

**IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
Alexandria Division**

NICHOLAS HARRISON, et al.,)
)
 Plaintiffs,)
)
 v.)
)
LLOYD J. AUSTIN III, et al.,)
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 Defendants.)
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_____)

No. 1:18-cv-641-LMB-IDD

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)
 RICHARD ROE, et al.,)
)
 Plaintiffs,)
)
 v.)
)
LLOYD J. AUSTIN III, et al.,)
)
 Defendants.)
)
)
_____)

No. 1:18-cv-1565-LMB-IDD

**DEFENDANTS’ OPPOSITION TO PLAINTIFFS’ MOTION TO ENFORCE
JUDGMENT AND FOR AN ORDER TO SHOW CAUSE**

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The Modern Military Association of America (MMAA) and Richard Roe (hereafter “Movants”), move the Court to enforce the permanent injunctions in these cases, *Harrison v. Austin*, 18-cv-641, ECF No. 314, and *Roe v. Austin*, 18-cv-1565, ECF No. 328, and to order Defendants to show cause why they should not be held in contempt for violating those injunctions. Movants bear the burden of demonstrating non-compliance. The facts indisputably demonstrate that Defendants are in compliance with the injunctions and that Movants have failed to shift the burden to Defendants to show cause. Not only have Defendants changed their policies to comply with the Court’s injunctions, but across all Services the vast majority of requested deployments and all requested commissions have been approved since the Court’s Orders. In reality, Movants seek not to enforce the existing injunctions, but to impose various additional obligations upon the Defendants that the Court did not include in its Orders. Movants’ attempts to rewrite the requirements of the injunctions should be rejected, and the motion for an order to show cause denied.

I. Background

On May 10, 2022,¹ the Court entered several injunctions in these related cases prohibiting Defendants from: (1) categorically barring the worldwide deployment or deployment to the United States Central Command (CENTCOM) of asymptomatic HIV-positive service members with an undetectable viral load due to their HIV status; and (2) denying the applications for commissioning of asymptomatic HIV-positive service members with an undetectable viral load because they are classified as ineligible for worldwide deployment or deployment to CENTCOM due to their HIV status.² *Harrison*, ECF No. 314; *Roe*, ECF No. 328. On June 6, 2022, the Secretary of Defense

¹ The Court originally entered its Orders in *Harrison*, ECF No. 308, and *Roe*, ECF No. 320, on April 6, 2022. Those Orders were amended pursuant to the parties’ motion for clarification adding one of the injunctions at issue in this motion.

² Other injunctions in the Orders, including an injunction barring separation of virally-suppressed

issued a memorandum, “Policy Regarding Human Immunodeficiency Virus-Positive Personnel Within the Armed Forces” (June 6 Memo), updating Department of Defense policy concerning “[i]ndividuals who have been identified as HIV-positive, are asymptomatic, and who have a clinically confirmed undetectable viral load,” otherwise known as “covered personnel.” Ex. 1, Declaration of Keri Berman, Ex. A, June 6 Memo.

The June 6 Memo immediately altered DoD’s accession and retention regulations, removing HIV as a disqualifying condition for commissioning of covered personnel and barring separation of covered personnel on the sole basis of HIV-positive status. *Id.* at 1. The June 6 Memo also altered DoD’s deployment policy, stating that covered personnel “are not non-deployable solely for the reason that they are HIV-positive,” and requiring a case-by-case deployment determination “justified by the Service members’ inability to perform the duties to which he or she would be assigned.” *Id.* at 2.

Since the issuance of the June 6 Memo, across the Army, Navy, and Air Force, every covered HIV-positive service member who has sought to commission has been approved. *See infra*. Of the 87 deployment (or for the Navy permanent change of station) requests for covered personnel requiring waiver considered by these Services since June 6, 2022, 70 have been approved.³ Of the 17 requests that were not approved, several are currently pending or were withdrawn. *See infra*. In the few instances where DoD or the Services have denied an assignment request for covered personnel, the denials resulted from individualized determinations based on circumstances such as changes to the service member’s health status and externally imposed

asymptomatic HIV-positive service members on the basis of deployment limitations and injunctions applicable to the individual plaintiffs, are not at issue in this motion.

³ These figures are drawn from information available based on a search for relevant information conducted by Defendants. Movants did not make any allegations concerning the United States Marine Corps so Defendants have not addressed the Marine Corps in this opposition.

foreign country entry-restrictions. *See infra*.

II. Legal Standard

“To ensure compliance with its orders, a district court has the inherent authority to hold parties in civil contempt.” *Rainbow Sch., Inc. v. Rainbow Early Educ. Holding LLC*, 887 F.3d 610, 617 (4th Cir. 2018). In the Fourth Circuit, “[a] party can be held in civil contempt when there is clear and convincing evidence of four elements: ‘(1) the existence of a valid decree of which the alleged contemnor had actual or constructive knowledge; (2) that the decree was in the movant’s favor; (3) that the alleged contemnor by its conduct violated the terms of the decree, and had knowledge (at least constructive knowledge) of such violations; and (4) that the movant suffered harm as a result.’” *Id.* (quoting *United States v. Ali*, 874 F.3d 825, 831 (4th Cir. 2017)). For civil contempt to be an “appropriate sanction,” there must be a court order “which sets forth in specific detail an unequivocal command which a party has violated.” *In re Gen. Motors Corp.*, 61 F.3d 256, 258 (4th Cir. 1995) (citation and alteration omitted); *see also Taggart v. Lorenzen*, 139 S. Ct. 1795, 1801 (2019) (explaining that “principles of ‘basic fairness require that those enjoined receive explicit notice’ of ‘what conduct is outlawed’ before being held in civil contempt,” and that “civil contempt ‘should not be resorted to where there is a *fair ground of doubt* as to the wrongfulness of the defendant’s conduct’”) (brackets and citations omitted).

III. Argument

Defendants do not contest that the Court issued several injunctions in the Movants’ favor. However, Movants have not shown, by clear and convincing evidence or otherwise, either that Defendants have violated the Court’s permanent injunction, or that Movants have been harmed by any of Defendants’ alleged conduct.

A. Defendants are in compliance with the Court’s injunctions.

Defendants have complied with the Court's injunctions and Movants have not supplied any evidence, *see infra* at 7, much less clear and convincing evidence, to the contrary. Indeed, Movants' theory of noncompliance is based on interpretations of the injunctions that are inconsistent with the plain terms of the Court's Orders. Defendants are in full compliance with the actual terms of the injunctions, and Movants' reading of the injunctions are meritless.

1. Defendants are in compliance with the commissioning injunction.

Movants allege, without any meaningful support or even argument, that Defendants have violated the Court's injunction as to the commissioning of covered personnel. That injunction reads:

defendants be and are ENJOINED from denying the application of Harrison and any other asymptomatic HIV-positive service member with an undetectable viral load to commission as officers because they are classified as ineligible for worldwide deployment or deployment to CENTCOM due to their HIV-positive status...

Amended Order, *Harrison*, ECF No. 314. The Secretary's June 6, 2022 memorandum directs the immediate revision of relevant DoD policies to permit the commissioning of covered personnel with HIV. June 6 Memo at 1; *see* Berman Decl., Ex. B, DoDI 6130.03, "Medical Standards for Military Service: Appointment, Enlistment, or Induction"; Berman Decl., Ex. C, DoDI 6485.01, "Human Immunodeficiency Virus (HIV) in Military Service Members." Since the date of issuance of the Court's Order, four service members living with HIV have received officer commissions, and no individual in the category described by the injunction has been denied a commission for any reason, much less on the basis of their deployability related to HIV-positive status. *See* Ex. 2, Declaration of LTC Amber Ellison ¶6 (Plaintiff Harrison has been offered a commission in the Army National Guard JAG corps and is awaiting orders to effectuate his appointment); Ex. 3 Declaration of Major Serena Staples ¶6; Ex. 4, Declaration of Kenneth Bonaparte ¶5 (Since June 6, 2022, two covered personnel requested to commission and both were cleared to commission);

Ex. 5, Declaration of Andrew House ¶¶4-5 (Since the issuance of the Court’s Order one covered Midshipman graduated from and was granted a commission by the Naval Academy); Ex. 6, Declaration of LTC Jennifer Stangle ¶9 (No covered personnel have requested to commission during the relevant period). Plaintiffs have set forth no basis to find that Defendants have been non-compliant with this injunction.⁴

2. Defendants are in compliance with the deployment injunction.

Movants also allege that Defendants have violated the Court’s injunction related to deployment of covered personnel. That injunction reads:

defendants be and are ENJOINED from categorically barring the worldwide deployment or deployment to the United States Central Command (“CENTCOM”) of plaintiff Nicholas Harrison and any other asymptomatic HIV-positive service member with an undetectable viral load due to their HIV-positive status...

Amended Order, *Harrison*, ECF No. 314; *see also* Amended Order, *Roe*, ECF No. 328. The natural reading of this injunction, and the one supported by the Court’s use of similar language in the accompanying opinion, *see infra* at 12, is that Defendants may not impose an unqualified prohibition, that is, one which does not permit individualized consideration and exceptions, on the deployment of service members who are asymptomatic and have an undetectable viral load. Defendants have indisputably complied with this injunction: the Department of Defense amended the controlling policy, the military considers relevant deployments on an individualized basis, and it has deployed the majority of covered personnel who have sought to deploy.

The Secretary of Defense’s June 6, 2022, memorandum states that “effective immediately” throughout the Department of Defense:

⁴ Plaintiffs appear to recognize that the lack of any adverse personnel action would eliminate the possibility of a violation of the injunction. Since the imposition of the Court’s other injunction in *Roe*, prohibiting the separation of covered personnel on the basis of HIV-related deployment restrictions, *see Roe*, ECF No. 328, no covered personnel have been involuntarily separated on that basis. The Movants have not alleged any violation of that injunction.

Covered personnel are not non-deployable solely for the reason that they are HIV-positive. Decisions on the deployability of covered personnel will be made on a case-by-case basis and must be justified by the Service Member's inability to perform the duties to which he or she would be assigned.

June 6 Memo at 2. Shortly thereafter, CENTCOM issued a "night order" modifying implementation of its Individual Protection and Individual-Unit Deployment Policy (MOD-16) to follow the requirements of the June 6 Memo. Ex. 8, Declaration of LTC Andrew Hall ¶3. More recently, CENTCOM issued revised Mod-17, which formally adopts the June 6 Memo's policy and states that in cases of "Confirmed HIV infection...[i]ndividuals that are asymptomatic with undetectable viral load may deploy depending on host nation requirements." Hall Decl. ¶¶ 3-4; Berman Decl., Ex. D, MOD-17, Tab A Section 7.C.2.

Pursuant to these changes, since the issuance of the June 6 Memo, the vast majority of HIV-positive service members across the Services who sought to deploy have been deployed, both to CENTCOM and elsewhere. Staples Decl. ¶6 (The Army processed 8 deployment waiver requests from covered personnel and approved 7); Ex. 7, Declaration of Capt. Michael Curry, ¶7 (The Navy processed 68 requests for change of duty station for covered personnel and approved 58)⁵; Stangle Decl. ¶10 (The Air Force processed 11 deployment waivers for covered personnel, 5 were approved, 2 were denied, 1 is pending, and 3 had other dispositions). Moreover, on the limited occasions where deployments have been denied, those denials have been premised not on the HIV-positive status of the service members, but on additional, individualized factors which either change their covered personnel status or render them unable to perform their assigned duties. *See* Staples Decl. ¶6 (Single denial premised on Kuwait HIV-entry restriction); Curry Decl. ¶7

⁵ As explained in detail in the Curry Declaration, Navy assignments operate different than the other services with most service members being assigned to a platform (i.e. moving vessel). Curry Decl. ¶7. These platforms travel throughout the world including to the CENTCOM area of operations. *Id.* A deployment to a platform that enters the CENTCOM area of operations is considered a deployment to CENTCOM by the Navy. *See Id.*

(Ten unapproved requests included 2 withdrawn requests, 2 denials for non-compliance with HIV treatment protocol, 3 denials for poor viral control, 2 platform resource limitations, and 1 denial for host-country HIV entry restrictions); Stangle Decl. ¶10 (One denial based on medical limitations for an unrelated condition, one denial based on host-country entry restrictions). In short, Defendants have fully complied with the Court's injunction. Relevant deployment policies have been amended so that there is no categorical prohibition on the deployment of asymptomatic individuals with an undetectable viral load, and most such deployments have been authorized. On the rare occasions a deployment has not been allowed, that disapproval has been based on an evaluation of the particular circumstances of the individual service member and the location of the deployment, not a categorical bar. While an injured party may seek to raise any individualized dispute in a separate lawsuit, such circumstances cannot form the basis for contempt of the Court's injunction.

B. Movants cannot establish that Defendants violated the injunctions.

Movants' allegation that the Defendants have violated the Court's deployment injunction is based not on the actual language of the injunction or the facts concerning actual military deployments, but on Movants' insertion of requirements that do not actually appear in the text of the injunction. Specifically, plaintiffs contend that the injunction should be read not only to require a presumption of deployability for covered personnel, but also to prohibit Defendants from denying the deployment of a covered individual related to HIV under any circumstances. As explained further below, any reasonable reading of the language of the injunction contradicts Movant' reading.

1. Movants' primary declaration is improper and the evidence submitted therein cannot be considered.

As an initial procedural matter, the evidence upon which Movants rely is improper. Specifically, Movants rely almost exclusively on a declaration of their counsel, *see* Perkowski Declaration, *Harrison*, ECF No. 350-1, as support for their motion.⁶ However, this declaration is mostly, if not entirely, composed of inadmissible evidence that may not be considered by the Court. The declaration provides, *inter alia*, Mr. Perkowski's recitation of information he alleges to have received from various unidentified persons or persons identified by pseudonym. *See* Perkowski Decl. ¶¶ 7-9, 23-72. Based on Mr. Perkowski's own statements in the declaration, it is indisputable that the information offered is not within his personal knowledge and is hearsay. *See id.* Moreover, as Plaintiffs' motion relies on the information presented by ¶¶ 7-9, 23-72, in support of their claims for relief, *see generally* Movs.' Br., these assertions are offered for the truth of the matter asserted and are inadmissible. *See* Fed. R. Evid. 602, 801(c)(2).

Federal Rule of Civil Procedure 56(c)(4) speaks directly to this limitation in the context of summary judgment:

Affidavits or Declaration, An affidavit or declaration used to support or oppose a motion must be made on personal knowledge, set out facts that would be admissible in evidence, and show that the affiant or declarant is competent to testify on the matters stated.

Mr. Perkowski's declaration, and specifically ¶¶ 7-9, 23-72, does not meet these requirements and is being offered to prove the truth of the matter asserted.

The Fourth Circuit has held that under Rule 56(c)(4) affidavits and declarations "must present evidence in substantially the same form as if the affiant were testifying in court," and must "contain admissible evidence and be based on personal knowledge." *Evans v. Techs. Apps. & Serv.*

⁶ Movants filed voluminous new and amended exhibits on the afternoon of June 2, 2023, the due date of this opposition. *Harrison*, ECF No. 358-62; *Roe*, ECF No. 368-71. However, that filing is clearly untimely and only serves to have wasted Defendants' resources in responding to the current record presented. Moreover, Plaintiffs did not amend their memoranda in support of their motions to reflect any new evidence.

Co., 80 F.3d 954, 962 (4th Cir. 1996). These submissions also “cannot be conclusory... or based on hearsay.” *Id.* Declarations and affidavits, or parts thereof, that do not comply with Rule 56(c)(4) may be stricken from the record. *See id.* The substantial majority of Mr. Perkowski’s declaration is based, by his own admission, on the statements of third parties who have not provided their own sworn statements – in other words, inadmissible hearsay. *See, e.g., McCray v. Pee Dee Reg’l Transp. Auth.*, 263 F. App’x 301, 306 n.5 (4th Cir. 2008) (“Finally, a large number of the statements put forth by McCray are based upon inadmissible hearsay, as McCray relies entirely on information relayed to him by third parties who are not party-opponents and who have not themselves provided affidavit or deposition testimony.”).⁷

The sworn representations of affiants are subject to discovery and cross-examination, and that type of examination is impossible when the factual circumstances are presented by the Movants’ counsel of record in this matter, who has no personal knowledge.⁸ Conversely, there would be no prejudice to Movants in providing properly sworn affidavits. There are protective orders in place in these cases, and the anonymous Plaintiffs have maintained their anonymity throughout. Moreover, Movants admitted in their brief in support of this motion that they could provide properly sworn affidavits but have not done so. *Movs.’ Br.* at 8 n.3.

⁷ The Perkowski Declaration proffers both first-level hearsay and hearsay-within-hearsay. *See* Fed. R. Evid. 805. Even if some exception might apply to the statements of government officials relayed by anonymous individuals to Mr. Perkowski, which Defendants dispute, no exception permits the admission of the statements of those anonymous individuals through Mr. Perkowski. *See* Berman Declaration, Ex. E at 7.

⁸ The problems inherent in an attorney serving as both an attorney and a witness in the same case militate against mixing those roles. *See* ABA Model Rule 3.7(a) (“A lawyer shall not act as an advocate at a trial in which the lawyer is likely to be a necessary witness....”). The reasoning is straightforward: “[c]ombining the roles of advocate and witness can prejudice the tribunal and the opposing party,” and “[i]t may not be clear whether a statement by an advocate-witness should be taken as proof or as an analysis of the proof,” because a witness is meant to testify as to their personal knowledge while an attorney is meant to explain the evidence provided by others. Comment to ABA Model Rule 3.7 at [1]; [2].

Additionally, the Perkowski Declaration attempts to describe and provide argument concerning various published regulations, *see id.* ¶¶ 10-20, rather than providing the text of the regulations for the record. In this respect, the declaration seeks to attest improperly to the content of the regulations, and thereby attempts to evade the Rules of Evidence as well as the Court's limitations on argument outside of the motion. *See United States v. Ivey*, 60 F.4th 99, 113 (4th Cir. 2023) (quoting Fed. R. Evid. 1002) (“[W]hen a party seeks to ‘prove [the] content’ of a ‘writing, recording, or photograph,’ it must do so with the original.”).

Defendants contacted Movants' counsel on May 19, 2023, informing them that the Perkowski Declaration was inadmissible and asking them to cure the various defects. Berman Decl., Ex. E, Email exchange between Attys Berman and Schoettes/Perkowski, at 7-8. Movants' counsel eventually admitted that the Declaration contained inadmissible hearsay but declined to cure, indicating that he believed submitting admissible evidence was a “merely administrative and time-consuming exercise.” *See id.* at 6; *id.* (“We acknowledge that some of the statements in paragraphs 23-72 are hearsay and don't satisfy an exception.”). Defendants once again requested that Movants cure the defective declaration and Movants represented that they would attempt to obtain sworn affidavits for the unsworn third-party hearsay and would enter the regulations at issue into the record, however they would only do so “in no event later than [their] reply.” *Id.* at 3.

