for a period of more than 30 days or who are not on full-time National Guard duty, and who show laboratory evidence of HIV infection, will be transferred involuntarily to the Standby Reserve only if they cannot be used in the SELRES.

e. AD and RC Service members with laboratory evidence of HIV infection who are determined to be unfit for further duty will be separated or retired pursuant to Reference (k).

3. TRANSMISSION CONTROL. Transmission of HIV will be controlled through aggressive disease surveillance and health education programs for Service members. A Service member with laboratory evidence of HIV infection will receive training on the prevention of further transmission of HIV infection to others and the legal consequences of exposing others to HIV infection.

4. ADVERSE PERSONNEL ACTION. Information obtained during or primarily as a result of an epidemiologic assessment interview will not be used to support any adverse personnel action against the Service member in accordance with section 705(c) of Public Law 99-661 (Reference (l)). This prohibition does not apply to the use of such information for otherwise authorized rebuttal or impeachment purposes.

5. PRIVACY. The privacy of a Service member with laboratory evidence of HIV infection will be protected consistent with DoD 5400.11-R and DoD 6025.18-R (References (m) and (n)).

GLOSSARY

PART I. ABBREVIATIONS AND ACRONYMS

AD	active duty
ASD(HA)	Assistant Secretary of Defense for Health Affairs
DoDD	DoD Directive
DoDI	DoD Instruction
HIV	human immunodeficiency virus
RC	Reserve Component
SELRES	Selected Reserves
USD(P&R)	Under Secretary of Defense for Personnel and Readiness
USD(P)	Under Secretary of Defense for Policy

PART II. DEFINITIONS

These terms and their definitions are for the purposes of this instruction.

adverse personnel action. A court-martial, non-judicial punishment, involuntary separation for other than medical reasons, administrative or punitive reduction in grade, denial of promotion, an unfavorable entry in a personnel record (other than an accurate entry concerning an action that is not an adverse personnel action), or a bar to reenlistment other than for medical reasons.

epidemiologic assessment interview. Questioning of a Service member who has been confirmed by DoD to have laboratory evidence of HIV infection for purposes of medical treatment or counseling or for epidemiologic or statistical purposes.

HIV. The virus(es) associated with the acquired immune deficiency syndrome (commonly referred to as "AIDS").

laboratory evidence of HIV infection. A reactive and confirmed serologic result, and/or, reactive or quantitative nucleic acid result for HIV infection according to a Food and Drug Administration-approved test.

EXHIBIT 29

DODI 6490.07 Deployment-Limiting Medical Conditions for Service Members and DoD Civilian Employees

Department of Defense
INSTRUCTION

NUMBER 6490.07
February 5, 2010

USD(P&R)

SUBJECT: Deployment-Limiting Medical Conditions for Service Members and DoD Civilian Employees

References: See Enclosure 1

1. PURPOSE. In accordance with the authority in DoD Directive (DoDD) 5124.02 (Reference (a)) and the guidance in DoDDs 6200.04 and 1400.31 (References (b) and (c)), this Instruction establishes policy, assigns responsibilities, and provides procedures for ensuring that Service members and DoD civilian employees, including Coast Guard Service members and civilian employees at all times, including when the Coast Guard is a Service in the Department of Homeland Security by agreement with that Department, (hereafter referred to collectively as "DoD personnel") deployed and deploying on contingency deployments are medically able to accomplish their duties in deployed environments.

2. APPLICABILITY. This Instruction:

a. Applies to:

(1) OSD, the Military Departments (including the Coast Guard at all times, including when it is a Service in the Department of Homeland Security by agreement with that Department), the Office of the Chairman of the Joint Chiefs of Staff and the Joint Staff, the Combatant Commands, the Office of the Inspector General of the Department of Defense, the Defense Agencies, the DoD Field Activities, and all other organizational entities within the Department of Defense (hereafter referred to collectively as the "DoD Components").

(2) DoD personnel deployed and deploying on contingency deployments consistent with DoD and Service-specific guidance, including Reference (c) and DoD Instruction (DoDI) 1400.32 (Reference (d)).

b. Does not apply to contingency contractor personnel, who shall comply with the guidance in DoDI 3020.41 (Reference (e)), or to shipboard operations that are not anticipated to involve operations ashore, which shall follow Service-specific guidance.

c. Shall be used as a minimum medical standard for all deploying and deployed DoD personnel, BUT does not alter or replace:

(1) With respect to military personnel, the accession, retention, and general fitness for duty standards previously established by the Department of Defense, including those described in DoDI 6130.4, DoDD 6130.3, Under Secretary of Defense for Personnel and Readiness (USD(P&R)) Memorandum, Assistant Secretary of Defense for Health Affairs (ASD(HA)) Memorandum, and DoDI 6485.01 (References (f) through (j), respectively).

(2) With respect to civilian employees covered by sections 791 and 794a of title 29, United States Code (also known and hereafter referred to as "The Rehabilitation Act of 1973, as amended" (Reference (k))), the legal obligations of a DoD Component as an employer pursuant to that Act.

(3) More stringent individual Military Department policy guidance or Service-specific readiness requirements.

3. DEFINITIONS. These terms and their definitions are for the purpose of this Instruction.

a. contingency. A situation requiring military operations in response to natural disasters, terrorists, subversives, or as otherwise directed by appropriate authority to protect US interests.

b. contingency deployment. A deployment that is limited to outside the continental United States, over 30 days in duration, and in a location with medical support from only non-fixed (temporary) military medical treatment facilities. It is a deployment in which the relocation of forces and materiel is to an operational area in which a contingency is or may be occurring.

c. deployment. The relocation of forces and materiel to desired operational areas. Deployment encompasses all activities from origin or home station through destination, specifically including intra-continental United States, inter-theater, and intra-theater movement legs, staging, and holding areas.

d. medical assessment. The total of the pre-deployment activities described in section 1 of Enclosure 2 of this Instruction and those listed in paragraph E4.A1.1 of DoDI 6490.03 (Reference (l)).

e. trained DoD health-care provider. A physician, physician assistant, nurse practitioner, advanced practice nurse, independent duty corpsman, independent duty medical technician, or special forces medical sergeant.

4. POLICY. It is DoD policy that:

a. The medical standards in this Instruction are mandatory for contingency deployments, and permissible for any other deployment, based on the commander's decision.

b. DoD personnel with existing medical conditions may deploy based upon a medical assessment as described in Enclosure 2 and subparagraph E4.A1.1.1. of Reference (l), which for civilian employees shall be consistent with subparagraph 4.g.(3)(c) of DoDD 1404.10 (Reference (m)), and the requirements of The Rehabilitation Act of 1973, as amended, when such civilian employees are covered by that Act, if all of these conditions are met:

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

(2) The condition is stable and reasonably anticipated by the pre-deployment medical evaluator not to worsen during the deployment in light of physical, physiological, psychological, and nutritional effects of the duties and location.

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

(4) There is no need for routine evacuation out of theater for continuing diagnostics or other evaluations. (All such evaluations should be accomplished before deployment.)

(5) In the case of civilian employees covered by The Rehabilitation Act of 1973, as amended, it is determined, based upon an individualized assessment, that the employee can perform the essential functions of the position in the deployed environment, with or without a reasonable accommodation, without causing undue hardship. In evaluating undue hardship, the nature of the accommodation and the location of the deployment must be considered. Further, the employee's medical condition must not pose a significant risk of substantial harm to the employee or others taking into account the condition of the relevant deployed environment.

c. Individuals with the conditions in Enclosure 3, based on medical assessments in accordance with Enclosure 2 and Reference (l), shall not deploy unless a waiver can be granted according to the procedures in section 3 of Enclosure 2.

d. If a Service member is found qualified for retention with no limitations on assignments or deployments following evaluation of a medical condition by competent medical and personnel authority of his or her respective Service, and if the condition remains stable, a deployment waiver of that same condition is not required by this Instruction.

e. Deploying commanders may add additional medical requirements to the standards in this Instruction based upon the demands of a specific deployment. Commanders may apply these medical standards to other deployments based on the health risk, physical demands, and medical

capabilities of the deployment. These additional standards must be consistent with The Rehabilitation Act of 1973, as amended, when applied to civilian employees covered by that Act.

f. Protected health information collected, used, and released in the execution of this Instruction shall be protected as required by DoD 6025.18-R (Reference (n)) and DoD 8580.02-R (Reference (o)).

5. RESPONSIBILITIES. See Enclosure 4.

6. PROCEDURES. See Enclosure 2.

7. RELEASABILITY. UNLIMITED. This Instruction is approved for public release and is available on the Internet from the DoD Issuances Web Site at http://www.dtic.mil/whs/directives.

8. EFFECTIVE DATE. This Instruction is effective immediately.

Gail H. McGinn
Deputy Under Secretary of Defense (Plans)
Performing the Duties of the
Under Secretary of Defense for
Personnel and Readiness

Enclosures:
1. References
2. Procedures
3. Medical Conditions Usually Precluding Contingency Deployment
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ENCLOSURE 1

REFERENCES

(a) DoD Directive 5124.02, "Under Secretary of Defense for Personnel and Readiness (USD(P&R))," June 23, 2008
(b) DoD Directive 6200.04, "Force Health Protection (FHP)," October 9, 2004
(c) DoD Directive 1400.31, "DoD Civilian Work Force Contingency and Emergency Planning and Execution," April 28, 1995
(d) DoD Instruction 1400.32, "DoD Civilian Work Force Contingency and Emergency Planning Guidelines and Procedures," April 24, 1995
(e) DoD Instruction 3020.41, "Contractor Personnel Authorized to Accompany the U.S. Armed Forces," October 3, 2005
(f) DoD Instruction 6130.4, "Medical Standards for Appointment, Enlistment, or Induction in the Armed Forces," January 18, 2005
(g) DoD Directive 6130.3, "Physical Standards for Appointment, Enlistment, and Induction," December 15, 2000
(h) Under Secretary of Defense for Personnel and Readiness Memorandum, "Policy Guidance for Medical Deferral," February 9, 2006
(i) Assistant Secretary of Defense for Health Affairs Memorandum, "Policy Guidance for Deployment-Limiting Psychiatric Conditions and Medications," November 7, 2006
(j) DoD Instruction 6485.01, "Human Immunodeficiency Virus," October 17, 2006
(k) Sections 791 and 794a of title 29, United States Code (also known as "The Rehabilitation Act of 1973, as amended")
(l) DoD Instruction 6490.03, "Deployment Health," August 11, 2006
(m) DoD Directive 1404.10, "DoD Civilian Expeditionary Workforce," January 23, 2009
(n) DoD 6025.18-R, "DoD Health Information Privacy Regulation," January 24, 2003
(o) DoD 8580.02-R, "DoD Health Information Security Regulation," July 12, 2007

ENCLOSURE 2

PROCEDURES

1. PERFORMANCE OF MEDICAL ASSESSMENTS. All DoD personnel serving in a contingency deployment as defined in section 3 of the front matter of this Instruction must undergo a medical assessment prior to deployment in accordance with subparagraph E4.A1.1.1. of Reference (l). The mandatory portions of the assessment are:

a. Completion of DD Forms 2795, "Pre-Deployment Health Assessment," and 2766, "Adult Preventive and Chronic Care Flowsheet" (available on the Internet at http://www.dtic.mil/whs/directives/infomgt/forms/formsprogram.htm). Except for Coast Guard personnel, completed copies of both of these forms must be submitted to the Defense Medical Surveillance System and included in DoD personnel deployment paperwork, and shall serve as the deployment medical record. For Coast Guard personnel, the DD Form 2766 shall be placed in the member's health record, but all other procedures for Coast Guard personnel shall be as described in this Instruction for DoD personnel.

b. Medical record review.

c. Current periodic health assessment (Service members only).

d. Physical exam within 1 year of deployment (DoD civilian employees only).