Defendants asked Movants to cure the acknowledged defect with the declaration by amending the schedule or withdrawing their motion, but Movants refused to do so before this Opposition was due. *See id.* at 2-3; Fed. R. Civ. P. 6(c)(2) (“[a]ny affidavit supporting a motion must be served with the motion.”); *Aldridge v. Marion Cty. Coal Co.*, Case No. 1:17CV79, 2017 U.S. Dist. LEXIS 127733, at *5 (N.D. W. Va. Aug. 10, 2017) (“affidavits may accompany a reply brief if they support the reply rather than the original motion.”); *Democracy N.C. v. N.C. State Bd.*

of Elections, Case No. 1:20-CV-457, 2020 U.S. Dist. LEXIS 131980 at *17 (M.D.N.C. July 27, 2020) (quoting *McGinnis v. Se. Anesthesia Assocs., P.A.*, 161 F.R.D. 41, 42 (W.D.N.C. 1995) (Rule 6(c)(2) “requires the supporting affidavits to be filed simultaneously with the motion it supports, affording the opposing party an opportunity to address the motion fully and squarely on its merits.”)).

For these reasons, Movants have submitted improper and inadmissible evidence to this Court, and the Perkowski Declaration should be struck from the record or the evidence therein should be barred from consideration in support of this motion. On the afternoon this Opposition was due, Movants filed hundreds of pages of exhibits and various new declarations, some under seal. Obviously, Defendants did not have an opportunity to review or respond to any of this material and the prejudice is apparent. These evidentiary defects should have been cured in time for Defendants to be able to review and respond to the evidence supporting Movants’ motion. Filing just hours before Defendants must submit their response effectively revises the record and is untimely, prejudicial to Defendants, and unacceptable under the Federal Rules of Civil Procedure.

2. Movants’ reading of the injunction is incorrect and untenable.

Aside from relying on an improper record at this time, Movants’ reading of the injunction, which would prohibit the denial of any deployment of covered personnel and impose various other unstated requirements, is not a reasonable construction of the injunction. The injunction does not enjoin Defendants “from barring the deployment” of covered personnel, it enjoins Defendants “from *categorically* barring the deployment” of covered personnel. The natural meaning of the modifier “categorical” is unqualified or absolute, *see* <https://www.merriam-webster.com/dictionary/categorical>, in other words, without exception. Under that reading of the

injunction Defendants are enjoined from prohibiting the deployment of asymptomatic HIV-positive service members with undetectable viral loads as a class on the basis of their HIV-positive status, without any individualized consideration. This understanding is consistent with the way the Court described Defendants' prior policy in its opinion. *See Harrison v. Austin*, 597 F. Supp. 3d 884, 910 (E.D. Va. 2022) ("It is irrational to *categorically* bar the deployment of *every* asymptomatic HIV-positive service member with an undetectable viral load...") (emphasis added); *see also Roe v. United States DoD*, 947 F.3d 207, 225 (4th Cir. 2020) ("the record contains no other justification for a categorical ban on deploying HIV-positive service members to CENTCOM's area of operations.").

Movants on the other hand seek to read the injunction far beyond its plain language and indeed any reasonable interpretation. They suggest that the Court forbade Defendants from limiting the deployment of individual covered personnel in any way. *See Movs.' Br.* at 18 ("The Court's orders specifically identify [CENTCOM] as an area to which AHPSMUVL *cannot be denied* deployment...") (emphasis added). Not only is this interpretation unsupported by the text of the Orders, it would be beyond the bounds of the Court's authority to require. *See infra* at 30.

The Court's injunction clearly includes the modifier "categorically," and thereby limits the scope of the injunction. The Court's opinion is also clear that the specific terms of the injunctions were deliberately chosen and intentional. *See Harrison v. Austin*, 597 F. Supp. 3d 884, 915 (E.D. Va. 2022). Court orders have the force of law, and under analogous rules of interpretation, when interpreting laws, the inclusion of any language is presumed to be intentional and meaning must be given to every word or sentence. *Cf., e.g., Navy Fed. Credit Union v. Ltd. Fin. Servs., LP*, 972 F.3d 344, 359 (4th Cir. 2020) (quoting *Fontenot v. Taser Intl. Inc.*, 736 F.3d 318, 327 (4th Cir. 2013) ("It is presumed the legislature intended each portion to be give full effect and did not intend

any provision to be mere surplusage.”)); *South Carolina v. USACE*, 66 F.4th 189, at *11 (4th Cir. 2023) (“[a] statute ought, upon the whole, to be so construed that, if it can be prevented, no clause, sentences, or word shall be superfluous, void, or insignificant.” (citation omitted)); *Id.* at *12 (quoting *Duncan v. Walker*, 533 U.S. 167, 174 (2001) (a word or phrase is surplusage if the writing would have “precisely the same content” with that term struck).

Movants appear to suggest that “categorical” should be understood to mean simply “as a group,” and that the injunction strips Defendants of all decision-making authority related to deployments in every individual case. *See* Movs.’ Br. 23-25. However, the natural reading of “categorically bar” is that Defendants are enjoined from barring the deployment of covered personnel as a group *without* individual consideration. Movants acknowledge that this is the primary meaning of the word “categorical,” *see* Movs.’ Br. at 23, yet the definition Movants attempt to impose would render the word “categorical” meaningless. The injunction does not state that Defendants are barred from making individual deployment decisions, and any such interpretation is not possible unless the inclusion of the word categorical was mere surplusage and a nullity. If “categorical” does not carry its plain meaning – devoid of any individualized consideration – then it has no meaning at all. The intent of the Court in crafting the injunction comports with Defendants’ understanding. *See Harrison*, 597 F. Supp. 3d at 906 (finding that the treatment of other medical conditions “underscore[s] the individualized determinations that people with HIV are categorically denied.”)

Thus, the Court’s injunction requires that Defendants not categorically enforce a policy, as to the covered group without meaningful opportunity for individual consideration. The Order does not direct Defendants to comply with this categorical prohibition in any particular way and does not state that Defendants must deploy every member of the group without regard of any individual

circumstances. For example, nothing in the order bars the use of individual medical waivers or consideration of particular medical circumstances or limitations on a particular deployment. It would have made sense for the Court to leave the military with discretion to make individualized determinations about commissions and deployability. Such decisions do not entail a categorical bar but, rather, judgments about particular circumstances involving an individual service members' circumstances. Moreover, that approach also comports with the "bedrock constitutional principle" that courts should not intrude in the area of "professional military judgments." *Austin v. U.S. Navy Seals 1-26*, 131 S. Ct. 1301, 1302 (2022) (Kavanaugh, J., concurring), and furthers the military's "extraordinarily compelling interest in maintaining strategic and operation control over the assignment and deployment" of personnel.

Under the applicable standard of review, contempt may only lie against a party that has violated an order that is detailed, clear, and unambiguous. *See infra* at 26. The Fourth Circuit has made clear that "a party must be able to discern *from the language* of a court's order the actions necessary to comply with the court's directive." *Life Techs. Corp. v. Govindarai*, 931 F.3d 259, 268 (4th Cir. 2019) (emphasis added). Whatever Movants think the injunction should have required, Defendants cannot be held in contempt because they are compliant with the injunctions' express terms. *See, e.g., United States v. Saoud*, No. 1:12CR113, 2018 U.S. Dist. LEXIS 111394, at *16 (N.D.W. Va. July 3, 2018) (quoting *In re GMC*, 61 F.3d at 259) ("[T]he relevant inquiry remains whether the [injunction] sets forth an 'unequivocal command' that is 'clear and unambiguous,' not whether the parties intended a particular restraint.").

Movants ask the Court to rely on outdated and out-of-circuit cases for the proposition that enjoined parties must comply with the "spirit" of an injunction even if it is not made explicit. Movs.' Br. at 14. However, even those cases make clear that courts may prevent enjoined parties

from relying on technicalities to dodge the obvious import of the injunctions. *See McComb v. Jacksonville Paper Co.*, 336 U.S. 187, 190, 192-93 (1949) (finding that the enjoined party could not evade the general scope of an injunction by creating novel ways, including “a completely false and fictitious method of calculating compensation,” to break the law that were not specifically identified in the injunction). Indeed, in the sole recent, in-circuit decision Movants cite for that proposition, the Court remarked that the proceeding was “in effect a continuation of the original lawsuit” where movants sought to impose additional obligations outside the bounds of the injunction. *See North Carolina State Conf. of the NAACP v. McCrory*, 214 F. Supp. 3d 466, 473-74 (M.D.N.C. 2016). Much like the present motion, the Court noted that the Order “did not direct the implementation of any particular form of relief ...nor is there any indication that the court’s decision contemplated ongoing monitoring or oversight,” so “while it may seem expedient to [movants] to raise their claims...in the guise of a violation of this court’s injunction, the proper vehicle ordinarily for such challenges is a separate action – which could have been brought earlier – that ensures the creation of a proper record.” *Id.* As described above, Defendants have changed their policies and practices such that there is no categorical bar to deployment by covered personnel. Movants have not introduced any evidence to the contrary. And individual claims must be raised in a separate lawsuit, not through contempt proceedings.

3. Movants’ other allegations of non-compliance are unsupported.

Movants also allege that Defendants violate the injunction if they continue to exercise any operational discretion to deny the deployment of any covered personnel for any reason related to HIV. *Movs. Br.* at 24. Specifically, they assert that the District Court and the Fourth Circuit found every reason presented by Defendants for limiting commissioning or deployment to be irrational. This is a misreading of both opinions that ignores the limitations on the actual injunctive relief

granted. Both opinions respond to the question of whether a categorical bar to deployment and commissioning is irrational based on the proffered justifications. *See Harrison*, 597 F. Supp. 3d at 890, *Roe*, 947 F.3d at 225-26. Neither decision opines that all, or perhaps any, of the justifications provided by the Defendants for their former policies would be irrational bases for denying an individual commissioning or deployment in all cases regardless of the individual circumstances. Instead, both opinions are careful to emphasize that they found a *categorical* bar on deployment (and consequently commissioning and separation) to be irrational based on the reasons put forward. *See Harrison* 597 F. Supp. 3d at 911, 915; *Roe*, 947 F.3d at 225-27. The Court was not squarely presented with the issue of individual operational decisions based on a full consideration of unique circumstances, and the relief awarded sidesteps such issues. Moreover, the opinion of this Court explicitly cautioned against going beyond the specific facts of the case. *See Harrison* 597 F. Supp. 3d at 890 n.5 (declining to reach the legality of the military’s policy with respect to initial accessions because none of the plaintiffs were subject to that policy, and noting “the government persuasively argues that relief should be limited to those similarly situated to [the plaintiff]”). Therefore, the Court’s opinion did not encompass whether certain specific considerations related to HIV-infection could serve as the basis to deny a deployment in an individual case. In particular, Movants are wrong that the Court has already determined that host-country restrictions on the entry of HIV-positive individuals to be an irrational basis for limiting deployment. This Court followed the Fourth Circuit, which concluded the record was insufficient to demonstrate the viability of that justification. *Roe* 947 F.3d at 225-26; *Harrison* 597 F. Supp. 3d at 908 n.22. This determination was based in part on the Court’s finding that host-nation restrictions had never been the basis for denying an HIV-positive individual a waiver to deploy to CENTCOM and the lack of record evidence that (1) the laws of host nations “appl[y] to both

military servicemembers and civilians” and (2) “the inability to enter one nation would preclude deployment to the entire area.” *Harrison*, 597 F. Supp. 3d at 908 n.22 (quoting *Roe*, 947 F.3d at 225-26). Now that Defendants have implemented the Court’s injunctions, as Movants are aware, host-nation restrictions have been the basis for the denial of at least one deployment waiver, but denying deployments to a particular country does not amount to a “categorical” bar to deployment to CENTCOM or elsewhere. Indeed, shortly after A.J.’s deployment initial waiver to Kuwait was denied, for example, he was subsequently granted a waiver to deploy to Saudi Arabia, which is also in CENTCOM, and he in fact deployed there. Ex. 9, Declarant 9 ¶5.⁹

Movants further contend that Defendants have improperly narrowed the scope of the Courts’ injunctions by including the words “solely” or “in itself” in the June 6 Memo and accompanying revised regulations. Movs.’ Br. at 26-28. Movants’ allegation that this “signals” a path to noncompliance for decision-makers is unfounded. These terms do not narrow the effect of the injunctions, which only prohibit a categorical bar on deployment on the sole basis of HIV-status, and categorical denials of commissioning on the sole basis of ineligibility for deployment based on HIV-status. Movants also assert that Defendants have violated the injunctions by not changing every regulation related to commissioning and deployment. In their view, the lack of certain changes confuses decisionmakers and “sends the wrong message” about commissioning and deployability of covered personnel. Movs.’ Br. at 27-29. This argument fails to establish any basis for finding contempt of the injunctions. The injunctions do not proscribe a particular set of regulations that must change; rather, the injunctions prohibit the military from “categorically” denying the commissioning or deployment of asymptomatic individuals with an undetectable viral load. As discussed above, there no longer is any such categorical bar, and numerous service

⁹ The names of Declarants 9, 10, and 11 are currently redacted pending sealing orders.

members living with HIV have since commissioned and/or deployed (to CENTCOM and elsewhere). Defendants also have amended relevant military policies and by publishing the June 6 Memo itself provided the controlling regulatory guidance. *See infra*; *see also* Hall Decl. ¶¶3-4; Staples Decl. ¶3. The specific actions preferred by Movants are not compelled by the text of the injunctions.

Movants next argue that the Department of Defense “Communication Plan” in some way invalidates its actual changes to policy and practice. Mavs.’ Br. at 4, 29. But that document is merely what it purports to be, a communications document conveying the substance of the actual regulatory change contained in the June 6 Memo. To the extent there is any discrepancy, the June 6 Memo and any accompanying changes to promulgated regulations are controlling.

Finally, Movants claim that the Defendants’ interpretation of the injunctions returns the parties to the status quo and permits Defendants to disguise constitutional violations under the fig leaf of a single approved deployment. *See* Mavs.’ Br. at 24-25. This hypothetical is plainly inconsistent with the facts. The uncontroverted evidence demonstrates that numerous service members falling within the scope of the injunctions have commissioned and been authorized deployment since the Court entered its injunctions. A hypothetical so at variance with the facts cannot form the basis for contempt.

C. Movants have not suffered any harm as a result of Defendants alleged violation of the injunction.

For the reasons explained *supra*, Defendants have not violated the Court’s injunctions, so Movants cannot have suffered any harm attributable to Defendants’ alleged conduct and no contempt sanction may issue. However, even if the Court were to determine that Defendants’ actions were in some way inconsistent with the injunctions, the lack of any evidence of harm to the Movants is a sufficient independent basis to deny their motion. *See Rainbow Sch.*, 887 F.3d at

617; *Estes v. Clarke*, Case No. 7:15-cv-0155, 2022 U.S. Dist. LEXIS 116778, at *15-16 (W.D. Va. July 1, 2022) (finding that contempt could not issue on a technical violation of an order because there was no harm to the movant).

The law of the Circuit is clear: it is only harm to the movants themselves that may be considered on a motion for contempt. *See Rainbow Sch.*, 887 F.3d at 617; *CFPB v. Klopp*, 957 F.3d 454, 461 (4th Cir. 2020). The only movants in this motion are Roe and MMAA, neither of whom have alleged any legally cognizable relief resulting from any of Defendants' actions.

1. The Movants' Alleged Harms Are Not Cognizable

As noted above, no covered personnel have been denied commissioning since the issuance of the court order for any reason. Nor have either of the Movants alleged their involvement in any commissioning process from which any harm could flow. Consequently, Movants have not established any harm to themselves from Defendants' actions related to commissioning, and in fact they have not even alleged any harm related to the requirements of that aspect of the injunction.

Movant Roe has not alleged that he has "suffered harm," from Defendants' alleged violation of the deployment injunction. The legal standard contemplates harm that has already occurred, and the courts' analysis in civil contempt cases turns on harms that have already transpired. *See, e.g., FTC v. Pukke*, 53 F.4th 80, 102, 104-05 (4th Cir. 2022). Roe does not allege that during the relevant time period he has requested to deploy, attempted to deploy, deployed, or been prevented from deploying. *See* Movs.' Br. at 12-13. Defendants' deployment policy has not been applied to Roe and thus he cannot have suffered any harm related to that policy. Additionally, even if the contempt standard contemplated future injuries, which it does not, those injuries would need to be legally cognizable. "When a plaintiff's purported injury is one that has not yet occurred, the injury must be 'certainly impending'; an allegation of a 'possible future injury' is not

sufficient....When a plaintiff's allegation of a future injury rests on a 'highly attenuated chain of possibilities,' that threatened injury is not imminent or 'certainly impending.'" *Patrick v. BATFE*, 860 F. App'x 828, 833-34 (4th Cir. 2021) (quoting *Clapper v. Amnesty Int'l USA*, 568 U.S. 398, 409-10 (2013)). Roe's claim that he expects at some unknown future point to be delayed or denied a deployment is entirely speculative. He has not alleged that he is seeking or being considered for a deployment. Moreover, his understanding of the Air Force deployment process is incorrect, and there would not be any preference given to Airmen without assignment limitation codes or delay that would prevent covered personnel from deploying. *See Stangle Decl.*, ¶¶7-8; *see generally*, Ex. 10, Declarant 10. The Court cannot find Defendants in contempt based on Roe's speculative fear of future injury.

As to MMAA, it also has not alleged, let alone proven by clear and convincing evidence, that it has suffered harm as a result of any conduct by Defendants allegedly in violation of the deployment injunction. As noted above, the contempt standard is concerned exclusively with harm to the movants. Consequently, Movants' various unsupported allegations, *see supra* at III.A, about non-movant service members are irrelevant. In addition to the fact that none of those individuals are movants, MMAA has not alleged or provided any evidence to establish that any of those individuals are members of or represented by MMAA. Therefore, even if MMAA could rely on a representative harm to its members as the basis to establish the fourth prong of the contempt standard, it cannot do so where it has not alleged or established any such membership. Moreover, Defendants maintain that MMAA is not a membership organization or the functional equivalent thereof, *see generally* Memorandum in Support of Renewed Motion to Dismiss, *Harrison*, ECF No. 155, and cannot establish standing on this basis. The Court declined to reach this issue previously, so Plaintiffs cannot assert that they have already established standing in this manner.

See Order Denying Motion to Dismiss, *Harrison* ECF No. 250 at 9, *Roe* ECF No. 261 at 9. To the extent MMAA is alleging that it has suffered on the theory that it represents its members, Defendants renew their objection to MMAA's standing to bring suit and MMAA cannot seek contempt on behalf of any purported members.

MMAA may only rely on any alleged direct injury to its organization to establish that it has suffered harm. MMAA asserts in a conclusory manner that it "has continued to expend resources to address these harms and the barriers service members living with HIV are facing as a result of Defendants' failure to comply with the Court's orders." Movs.' Br. at 15. The only support Movants' provide for this claim is an assertion that Plaintiffs' counsel exchanged several letters with and had several phone conversation with Defendants' counsel. *Id.* at 16, Perkowski Decl. ¶¶ 74-80. Assuming these minimal activities could be understood as a sufficient expenditure of resources in the first place, they do not establish harm to MMAA for at least two reasons. First, as explained above, Movants are actually seeking additional requirements that go beyond the Court's Orders, *see also infra*. Self-imposed expenditures related to this purpose cannot establish harm for the purpose of contempt. Second, an expenditure of resources, without more, is insufficient to allege a cognizable direct harm to an organization in the Fourth Circuit. "The Fourth Circuit has explained that an organization must have both 'expended resources' and had their activities 'perceptibly impaired' as a result of the alleged violations" to establish a cognizable harm. *South Carolina State Conf. of NAACP v. South Carolina Dep't of Juvenile Justice*, Case No. 22-cv-1338, 2023 U.S. Dist. LEXIS 19041, at * 5 (D.S.C. Feb. 2, 2023) (quoting *Maryland Shall Issue, Inc. v. Hogan*, 963 F.3d 356, 362 (4th Cir. 2020)). MMAA has not alleged any perceptible impairment to its activities attributable to Defendants' alleged conduct in complying with the injunction. MMAA has not established or even asserted that it has been prevented from

“achiev[ing] its stated goals and conduct[ing] its regular business” and therefore have not demonstrated MMAA has suffered harm as a result of Defendants’ alleged actions. *Id.* While it may have voluntarily expended funds in support of additional actions to benefit the covered class, such expenditures cannot constitute a cognizable harm for purposes of obtaining an order of contempt. This is especially so where, far from frustrating the Court’s orders, Defendants have commissioned and deployed nearly everyone in the covered group. Accordingly, neither of the two Movants – MMAA and Roe – have established any harm for purposes of obtaining contempt relief.

2. The Alleged Harms to Non-Movants are Neither Relevant Nor Cognizable

Even if the alleged harms of the individuals referenced in Movants’ brief could somehow be attributed to the Movants,¹⁰ they still could not establish harm. First, Movants make general assertions that service members, including the referenced individuals, are harmed by the manner in which the Military Services track service members with HIV and process medical waivers. In addition to being conclusory and insufficiently supported, these assertions are inaccurate and cannot support an order of contempt.

Movant Roe’s assumptions that service members who do not require medical waivers are routinely given preference for deployments over service members who do require them, *see* Movs.’ Br. at 5, 21, is speculative and misapprehends how the selection and waiver process works. *See* Stangle Decl. ¶¶7-8. The waiver process takes place after assignments are initially received and seeks to qualify Airmen to fill the roles for which they have already been tapped. *Id.* Moreover, deployments seek volunteers. Decl. 10 ¶4. Similarly, Movants’ characterization of the medical

¹⁰ There are several other anonymous individuals referenced in the Perkowski Declaration. Movants have not relied on any allegations related to those individuals to present their arguments but those individuals also have not suffered any cognizable harms and Defendants reiterate that their purported statements are inadmissible hearsay.

waiver process as unreasonably onerous does not align with the reality. *See* Stangle Decl. ¶7.

Second, Nicholas Harrison, who did not join this motion despite being a Plaintiff in one of the cases, did not suffer any harm. He has been recommended for and is in the final steps of obtaining a commission, and has neither sought nor been denied a deployment in the relevant period. *See* Ellison Decl. ¶¶5-6. The harms Movants allege Harrison has faced, including an unwarranted delay in processing his commission and an insufficient rank, are neither true, *see id.* ¶¶3-6, nor related to the Court's commissioning injunction. Since these supposed harms are not attributable to any conduct prohibited by the injunction, they cannot satisfy the fourth prong of the contempt standard.

Third, non-Movant A.J. did not suffer any harm cognizable under the deployment injunction. A.J. has deployed to Saudi Arabia, a country within the CENTCOM area of operations. Decl. 9 ¶5. Although A.J.'s deployment waiver was initially denied because he was scheduled to initially travel to Kuwait, his waiver was later approved for the actual substance of his deployment to Saudi Arabia. *See id.* As explained *supra*, the Court's injunction only prohibits categorically barring deployment of covered personnel to CENTCOM so Defendants committed no violation with regard to A.J. Contrary to Movants' allegations, missing "important aspects of pre-deployment training and preparation with [A.J.'s] unit," Movs.' Br. at 9, is not a cognizable harm under the deployment injunction. Moreover, a number of individuals in A.J.'s battalion also arrived late to the deployment and some did not deploy at all, with no effects on their career progression. Decl. 9 ¶ 6. Therefore, even if his delay could be considered relevant, A.J. did not experience any unusual, significant, or detrimental effects.

Fourth, non-Movant B.J. has not alleged any harms cognizable under either the commissioning or deployment injunctions. His commission was granted, *see* Ex. 11, Declarant 11

¶2, and Defendants did not violate the terms of that injunction, *i.e.*, the prohibition on denying commissions to covered personnel on the basis of ineligibility for deployment. Movants also do not allege that Defendants barred B.J. from deploying on the basis of his HIV-status. *See* Movs.’ Br. at 9-10. Thus B.J. has not suffered any harm attributable to any alleged violation of either injunction. Indeed, B.J. has not been denied the opportunity to seek a deployable position, and whether he obtains such a position or not will not matter for progression in his career field. Decl. 11 ¶¶4-6, 9. B.J. did not pursue the path available to him to qualify for a deployable position, and even if any harm had issued from that decision, it would not be attributable to a violation of the injunction by Defendants. *See* Movs.’ Br. at 9-10; Decl. 11 ¶9.

Finally, non-movant C.J. has not alleged any harm attributable to an alleged violation of the deployment injunction. C.J. sought a position requiring travel throughout the CENTCOM area of operations. Movs.’ Br. at 10-11; Curry Decl. ¶¶8, 10. C.J. was made aware that he would not be able to perform the duties to which he would have been assigned because of HIV entry restrictions in one or more countries to which he would be expected to travel. Curry Decl. ¶11. C.J. was not categorically barred from deploying to CENTCOM but rather was determined to be ineligible for a specific assigned position (outside of CENTCOM) because it would require him to be authorized and able to travel on short notice to every country within CENTCOM, including some which would forbid his entry. C.J. was informed of the opportunity to seek a waiver to be considered for the position notwithstanding his disqualification, but he chose not to pursue it. *Id.* ¶14. After declining to further pursue his desired position, C.J. was nominated, in the course of the normal assignment process for a billet that would advance his career progress. *Id.* ¶¶4, 8, 13. Accordingly, Defendants did not violate the deployment injunction with respect to C.J., whose assignment request was given individualized consideration, and who did not to pursue the necessary steps to be approved for a

waiver for that preferred assignment and therefore suffered no harm attributable to Defendants' conduct.

D. Even if the Court concludes Movants have met their initial burden, contempt sanctions are unwarranted.

The contempt standard is a burden shifting framework and "unless Plaintiff makes the necessary showing, as outlined above, there is no need to require Defendants to show cause why they should not be held in contempt." *Ri Ra Holdings LLC v. Ri Ra*, No. 1:99CV0374, 2002 U.S. Dist. LEXIS 18880, at *17 (M.D.N.C. May 16, 2002). Movants have not made the necessary showing as explained above. However, if, despite Movants' failure to prove the third and fourth elements of contempt by clear and convincing evidence, the Court nevertheless determines that Defendants are not in strict compliance with the injunctions, Defendants still should not be subject to contempt sanctions.

"Contempt is an awesome and potentially oppressive power, a sanction not to be lightly imposed." *Pukke*, 53 F.4th at 103. Consequently, contempt is only appropriate "if there is no objectively reasonable basis for concluding that the [offender's] conduct *might* be lawful." *De Simone v. VSL Pharm., Inc.*, 36 F.4th 518, 530 (4th Cir. 2022) (quoting *Taggart v. Lorenzen*, 139 S. Ct. 1795, 1799 (2019) (emphasis added)). Defendants have taken the necessary steps to, and have in fact, complied with the plain meaning of the Court's injunctions and contempt sanctions are not justified.

First, as Defendants explained *supra*, the Court's injunctions are limited and most naturally read to prohibit Defendants from barring covered personnel, as a class and without individualized consideration, from commissioning and deployment. Defendants are in full compliance with this plain meaning of the injunctions. None of the additional relief Movants demand is stated or implied by the text of the Orders. Assuming Movants' alternative interpretation can be given any credence

as a viable reading of the injunctions it does not render Defendants' reading unreasonable or incorrect. At most, Movants' alternative proposal would indicate that the language of the injunctions is ambiguous.

“A party cannot be held in contempt for violating an ambiguous court order.” *CFPB*, 957 F.3d at 464 (quoting *Acosta v. La Piedad Corp.*, 894 F.3d 947, 951 (8th Cir, 2018)). The Fourth Circuit has repeatedly made clear that “subjecting a litigant to contempt liability...requires a clear indication of what is prohibited.” *Id.*; *In re GMC*, 61 F.3d 256, 258 (4th Cir. 1995) (“Civil contempt is an appropriate sanction if we can point to an order...which sets forth in specific detail an unequivocal command which a party has violated.” (citation omitted)); *In re Wilson*, No. 98-2831, 1999 U.S. App. LEXIS 27340, at *6-7 (4th Cir. Oct. 27, 1999) (“Fairness dictates giving a party clear notice of what it is violating before holding that party in contempt.”); *see also, e.g., Taggart*, 139 S. Ct. at 1802 (“[P]rinciples of ‘basic fairness requir[e] that those enjoined receive explicit notice’ of ‘what conduct is outlawed’ before being held in civil contempt.” (quoting *Schmidt v. Lessard*, 414 U. S. 473, 476, (1974) (*per curiam*))). Defendants changed their policy such that there is no longer a blanket restriction on commissioning or deployment for covered personnel. As that policy has been applied, every covered personnel attempting to commission, and the vast majority of covered personnel attempting to deploy, has been approved. *See supra*. For the reasons stated above, the Court’s injunctions require nothing more; but to the extent the Court concludes that the injunctions do require different actions, the orders are ambiguous and Defendants did not have fair notice of all the conduct that was required. *See Life Techs. Corp.*, 931 F.3d at 268 (“a party must be able to discern from the language of a court’s order the actions necessary to comply.”)

Second, Defendants are at least in substantial compliance with the natural reading of the

injunctions. “Substantial compliance with a decree is a defense to civil contempt...[and] ‘is found where all reasonable steps have been taken to ensure compliance.’” *De Simone v. VSL Pharm., Inc.*, 36 F.4th 518, 530 (4th Cir. 2022) (quoting *United States v. Darwin Constr. Co.*, 873 F.2d 750, 755 (4th Cir. 1989)). Defendants are in fact in full compliance with the stated purpose of the injunctions, to prevent the categorical prohibition of deployment and commissioning of covered personnel, as indicated by changes in policy and the high rate of deployments and commissioning for covered personnel. *See supra*. As discussed above, Movants contend that Defendants cannot have substantially complied because they have not made covered personnel presumptively deployable, eliminated the medical waiver process, or explicitly changed all HIV-related regulations to reflect the change in policy. But such changes were not reasonably necessary to assure compliance with the requirements of the injunctions. *See generally supra*. The Secretary’s June 6, 2022 Memorandum sufficiently changed both the policy and practice of Defendants. A memorandum from the Secretary issued as a Directive Type Memorandum (DTM) has the force of regulation, and all other regulations within the Department of Defense and the Military Services, must be implemented in compliance with that DTM.¹¹ Changing the policy, in and of itself, was sufficient to ensure compliance, but the evidence of commissions and deployments underscores that Defendants are in compliance with the Court’s orders.

E. The specific relief Movants seek is beyond the scope of the injunctions and improper.

Finally, while courts have inherent authority to hold parties in contempt, *Rainbow Sch.*, 887 F.3d at 617, that authority is nonetheless cabined in several ways.

¹¹ Movants note in passing that the June 6 Memo directed the Military Services to make changes to their regulations within 60 days of the issuance of the Memo. *Movs.’ Br.* at 27 n.6. However, this is an internal directive not a requirement imposed by the Court, and is therefore not necessary to comply with the injunctions.

First, “only the least possible power adequate to the end proposed should be used in contempt cases.” *Taggart*, 139 S. Ct. at 1802 (quoting *Young v. U.S. ex rel. Vuitton et Fils S. A.*, 481 U. S. 787, 801 (1987)). Second, “the sanctions for civil contempt must be causally related to contemptuous conduct.” *CFPB*, 957 F.3d at 461. Third, “[r]emedies and sanctions for civil contempt ‘must be remedial and compensatory and. . . nonpunitive.... [they] must be tied to the contemnor's specific losses.’” *Kroger Ltd. P'ship I Mid-Atlantic Mktg. Area v. United Food*, No. 2:17cv470, 2019 U.S. Dist. LEXIS 250737, at *11 (E.D. Va. Apr. 22, 2019) (quoting *In re GMC*, 61 F.3d at 259). Thus, the Court may order such relief only as is strictly necessary to compel compliance with the explicit terms of the injunction and to compensate Movants for any specific losses caused directly by any conduct in violation of the injunctions.

In this instance, no relief is required or warranted because Defendants are fully in compliance with the injunctions. Moreover, as explained, the Movants themselves have not suffered any harm. Contempt sanctions thus cannot issue because Defendants have complied with the injunctions.

But even if the injunctions were ambiguous in some respect, and Defendants could have done something more or different to comply, the imposition of contempt sanctions still would not be appropriate, *see supra* at 13-15, and the Movants would not be entitled to any additional relief. *See, e.g., McCrory*, 214 F. Supp. 3d at 473-74 (finding movants should have filed a new suit for additional specific relief rather than attempting to impose requirements of implementation and monitoring through contempt).

Movants assert, without any additional support, that they have standing to pursue the various types of relief they seek in this motion because they have already “acquire[d] a judicially cognizable interest in ensuring compliance with [the] judgment.” *Salazar v. Buono*, 559 U.S. 700,

712 (2010) (plurality). Assuming, without conceding, that this may be true up to the limits of what the injunction actually requires, *see supra*, Movants nevertheless lack standing to pursue the types of relief that they seek in this motion. Specifically, Movants now ask the Court, *inter alia*, to declare covered personnel presumptively deployable, to eliminate entirely Defendants' medical waiver process, to alter additional regulations, and to remove any operational discretion Defendants retain to make deployment decisions on the basis of military considerations.

But as the concurring Justices explained at length in the *Salazar* opinion, a plaintiff may not seek relief beyond that necessary to comply with the existing injunction without independently establishing standing for that specific relief at that juncture. *See Salazar*, 559 U.S. at 730-34 (Scalia, J., concurring). The “party invoking federal-court jurisdiction...‘bears the burden of showing that he has standing for each type of relief sought’...[and] cannot sidestep Article III’s requirements by combining a request for injunctive relief for which he *has* standing with a request for injunctive relief for which he *lacks* standing.” *Id.* at 731 (quoting *Summers v. Earth Island Inst.*, 555 U.S. 488, 493 (2009) (citation omitted)). In other words “a plaintiff cannot ask a court to expand an existing injunction unless he has standing to seek additional relief.” *Id.*

The Court enjoined Defendants from “categorically barring the worldwide deployment or deployment to [CENTCOM] of plaintiffs...and any other asymptomatic HIV-positive service members with an undetectable viral load due to their HIV-positive status,” and from “denying the application of [plaintiff] Harrison and any other asymptomatic HIV-positive service member with an undetectable viral load to commission as officers because they are classified as ineligible for worldwide deployment or deployment to CENTCOM due to their HIV-positive status.” Harrison, ECF No. 314. Defendants have complied with these injunctions and their deployment and commissioning statistics demonstrate as much. *See supra*.

Accordingly, none of the new relief the Movants seek is necessary to comply with the terms of the injunctions, and all such relief seeks to expand the bounds of the injunctions. Indeed, Movants' requests for relief are in excess of what the injunctions have already granted. They request not only that the Court directly superintend Defendants' "proposed actions and regulatory changes," and "conduct additional oversight" of Defendants' compliance for "the next two years," but even demand that the Court provide "an opportunity for Movants to comment upon" Defendants proposed regulatory changes. Movs.' Br. at 30. These requests are not only far outside the bounds of the injunction that Movants may seek to enforce, but would also result in an inappropriate, and unprecedented, invasion of the core functions of a coordinate branch by the Court in military matters. As the Supreme Court has long emphasized, the "complex, subtle, and professional decisions as to the composition, training, equipping, and control of a military force are essentially professional military judgments." *Gilligan v. Morgan*, 413 U. S. 1, 10 (1973). . The Court may not impose specific requirements on military commissioning and deployment decisions, *see Austin*, 131 S. Ct. at 1302 particularly where such internal military procedures were never addressed by the injunctions.

Finally, Movants cannot establish standing to seek such relief, as they must. Movants have not established or even meaningfully alleged any actual or imminent harms to themselves, *see supra* at 18, that would justify a new or expanded injunction, let alone the kind of harm necessary to obtain prospective relief. *See L.A. v. Lyons*, 461 U.S. 95, 105-06 (1983); *Salazar*, 559 U.S. at 730-34. Movants have neither proven an entitlement to such relief, nor that any such relief that would be necessary and appropriate in light of Defendants' demonstrated compliance.

IV. Conclusion

EXHIBIT 1

**IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
Alexandria Division**

NICHOLAS HARRISON, *et al.*,

Plaintiffs,

v.

LLOYD J. AUSTIN III, *et al.*,

Defendants.

No. 1:18-cv-641 (LMB/IDD)

RICHARD ROE, *et al.*,

Plaintiffs,

v.

LLOYD J. AUSTIN III, *et al.*,

Defendants.

No. 1:18-cv-1565 (LMB/IDD)

DECLARATION OF KERLL BERMAN

I, KERI L. BERMAN, declare as follows:

1. I am a Trial Attorney in the United States Department of Justice and represent Defendants in this matter. The facts set forth in this declaration are within my personal knowledge or based on documents and information that I have received in the course of litigating this case.
2. A true and correct copy of the Department of Defense's "Policy Regarding Human Immunodeficiency Virus-Positive Personnel Within the Armed Forces" is attached as Exhibit A.

3. A true and correct copy of the Department of Defense Instruction 6130.03, Vol. 1 “Medical Standards for Military Service: Appointment, Enlistment, or Induction” is attached as Exhibit B.
4. A true and correct copy of the Department of Defense Instruction 6485.01, “Human Immunodeficiency Virus (HIV) in Military Service Members” is attached as Exhibit C.
5. A true and correct copy of United States Central Command’s Individual Protection and Individual-Unit Deployment Policy, MOD-17 and Tab A to MOD 17 is attached as Exhibit D.
6. A true and correct copy of an Email exchange between the Declarant, and opposing counsel Scott Schoettes and Peter Perkowski beginning on May 19, 2023, is attached as Exhibit E.

If called upon to testify to the truth of the matters asserted in this declaration, I could and would be able to do so competently of my own personal knowledge. I declare under penalty of perjury that the foregoing is true and correct. Executed this Second day of June, 2023, in Washington, DC.

DATE: June 2, 2023

KERI
BERMAN

Digitally signed by
KERI BERMAN
Date: 2023.06.02
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EXHIBIT A



SECRETARY OF DEFENSE
1000 DEFENSE PENTAGON
WASHINGTON, DC 20301-1000

JUN 06 2022

MEMORANDUM FOR SENIOR PENTAGON LEADERSHIP
COMMANDERS OF THE COMBATANT COMMANDS
DEFENSE AGENCY AND DOD FIELD ACTIVITY DIRECTORS

SUBJECT: Policy Regarding Human Immunodeficiency Virus-Positive Personnel Within the Armed Forces

In view of significant advances in the diagnosis, treatment, and prevention of Human Immunodeficiency Virus (HIV), it is necessary to update DoD policy with respect to individuals who have been identified as HIV-positive. Individuals who have been identified as HIV-positive, are asymptomatic, and who have a clinically confirmed undetectable viral load (hereinafter, "covered personnel") will have no restrictions applied to their deployability or to their ability to commission while a Service member solely on the basis of their HIV-positive status. Nor will such individuals be discharged or separated solely on the basis of their HIV-positive status. This definition of "covered personnel" will be added to the affected DoD Instructions.