2. DETERMINATIONS OF DEPLOYABILITY. A trained DoD health-care provider must make a provisional determination on DD Form 2795 as to the deployability of DoD personnel. This decision should be based on all of the information obtained in the medical assessment described in section 1 of this enclosure.

a. In general, DoD personnel with any of the medical conditions in Enclosure 3, and based on a medical assessment, shall not deploy unless a waiver is granted. Consideration should be made for the nature of the disability and if it would put the individual at increased risk of injury or illness, or if the condition is likely to significantly worsen in the deployed environment.

(1) For civilian employees covered by The Rehabilitation Act of 1973, as amended, it must be determined, before deployment and based upon an individualized assessment, that the employee can perform the essential functions of the position in the deployed environment, with or without a reasonable accommodation, without causing undue hardship. In evaluating undue hardship, the nature of the accommodation and the location of the deployment must be considered. Further, the employee's medical condition must not pose a significant risk of substantial harm to the employee or others taking into account the condition of the relevant deployed environment.

(2) The requirement to provide reasonable accommodations for disabilities does not apply to deployment of military members, nor to civilian employees not covered by The Rehabilitation Act of 1973, as amended.

b. All individuals deemed not deployable at the deployment processing center shall be returned to their originating unit with a DD Form 2795 and a summary of their non-deployable medical condition to provide to the unit medical personnel. The civilian supervisor shall also be notified if the individual is deemed not deployable.

3. WAIVERS. If a commander or supervisor of DoD personnel (except for SOF personnel) wishes to deploy an individual with a medical condition that could be disqualifying (see Enclosure 3, the commander or supervisor must request a waiver. The waiver request shall be submitted to the applicable Combatant Commander through the individual's servicing military medical unit in the case of a Service member, or through the individual's personnel office in the case of a civilian employee, with medical input provided by the individual's medical provider.

a. Requests for a waiver shall include a summary of a detailed medical evaluation or consultation concerning the medical condition(s). Maximization of mission accomplishment and the protection of the health of personnel are the ultimate goals. Justification shall include statements indicating service experience, position to be placed in, any known specific hazards of the position, anticipated availability and need for care while deployed, the benefit expected to accrue from the waiver, the recommendation of the commander or supervisor, and the reasonable accommodations that can be provided for civilian employees covered by The Rehabilitation Act of 1973, as amended. For all DoD personnel, the factors listed in subparagraphs 4.b.(1) through 4.b.(4), (and subparagraph 4.b.(5) for civilian employees only) of the front matter shall be discussed.

b. For SOF personnel with any of the conditions listed in Enclosure 3, medical clearance may be granted by the CDRUSSOCOM, subject to the approval of the Combatant Commander under which the Service member is deployed or will deploy.

c. In the case of civilian employees covered by The Rehabilitation Act of 1973, as amended, a waiver must be granted if it is determined, based upon an individualized assessment, that the employee can perform the essential functions of the position in the deployed environment, with or without a reasonable accommodation, without causing undue hardship. In evaluating undue hardship, the nature of the accommodation and the location of the deployment must be considered. Further, the employee's medical condition must not pose a significant risk of substantial harm to the employee or others taking into account the condition of the relevant deployed environment.

4. ROLES AND RESPONSIBILITIES

a. Commanders and Supervisors. Commanders and supervisors shall:

(1) Ensure deploying DoD personnel are appropriately assessed by competent medical authority before deployment, in accordance with Reference (l).

(2) Request waivers for DoD personnel they wish to deploy who have the medical conditions described in Enclosure 3.

(3) Ensure that DoD personnel under their command meet the medical standards of the gaining commander when individuals and their leaders deploy in support of other DoD Components. As these standards may differ by assignment, they must be coordinated separately for each deployment.

b. Supervisors. Supervisors shall additionally:

(1) Identify medical and physical requirements for deployable positions designated for fill by DoD civilian employees.

(2) Ensure that such requirements are documented in position descriptions, vacancy announcements, and other appropriate sources.

(3) Ensure that DoD civilian employees meet such requirements; take appropriate action when employees no longer meet identified requirements.

c. DoD Personnel

(1) DoD personnel in deployable positions shall be responsible for meeting the medical and physical requirements of their deployment-specific tasks.

(2) DoD personnel who are civilian employees selected for deployment opportunities outside their chain of supervision shall be responsible for meeting and maintaining the medical standards identified for the deployment by the responsible commanding officer.

ENCLOSURE 3

MEDICAL CONDITIONS USUALLY PRECLUDING CONTINGENCY DEPLOYMENT

This list of conditions is not intended to be all-inclusive. A list of all possible diagnoses and their severity that may cause an individual to be potentially non-deployable, pending further evaluation, would be too extensive. Medical evaluators must consider climate, altitude, rations, housing, duty assignment, and medical services available in theater when deciding whether an individual with a specific medical condition is deployable. In general, individuals with the conditions in paragraphs a. through h. of this enclosure, based upon a medical assessment as described in Enclosure 2 and Reference (l), shall not deploy unless a waiver is granted.

a. Conditions Affecting Force Health Protection

(1) Physical or psychological conditions resulting in the inability to effectively wear personal protective equipment, including protective mask, ballistic helmet, body armor, and chemical and/or biological protective garments, regardless of the nature of the condition that causes the inability to wear the equipment if wearing such equipment may be reasonably anticipated or required in the deployed location.

(2) Conditions that prohibit immunizations or the use of force health protection prescription products (FHPPPs) required for the specific deployment. Depending on the applicable threat assessment, required FHPPPs may include atropine, epinephrine, and/or pralidoxime chloride (2-PAM chloride) auto-injectors; certain antimicrobials and antimalarials; and pyridostigmine bromide.

b. Unresolved Health Conditions Requiring Care or Affecting Performance

(1) Any chronic medical condition that requires frequent clinical visits, fails to respond to adequate conservative treatment, or necessitates significant limitation of physical activity.

(2) Absence of a dental exam within the last 12 months or presence of the likelihood that dental treatment or reevaluation for oral conditions will result in dental emergencies within 12 months. Individuals being evaluated by a non-DoD civilian dentist should use DD Form 2813, "DoD Active Duty/Reserve Forces Dental Examination," as proof of dental examination (available on the Internet at http://www.dtic.mil/whs/directives/infomgt/forms/formsprogram.htm).

(3) Pregnancy.

(4) Any medical condition that requires either durable medical equipment or appliances, or periodic evaluation or treatment by medical specialists that is not readily available in theater.

(5) Any unresolved acute or chronic illness or injury that would impair duty performance in a deployed environment during the duration of the deployment.

(6) Cancer that requires continuing treatment or specialty medical evaluations during the anticipated duration of the deployment.

(7) Precancerous lesions that have not been treated and/or evaluated and that require treatment and/or evaluation during the anticipated duration of the deployment.

(8) Any medical condition that requires surgery or for which surgery has been performed that requires rehabilitation or additional surgery to remove devices.

(9) Any musculoskeletal condition that significantly impairs performance of duties in a deployed environment.

(10) An acute exacerbation of a physical or mental health condition that could significantly affect duty performance.

c. Conditions That Could Cause Sudden Incapacitation

(1) Recurrent loss of consciousness for any reason.

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

d. Pulmonary Disorders. Asthma that has a forced expiratory volume-1 (FEV-1) of less than or equal to 60 percent of predicted FEV-1 despite appropriate therapy and that has required hospitalization at least 2 times in the last 12 months, or that requires daily systemic (not inhalational) steroids.

e. Infectious Disease

(1) Active tuberculosis or known blood-borne diseases that may be transmitted to others in a deployed environment.

(2) A diagnosis of human immunodeficiency (HIV) antibody positive with the presence of progressive clinical illness or immunological deficiency. The cognizant Combatant Command surgeon shall be consulted in all instances of HIV seropositivity before medical clearance for deployment.

f. Sensory Disorders

(1) Hearing Loss. The requirement for use of a hearing aid does not necessarily preclude deployment. However, the individual must have sufficient unaided hearing to perform duties safely.

(2) Vision Loss. Best corrected visual acuity must meet job requirements to perform duties safely.

g. Cardiac and Vascular Disorders

(1) Hypertension not controlled with medication or that requires frequent monitoring.

(2) Symptomatic coronary artery disease.

(3) History of myocardial infarction within 1 year of deployment.

(4) History of coronary artery bypass graft, coronary artery angioplasty, carotid endarterectomy, other arterial stenting, or aneurysm repair within 1 year of deployment.

(5) Cardiac dysrhythmias or arrhythmias, either symptomatic or requiring medical or electrophysiologic control (presence of an implanted defibrillator and/or pacemaker).

(6) Heart failure.

h. Mental Health Disorders

(1) Psychotic and/or bipolar disorders. (See Reference (i) for detailed guidance on deployment-limiting psychiatric conditions or psychotropic medications.)

(2) Psychiatric disorders under treatment with fewer than 3 months of demonstrated stability.

(3) Clinical psychiatric disorders with residual symptoms that impair duty performance.

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

(5) Chronic medical conditions that require ongoing treatment with antipsychotics, lithium, or anticonvulsants.

ENCLOSURE 4

RESPONSIBILITIES

1. ASD(HA). The ASD(HA), under the authority, direction, and control of the USD(P&R), shall review and issue to the Secretaries of the Military Departments and the Directors of the Defense Agencies and the DoD Field Activities technical adjustments to the deployment standards in Enclosure 3 as needed, based on changing conditions or additional unanticipated difficulties encountered in the in-theater management of medical conditions.

2. SECRETARIES OF THE MILITARY DEPARTMENTS, COMMANDANT OF THE COAST GUARD, AND DIRECTORS OF THE DEFENSE AGENCIES AND THE DoD FIELD ACTIVITIES. The Secretaries of the Military Departments, the Commandant of the Coast Guard, and the Directors of the Defense Agencies and the DoD Field Activities shall:

a. Direct their respective Components to apply and uniformly implement the standards in this Instruction.

b. Ensure that:

(1) All deploying DoD personnel assigned to their respective Service, Defense Agency, or DoD Field Activity have a medical assessment in accordance with Reference (l), including a medical record review, to evaluate their medical status before contingency deployments and other deployments pursuant to paragraph 4.a. of the front matter of this Instruction.