Accordingly, effective immediately I direct the following actions:

- Accession:
 - DoD Instruction 6130.03, "Medical Standards for Military Service: Appointment, Enlistment, or Induction," volume 1, section 5: Disqualifying Conditions, 5.23.b., is revised by adding the following language in boldface: "Presence of human immunodeficiency virus or laboratory evidence of infection for false-positive screening test(s) with ambiguous results by supplemental confirmation test(s) **is not, in itself, disqualifying with respect to covered personnel (including Military Service Academy cadets and midshipmen, contracted SROTC cadets and midshipmen, and other participants in in-service commissioning programs) seeking to commission while a Service member.** Such covered personnel will be evaluated on a case-by-case basis."
 - DoD Instruction 6485.01, "Human Immunodeficiency Virus (HIV) in Military Service Members," section 3.a., is revised to read: "It is DoD policy to . . . Deny eligibility for Military Service to persons with laboratory evidence of HIV infection for appointment (**other than covered personnel who are seeking to commission while a Service member**), enlistment, pre-appointment, or initial entry training for Military Service pursuant to DoDI 6130.03."
- Retention: DoD Instruction 6130.03, "Medical Standards for Military Service: Retention," volume 2, section 5.23.b.(1), is revised by adding the following language in boldface: "A Service member with laboratory evidence of Human Immunodeficiency Virus infection will



OSD004582-22/CMD005839-22

be referred for appropriate treatment and a medical evaluation of fitness for continued service in the same manner as a Service member with other chronic or progressive illnesses, **including evaluation on a case-by-case basis. Covered personnel will not be discharged or separated solely on the basis of their HIV-positive status.**

- Deployability: Covered personnel are not non-deployable solely for the reason that they are HIV-positive. Decisions on the deployability of covered personnel will be made on a case-by-case basis and must be justified by the Service member's inability to perform the duties to which he or she would be assigned. DoD Instruction 1332.45, "Retention Determinations for Non-Deployable Service Members," will be implemented consistent with this direction.
- The Director of Administration and Management will make the revisions directed above in the cited DoD Instructions.
- The Under Secretary of Defense for Personnel and Readiness will convene a working group, chaired by his designee and composed of members named by himself, the Secretaries of the Military Departments, the Chairman of the Joint Chiefs of Staff, the Office of the Secretary of Defense, and the General Counsel of the DoD. The working group shall:
 - Develop proposed standards for conducting the case-by-case determinations directed above. Included in such standards will be the period during which, and method by which, covered personnel must exhibit an undetectable viral load and be symptom free. The Under Secretary of Defense for Personnel and Readiness will report those proposed standards to me within six months from the date of this memorandum.
 - Consider such additional matters as may be referred to it by the Under Secretary of Defense for Personnel and Readiness.
- The Secretaries of the Military Departments and the Commanders of the Combatant Commands, will, as necessary, revise their respective regulations, policies, and other guidance consistent with this memorandum and no later than 60 days from the date of this memorandum.
- The Secretaries of the Military Departments will report to the Under Secretary of Defense for Personnel and Readiness on a semi-annual basis beginning six months from the date of this memorandum: (1) the number of HIV-positive Service members in their respective Services who have been separated; and (2) the number of HIV-positive individuals, who are asymptomatic with a clinically confirmed undetectable viral load, and who have been refused accession.



EXHIBIT B



DoD INSTRUCTION 6130.03, VOLUME 1

MEDICAL STANDARDS FOR MILITARY SERVICE: APPOINTMENT, ENLISTMENT, OR INDUCTION

Originating Component: Office of the Under Secretary of Defense for Personnel and Readiness

Effective: May 6, 2018
Change 3 Effective: June 6, 2022

Releasability: Cleared for public release. Available on the Directives Division Website at <https://www.esd.whs.mil/DD/>.

Reissues and Cancels: DoD Instruction 6130.03, "Medical Standards for Appointment, Enlistment, or Induction in the Military Services," April 28, 2010, as amended

Approved by: Robert L. Wilkie, Under Secretary of Defense for Personnel and Readiness
Change 3 Approved by: Lloyd J. Austin III, Secretary of Defense

Purpose: This instruction is composed of two volumes, each containing its own purpose. In accordance with the authority in DoD Directive 5124.02:

- This instruction establishes policy, assigns responsibilities, and prescribes procedures for medical standards for the Military Services.
- This volume establishes physical and medical standards for appointment, enlistment, or induction into the Military Services.

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SECTION 1: GENERAL ISSUANCE INFORMATION

1.1. APPLICABILITY.

a. This volume 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 Inspector General of the Department of Defense, the Defense Agencies, the DoD Field Activities, and all other organizational entities within the DoD.

(2) The Reserve Components, which include the Army and the Air National Guards of the United States, in accordance with Title 10, United States Code (U.S.C.).

(3) The United States Merchant Marine Academy in accordance with Section 310.56 of Title 46, Code of Federal Regulations.

b. The entities in Paragraphs 1.1.a.(1) through 1.1.a.(3) are referred to collectively in this volume as the “DoD Components.”

1.2. POLICY.

It is DoD policy to:

a. Use the guidance in this volume for appointment, enlistment, or induction of personnel into the Military Services.

b. Use common medical standards for appointment, enlistment, or induction of personnel into the Military Services and eliminate inconsistencies and inequities in the DoD Components based on race, sex, or location of examination when applying these standards.

c. Ensure that individuals considered for appointment, enlistment, or induction into the Military Services are:

(1) Free of contagious diseases that may endanger the health of other personnel.

(2) Free of medical conditions or physical defects that may reasonably be expected to require excessive time lost from duty for necessary treatment or hospitalization, or may result in separation from the Military Service for medical unfitness.

(3) Medically capable of satisfactorily completing required training and initial period of contracted service.

(4) Medically adaptable to the military environment without geographical area limitations.

(5) Medically capable of performing duties without aggravating existing physical defects or medical conditions.

d. Allow applicants who do not meet the physical and medical standards in this volume to be considered for a medical waiver.

1.3. INFORMATION COLLECTIONS.

DD Form 2807-2, "Accessions Medical Prescreen Report;" DD Form 2808, "Report of Medical Examination;" and the supplemental health documents referred to in Paragraph 2.3.d. of this volume have been assigned Office of Management and Budget control number 0704-0413 in accordance with the procedures in Volume 2 of DoD Manual 8910.01. The expiration date of this information collection is listed on the DoD Information Collections System at <https://apps.sp.pentagon.mil/sites/dodiic/Pages/default.aspx>.

1.4. SUMMARY OF CHANGE 3.

In accordance with the June 6, 2022 Secretary of Defense Memorandum, the changes to this issuance update DoD policy with respect to individuals who have been identified as HIV positive. Individuals who have been identified as HIV positive, are asymptomatic, and who have a clinically confirmed undetectable viral load will have no restrictions applied to their deployability or to their ability to commission while a Service member solely on the basis of their HIV-positive status. Nor will such individuals be discharged or separated solely on the basis of their HIV positive status.

SECTION 2: RESPONSIBILITIES

2.1. UNDER SECRETARY OF DEFENSE FOR PERSONNEL AND READINESS (USD(P&R)).

The USD(P&R):

- a. Ensures that the standards in Sections 4 and 5 are implemented throughout the DoD Components.
- b. Eliminates inconsistencies and inequities based on race, sex, or location of examination in DoD Component application of these standards.
- c. Maintains and convenes the chartered Medical and Personnel Executive Steering Committee (MEDPERS).

2.2. ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS (ASD(HA)).

Under the authority, direction, and control of the USD(P&R), the ASD(HA):

- a. Reviews, approves, and issues technical modifications to the standards in Sections 4 and 5 to the Secretaries of the Military Departments.
- b. Provides guidance to the DoD Medical Examination Review Board to implement the standards in Sections 4 and 5.

2.3. SECRETARIES OF THE MILITARY DEPARTMENTS AND COMMANDANT, UNITED STATES COAST GUARD.

The Secretaries of the Military Departments and the Commandant, United States Coast Guard:

- a. Direct their respective Military Services to apply and uniformly implement the standards contained in this volume.
- b. Authorize the medical waiver of the standards in individual cases for applicable reasons and ensure uniform waiver determinations.
- c. Ensure that accurate International Classification of Diseases codes are assigned to all medical conditions resulting in a personnel action, such as separation, waiver, or assignment limitation, and that such codes are included in all records of such actions.
- d. Ensure that medical information for “Existed Prior to Service” (EPTS) discharges is provided to the U.S. Military Entrance Processing Command by Service training centers conducting basic military training. Medical information will include:

- (1) A copy of the trainee's medical discharge summary and related medical documents.
 - (2) Copies of DD Forms 2807-2, 2807-1, and 2808, including supplemental behavioral health screening documents.
 - (3) Consultation reports or other medical documentation used in the enlistment process and qualification decision.
- e. Eliminate inconsistencies and inequities based on race, sex, or examination location in the application of these standards by the DoD Components.

2.4. SECRETARY OF THE NAVY.

In addition to the responsibilities in Paragraph 2.3., the Secretary of the Navy will direct the medical processing for applicants seeking entry into the Military Services from Guam and environs while applying and uniformly implementing the standards contained within this volume.

SECTION 3: MEDPERS

3.1. ORGANIZATION.

The MEDPERS convenes at least twice a year under the joint guidance of the Deputy Assistant Secretary of Defense for Military Personnel Policy and the Deputy Assistant Secretary of Defense for Health Services Policy and Oversight and in accordance with the MEDPERS charter.

3.2. AGENDA.

The MEDPERS:

- a. Provides the Accession Medical Standards Working Group with guidance and oversight on setting standards for accession medical and physical processes.
- b. Directs research and studies as necessary to produce evidence-based accession standards using the Accession Medical Standards Analysis and Research Activity.
- c. Ensures medical and personnel community coordination when changing policies that affect each community and other relevant DoD Components.

SECTION 4: MEDICAL STANDARDS FOR APPOINTMENT, ENLISTMENT, OR INDUCTION

4.1. APPLICABILITY.

The medical standards in this volume apply to:

- a. Applicants for appointment as commissioned or warrant officers in the Active and Reserve Components.
- b. Applicants for enlistment in the Military Services. For medical conditions or defects that predate the current enlistment and were not aggravated in the line of duty during the current enlistment, these standards apply to enlistees during the first 6 months of the current period of active duty.
- c. Applicants for accession in the Reserve Components and federally recognized units or organizations of the National Guard. For medical conditions or defects that predate the original term of service and were not aggravated in the line of duty during such term of service, these standards apply during the applicant's initial period of active duty for training until their return to the Reserve Components.
- d. Applicants for re-accession in Regular and Reserve Components and in federally recognized units or organizations of the National Guard after a period of more than 12 months have elapsed since the date on their DD Form 214, "Certificate of Release or Discharge from Active Duty," or separation orders, as applicable.
- e. Applicants for the Service academies, Reserve Officer Training Corps, Uniformed Services University of the Health Sciences, and all other DoD Component special officer personnel procurement programs.
- f. Cadets and midshipmen at the Service academies and students enrolled in Reserve Officer Training Corps scholarship programs applying for retention in their respective programs.
- g. Individuals on the Temporary Disability Retired List who have been found fit when reevaluated by the Disability Evaluation System and who elect to return to active duty or to active status in the Reserve Components within the time standards prescribed by Service regulations. These individuals are exempt from the procedures in this volume only for the conditions for which they were found fit on reevaluation by the Disability Evaluation System. Applicants must meet all other medical standards contained in this section with the exception of the medical condition for which they were placed on the Temporary Disability Retired List.
- h. All individuals being inducted into the Military Services.

4.2. PROCEDURES.

a. Applicants for appointment, enlistment, or induction into the Military Services will:

(1) Fully disclose all medical history.

(2) Submit all medical documentation related to medical history as requested to the U.S. Military Entrance Processing Command and DoD Medical Examination Review Board, including the names of their medical insurer and past medical providers.

(3) Provide authorization for the DoD Components to request and obtain their medical records.

(a) Authorize the DoD to request medical or behavioral health data holders (e.g. healthcare providers, clinics, hospitals, insurance companies, pharmacy benefit managers, pharmacies, health information exchanges, and federal and State agencies) release complete transcripts of health data to the DoD medical authority for the processing of their application for military service.

(b) Authorize holders of their health data to report to the DoD whether any data they hold or have held about them has been amended or restricted.

(4) Acknowledge that information provided constitutes an official statement, and that any persons making false statements could face fines, penalties, and imprisonments pursuant to Section 1001 of Title 18, U.S.C. If the applicant is selected for enlistment, commission, or entrance into a commissioning program based on a false statement, the applicant can be tried by court-martial or meet an administrative board for discharge and could receive a less than honorable discharge.

(5) Acknowledge that any cadet or midshipman, whether contracted or noncontracted, who has a change in medical status that is related to a standard in this regulation, understands that the change may disqualify them and that they will require an evaluation or physical prior to determining accession qualifications.

b. The U.S. Military Entrance Processing Command and DoD Medical Examination Review Board will:

(1) Render medical qualification decisions by using standard medical terminology to describe a medical condition, rather than International Classification of Disease codes.

(2) Use coding to document personnel actions in order to collect information to enable research, analyses, and support for evidence-based medical standards.

c. The DoD Components:

(1) May initiate and request a medical waiver. Each DoD Component's waiver authority for medical conditions will make a determination based on all available information regarding the issue or condition, as well as the specific needs of the Military Service.

(2) Will specify any medical condition which causes a personnel action, such as separation, medical waiver, or assignment limitation, by utilizing standard medical terminology, the International Classification of Diseases, Current Procedural Terminology, or the Healthcare Common Procedure Coding System for data collection and analysis in support of evidence based standards.

SECTION 5: DISQUALIFYING CONDITIONS

5.1. MEDICAL STANDARDS.

Unless otherwise stipulated, the conditions listed in this section are those that do **not** meet the standard by virtue of current diagnosis, or for which the candidate has a verified past medical history. The medical standards for appointment, enlistment, or induction into the Military Services are classified into general systems in Paragraphs 5.2. through 5.30.

5.2. HEAD.

a. Deformities of the skull, face, or mandible of a degree that may reasonably be expected to prevent the individual from properly wearing a protective mask or military headgear.

b. Loss, or absence of the bony substance of the skull not successfully corrected by reconstructive materials, or leaving any residual defect in excess of 1 square inch (6.45 square centimeters), or the size of a U.S. quarter coin.

5.3. EYES.

a. Lids.

(1) Current symptomatic blepharitis.

(2) Current blepharospasm.

(3) Current dacryocystitis, acute or chronic.

(4) Defect or deformity of the lids or other disorders affecting eyelid function, including ptosis, sufficient to interfere with vision, require head posturing, or impair protection of the eye from exposure.

(5) Current growths or tumors of the eyelid, other than small, non-progressive, asymptomatic, benign lesions.

b. Conjunctiva.

(1) Current acute or chronic conjunctivitis excluding seasonal allergic conjunctivitis.

(2) Current pterygium if condition encroaches on the cornea in excess of 3 millimeters (mm), is symptomatic, interferes with vision, or is progressive.

(3) History of pterygium recurrence after any prior surgical removal.

c. Cornea.

(1) Corneal dystrophy or degeneration of any type, including but not limited to keratoconus of any degree.

(2) History of any incisional corneal surgery including, but not limited to, partial or full thickness corneal transplant, radial keratotomy, astigmatic keratotomy, or corneal implants (e.g., Intacs[®]).

(3) Corneal refractive surgery performed with an excimer or femtosecond laser, including but not limited to photorefractive keratectomy, laser epithelial keratomileusis, laser-assisted in situ keratomileusis, and small incision lenticule extraction, if any of the following conditions are met:

(a) Pre-surgical refractive error in either eye exceeded a spherical equivalent of +8.00 or -8.00 diopters.

(b) Pre-surgical astigmatism exceeded 3.00 diopters.

(c) Within 180 days of accession medical examination.

(d) Complications, ongoing medications, ophthalmic solutions, or any other therapeutic interventions required beyond 180 days of procedure.

(e) Post-surgical refraction in each eye is not stable as demonstrated by at least two separate refractions at least 1 month apart, with initial refraction at least 90 days post-procedure, and the most recent of which demonstrates either more than +/- 0.50 diopters difference for spherical vision or more than +/- 0.50 diopters for cylinder vision.

(4) Current or recurrent keratitis.

(5) History of herpes simplex virus keratitis.

(6) Current corneal neovascularization, unspecified, or corneal opacification from any cause that is progressive or reduces vision.

(7) Any history of uveitis or iridocyclitis.

d. Retina.

Any history of any abnormality of the retina, choroid, or vitreous.

e. Optic Nerve.

(1) Any history of optic nerve disease, including but not limited to optic nerve inflammation, optic nerve swelling, or optic nerve atrophy.

(2) Any optic nerve anomaly.

f. Lens.

(1) Current aphakia, history of lens implant to include implantable collamer lens, or any history of dislocation of a lens.

(2) Any history of opacities of the lens, including cataract.

g. Ocular Mobility and Motility.

(1) Current or recurrent diplopia.

(2) Current nystagmus other than physiologic “end-point nystagmus.”

(3) Esotropia, exotropia, and hypertropia.

(4) History of restrictive ophthalmopathies.

h. Miscellaneous Defects and Diseases.

(1) History of abnormal visual fields.

(2) Absence of an eye.

(3) History of disorders of globe.

(4) Current unilateral or bilateral exophthalmoses.

(5) History of glaucoma, ocular hypertension, pre-glaucoma, or glaucoma suspect.

(6) Any abnormal pupillary reaction to light or accommodation.

(7) Asymmetry of pupil size greater than 2 mm.

(8) Current night blindness.

(9) History of intraocular foreign body, or current corneal foreign body.

(10) History of ocular tumors.

(11) History of any abnormality of the eye or adnexa, not specified in Paragraphs 5.3.h.(1)-(10), which threatens vision or visual function.

5.4. VISION.

a. Current distant visual acuity of any degree that does not correct with spectacle lenses to at least 20/40 in each eye.

- b. For entrance into Service academies and officer programs, the individual DoD Components may set additional requirements. The DoD Components will determine special administrative criteria for assignment to certain specialties.
- c. Current near visual acuity of any degree that does not correct to 20/40 in the better eye.
- d. Current refractive error (hyperopia, myopia, astigmatism) in excess of -8.00 or +8.00 diopters spherical equivalent or astigmatism in excess of 3.00 diopters.
- e. Any condition that specifically requires contact lenses for adequate correction of vision, such as corneal scars and opacities and irregular astigmatism.
- f. Color vision requirements will be set by the individual DoD Components.