(2) Pre-deployment processes are in place to identify individuals with deployment-limiting medical conditions.

(3) DoD personnel who occupy deployable positions maintain a high state of pre-deployment health and medical readiness.

3. CHAIRMAN OF THE JOINT CHIEFS OF STAFF. The Chairman of the Joint Chiefs of Staff shall ensure that the Combatant Commanders:

a. Establish a minimum standard when developing medical requirements for entering the theater of operations that factors in the medical conditions described in Enclosure 3 of this Instruction.

b. Implement a medical requirements waiver process that includes waiver computerization and archival storage.

4. COMBATANT COMMANDERS. For all DoD personnel deployed or deploying to a theater within their respective Combatant Commands, the Combatant Commanders shall:

a. Establish a process for reviewing recommendations from the Services regarding the granting of exceptions to medical standards (waivers) for the conditions in Enclosure 3, including a mechanism to track and archive all approved or denied waivers and the medical conditions requiring the waivers.

b. Serve as the final approval authority for exceptions to the medical standards (waivers) made pursuant to the procedures in this Instruction.

5. COMMANDER, UNITED STATES SPECIAL OPERATIONS COMMAND (CDRUSSOCOM). The CDRUSSOCOM shall perform the responsibilities in section 2 of this enclosure for SOF personnel.

EXHIBIT 30

Excerpts from the February 13, 2019 Deposition of Lt. Col. Paul Tumminello

UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
ALEXANDRIA DIVISION

NICHOLAS HARRISON, ET AL.,

Plaintiffs,

vs. Case No. 1:18-CV-00641-LMB-IDD

PATRICK SHANAHAN, IN HIS OFFICIAL CAPACITY AS ACTING SECRETARY OF DEFENSE, ET AL.,

Defendants.

Washington, D.C.

Wednesday, February 13, 2019

Deposition of:

LT. COL PAUL TUMMINELLO

called for oral examination by counsel for Plaintiffs, pursuant to notice, at the office of Winston & Strawn, 1700 K Street, N.W., Washington, D.C., before KAREN LYNN JORGENSON, RPR, of Capital Reporting Company, beginning at 9:02 a.m., when were present on behalf of the respective parties:

Q And you just referred to access into the military, but it is true that you also cannot get a waiver to access and commission as an officer if you are not already in the military; isn't that correct?

A Same standard.

Q The -- so I understand there's not a right to obtain a waiver, but the waiver you've just described about the eye surgery is based on an individualized assessment of that person's medical condition, correct?

A I -- I guess, yes. Yes.

Q But for people living with HIV, it is a blanket decision or policy that they cannot obtain a medical waiver to access; is that correct?

A I believe it's regulation, right. Yes.

Q So, yes?

A Yes.

Q And it doesn't really matter if they have a progressive clinical illness or immunological deficiency, they are still not going to be able to get a waiver to access?

A Correct.

Q You're speaking or answering on behalf of the Army National Guard. Do you know if the Army has the authority to waive HIV for accession?

MS. BERMAN: Objection. Outside the scope.

THE WITNESS: That probably -- I suspect it's DoD level. I don't work for the Army.

BY MR. SCHOETTES:

Q Okay. Can you go back to Exhibit 4, which is AR40-501, and look to Page 2 under Paragraph 1-6H?

(Thereupon, the court reporter clarified.)

THE WITNESS: Hotel.

BY MR. SCHOETTES:

Q H, as in hotel.

And H says, "Waivers for enlistment" -- I'm sorry, "Waivers for initial enlistment or appointment, including entrance and retention in officer procurement programs, will not be granted if the applicant does not meet the

* * * * *

CERTIFICATE OF REPORTER

I, KAREN LYNN JORGENSON, RPR, CSR, CCR the officer before whom the foregoing deposition was taken, do hereby certify that the witness whose testimony appears in the foregoing deposition was duly sworn by me; that the testimony of said witness was taken by me in stenotype and thereafter reduced to typewriting under my direction; that the said deposition is a true record of the testimony given by said witness; that I am neither counsel for, related to, nor employed by any of the parties to the action in which this deposition was taken; and further, that I am not a relative or employee of any counsel or attorney employed by the parties hereto, nor financially or otherwise interested in the outcome of this action

KAREN LYNN JORGENSON, RPR, CCR, CSR

Dated this 28th day of February, 2019.

EXHIBIT 31

Excerpts from the March 12, 2019 Deposition of Paul Aswell

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
UNITED STATES ARMY GIVEN BY PAUL ASWELL

DATE: Tuesday, March 12, 2019
TIME: 9:10 a.m.
LOCATION: Winston & Strawn
1700 K Street, N.W.
Washington, D.C.
REPORTED BY: Denise M. Brunet, RPR
Reporter/Notary

Veritext Legal Solutions
1250 Eye Street, N.W., Suite 350
Washington, D.C. 20005

not have the actual infection present.

And -- now, whether you would call that a waiver or an exception or just a further review, that was how the -- that was how I would characterize it. It just -- it was a -- to correct an erroneous test.

Q So I think my question maybe was still accurate, even though it didn't attempt to catch that nuance. But -- so it would still be true that a -- or is it true that an accessions waiver has never been granted by the Army to an individual actually living with HIV?

A As you know, I've been doing this since 2009. I'm not aware of any in that time. And I -- I've in the past asked the question, have we ever, and I cannot recall anyone ever identifying an individual that was granted an accession waiver for -- if they were HIV-positive.

Q If you would turn to page -- also on page 4, actually, the next section, 1-16a says, "HIV-infected personnel are not eligible for appointment or enlistment into the active Army, the ARNG, or the USAR (see chapter 5)."

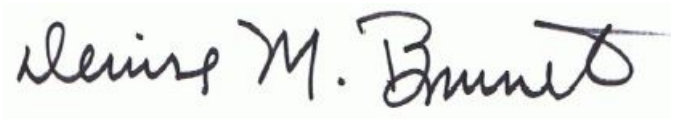
First of all, the ARNG is the Army National Guard?

A Army National Guard.
Q And then the USAR is the U.S. Army reserve?
A Yes.
Q So the accessions policy operates in precisely the same way for all three components of the military -- of the Army?
A As far as medical screening goes, yes.
Q Is there some part of it that is different?
A Because of the various agencies that do accessions, different medical waiver authorities, different locations, different procedures and so forth. 54 states and territories in the Army National Guard, from Guam to D.C. And so you can see that there's considerably different processes, whereas there's only one U.S. Army recruiting command and they recruit everyone for the U.S. Army reserve and for the regular Army, active Army.

And that's why I would say that there was a slightly different -- but for the most part, the medical screening is done the same way by the same agencies, the same two defense agencies.
Q And the substance of the policy with

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 32

Excerpts from the March 13, 2019 Deposition of Captain Devin Kelly D.O.

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
ALEXANDRIA DIVISION
~~~~~~~~~~~~~~~~~~~~

RICHARD ROE, et al.,

Plaintiffs,

vs. Civil Action No.
1:18-cv-01565

PATRICK M. SHANAHAN, et al.,

Defendants.
~~~~~~~~~~~~~~~~~~~~

Deposition of
CAPTAIN DEVIN KELLY, DO

March 13, 2019
10:10 a.m.
Taken at:
Dinsmore & Shohl, LLP
1 South Main Street, Suite 1300
Dayton, Ohio

Kimberly A. Kaz, RPR, Notary Public

that it may be related to increased inflammation within the central nervous system which may be related to increased glutamate levels. The exact mechanism, I believe, is still unclear, but some progression of neurocognitive disorders can be seen even on -- even in patients living with HIV who are virologically suppressed.

Q. Okay. What is the current treatment regiment within the Air Force for a person after they have been diagnosed as HIV positive?

A. Can you clarify treatment regimen?

Q. Sure. What I want to know -- not a very good question, but after they have been tested as HIV positive, how often are they seen? I take it they go quickly on an antiretroviral therapy; is that right?

A. Yes. After initial diagnosis, they -- members diagnosed with HIV are started on HIV therapy quickly.

Q. Okay. And how frequently after that initial diagnosis, then, are they seen by a doctor?

A. Can you clarify what type of

doctor?

Q. Sure. Let me ask first by -- as I understand it, they all go to San Antonio to be seen by an HIV specialist; is that right?

A. Yes. Shortly after diagnosis, all Air Force members diagnosed as HIV positive go for their initial evaluation at San Antonio Military Medical Center.

Q. Okay. And are they prescribed with antiretroviral medication while they're there?

A. Yes.

Q. Okay. And then do they go back to San Antonio for a follow-up visit?

A. Yes. The -- they go for a follow-up visit six months after their initial visit, and then after that, every 12 months.

Q. Back to San Antonio every 12 months?

A. Yes. That's correct.

Q. And do any of their follow-up visits involve any testing for neurocognitive impairments?

A. To my knowledge, there is not routine testing for neurocognitive impairments.

Q. When you spoke to Dr. Jason Okulicz

in preparation for this deposition, did you talk to him about HIV related neurocognitive impairments?

A. No, I did not.

Q. When the Air Force starts an HIV positive service member on antiretroviral treatment, is there any standard therapy in terms of what medication they're given?

MS. ZEIDNER MARCUS: Objection. Form.

THE WITNESS: When starting a person with HIV on antiretroviral therapy, there are medicine considerations in which medication to use. There are situations where you would choose a different medication based upon the patient's preference, drug/drug interactions, underlying medical conditions. Often, providers will make every attempt to start a preferred regimen that is listed in the HIV treatment guidelines published through Department of Health and Human Services.

Q. And those are the guidelines that you looked at in preparation for your deposition today; is that right?

A. Yes. That's correct.

Q. And what do those guidelines provide with respect to starting people on medication?

MS. ZEIDNER MARCUS: Objection. Form.

THE WITNESS: Can you clarify?

Q. Sure. What type of -- what do they suggest with respect to starting a patient on an antiretroviral therapy? What's the recommendation?

A. The preferred regimens listed in the guidelines include Biktarvy, Triumeq, Dolutegravir.

Q. Can you spell that one?

A. D-o-l-u-t-e-g-r-a-v-i-r with either Truvada or Descovy.

Q. And how are these medications provided?

A. Medications can be dispensed at the pharmacy at the facility. Refills may be obtained by Express Scripts, which is a mail pharmacy.

Q. And are they taken -- do I understand correctly that it's either a one pill a day or a two pill a day regimen,

generally?

A. In general, the preferred regimens are either one pill once a day or two pills once a day.

Q. Okay. And when they receive the prescriptions filled, what's the quantity that they're given, the airmen?

A. In general, a 90-day supply is given.

Q. And how long, on average, does it take the airmen to start on these antiretroviral medications to achieve viral suppression?

A. Can you clarify? Are you asking about in general to achieve the virologic suppression?

Q. Yeah. Is there an average number?

A. It may take weeks with medications, up to six months.

Q. And what is the percentage of HIV positive persons who are able to achieve viral suppression?

A. Within the Air Force?

Q. Yes.

A. At 24 months, approximately 90

percent.