5.5. EARS.

- a. Current defect that would require either recurrent evaluation or treatment or that may reasonably be expected to prevent or interfere with the proper wearing or use of military equipment (including hearing protection) to include atresia of the external ear or severe microtia, congenital or acquired stenosis, chronic otitis externa, or severe external ear deformity.
- b. Any history of Ménière's Syndrome or other chronic diseases of the vestibular system.
- c. History of any surgically implanted hearing device.
- d. History of cholesteatoma.
- e. History of any inner or middle ear surgery.
- f. Current perforation of the tympanic membrane or history of surgery to correct perforation during the preceding 180 days.
- g. Chronic Eustachian tube dysfunction within the last 3 years as evidenced by retracted tympanic membrane, or recurrent otitis media, or the need for pressure-equalization tube.

5.6. HEARING.

- a. Audiometric hearing levels are measured by audiometers calibrated to the standards in American National Standards Institute S3.6-2010 and will be used to test the hearing of all applicants.
- b. Current hearing threshold level in either ear that exceeds:
 - (1) Pure tone at 500, 1000, and 2000 cycles per second for each ear of more than 25 decibels (dB) on the average with any individual level greater than 30 dB at those frequencies.

(2) Pure tone level more than 35 dB at 3000 cycles per second or 45 dB at 4000 cycles per second for each ear.

(3) There is no standard for 6000 cycles per second.

c. History of using hearing aids.

5.7. NOSE, SINUSES, MOUTH, AND LARYNX.

a. Current cleft lip or palate defects not satisfactorily repaired by surgery or that prevent drinking from a straw or that may reasonably be expected to interfere with using or wearing military equipment.

b. Current ulceration of oral mucosa or tongue, excluding aphthous ulcers.

c. Symptomatic vocal cord dysfunction to include but not limited to vocal cord paralysis, paradoxical vocal cord movement, spasmodic dysphonia, non-benign polyps, chronic hoarseness, or chronic laryngitis (lasting longer than 21 days). History of vocal cord dysfunction with respiratory symptoms or exercise intolerance.

d. Current olfactory deficit.

e. Recurrent, unexplained epistaxis requiring medical intervention within the last 2 years.

f. Current chronic sinusitis, current nasal polyp or polypoid mass(es) or history of sinus surgery within the last 2 years, excluding antralchoanal polyp or sinus mucosal retention cyst.

g. Current symptomatic perforation of nasal septum.

h. History of deformities, or conditions or anomalies of the upper alimentary tract, mouth, tongue, palate, throat, pharynx, larynx, and nose, that interfered with chewing, swallowing, speech, or breathing.

5.8. DENTAL.

a. Current diseases or pathology of the jaws or associated tissues that prevent the jaws' normal functioning. A minimum of 6 months healing time must elapse for any individual who completes surgical treatment of any maxillofacial pathology lesions.

b. Temporomandibular disorders or myofascial pain that has been symptomatic or required treatment within the last 12 months.

c. Current severe malocclusion, which interferes with normal chewing or requires immediate and protracted treatment, or a relationship between the mandible and maxilla that prevents satisfactory future prosthodontic replacement.

d. Eight or more grossly (visually) cavitated or carious teeth. Applicants who are edentulous must have functioning dentures. Lack of a serviceable prosthesis that prevents adequate biting and chewing of a normal diet. Individuals undergoing endodontic care are acceptable for entry into the Delayed Entry Program only if a civilian or military dentist or endodontist provides documentation that active endodontic treatment will be completed prior to being sworn to active duty.

e. Current orthodontic appliances (mounted or removable, e.g., Invisalign®) for continued active treatment unless:

(1) The appliance is permanent or removable retainer(s); or

(2) An orthodontist (civilian or military) provides documentation that:

(a) Active orthodontic treatment will be completed before being sworn in to active duty; or

(b) All orthodontic treatment will be completed before beginning active duty.

5.9. NECK.

a. Current symptomatic cervical ribs.

b. Current congenital mass, including cyst(s) of branchial cleft origin or those developing from the remnants of the thyroglossal duct or history of surgical correction, within 12 months.

c. Current contraction of the muscles of the neck, spastic or non-spastic, or cicatricial contracture of the neck to the extent that it may reasonably be expected to interfere with properly wearing a uniform or military equipment, or is so disfiguring as to reasonably be expected to interfere with or prevent satisfactorily performing military duty.

5.10. LUNGS, CHEST WALL, PLEURA, AND MEDIASTINUM.

a. Any abnormal findings on imaging or other examination of body structure, such as the lungs, diaphragm, or other thoracic or abdominal organs, unless the findings have been evaluated and further surveillance or treatment is not required.

b. Current abscess of the lung or mediastinum.

c. Infectious pneumonia within the last 3 months.

d. History of recurrent (2 or more episodes within an 18 month period) infectious pneumonia after the 13th birthday.

e. History of airway hyper responsiveness including asthma, reactive airway disease, exercise-induced bronchospasm or asthmatic bronchitis, after the 13th birthday.

(1) Symptoms suggestive of airway hyper responsiveness include but are not limited to cough, wheeze, chest tightness, dyspnea or functional exercise limitations after the 13th birthday.

(2) History of prescription or use of medication (including but not limited to inhaled or oral corticosteroids, leukotriene receptor antagonists, or any beta agonists) for airway hyper responsiveness after the 13th birthday.

f. Chronic obstructive pulmonary disease including but not limited to bullous or generalized pulmonary emphysema or chronic bronchitis.

g. Bronchiectasis (after the 1st birthday).

h. Bronchopleural fistula, unless resolved with no sequelae.

i. Current chest wall malformation, including but not limited to pectus excavatum or pectus carinatum which has been symptomatic, interfered with vigorous physical exertion, has been recommended for surgery, or may interfere with wearing military equipment.

j. History of empyema unless resolved with no sequelae.

k. Interstitial lung disease including pulmonary fibrosis.

l. Current foreign body in lung, trachea, or bronchus.

m. History of thoracic surgery including open and endoscopic procedures.

n. Pleurisy or pleural effusion within the previous 3 months.

o. History of spontaneous pneumothorax occurring within the past 2 years, or pneumothorax due to trauma or surgery occurring within the past year.

p. Recurrent spontaneous pneumothorax.

q. History of chest wall surgery, including breast, during the preceding 6 months, or with persistent functional limitations.

r. Tuberculosis:

(1) History of active pulmonary or extra-pulmonary tuberculosis in the previous 2 years or history of active pulmonary or extra-pulmonary tuberculosis without reliable documentation of adequate treatment, or

(2) History of latent tuberculosis infection, as defined by current Centers for Disease Control and Prevention guidelines, unless documentation of completion of appropriate treatment.

s. History of pulmonary or systemic embolus.

t. History of other disorders, including but not limited to cystic fibrosis or porphyria, that prevent satisfactorily performing duty, or require frequent or prolonged treatment.

u. History of nocturnal ventilation support, respiratory failure, pulmonary hypertension, or any requirement for chronic supplemental oxygen use.

5.11. HEART.

a. History of valvular repair or replacement.

b. History of the following valvular conditions as listed in the current American College of Cardiology and American Heart Association guidelines and evidenced by echocardiogram within the last 12 months:

(1) Moderate or severe pulmonic regurgitation.

(2) Moderate or severe tricuspid regurgitation.

(3) Moderate or severe mitral regurgitation.

(4) Mild, moderate, or severe aortic regurgitation.

(5) Mitral valve prolapse associated with:

(a) Mild or greater mitral regurgitation.

(b) Cardiopulmonary symptoms.

(c) Medical therapy specifically for this condition.

c. Bicuspid aortic valve with any degree of stenosis or regurgitation or aortic dilatation.

d. All valvular stenosis.

e. History of atherosclerotic coronary artery disease.

f. History of pacemaker or defibrillator implantation.

g. History of supraventricular tachycardia if:

(1) History of atrial fibrillation or flutter.

(2) Any atrioventricular nodal reentrant tachycardia or atrioventricular reentrant tachycardia (e.g., Wolff-Parkinson-White syndrome) unless successfully treated with ablative therapy, no recurrence of symptoms after 3 months, and documentation of normal electrocardiograph.

h. Premature atrial or ventricular contractions sufficiently symptomatic to require treatment, or result in physical or psychological impairment.

i. The following abnormal electrocardiograph patterns:

(1) Long QT.

(2) Brugada pattern.

(3) Pre-excitation pattern, unless it is asymptomatic and associated with low-risk accessory pathway by appropriate diagnostic testing.

j. History of ventricular arrhythmias including ventricular fibrillation, tachycardia, or multifocal premature ventricular contractions other than occasional asymptomatic unifocal premature ventricular contractions.

k. History of conduction disorders, including but not limited to disorders of sinus arrest, asystole, Mobitz type II second-degree atrioventricular (AV) block, and third-degree AV block.

l. Any conductive disorder, if symptomatic, including but not limited to:

(1) Sinus arrhythmia.

(2) First degree AV block.

(3) Left axis deviation of less than -45 degrees.

(4) Early repolarization.

(5) Incomplete right bundle branch block.

(6) Wandering atrial pacemaker or ectopic atrial rhythm.

(7) Sinus bradycardia.

(8) Mobitz type I second-degree AV block.

m. History of conduction disturbances, including right bundle branch block, unless it is asymptomatic with a normal echocardiogram.

n. All left bundle branch block, left anterior/posterior hemiblock.

o. History of myocardial infarction, cardiomyopathy, cardiomegaly, hypertrophy (defined as septal wall thickness of 15 mm or greater), or congestive heart failure.

p. History of myocarditis or pericarditis unless the individual is free of all cardiac symptoms, does not require medical therapy, and has normal echocardiography for at least 1 year after the event.

- q. History of recurrent myocarditis or pericarditis.
- r. Current persistent tachycardia (as evidenced by an average heart rate of 100 beats per minute or greater over a 24-hour period of continuous monitoring).
- s. History of congenital anomalies of the heart and great vessels other than the following conditions. Excepted conditions require an otherwise normal current echocardiogram within the last 12 months.
 - (1) Dextrocardia with situs inversus without any other anomalies.
 - (2) Ligated or occluded patent ductus arteriosus.
 - (3) Corrected atrial septal defect without residua.
 - (4) Patent foramen ovale.
 - (5) Corrected ventricular septal defect without residua.
- t. History of recurrent syncope or presyncope, including black out, fainting, loss or alteration of level of consciousness (excludes single episode of vasovagal reaction with identified trigger such as venipuncture) unless it has not recurred during the preceding 2 years while off all medication for treatment of this condition.
- u. Unexplained ongoing or recurring cardiopulmonary symptoms (to include but not limited to syncope, presyncope, chest pain, palpitations, and dyspnea on exertion).
- v. History of Postural Orthostatic Tachycardia Syndrome.
- w. History of rheumatic fever if associated with rheumatic heart disease or indication for ongoing prophylactic medication.

5.12. ABDOMINAL ORGANS AND GASTROINTESTINAL SYSTEM.

a. Esophageal Disease.

- (1) History of Gastro-Esophageal Reflux Disease, with complications, including, but not limited to:
 - (a) Stricture.
 - (b) Dysphagia.
 - (c) Recurrent symptoms or esophagitis despite maintenance medication.
 - (d) Barrett's esophagus.

(e) Extraesophageal complications such as: reactive airway disease; recurrent sinusitis or dental complications; unresponsive to acid suppression.

(2) History of surgical correction (e.g., fundoplication) for Gastro-Esophageal Reflux Disease within 6 months or with complications.

(3) History of dysmotility disorders to include but not limited to diffuse esophageal spasm, nutcracker esophagus, and achalasia.

(4) History of eosinophilic esophagitis.

(5) History of other esophageal strictures (e.g., from ingesting lye).

(6) History of esophageal disease not specified above; including but not limited to neoplasia, ulceration, varices, or fistula.

b. Stomach and Duodenum.

(1) Current dyspepsia, gastritis, or duodenitis despite medication (over the counter or prescription).

(2) Current gastric or duodenal ulcers, including but not limited to peptic ulcers and gastrojejunal ulcers:

(a) History of a treated ulcer within the last 3 months.

(b) Recurrent or complicated by bleeding, obstruction, or perforation within the previous 5 years.

(3) History of surgery for peptic ulceration or perforated ulcer.

(4) History of gastroparesis of greater than 6 week's duration, confirmed by scintigraphy or equivalent test.

(5) History of bariatric surgery of any type (e.g., lap-band or gastric bypass surgery for weight loss).

(6) History of gastric varices.

c. Small and Large Intestine.

(1) History of inflammatory bowel disease, including but not limited to Crohn's disease, ulcerative colitis, ulcerative proctitis, or indeterminate colitis.

(2) Current infectious colitis.

(3) History of intestinal malabsorption syndromes, including but not limited to celiac sprue, pancreatic insufficiency, post-surgical and idiopathic.

(4) Dietary intolerances that may interfere with military duty or consuming military rations. Lactase deficiency does not meet the standard only if of sufficient severity to require frequent intervention, or to interfere with military duties.

(5) History of gastrointestinal functional or motility disorders including but not limited to volvulus within the past 24 months, or any history of pseudo-obstruction or megacolon.

(6) Current chronic constipation, requiring prescription medication or medical interventions (e.g., pelvic floor physical therapy, biofeedback therapy).

(7) History of diarrhea of greater than 6 weeks duration, regardless of cause, persisting or symptomatic in the past 2 years.

(8) History of gastrointestinal bleeding, including positive occult blood, if the cause requires treatment and has not been corrected.

(9) History of irritable bowel syndrome of sufficient severity to require frequent intervention or prescription medication or that may reasonably be expected to interfere with military duty.

(10) History of symptomatic diverticular disease of the intestine.

(11) Personal or family history of familial adenomatous polyposis syndrome or hereditary non-polyposis colon cancer (Lynch syndrome).

d. Hepatic-Biliary Tract.

(1) History of chronic Hepatitis B unless successfully treated and the cure is documented. A documented cure for Hepatitis B is viral clearance manifested by Hepatitis B surface antigen negative/Hepatitis B surface antibody positive/Hepatitis B core antibody positive.

(2) History of chronic Hepatitis C, unless successfully treated and with documentation of a cure 12 weeks after completion of a full course of therapy.

(3) Other acute hepatitis in the preceding 6 months, or persistence of symptoms or abnormal serum aminotransferases after 6 months, or objective evidence of impairment of liver function.

(4) History of cirrhosis, hepatic abscess, or complications of chronic liver disease.

(5) History of symptomatic gallstones or gallbladder disease unless successfully treated.

(6) History of sphincter of Oddi dysfunction.

(7) History of choledochal cyst.

(8) History of primary biliary cirrhosis or primary sclerosing cholangitis.

(9) History of metabolic liver disease, excluding Gilbert's syndrome. This includes but is not limited to hemochromatosis, Wilson's disease, or alpha-1 anti-trypsin deficiency.

(10) History of alcoholic or non-alcoholic fatty liver disease if there is evidence of chronic liver disease, manifested as impairment of liver function or hepatic fibrosis.

(11) History of traumatic injury to the liver within the preceding 6 months.

e. Pancreas.

History of:

(1) Pancreatic insufficiency.

(2) Acute pancreatitis, unless due to cholelithiasis successfully treated by cholecystectomy.

(3) Chronic pancreatitis.

(4) Pancreatic cyst or pseudocyst.

(5) Pancreatic surgery.

f. Anorectal.

(1) Current anal fissure or anal fistula.

(2) History of rectal prolapse or stricture within the last 2 years.

(3) History of fecal incontinence after the 13th birthday.

(4) Current hemorrhoid (internal or external), if symptomatic or requiring medical intervention within the last 60 days.

g. Abdominal Wall.

(1) Current abdominal wall hernia other than small (less than 2 centimeters (cm) in size), asymptomatic inguinal or umbilical hernias.

(2) History of open or laparoscopic abdominal surgery during the preceding 3 months.

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

5.13. FEMALE GENITAL SYSTEM.

a. Abnormal uterine bleeding (period greater than 7 days, or more frequent than 21 days or greater than 35 days, or soaking more than one pad per hour for several hours) within the last 12 months.

- b. Primary amenorrhea.
- c. Current unexplained secondary amenorrhea.
- d. Dysmenorrhea resulting in recurrent absences or activity modification within the last 6 months.
- e. History of symptomatic endometriosis.
- f. History of major abnormalities or defects of the genitalia including, but not limited to:
 - (1) Hermaphroditism, pseudohermaphroditism, or pure gonadal dysgenesis.
 - (2) A history of sex reassignment or genital reconstruction surgery is disqualifying unless all of the following conditions are met, as certified by a licensed medical provider:
 - (a) A period of 18 months has elapsed since the date of the most recent of any such surgery.
 - (b) No functional limitations or complications persist, and no additional surgery is required.
- g. Current ovarian cyst(s) greater than 5 cm.
- h. Polycystic ovarian syndrome unless no evidence of metabolic complications as specified by National Heart, Lung, and Blood Institute and American Heart Association Guidelines.
- i. Pelvic inflammatory disease within the preceding 6 months.
- j. History of chronic pelvic pain (6 months or longer) within the last 24 months.
- k. Pregnancy through 6 months after the completion of the pregnancy.
- l. Uterine enlargement due to any cause.
- m. History of genital infection or ulceration, including but not limited to herpes genitalis or condyloma acuminatum, if any of the following apply:
 - (1) Current lesions are present.
 - (2) Use of chronic suppressive therapy is needed.
 - (3) There have been three or more outbreaks per year.
 - (4) Any outbreak in the past 12 months that interfered with normal life activities.
 - (5) After the initial outbreak, treatment that included hospitalization or intravenous therapy.

n. Abnormal gynecologic cytology within the preceding 3 years, including but not limited to unspecified abnormalities of the Papanicolaou smear of the cervix, excluding atypical squamous cells of undetermined significance without human papillomavirus and confirmed low-grade squamous intraepithelial lesion. For the purposes of this volume, confirmation is by colposcopy or repeat cytology.

o. History of abnormal cervical, vaginal, or vulvar cytology or pathology to include atypical squamous cells that cannot exclude high grade squamous intraepithelial lesions, low-grade squamous intraepithelial lesions, high-grade squamous intraepithelial lesions, cervical intraepithelial neoplasia grades 2 or 3, vaginal intraepithelial neoplasia grades 2 or 3, vulvar intraepithelial neoplasia grades 2 or 3 without demonstrated resolution in accordance with American Society for Colposcopy and Cervical Pathology guidelines.

p. History of abnormal endometrial pathology within the last 3 years (e.g., simple or complex hyperplasia with or without atypia) without demonstrated resolution in accordance with American Society for Colposcopy and Cervical Pathology guidelines.

5.14. MALE GENITAL SYSTEM.

a. Absence of both testicles, current undescended testicle, or congenital absence of one testicle not verified by surgical exploration.

b. History of epispadias or hypospadias when accompanied by history of urinary tract infection, urethral stricture, urinary incontinence, symptomatic chordee, or voiding dysfunction or surgical intervention for these issues within the past 24 months.

c. Current enlargement or mass of testicle, epididymis, or spermatic cord, in addition to those described elsewhere in Paragraph 5.14.

d. Current hydrocele or spermatocele associated with pain or which precludes a complete exam of the scrotal contents.

e. Current varicocele, unless it is:

- (1) On the left side only.
- (2) Asymptomatic and smaller than the testes.
- (3) Reducible.
- (4) Without associated testicular atrophy.

f. Current or history of recurrent orchitis or epididymitis.

g. History of penis amputation.

h. Current penile curvature if associated with pain.

i. History of genital infection or ulceration, including but not limited to herpes genitalis or condyloma acuminatum, if:

- (1) Current lesions are present;
- (2) Use of chronic suppressive therapy is needed;
- (3) There are three or more outbreaks per year;
- (4) Any outbreak in the past 12 months interfered with normal activities; or
- (5) After the initial outbreak, treatment included hospitalization or intravenous therapy.

j. History of urethral condyloma acuminatum.

k. History of acute prostatitis within the last 24 months, history of chronic prostatitis, or history of chronic pelvic pain syndrome.

l. History of chronic or recurrent scrotal pain or unspecified symptoms associated with male genital organs.

m. History of major abnormalities or defects of the genitalia including, but not limited to:

- (1) Hermaphroditism, pseudohermaphroditism, or pure gonadal dysgenesis.
- (2) A history of sex reassignment or genital reconstruction surgery is disqualifying unless all of the following conditions are met, as certified by a licensed medical provider:
 - (a) A period of 18 months has elapsed since the date of the most recent of any such surgery.
 - (b) No functional limitations or complications persist, and no additional surgery is required.

5.15. URINARY SYSTEM.

a. History of interstitial cystitis or painful bladder syndrome.

b. Lower urinary tract infection (cystitis):

- (1) For males, any cystitis not related to an indwelling catheter during a hospitalization.
- (2) For females, current cystitis or recurrent cystitis of greater than two episodes per year, or requiring daily suppressive antibiotics, or non-responsive to antibiotics for 10 days.

c. Current urethritis.

d. History or treatment of the following voiding symptoms within the previous 12 months in the absence of a urinary tract infection:

- (1) Urinary frequency or urgency more than every 2 hours on a daily basis.
- (2) Nocturia more than two episodes during sleep period.
- (3) Enuresis.
- (4) Incontinence of urine, such as urge or stress.
- (5) Urinary retention.
- (6) Dysuria.

e. History of neurogenic bladder or other functional disorder of the bladder that requires urinary catheterization with intermittent or indwelling catheter for any period greater than 2 weeks.

f. History of bladder augmentation, urinary diversion, or urinary tract reconstruction.

g. History of abnormal urinary findings in the absence of urinary tract infection:

- (1) Gross hematuria.
- (2) Persistent microscopic hematuria (3 or more red blood cells per high-powered field on properly collected urinalyses, unless urology evaluation determines benign essential hematuria).
- (3) Pyuria (6 or more white blood cells per high-powered field in 2 of 3 properly collected urinalyses).

h. Current or recurrent urethral or ureteral stricture or fistula involving the urinary tract.

i. Absence of one kidney, congenital or acquired.

j. Asymmetry in size or function of kidneys.

k. History of renal transplant.

l. Chronic or recurrent pyelonephritis or any other unspecified infections of the kidney.

m. History of polycystic kidney.

n. History of horseshoe kidney.

o. Hydronephrosis on most recent imaging not related to pregnancy.

p. History of acute nephritis or chronic kidney disease of any type as evidenced by 3 months or longer of:

(1) Estimated glomerular filtration rate of less than 60cc per minute per 1.73 square meter of body surface area or abnormal renal imaging;

(2) Casturia; or

(3) Abnormal renal biopsy.

q. History of acute kidney injury requiring dialysis.

r. History of proteinuria with a protein-to-creatinine ratio greater than 0.2 in a random urine sample, more than 48 hours after strenuous activity, excluding benign orthostatic proteinuria.

s. Urolithiasis if any of the following apply:

(1) Current stone of 3 mm or greater.

(2) Current multiple stones of any size.

(3) History of symptomatic urolithiasis within the preceding 12 months.

(4) History of nephrocalcinosis, bilateral renal calculi, or recurrent urolithiasis at any time.

(5) History of urolithiasis requiring a procedure.

5.16. SPINE AND SACROILIAC JOINT CONDITIONS.

a. Ankylosing spondylitis or other inflammatory spondylopathies.

b. History of any condition, in the last 2 years, or any recurrence, including but not limited to the spine or sacroiliac joints, with or without objective signs, if:

(1) It prevents the individual from successfully following a physically active avocation in civilian life, or is associated with local or radicular pain, muscular spasms, postural deformities, or limitation in motion;

(2) It requires external support;

(3) It requires limitation of physical activity or frequent treatment; or

(4) It requires the applicant to use medication for more than 6 weeks.

(5) It causes one or more episodes of back pain lasting greater than 6 weeks requiring treatment other than self-care.

- c. Current deviation or curvature of the spine from normal alignment, structure, or function if:
 - (1) It prevents the individual from following a physically active avocation in civilian life;
 - (2) It can reasonably be expected to interfere with the proper wearing of military uniform or equipment;
 - (3) It is symptomatic; or
 - (4) There is lumbar or thoracic scoliosis greater than 30 degrees, or thoracic kyphosis greater than 50 degrees when measured by the Cobb Method.
- d. History of congenital fusion involving more than 2 vertebral bodies or any surgical fusion of spinal vertebrae.
- e. Current dislocation of the vertebra.
- f. Vertebral fractures including but not limited to:
 - (1) Any cervical spine fracture.
 - (2) History of fracture of lumbar or thoracic vertebral body that exceeds 25 percent of the height of a single vertebra or that has occurred within the last 12 months or is symptomatic.
 - (3) A history of fractures of the transverse or spinous process if currently symptomatic.
- g. History of juvenile epiphysitis with any degree of residual change indicated by X-ray or Scheuermann's kyphosis.
- h. History of uncorrected herniated nucleus pulposus associated with any treatment, symptoms, or activity limitations.
- i. History of surgery to correct herniated nucleus pulposus other than a single-level lumbar or thoracic discectomy that is currently asymptomatic with full resumption of unrestricted activity for at least 12 months.
- j. Spinal dysraphisms other than spina bifida occulta.
- k. History of spondylolysis or spondylolisthesis, congenital or acquired.

5.17. UPPER EXTREMITY CONDITIONS.

a. Limitation of Motion.

Current active joint ranges of motion less than:

(1) Shoulder.

- (a) Forward elevation to 130 degrees.
- (b) 130 degrees abduction.
- (c) 60 degrees external and internal rotation at 90 degrees abduction.
- (d) Cross body reaching 115 degrees adduction.

(2) Elbow.

- (a) Flexion to 130 degrees.
- (b) Extension to 30 degrees.

(3) Wrist.

A total range of 60 degrees (extension plus flexion), or radial and ulnar deviation combined are 30 degrees.

(4) Hand.

- (a) Pronation to 45 degrees.
- (b) Supination to 45 degrees.

(5) Fingers and Thumb.

Inability to clench fist, pick up a pin, grasp an object, or touch tips of at least three fingers with thumb.

b. Hand and Fingers.

- (1) Absence of the distal phalanx of either thumb.
- (2) Absence of any portion of the index finger.
- (3) Absence of 2 or more distal and middle phalanges of the middle, ring, or small finger of either hand.
- (4) Absence of 2 or more distal phalanges of any finger on either hand.
- (5) Absence of hand or any portion thereof, except for specific absence of fingers as noted in Paragraphs 5.17.b.(1)-(4).
- (6) Current polydactyly or syndactyly.

(7) Intrinsic paralysis or weakness of upper limbs, including but not limited to nerve paralysis, carpal tunnel, and cubital syndromes, lesion of ulnar, median, or radial nerve, sufficient to produce physical findings in the hand such as muscle atrophy and weakness.

c. Residual Weakness and Pain.

Current disease, injury, or congenital condition with residual weakness, pain, sensory disturbance, or other symptoms that may reasonably be expected to prevent satisfactory performance of duty, including but not limited to chronic joint pain associated with the shoulder, the upper arm, the forearm, and the hand; or chronic joint pain as a late effect of fracture of the upper extremities, as a late effect of sprains without mention of injury, and as late effects of tendon injury.

5.18. LOWER EXTREMITY CONDITIONS.

a. General.

(1) Current deformities, disease, or chronic joint pain of pelvic region, thigh, lower leg, knee, ankle or foot that prevent the individual from following a physically active avocation in civilian life, or that may reasonably be expected to interfere with walking, running, weight bearing, or with satisfactorily completing training or military duty.

(2) Current discrepancy in leg-length that causes a limp.

b. Limitation of Motion.

Current active joint ranges of motion less than:

(1) Hip.

- (a) Flexion to 90 degrees.
- (b) No demonstrable flexion contracture.
- (c) Extension to 10 degrees (beyond 0 degrees).
- (d) Abduction to 45 degrees.
- (e) Rotation of 60 degrees (internal and external combined).

(2) Knee.

- (a) Full extension to 0 degrees.
- (b) Flexion to 110 degrees.

(3) **Ankle.**

- (a) Dorsiflexion to 10 degrees.
- (b) Planter flexion to 30 degrees.
- (c) Subtalar eversion and inversion totaling 5 degrees.

c. Foot and Ankle.

(1) Current absence of a foot or any portion thereof, other than absence of a single lesser toe that is asymptomatic and does not impair function of the foot.

(2) Deformity of the toes that may reasonably be expected to prevent properly wearing military footwear or impair walking, marching, running, maintaining balance, or jumping.

(3) Symptomatic deformity of the toes (acquired or congenital), including but not limited to conditions such as hallux valgus, hallux varus, hallux rigidus, hammer toe(s), claw toe(s), or overriding toe(s).

(4) Clubfoot or pes cavus that may reasonably be expected to properly wearing military footwear or causes symptoms when walking, marching, running, or jumping.

(5) Rigid or symptomatic pes planus (acquired or congenital).

(6) Current ingrown toenails, if infected or symptomatic.

(7) Current or recurrent plantar fasciitis.

(8) Symptomatic neuroma.

d. Leg, Knee, Thigh, and Hip.

(1) Current loose or foreign body in the knee joint.

(2) History of uncorrected anterior or posterior cruciate ligament injury.

(3) History of surgical reconstruction of knee ligaments within the last 12 months, or which is symptomatic or unstable or shows signs of thigh or calf atrophy.

(4) Recurrent anterior cruciate ligament reconstruction.

(5) Current medial or lateral meniscal injury with symptoms or limitation of activity.

(6) Surgical meniscal repair, within the last 6 months or with residual symptoms or limitation of activity.

(7) Surgical partial meniscectomy within the last 3 months or with residual symptoms or limitation of activity.

(8) Meniscal transplant.

(9) Symptomatic medial and lateral collateral ligament instability.

(10) History of developmental dysplasia (congenital dislocation) of the hip, osteochondritis of the hip (Legg-Calve-Perthes Disease), or slipped capital femoral epiphysis of the hip.

(11) History of hip dislocation.

(12) Symptomatic osteochondritis of the tibial tuberosity (Osgood-Schlatter Disease) within the past 12 months.

(13) Stress fractures, either recurrent or a single episode occurring during the past 12 months.

5.19. MISCELLANEOUS CONDITIONS OF THE EXTREMITIES.

a. History of chondromalacia, including but not limited to chronic patello-femoral pain syndrome and retro-patellar pain syndrome, osteoarthritis, or traumatic arthritis.

b. Dislocation of patella if two or more episodes, or any occurring within the last 12 months.

c. History of any dislocation, subluxation, or instability of the hip, knee, ankle, subtalar joint, foot, shoulder, wrist, elbow except for “nursemaid’s elbow” or dislocated finger.

d. Acromioclavicular separation within the last 12 months or if symptomatic.

e. History of osteoarthritis or traumatic arthritis of isolated joints that has interfered with a physically active lifestyle, or that may reasonably be expected to prevent satisfactorily performing military duty.

f. Fractures, if:

(1) Current malunion or non-union of any fracture (except asymptomatic ulnar styloid process fracture).

(2) Current retained hardware (including plates, pins, rods, wires, or screws) used for fixation that is symptomatic or may reasonably be expected to interfere with properly wearing military equipment or uniforms. Retained hardware is not disqualifying if fractures are healed, ligaments are stable, and there is no pain.

g. Current orthopedic implants or devices to correct congenital or post-traumatic orthopedic abnormalities except for bone anchor and hardware as allowed in accordance with Paragraph 5.19.f.(2).

h. History of contusion of bone or joint if:

(1) The injury is of more than a minor nature with or without fracture, nerve injury, open wound, crush, or dislocation which occurred within the last 6 months;

(2) Recovery has not been sufficiently completed or rehabilitation has not been sufficiently resolved;

(3) The injury may reasonably be expected to interfere with or prevent performance of military duty; or

(4) The contusion requires frequent or prolonged treatment.

i. History of joint replacement or resurfacing of any site.

j. History of hip arthroscopy or femoral acetabular impingement.

k. History of neuromuscular paralysis, weakness, contracture, or atrophy not completely resolved and of sufficient degree to reasonably be expected to interfere with or prevent satisfactory performing military duty.

l. Current symptomatic osteochondroma or history of two or more osteocartilaginous exostoses.

m. History of atraumatic fractures or bone mineral density below the expected range for age with risk factors for low bone density.

n. Osteopenia, osteoporosis, or history of fragility fracture.

o. History of osteomyelitis within the past 12 months, or history of recurrent osteomyelitis.

p. History of osteochondral defect, formerly known as osteochondritis dissecans.

q. History of cartilage surgery, including but not limited to cartilage debridement or chondroplasty for Grade III or greater chondromalacia, microfracture, or cartilage transplant procedure.

r. History of any post-traumatic or exercise-induced compartment syndrome.

s. History of osteonecrosis of any bone.

t. History of recurrent tendon disorder, including but not limited to tendonitis, tendonopathy, tenosynovitis.

5.20. VASCULAR SYSTEM.

a. History of abnormalities of the arteries, including but not limited to aneurysms, arteriovenous malformations, atherosclerosis, or arteritis (e.g., Kawasaki's disease).

b. Current or medically-managed hypertension. Hypertension is defined as systolic pressure greater than 140 millimeters of mercury (mmHg) or diastolic pressure greater than 90 mmHg confirmed by manual blood pressure cuff averaged over two or more properly measured, seated, blood pressure readings on separate days within a 5-day period (isolated, single-day blood pressure elevation is not disqualifying unless confirmed on 2 separate days within a 5-day period).

c. History of peripheral vascular disease, including but not limited to diseases such as Raynaud's Disease and vasculitides.

d. History of venous diseases, including but not limited to recurrent thrombophlebitis, thrombophlebitis during the preceding year, or evidence of venous incompetence, such as edema, skin ulceration, or symptomatic varicose veins that would reasonably be expected to limit duty or properly wearing military uniform or equipment.

e. History of deep venous thrombosis.

f. History of operation or endovascular procedure on the arterial or venous systems, including but not limited to vena cava filter, angioplasty, venoplasty, thrombolysis, or stent placement.

g. History of Marfan's Syndrome, Loey-Dietz, or Ehlers Danlos IV.

5.21. SKIN AND SOFT TISSUE CONDITIONS.

a. Applicants under treatment with systemic retinoids, including, but not limited to isotretinoin (e.g. Accutane®), do not meet the standard until 4 weeks after completing therapy.

b. Severe nodulocystic acne, on or off antibiotics.

c. History of dissecting scalp cellulitis, acne inversa, or hidradenitis suppurativa.

d. History of atopic dermatitis or eczema after the 12th birthday. History of residual or recurrent lesions in characteristic areas (face, neck, antecubital or popliteal fossae, occasionally wrists and hands).

e. History of recurrent or chronic non-specific dermatitis within the past 2 years to include contact (irritant or allergic) or dyshidrotic dermatitis requiring more than treatment with topical corticosteroid.

f. Cysts, if:

(1) The current cyst (other than pilonidal cyst) is of such a size or location as to reasonably be expected to interfere with properly wearing military equipment.

(2) The current pilonidal cyst is associated with a tumor mass or discharging sinus, or is a surgically resected pilonidal cyst that is symptomatic, unhealed, or less than 6 months post-

operative. A pilonidal cyst that has been simply incised and drained does not meet the military accession medical entrance standard.

- g. History of bullous dermatoses, including but not limited to dermatitis herpetiformis, pemphigus, and epidermolysis bullosa.
- h. Current or chronic lymphedema.
- i. History of furunculosis or carbuncle if extensive, recurrent, or chronic.
- j. History of severe hyperhidrosis of hands or feet unless controlled by topical medications.
- k. History of congenital or acquired anomalies of the skin, such as nevi or vascular tumors that may interfere with military duties or cause constant irritation.
- l. History of severe keloid formation.
- m. History of pseudofolliculitis barbae or keloidalis nuchae, severe enough to prevent daily shaving or would reasonably be expected to interfere with wearing military equipment.
- n. Current lichen planus (either cutaneous or oral).
- o. History of oculocutaneous albinism, Neurofibromatosis I (Von Recklinghausen's Disease), Neurofibromatosis II, and tuberous sclerosis.
- p. History of photosensitivity, including but not limited to any primary sun-sensitive condition, such as polymorphous light eruption or solar urticaria, or any dermatosis aggravated by sunlight, such as lupus erythematosus, porphyria, and xeroderma pigmentosa.
- q. History of psoriasis excluding non-recurrent childhood guttate psoriasis.
- r. History of chronic radiation dermatitis (radiodermatitis).
- s. History of scleroderma.
- t. History of chronic urticaria lasting longer than 6 weeks even, if it is asymptomatic when controlled by daily maintenance therapy.
- u. Current symptomatic plantar wart(s).
- v. Current scars that can reasonably be expected to interfere with properly wearing military clothing or equipment, or to interfere with satisfactorily performing military duty due to pain or decreased range of motion, strength, or agility.
- w. Prior burn injury involving 18 percent or more body surface area (including graft sites), or resulting in functional impairment to such a degree, due to scarring, as to interfere with satisfactorily performing military duty due to pain or decreased range of motion, strength, temperature regulation, or agility.

x. Current localized fungal infections, if they can be reasonably expected to interfere with properly wearing military equipment or performing military duties. For systemic fungal infections, refer to Paragraph 5.23.s.

y. History of any medical condition severe enough to warrant use of systemic steroids for greater than 2 months, or any use of other systemic immunosuppressant medications.

z. Conditions with malignant potential in the skin including but not limited to basal cell nevus syndrome, oculocutaneous albinism, xeroderma pigmentosum, Muir-Torre Syndrome, Dyskeratosis Congenita, Gardner Syndrome, Peutz-Jeghers Syndrome, Cowden Syndrome, Multiple Endocrine Neoplasia, Familial Atypical Multiple Mole Melanoma Syndrome, and Birt-Hogg-Dube Syndrome.

aa. History of cutaneous malignancy before the 25th birthday including but not limited to basal cell carcinoma and squamous cell carcinoma. History of the following skin cancers at any age: malignant melanoma, Merkel cell carcinoma, sebaceous carcinoma, Paget's disease, extramammary Paget's disease, microcystic adnexal carcinoma, other adnexal neoplasms, and cutaneous lymphoma including mycosis fungoides.

ab. History of lupus erythematosus.

ac. History of congenital disorders of cornification including but not limited to ichthyosis vulgaris, x-linked ichthyosis, lamellar ichthyosis, Darier's Disease, Epidermal Nevus Syndrome, and any palmo-plantar keratoderma.

ad. History of congenital disorder of the hair and nails including but not limited to pachyonychia congenita or ectodermal dysplasia.

ae. History of dermatomyositis.