Q. Is an undetectable viral load different than viral suppression?

A. Yes.

Q. Okay. Can you explain the differences between those two to me?

A. An undetectable viral load indicates that the assay being used to measure HIV is below the detection of -- limit of detection. Virologic suppression is less than 200.

Q. And do you know what the limit of detection is generally today?

A. Depends on the assay, but the newer assays detection limit is 20.

Q. Twenty?

A. Copies per milliliter.

Q. Okay. Do you agree that a person who's HIV positive with an undetectable viral load who adheres to an antiretroviral treatment regimen has effectively no risk of transmitting HIV?

A. According to the CDC statement, a person living with HIV who's virologically suppressed has effectively zero risk for

transmitting HIV through sexual transmission. This, however, does not cover other routes of transmission.

MS. BAUER: We can take a break now.

(Recess taken.)

Q. Captain Kelly, if you take a look at Kelly Deposition Exhibit 1, which is the notice of deposition, and I'm looking at Topic No. 11, which is the reasoning behind the manner in which DoDI 6485.01 is being implemented in the Air Force including the referral of individuals with laboratory evidence of HIV for medical evaluation and fitness for continued service. Do you see that?

A. Yes, I do.

Q. And that's one of the topics that you're prepared to testify about today; is that right?

A. Yes. That's correct.

Q. Okay. And then I will hand you a copy of what the court reporter has marked as Kelly Deposition Exhibit No. 2.

- - - - -

A. Correct.
Q. Regardless of whether that's a contingency deployment or a --
A. Yes. That's my understanding.
Q. Okay. Is there a term for a non-contingency deployment, or is it just deployments and contingency deployments?
A. Deployments can occur -- a contingency deployment, there can be deployments within the United States and different areas throughout the world.
Q. Okay. Is there an average length of time for an Air Force servicemen to be sent out on a contingency deployment?
A. In general, maybe around 180 days. It may be longer, may be shorter.
Q. If I look down on -- continuing on Page 6 of Kelly Deposition Exhibit 2 under the heading management, do you see where I am?
A. Part two, management?
Q. Right.
A. Yes.
Q. Okay. And it provides: A clinical management of an active duty service member with laboratory evidence of HIV infection will

retirement of active duty members who are determined to be unfit for further duty; is that right?

A. Yes.

Q. And then A9.2.2 provides that active duty 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; is that right?

A. Yes.

Q. And so is this essentially providing that HIV positive service members who don't follow instructions on preventive medicine can be separated from the Air Force; is that right?

A. Yes.

Q. Okay. And then if I look back at Attachment 13 on Page A336.

A. Yes.

Q. Okay. And it continues over to Page A337; is that right?

A. Yes.

Q. Okay. And is Attachment 13 the

order that is to be given to HIV positive Air Force members requiring them to follow certain preventive medicine requirements?

A. Yes.

Q. Okay. And to your knowledge, is this order administered to all HIV positive Air Force service members?

A. Yes.

Q. And the page on A337 is an acknowledgement that the HIV positive service member is to sign upon receiving those orders?

A. Can you repeat?

Q. Sure. I'll rephrase.

Page A337 is the acknowledgement that the HIV positive Air Force service member is to sign upon receiving those orders?

A. Yes.

Q. Okay. And looking back at Page A336, one of the orders that they receive is that they are not to donate blood, sperm, tissues or other organs; is that true?

A. Yes.

Q. Is that -- I haven't talked about all of Air Force Instruction 44-178, but my question is: As you're sitting here today, is

Bates numbers A87 to A100. And do you recognize this to be a copy of DoDI 6490.07?

A. Yes.

Q. Okay. And this is the Department of Defense Instruction that is referred to in Topic 10 of the notice of deposition; is that right?

A. Yes, that is correct.

Q. Okay. And DoDI No. 6490.07 applies to the Air Force?

A. Yes.

Q. And the Air Force is following DoDI 6490.07; is that right?

A. Yes.

Q. Is there a specific Air Force Instruction that implements DoDI 6490.07?

A. Yes.

Q. And what Air Force Instruction is that?

A. There are two AFIs that I may not know the exact number, but those AFIs cover medical standards and deployment limiting conditions.

Q. And did you look at those two AFIs in preparation for your testimony here this

morning?

A. Yes.

Q. I want to direct your attention to Enclosure 3 to Kelly Deposition Exhibit 4, which starts on Page A96. Do you see where I'm at?

A. Yes.

Q. Okay. And Enclosure 3 is entitled medical conditions easily precluding contingency deployment; is that right?

A. Yes.

Q. And under Paragraph E for infectious disease, Paragraph 1 is active tuberculosis or known bloodborne diseases that may be transmitted to others in a deployed environment; is that right?

A. Yes.

Q. And the second one is a diagnosis of HIV antibody positive with the presence of progressive clinical illness or immunological deficiency; is that right?

A. Yes.

Q. And then 2 goes on to provide: The cognizant combatant command surgeon shall be consulted in all instances of HIV

seropositivity before medical clearance for deployment. Is that right?

A. Yes.

Q. The first statement: Active tuberculosis or known bloodborne diseases that may be transmitted to others in the deployed environment.

Are there specifically known bloodborne diseases that usually preclude contingency deployment?

A. Bloodborne diseases that may be transmitted to others in a deployed environment can include -- could include hepatitis B, HIV, potentially hepatitis C because transmission could occur through blood transfusion.

Q. Any others?

A. There may be others that could be transmitted through blood transfusions as well.

Q. Okay. Looking at Section 2, that first sentence again reads: A diagnosis of human immunodeficiency antibody positive with the presence of progressive clinical illness or immunological deficiency. And my question to you is: How does the Air Force define the presence of progressive clinical illness or

immunological deficiency?