5.22. BLOOD AND BLOOD FORMING SYSTEM.

a. Current hereditary or acquired anemia.

b. History of coagulation defects.

c. Any history of chronic, or recurrent thrombocytopenia.

d. History of deep venous thrombosis or pulmonary embolism.

e. History of chronic or recurrent agranulocytosis or leukopenia.

f. History of chronic polycythemia, chronic leukocytosis or chronic thrombocytosis.

g. Disorders of the spleen including:

(1) Current splenomegaly.

(2) History of splenectomy.

5.23. SYSTEMIC CONDITIONS.

a. History of disorders involving the immune mechanism, including immunodeficiencies.

b. Presence of human immunodeficiency virus or laboratory evidence of infection or false-positive screening test(s) with ambiguous results by supplemental confirmation test(s) is not, in itself, disqualifying with respect to covered personnel (including Military Service Academy cadets and midshipmen, contracted Senior Reserve Officers' Training Corps cadets and midshipmen, and other participants in in-service commissioning programs) seeking to commission while a Service member. Such covered personnel will be evaluated on a case-by-case basis.

c. Tuberculosis.

(1) History of active pulmonary or extra pulmonary tuberculosis in the previous 2 years or history of active pulmonary or extra-pulmonary tuberculosis without reliable documentation of adequate treatment.

(2) History of latent tuberculosis infection, as defined by current Centers for Disease Control guidelines, unless documentation of completion of appropriate treatment.

d. History of syphilis without appropriate documentation of treatment and cure.

e. History of anaphylaxis. Anaphylaxis is highly likely when any one of the following three criteria are fulfilled:

(1) Acute onset of an illness (minutes to several hours) with involvement of the skin, mucosal tissue, or both (e.g., generalized hives, pruritus or flushing, swollen lips-tongue-uvula) and at least one of the following:

(a) Respiratory compromise (e.g., dyspnea, wheeze-bronchospasm, stridor, reduced peak expiratory flow, hypoxemia); or

(b) Reduced blood pressure (BP) or associated symptoms of end-organ dysfunction (e.g., hypotonia [collapse], syncope, incontinence).

(2) Two or more of the following that occur rapidly after exposure to a likely allergen for that patient (minutes to several hours):

(a) Involvement of the skin-mucosal tissue (e.g., generalized hives, itch-flush, swollen lips-tongue-uvula).

(b) Respiratory compromise (e.g., dyspnea, wheeze-bronchospasm, stridor, reduced peak expiratory flow, hypoxemia).

(c) Reduced BP or associated symptoms (e.g., hypotonia [collapse], syncope, incontinence).

(d) Persistent gastrointestinal symptoms (e.g., crampy, abdominal pain, vomiting).

(3) Reduced blood pressure after exposure to known allergen for that patient (minutes to several hours):

(a) *Infants and Children.*

Low systolic BP (less than 70 mmHg from 1 month to 1 year, less than $(70 \text{ mmHg} + [2 \times \text{age}])$ from 1 to 10 years, and less than 90 mm Hg from 11 to 17 years) or greater than 30 percent decrease in systolic blood pressure.

(b) *Adults.*

Systolic BP of less than 90 mmHg or greater than 30 percent decrease from that person's baseline.

f. History of systemic allergic reaction to biting or stinging insects, unless it was limited to a large local reaction, a cutaneous only reaction (including hives) occurring under the age of 16, or unless there is documentation of 3-5 years of maintenance venom immunotherapy.

g. History of acute allergic reaction to fish, shellfish, peanuts, or tree nuts including the presence of a food-specific immunoglobulin E antibody if accompanied by a correlating clinical history.

h. History of cold urticaria.

i. History of malignant hyperthermia.

j. History of industrial solvent or other chemical intoxication with sequelae.

k. History of motion sickness resulting in recurrent incapacitating symptoms.

l. History of rheumatic fever if associated with rheumatic heart disease or indication for ongoing prophylactic medication.

m. History of muscular dystrophies or myopathies.

n. History of amyloidosis.

o. History of eosinophilic granuloma and all other forms of histiocytosis except for healed eosinophilic granuloma, when occurring as a single localized bony lesion and not associated with soft tissue or other involvement.

p. History of polymyositis or dermatomyositis complex with or without skin involvement.

- q. History of rhabdomyolysis.
- r. History of sarcoidosis.
- s. Current active systemic fungus infections or ongoing treatment for systemic fungal infection. History of systemic fungal infection unless resolved or treated without sequelae.

5.24. ENDOCRINE AND METABOLIC CONDITIONS.

- a. Current adrenal dysfunction or any history of adrenal dysfunction requiring treatment or hormone replacement.
- b. Diabetic disorders, including:
 - (1) History of diabetes mellitus.
 - (2) History of unresolved pre-diabetes mellitus (as defined by the American Diabetes Association) within the last 2 years.
 - (3) History of gestational diabetes mellitus.
 - (4) Current persistent glycosuria, when associated with impaired glucose metabolism or renal tubular defects.
- c. History of pituitary dysfunction except for resolved growth hormone deficiency.
- d. History of pituitary tumor unless proven non-functional, less than 1 cm and stable in size for the last 12 months.
- e. History of diabetes insipidus.
- f. History of primary hyperparathyroidism unless surgically corrected.
- g. History of hypoparathyroidism.
- h. Current goiter.
 - i. Thyroid nodule unless a solitary thyroid nodule less than 5 mm or less than 3 cm with benign histology or cytology, and that does not require ongoing surveillance.
- j. History of complex thyroid cyst or simple thyroid cyst greater than 2 cm.
- k. Current hypothyroidism unless asymptomatic and demonstrated euthyroid by normal thyroid stimulating hormone testing within the preceding 12 months.
- l. History of hyperthyroidism unless treated successfully with surgery or radioactive iodine.

m. Current nutritional deficiency diseases, including but not limited to beriberi, pellagra, and scurvy.

n. Dyslipidemia with low-density lipoprotein greater than 200 milligrams per deciliter (mg/dL) or triglycerides greater than 400 mg/dL. Dyslipidemia requiring more than one medication or low-density lipoprotein greater than 190 mg/dL on therapy. All those on medical management must have demonstrated no medication side effects (e.g., myositis, myalgias, or transaminitis) for a period of 6 months.

o. Metabolic syndrome, as defined in accordance with the 2005 National Heart, Lung, and Blood Institute and American Heart Association Scientific Statement as any three of the following:

(1) Medically-controlled hypertension or elevated blood pressure of greater than 130 mmHg systolic or greater than 85 mmHg diastolic.

(2) Waist circumference greater than 35 inches for women and greater than 40 inches for men.

(3) Medically controlled dyslipidemia or triglycerides greater than 150 mg/dL.

(4) Medically controlled dyslipidemia or high-density lipoprotein less than 40 mg/dL in men or less than 50 mg/dL in women.

(5) Fasting glucose greater than 100 mg/dL.

p. Metabolic bone disease including but not limited to:

(1) Osteopenia, osteoporosis, or low bone mass with history of fragility fracture.

(2) Paget's disease.

(3) Osteomalacia.

(4) Osteogenesis imperfecta.

q. History of hypogonadism that is congenital, treated with hormonal supplementation, or of unexplained etiology.

r. History of islet-cell tumors, nesidioblastosis, or hypoglycemia.

s. History of gout.

t. History of cross-sex hormone therapy associated with gender transition is disqualifying unless the individual has been stable on such hormones for 18 months or no longer requires such hormones, as certified by a licensed medical provider.

5.25. RHEUMATOLOGIC CONDITIONS.

- a. History of mixed connective tissue disease variant or systemic lupus erythematosus.
- b. History of progressive systemic sclerosis, including calcinosis, Raynaud's phenomenon, esophageal dysmotility, scleroderma, or telangiectasia syndrome.
- c. History of reactive arthritis (formerly known as Reiter's disease).
- d. History of rheumatoid arthritis.
- e. History of Sjögren's syndrome.
- f. History of vasculitis, including but not limited to polyarteritis nodosa, arteritis, Behçet's, Takayasu's arteritis, and Anti Neutrophil Cytoplasmic Antibody associated vasculitis.
- g. History of Henoch-Schonlein Purpura occurring after the 19th birthday or within the last 2 years.
- h. History of non-inflammatory myopathy including but not limited to metabolic myopathy such as glycogen storage disease, lipid storage disease, and mitochondrial myopathy.
- i. History of fibromyalgia or myofascial pain syndrome.
- j. History of chronic wide-spread pain requiring prescription medication for greater than 6 weeks within the last 2 years.
- k. History of chronic fatigue syndrome, systemic exertion intolerance disease, or chronic multisystem illness.
- l. History of spondyloarthritis including but not limited to ankylosing spondyloarthritis, psoriatic arthritis, reactive arthritis, or spondyloarthritis associated with inflammatory bowel disease.
- m. History of joint hypermobility syndrome (formerly Ehler's Danlos syndrome, Type III).
- n. Any history of connective tissue disease including but not limited to Ehlers-Danlos syndrome, Marfan syndrome, Pseudoxanthoma Elasticum, and osteogenesis imperfecta.
- o. History of scleroderma.
- p. History of IgG-4 related disease.
- q. History of polymyositis or dermatomyositis complex, with or without skin involvement.

5.26. NEUROLOGIC CONDITIONS.

- a. History of cerebrovascular conditions, including but not limited to subarachnoid or intracerebral hemorrhage, vascular stenosis, aneurysm, stroke, transient ischemic attack or arteriovenous malformation.
- b. History of congenital or acquired anomalies of the central nervous system or meningocele.
- c. History of disorders of meninges, including but not limited to cysts except for asymptomatic incidental arachnoid cysts demonstrated to be stable by neurological imaging over a 6-month or longer time period.
- d. History of neurodegenerative disorders, including but not limited to those disorders affecting the cerebrum, basal ganglia, cerebellum, spinal cord, peripheral nerves, or muscles.
- e. History of headaches, including but not limited to, migraines and tension headaches that:
 - (1) Are severe enough to disrupt normal activities (e.g., loss of time from school or work) more than twice per year in the past 2 years;
 - (2) Require prescription medications more than twice per year within the last 2 years; or
 - (3) Are associated with neurological deficit other than scotoma.
- f. Cluster headaches.
- g. History of moderate or severe brain injury if associated with:
 - (1) Post-traumatic seizure(s) occurring more than 30 minutes after injury;
 - (2) Persistent motor, sensory, vestibular, visual, or any other focal neurological deficit;
 - (3) Persistent impairment of cognitive function;
 - (4) Persistent alteration of personality or behavior;
 - (5) Cerebral traumatic findings, including but not limited to epidural, subdural, subarachnoid, or intracerebral hematoma on neurological imaging;
 - (6) Associated abscess or meningitis;
 - (7) Cerebrospinal fluid rhinorrhea or otorrhea persisting more than 7 days;
 - (8) Penetrating head trauma to include radiographic evidence of retained foreign body or bony fragments secondary to the trauma, or operative procedure in the brain; or
 - (9) Any skull fracture.
- h. History of mild brain injury if:

- (1) The injury occurred within the past month;
- (2) Neurological evaluation shows residual symptoms, dysfunction or activity limitations, or complications;
- (3) Two episodes of mild brain injury occurred with or without loss of consciousness within the last 12 months; or
- (4) Three or more episodes of mild brain injury.
 - i. History of persistent post-concussive symptoms that interfere with normal activities or have duration of more than 1 month. Symptoms include but are not limited to headache, vomiting, disorientation, spatial disequilibrium, impaired memory, poor mental concentration, shortened attention span, dizziness, or altered sleep patterns.
 - j. History of infectious processes of the central nervous system, including but not limited to encephalitis, neurosyphilis, or brain abscess.
 - k. History of meningitis within the last 12 months or with persistent neurologic defects.
 - l. History of paralysis, weakness, lack of coordination, chronic pain syndrome (including but not limited to complex regional pain syndrome or neuralgias), or sensory disturbance or other specified paralytic syndromes, including but not limited to Guillain-Barre Syndrome.
 - m. Any atraumatic seizure occurring after the 6th birthday, unless the applicant has been free of seizures for a period of 5 years while taking no medication for seizure control, and has a normal sleep-deprived electroencephalogram and normal neurology evaluation while taking no medications for seizure control.
 - n. Chronic nervous system disorders, including but not limited to myasthenia gravis, multiple sclerosis, tremor, and tic disorders (e.g., Tourette's Syndrome).
 - o. History of central nervous system shunts of all kinds including endoscopic third ventriculocisternostomy.
 - p. Syncope or atraumatic loss of consciousness. History of recurrent syncope or presyncope, including blackout, fainting, loss or alteration of level of consciousness (excludes single episode of vasovagal reaction with identified trigger such as venipuncture), unless there has been no recurrence during the preceding 2 years while off all medication for treatment of this condition.
 - q. History of muscular dystrophies or myopathies.

5.27. SLEEP DISORDERS.

- a. Chronic insomnia as defined by the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, or the use of medications or other substances to promote sleep 15 or more times over the past year.

- b. Current diagnosis or treatment of sleep-related breathing disorders, including but not limited to sleep apnea.
- c. History of narcolepsy, cataplexy, or other hypersomnia disorders.
- d. Circadian rhythm disorders requiring treatment or special accommodation.
- e. History of parasomnia, including but not limited to sleepwalking, or night terrors, after the 13th birthday.
- f. Current diagnosis or treatment of sleep-related movement disorders to include but not limited to restless leg syndrome (i.e., Willis-Ekbom Disease) for which prescription medication is recommended.

5.28. LEARNING, PSYCHIATRIC, AND BEHAVIORAL DISORDERS.

- a. Attention Deficit Hyperactivity Disorder, if with:
 - (1) A recommended or prescribed Individualized Education Program, 504 Plan, or work accommodations after the 14th birthday;
 - (2) A history of comorbid mental disorders;
 - (3) Prescribed medication in the previous 24 months; or
 - (4) Documentation of adverse academic, occupational, or work performance.
- b. History of learning disorders after the 14th birthday, including but not limited to dyslexia, if any of the following apply:
 - (1) With a recommended or prescribed Individualized Education Program, 504 Plan, or work accommodations after the 14th birthday;
 - (2) With a history of comorbid mental disorders; or
 - (3) With documentation of adverse academic, occupational, or work performance.
- c. Autism spectrum disorders.
- d. History of disorders with psychotic features such as schizophrenic disorders, delusional disorders, or other unspecified psychoses or mood disorders with psychotic features.
- e. History of bipolar and related disorders (formerly identified as mood disorders not otherwise specified) including but not limited to cyclothymic disorders and affective psychoses.
- f. Depressive disorder if:
 - (1) Outpatient care including counseling required for longer than 12 cumulative months;

- (2) Symptoms or treatment within the last 36 months;
 - (3) The applicant required any inpatient treatment in a hospital or residential facility;
 - (4) Any recurrence; or
 - (5) Any suicidality (in accordance with Paragraph 5.28.m.).
- g. History of a single adjustment disorder if treated or symptomatic within the previous 6 months, or any history of chronic (lasting longer than 6 months) or recurrent episodes of adjustment disorders.
- h. History of disruptive, impulse control and conduct disorder to include but not limited to oppositional defiant and other behavior disorders.
- i. Any personality disorder including unspecified personality disorder or maladaptive personality traits demonstrated by:
- (1) Repeated inability to maintain reasonable adjustment in school, with employers or fellow workers, other social groups, or psychological testing revealing that the degree of immaturity, instability, of personality inadequacy, impulsiveness, or dependency may reasonably be expected to interfere with their adjustment to the Military Services;
 - (2) Recurrent encounters with law enforcement agencies (excluding minor traffic violations) or antisocial behaviors are tangible evidence of impaired capacity to adapt to military service; or
 - (3) Any behavioral health issues that have led to incarceration for any period.
- j. Encopresis after 13th birthday.
- k. History of any feeding or eating disorder.
- l. Any current communication disorder that significantly interferes with producing speech or repeating commands.
- m. Suicidality, including suicidal ideation with a plan, suicidal gesture(s), or attempt(s).
- n. History of self-mutilation.
- o. History of obsessive-compulsive disorder.
- p. History of post-traumatic stress disorder.
- q. History of anxiety disorders if:
- (1) Outpatient care including counseling was required for longer than 12 cumulative months.

- (2) Symptomatic or treatment within the last 36 months.
 - (3) The applicant required any inpatient treatment in a hospital or residential facility.
 - (4) Any recurrence.
 - (5) Any suicidality (in accordance with Paragraph 5.28.m.).
- r. History of dissociative disorders.
 - s. History of somatic symptoms and related disorders.
 - t. History of gender dysphoria is disqualifying unless, as certified by a licensed mental health provider, the applicant has been stable without clinically significant distress or impairment in social, occupational, or other important areas of functioning for 18 months.
 - u. History of paraphilic disorders.
 - v. Any history of substance-related and addictive disorders (except using caffeine or tobacco).
 - w. History of other mental disorders that may reasonably be expected to interfere with or prevent satisfactory performance of military duty.
 - x. Prior psychiatric hospitalization for any cause.

5.29. TUMORS AND MALIGNANCIES.

- a. Current benign tumors or conditions that would reasonably be expected to interfere with function, to prevent properly wearing the uniform or protective equipment, or would require frequent specialized attention.
- b. History of malignancy.
- c. History of cutaneous malignancy, meeting criteria in Paragraph 5.21.aa.

5.30. MISCELLANEOUS CONDITIONS.

- a. Any current acute pathological condition, including but not limited to communicable, infectious, parasitic, or tropical diseases, until recovery has occurred without relapse or sequelae.
- b. History of porphyria.
- c. History of cold-related disorders, including but not limited to frostbite, chilblain, and immersion foot.
- d. History of angioedema, including hereditary angioedema.

- e. History of receiving organ or tissue transplantation other than dental.
- f. History of pulmonary or systemic embolism.
- g. History of untreated acute or chronic metallic poisoning (including but not limited to lead, arsenic, silver, beryllium, or manganese), or current complications or residual symptoms of such poisoning.
- h. History of heatstroke, or heat injury with evidence of organ or muscle damage, or recurrent heat exhaustion.
- i. History of any condition that may reasonably be expected to interfere with the successful performance of military duty or training or limit geographical assignment.
- j. History of any medical condition severe enough to warrant use of systemic steroids for greater than 2 months, or any use of other systemic immunosuppressant medications.

GLOSSARY

G.1. ACRONYMS.

ACRONYM	MEANING
ASD(HA)	Assistant Secretary of Defense for Health Affairs
AV	Atrioventricular
BP	blood pressure
cm	Centimeters
dB	decibel
DoDI	DoD instruction
MEDPERS	Medical and Personnel Executive Steering Committee
mg/dL	milligrams per deciliter
mm	millimeters
mmHg	millimeters of mercury
U.S.C.	United States Code
USD(P&R)	Under Secretary of Defense for Personnel and Readiness

G.2. DEFINITIONS.