A. The Air Force can use the CDC staging of HIV to help make a determination. So following published guidelines through the form of Health and Human Service that may indicate virologic failure or other organ systems involved with -- as related to the HIV.

Q. Are there particular stages as defined by the CDC that are associated with the presence of progressive clinical illness or immunological deficiency?

MS. ZEIDNER MARCUS: Objection. Form.

THE WITNESS: In particular, Stage 3 of the CDC staging is a CD4 count less than 200, which does indicate AIDS. That would be one stage that may be seen as immunological deficiency.

Q. Okay. Asymptomatic HIV is not HIV positive with the presence of progressive clinical illness or immunological deficiency; is that right?

A. Can you repeat?

Q. Sure. Let me rephrase it in a different way.

Someone who's HIV positive with the presence of progressive clinical illness or immunological deficiency is not someone who would be described as having asymptomatic HIV; is that right?

A. Most clinicians would denote someone who has progressive clinical illness or immunologic deficiency as they would not classify that person as asymptomatic.

Q. Okay. And what does asymptomatic HIV mean?

A. Asymptomatic HIV may indicate a person with HIV who has no manifestations of HIV, which can include multiple organ systems and no evidence of progressive clinical illness or immunodeficiency.

Q. The second sentence of that Paragraph 2 says: The cognizant combatant command surgeon shall be consulted in all instances of HIV seropositivity before medical clearance for deployment. Is that right?

A. Yes.

Q. And is that sentence very similar to a sentence we looked at earlier in another instruction; is that right?

A. Yes.

Q. Okay. And how is Section E2 to Enclosure 3 being applied in the -- by the Air Force?

A. For any active duty member who is seropositive for HIV prior to deployment, the cognizant combatant command must approve that deployment.

Q. So the way the Air Force is applying the section, even those persons who are -- who are -- have asymptomatic HIV cannot deploy without the permission of the cognizant combatant command surgeon. Is that your understanding?

MS. ZEIDNER MARCUS: Objection. Form.

THE WITNESS: To my knowledge, yes. The Air Force is implementing this Department of Defense Instruction that requires the cognizant combatant command to approve medical clearance for deployment.

Q. Okay. And the cognizant combatant command surgeon is not consulted only in cases of HIV antibody positive with the presence of progressive clinical illness or immunological

hepatitis C, that you're unaware of any order that a service member would hepatitis C not give blood?

A. In my practice, I do treat hepatitis C in a similar situation of my hepatitis B patients. All the patients I have treated for hepatitis C have been beneficiaries, not active duty to date. I would advise them not to donate blood, however, I do not know of an order such as Attachment 13.

Q. Okay. You don't know of an order?

A. No, I do not know of an order.

Q. Okay. I just wanted to make sure I heard you correctly.

A. Yeah.

Q. If I could direct your attention to Topic 14 in Kelly Deposition Exhibit No. 1. Topic No. 14 provides the process by which the Air Force provides airmen requiring daily medication with that medication while they're deployed in the cent com area of responsibility. Do you see that?

A. Yes.

Q. And are you prepared to address

that topic on behalf of the Air Force today?

A. Yes.

Q. Okay. What can you tell me about the process by which the Air Force provides airmen requiring daily medication with that medication while they're deployed in the cent com area of responsibility?

MS. ZEIDNER MARCUS: Objection. Calls for a narrative.

THE WITNESS: In general, when deploying to the cent com area take with them an adequate supply of medication with them, however, there may be some situations in which a refill may be needed or medication could be lost, destroyed. If that were the case, refilling the medication or resupplying would depend on the area where the service member is. Are they in a remote austere area in which it may be difficult to send medications? Certain areas may have a mission in which different supplies. For example, ammunition may be the highest priorities in the logistic chain to get to that area depending where it is, what location that may be through air, may be through convoy. There is a -- it's a priority,

depending on the mission, to get certain supplies there, and there is a possibility that medications may not be able to be restocked in certain time frames. It depends on the situation and the location.

Q. Okay. And, again, just to make sure I understand, you're saying even within cent com, the answer to that question can vary depending on the specific location within cent com?

A. Correct.

Q. Okay. And when you say in general, the service members take with them an adequate supply of medicine with them, they take with them -- tell me if I'm wrong, but more pills than they think they're going to need for the length of their anticipated deployment. Is that the idea?

A. Service members should take supply for approximately 180 days.

Q. Okay.

A. Approximately, and there's some situations in which deployments can get extended or return can be delayed because of logistical reasons.

Q. Okay. And is it true that those risks exist regardless of the reason for the evacuation?

A. Yes.

Q. Okay. And you testified also on defense counsel's questioning that there was no routine testing for neurocognitive impairments at the San Antonio Military Medical Center; is that right?

A. To my knowledge, there is no dedicated specifically for cognitive evaluation. That happens on a fixed schedule.

Q. Do you know what that is?

A. In general, we follow published guidelines on management of persons living with HIV, and to my knowledge, that is not a recommendation within those guidelines.

Q. And do you know whether that's because there's no consensus about whether persons living with HIV are likely to develop neurocognitive impairments at any point?

A. Can you repeat that?

MS. BAUER: Sure. Can you read it back?

(Question read back as requested.)

I do further certify that I am not a relative, counsel or attorney for either party, or otherwise interested in the event of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, on this 5th day of April, 2019.

Kimberly A. Kaz, RPR, Notary Public within and for the State of Ohio

My commission expires March 31, 2023.