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

TERM	DEFINITION
504 Plan	The 504 Plan is a plan developed to ensure that a child who has a disability identified under Section 504 of the Rehabilitation Act of 1973 as amended and codified at Section 701 of Title 29, U.S.C. and is attending an elementary or secondary educational institution, receives accommodations that will ensure their academic success and access to the learning environment.
accession	An enlistment that increases the incremental strength of the Regular or Reserve Components of the Military Services. Personnel enlisted under the Delayed Entry Program are not involved in this category.
covered personnel	Individuals who have been identified as HIV positive, are asymptomatic, and who have a clinically confirmed undetectable viral load.

TERM	DEFINITION
cross-sex hormone therapy	The use of feminizing hormones in an individual with a biological sex of male or the use of masculinizing hormones in an individual with a biological sex of female.
existed prior to Service	A term used to signify there is clear and unmistakable evidence that the disease or injury, or the underlying condition producing the disease or injury, existed prior to the individual's entry into military service.
induction	Transition from civilian to military status for a period of definite military obligation under Chapter 49 of Title 50, U.S.C. also known as the "Military Selective Service Act."
licensed mental health provider	A psychiatrist, clinical psychologist, clinical social worker with a master's degree or doctorate in clinical social work, or psychiatric nurse practitioner.
medical waiver	A formal request to consider the suitability for service of an applicant who, because of current or past medical conditions, does not meet medical standards. Upon the completion of a thorough review, the applicant may be considered for a waiver. The applicant must have displayed sufficient mitigating circumstances/provided medical documentation that clearly justify waiver consideration. The Secretaries of the Military Departments may delegate the final approval authority for all waivers.
medpers	Includes leaders from the medical and personnel communities to develop, discuss, and make decisions about common medical issues that require resolution. The primary focus is the nexus of medical and personnel systems that impact the total force to include those seeking entry into the armed forces and those who must depart prior to completion of an enlistment or career.
mild head injury	Unconsciousness of less than 30 minutes post-injury, or amnesia or disorientation of person, place, or time, alone or in combination, of less than 24 hours post-injury.
military department	Defined in the DoD Dictionary of Military and Associated Terms.
moderate brain injury	Unconsciousness of more than 30 minutes but less than 24 hours, or amnesia, or disorientation of person, place or time, alone or in combination, lasting more than 24 hours but less than 7 days after the injury.

TERM	DEFINITION
national heart, lung, and blood institute	An agency within the National Institutes of Health that provides global leadership for a research, training, and education program to promote the prevention and treatment of heart, lung, and blood diseases and enhance the health of all individuals so that they can live longer and more fulfilling lives.
self-identified gender	The gender with which an individual identifies.
severe brain injuries	Unconsciousness of 24 hours or more post injury, or amnesia or disorientation of person, place or time longer than 7 days after the injury.

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- United States Code, Title 10
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¹ Available at https://catalog.ama-assn.org/Catalog/cpt/cpt_home.jsp

² Available for purchase at <http://www.ansi.org/>

³ Available at <http://www.cdc.gov/nchs/icd/icd10cm.htm#icd2016>.

EXHIBIT C



Department of Defense INSTRUCTION

NUMBER 6485.01

June 7, 2013

Incorporating Change 2, Effective June 6, 2022

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 (other than covered personnel who are seeking to commission while a Service member), 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.

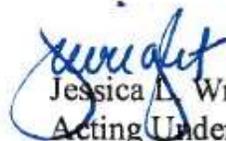
5. PROCEDURES. See Enclosure 3.

DoDI 6485.01, June 7, 2013

6. **RELEASABILITY. Cleared for public release.** This instruction is available on the Directives Division Website at <https://www.esd.whs.mil/DD/>.

7. **SUMMARY OF CHANGE 2.** In accordance with the June 6, 2022 Secretary of Defense Memorandum (Reference (m)), the changes to this issuance update DoD policy with respect to individuals who have been identified as HIV-positive. Individuals who have been identified as HIV-positive, are asymptomatic, and who have a clinically confirmed undetectable viral load will have no restrictions applied to their deployability or to their ability to commission while a Service member solely on the basis of their HIV-positive status. Nor will such individuals be discharged or separated solely on the basis of their HIV-positive status.

8. **EFFECTIVE DATE.** This instruction is effective June 7, 2013.


Jessica A. Wright
Acting Under Secretary of Defense for
Personnel and Readiness

Enclosures

1. References
2. Responsibilities
3. Procedures

Glossary

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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," May 6, 2018
- (d) DoD Directive 6490.02E, "Comprehensive Health Surveillance," February 8, 2012, as amended
- (e) DoD Instruction 6025.19, "Individual Medical Readiness (IMR)," June 9, 2014
- (f) DoD Instruction 6490.03, "Deployment Health," June 19, 2019
- (g) DoD Instruction 6025.13, "Medical Quality Assurance (MQA) and Clinical Quality Management in the Military Health System (MHS)," February 17, 2011, as amended
- (h) DoD Instruction 6490.07, "Deployment-Limiting Medical Conditions for Service Members and DoD Civilian Employees," February 5, 2010
- (i) DoD Instruction 1332.18, "Disability Evaluation System (DES)," August 5, 2014, as amended
- (j) Section 705(c) of Public Law 99-661, "National Defense Authorization Act for Fiscal Year 1987," November 14, 1986
- (k) DoD 5400.11-R, "Department of Defense Privacy Program," May 14, 2007
- (l) DoD 6025.18, "Implementation of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule in DoD Health Care Programs," March 13, 2019
- (m) Secretary of Defense Memorandum, "Policy Regarding Human Immunodeficiency Virus-Positive Personnel within the Armed Forces," June 6, 2022

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 (d)).

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 (e)) and DoDI 6490.03 (Reference (f)).

d. A serum sample from all HIV force screenings will be forwarded to the DoD Serum Repository as directed by Reference (d).

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 (References (g)).

b. In accordance with DoDI 6490.07 (Reference (h)), the cognizant Combatant Command surgeon will be consulted in all instances of HIV seropositivity before medical clearance for deployment.

DoDI 6485.01, June 7, 2013

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 1332.18 (Reference (i)). 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 (i).

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 (j)). 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 Manual 6025.18 (References (k) and (l)).

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.

covered personnel. Individuals who have been identified as HIV-positive, are asymptomatic, and who have a clinically confirmed undetectable viral load.

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 D

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USCENTCOM 171924Z APR 23 MOD SEVENTEEN TO USCENTCOM INDIVIDUAL PROTECTION AND INDIVIDUAL-UNIT DEPLOYMENT POLICY

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SUBJ/MOD SEVENTEEN TO USCENTCOM INDIVIDUAL PROTECTION AND INDIVIDUAL/UNIT DEPLOYMENT POLICY//

REF/A/MSG/CDRUSCENTCOM/SG/032024ZOCT2001//
AMPN/ORIGINAL USCINCCENT INDIVIDUAL PROTECTION AND INDIVIDUAL UNIT DEPLOYMENT POLICY MESSAGE//

REF/B/MSG/CDRUSCENTCOM/SG/061600ZJAN22//
AMPN/MOD SIXTEEN TO USCENTCOM INDIVIDUAL PROTECTION AND UNIT DEPLOYMENT POLICY MESSAGE. MOD SIXTEEN IS NO LONGER VALID AND IS SUPERSEDED BY MOD SEVENTEEN//

REF/C/DOC/USD(P&R)/19JUN2019//
AMPN/DODI 6490.03/DEPLOYMENT HEALTH//

REF/D/DOC/USD(P&R)/13JUL2022//
AMPN/DODI 6025.19/INDIVIDUAL MEDICAL READINESS//

REF/E/DOC/COMDT CG/05JUN2018//
AMPN/CH-2 TO COMDTINST M6000.1F/COAST GUARD MEDICAL MANUAL//

REF/F/DOC/HQ USAF/07AUG2020//
AMPN/AFI 48-133/DUTY LIMITING CONDITIONS//

REF/G/DOC/HQDA/27JUN2019//
AMPN/AR 40-501/STANDARDS OF MEDICAL FITNESS//

REF/H/DOC/BUMED/20 FEB 2019//
AMPN/NAVMED P-117/MANUAL OF THE MEDICAL DEPARTMENT (MANMED)//

REF/I/DOC/USD(P&R)/05FEB2010//
AMPN/DODI 6490.07/DEPLOYMENT-LIMITING MEDICAL CONDITIONS FOR SERVICE MEMBERS AND DOD CIVILIAN EMPLOYEES//

REF/J/DOC/USD(A&S)/20DEC2011, CHANGE 2 31AUG2018//
AMPN/DODI 3020.41/OPERATIONAL CONTRACT SUPPORT//

REF/K/DOC/USD(P&R)/25JAN2017, CHANGE 3 12FEB2020//
AMPN/ DTM 17-004/DOD CIVILIAN EXPEDITIONARY WORKFORCE//

REF/L/DOC/ASD(FMP)/27MAR2019//
AMPN/DODI 1100.21/VOLUNTARY SERVICES IN THE DEPARTMENT OF DEFENSE//

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REF/M/DOC/ASD(P&R)/16JUN2016, CHANGE 1 21DEC2017//
AMPN/DODI 6200.05/FORCE HEALTH PROTECTION QUALITY ASSURANCE (FHPQA) PROGRAM//

REF/N/DOC/HQDA/BUMED/SECAF/07OCT2013//
AMPN/AR 40-562, BUMEDINST 6230.15B, AFI 48-110 IP, CG COMDTINST M6230.4G/
IMMUNIZATIONS AND CHEMOPROPHYLAXIS FOR THE PREVENTION OF INFECTIOUS DISEASES//

REF/O/DOC/DEPSECDEF/12NOV2015//
AMPN/DEPUTY SECRETARY OF DEFENSE MEMO/CLARIFYING GUIDANCE FOR SMALLPOX AND ANTHRAX VACCINE IMMUNIZATION PROGRAMS//

REF/P/DOC/DEPSECDEF/12OCT2006//
AMPN/DEPUTY SECRETARY OF DEFENSE MEMO/ANTHRAX VACCINE IMMUNIZATION PROGRAM//

REF/Q/DOC/ASD(HA)/31JUL2009//
AMPN/ASSISTANT SECRETARY OF DEFENSE MEMO/CLINICAL POLICY FOR THE ADMINISTRATION OF THE ANTHRAX VACCINE ABSORBED//

REF/R/DOC/AFPMB OUSD (A&S)/06NOV2015//
AMPN/TECHNICAL GUIDE NO. 36/PERSONAL PROTECTIVE MEASURES AGAINST INSECTS AND OTHER ARTHROPODS OF MILITARY SIGNIFICANCE//

REF/S/DOC/USD(P&R)/07JUN2013//
AMPN/DODI 6485.01/HUMAN IMMUNODEFICIENCY VIRUS (HIV) IN MILITARY SERVICE MEMBERS//

REF/T/DOC/ASD(HA)/14MAR2006//
AMPN/ASSISTANT SECRETARY OF DEFENSE MEMO/POLICY FOR PRE AND POST DEPLOYMENT SERUM COLLECTION//

REF/U/DOC/ASD(P&R)/17JUL2015//
AMPN/DODI 6465.01/ERYTHROCYTE GLUCOSE-6-PHOSPHATE DEHYDROGENASE DEFICIENCY (G6PD) AND SICKLE CELL TRAIT SCREENING PROGRAMS//

REF/V/DOC/ASD(HA)/20APR2012//
AMPN/ASSISTANT SECRETARY OF DEFENSE MEMO/GUIDELINE FOR TUBERCULOSIS SCREENING AND TESTING//

REF/W/DOC/ASD(HA)/26JUL2012//
AMPN/ASSISTANT SECRETARY OF DEFENSE MEMO/IMPLEMENTATION OF REVISED DEPARTMENT OF DEFENSE FORMS 2795, 2796 AND 2900//

REF/X/DOC/USD(P&R)/11SEP2015, CHANGE 1 31MAR2017//
AMPN/DODI 6490.13/COMPREHENSIVE POLICY ON TRAUMATIC BRAIN INJURY-RELATED NEUROCOGNITIVE ASSESSMENTS BY THE MILITARY SERVICES//

REF/Y/DOC/USD(P&R)/ 19JUN2019//
AMPN/DODI 6490.03/DEPLOYMENT HEALTH//

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REF/Z/DOC/USD(P&R)/16MAR2018//
AMPN/DODI 1322.24/MEDICAL READINESS TRAINING (MRT)//

REF/AA/USD(I)/20MAR2009, CHANGE 2 25APR2018//
AMPN/DODI 6420.01/NATIONAL CENTER MEDICAL INTELLIGENCE (NCMI)//

REF/BB/DOC/ASD(HA)/15APR2013//
AMPN/ASSISTANT SECRETARY OF DEFENSE MEMO/GUIDANCE ON MEDICATIONS FOR
PROPHYLAXIS OF MALARIA//

REF/CC/DOC/ASD(HA)/12AUG2013//
AMPN/ASSISTANT SECRETARY OF DEFENSE MEMO/NOTIFICATION FOR HEALTHCARE
PROVIDERS OF MEFLUQUINE BOX WARNING//

REF/DD/DOC/ASD(HA)/18MAY2007//
AMPN/ASSISTANT SECRETARY OF DEFENSE MEMO/UPDATED POLICY FOR PREVENTION OF
ARTHROPOD-BORNE DISEASES AMONG DEPARTMENT OF DEFENSE PERSONNEL DEPLOYED
TO ENDEMIC AREAS//

REF//EE/DOC/J4/02NOV2007//
AMPN/MCM-0028-07/PROCEDURES FOR DEPLOYMENT HEALTH SURVEILLANCE//

REF/FF/DOC/CENTCOM/21MAY2020//
AMPN/CCR 40-2/DEPLOYMENT FORCE HEALTH PROTECTION//

REF/GG/DOC/AFHSB/01JAN2020//
AMPN/ARMED FORCES REPORTABLE MEDICAL EVENTS GUIDELINES & CASE DEFINITIONS//

REF/HH/ DOC/CENTCOM/19APR2018//
AMPN/CCR 40-5/MEDICAL INFORMATION SYSTEMS//

REF/II/DOC/USD(P&R)/18SEP2012, CHANGE 2 26NOV2019//
AMPN/DODI 6490.11/DOD POLICY GUIDANCE FOR MANAGEMENT OF MILD TRAUMATIC BRAIN
INJURY/ AND CONCUSSION IN THE DEPLOYED SETTING//

REF/JJ/DOC/OTSG/16MAR2018//
AMPN/MEDCOM POLICY MEMO 18-008/STINGING INSECT ALLERGY RETENTION AND READINESS
POLICY//

REF/KK/DOC/ASD(HA)/07OCT2013//
AMPN/ASSISTANT SECRETARY OF DEFENSE MEMO/CLINICAL PRACTICE GUIDELINES FOR
DEPLOYMENT LIMITING MENTAL DISORDERS AND PSYCHOTROPIC MEDICATIONS//

REF/LL/DOC/USD(P&R)/30APR2021//
AMPN/DODI 1300.28/IN-SERVICE TRANSITION FOR TRANSGENDER SERVICE MEMBERS//

REF/MM/DOC/HHS/OCT2015//

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STIMULANT AND RELATED MEDICATIONS: U.S. FOOD AND DRUG ADMINISTRATION-APPROVED INDICATIONS AND DOSAGES FOR USE IN ADULTS//

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

REF/OO/DOC/USD(P&R)/06MAY2018, CHANGE 4 16NOV2022//AMPN/DODI 6130.03, VOL1/MEDICAL STANDARDS FOR MILITARY SERVICE: APPOINTMENT, ENLISTMENT, OR INDUCTION

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

1.A. PARAGRAPH 15 REQUIRED CHANGES IN RESPONSE TO THE ELIMINATION OF A UNIVERSAL COVID-19 VACCINATION MANDATE. MOD 17 SUPERSEDES ALL PREVIOUS VERSIONS.

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

15.A. DEFINITIONS.

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

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

15.A.3. PERMANENT CHANGE OF STATION (PCS). PCS PERSONNEL, INCLUDING EMBASSY PERSONNEL, WILL COORDINATE WITH THEIR RESPECTIVE SERVICE COMPONENT MEDICAL PERSONNEL FOR MEDICAL GUIDANCE AND REQUIREMENTS FOR PCS TO SPECIFIC COUNTRIES IN THE USCENTCOM AOR. AUTHORIZED DEPENDENTS MUST PROCESS THROUGH THE OVERSEAS SCREENING PROCESS AND EXCEPTIONAL FAMILY MEMBER PROGRAM (EFMP), IF REQUIRED. ALL PERSONNEL MUST BE CURRENT WITH ADVISORY COMMITTEE ON IMMUNIZATION PRACTICES (ACIP) IMMUNIZATION GUIDELINES AND DOD TRAVEL GUIDELINES. HOST NATION IMMUNIZATION AND MEDICAL SCREENING REQUIREMENTS APPLY. PORTIONS OF MOD 17 WILL APPLY AS DELINEATED IN TAB B.

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

15.B. APPLICABILITY. THIS MOD APPLIES TO U. S. MILITARY PERSONNEL, TO INCLUDE ACTIVATED RESERVE AND NATIONAL GUARD PERSONNEL, DOD CIVILIANS, DOD CONTRACTORS, DOD SUB-CONTRACTORS, VOLUNTEERS, AND THIRD COUNTRY NATIONALS (TCN) DEPLOYING TO THE CENTCOM AOR AND WORKING UNDER THE AUSPICES OF THE DOD. LOCAL NATIONALS (LN) WILL MEET THE MINIMAL MEDICAL STANDARDS ADDRESSED IN SECTION 15.C.1.F. MILITARY WORKING DOGS (MWD) AND CONTRACT WORKING DOGS (CWD) WILL MEET MINIMAL STANDARDS ADDRESSED IN SECTION 15.C.1.G.

15.C. MEDICAL DEPLOYABILITY. THE FINAL AUTHORITY FOR ENTRY INTO THE CENTCOM AOR RESTS WITH THE CENTCOM SURGEON AND MAY BE DELEGATED TO CENTCOM SERVICE COMPONENT SURGEONS. THE DEPLOYER'S MEDICAL EVALUATING ENTITY OR DEPLOYING PLATFORM OR COMMANDER ARE NOT AUTHORIZED TO WAIVE MEDICAL DEPLOYMENT STANDARDS. DEPLOYED HEALTH SERVICE SUPPORT INFRASTRUCTURE IS DESIGNED AND

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PRIORITIZED TO PROVIDE ACUTE AND EMERGENCY SUPPORT TO THE EXPEDITIONARY MISSION. ALL PERSONNEL (UNIFORMED SERVICE MEMBERS, GOVERNMENT CIVILIAN EMPLOYEES, VOLUNTEERS, DOD CONTRACTOR EMPLOYEES), CONTRACT WORKING DOGS (CWD) AND MWD TRAVELING TO THE CENTCOM AOR MUST MEET MEDICAL, DENTAL, AND BEHAVIORAL HEALTH FITNESS STANDARDS, AND BE REASONABLY EXPECTED TO REMAIN SO FOR THE DURATION OF THEIR DEPLOYMENT. INDIVIDUALS DEEMED UNABLE TO COMPLY WITH CENTCOM DEPLOYMENT REQUIREMENTS ARE DISQUALIFIED FOR DEPLOYMENT IAW SERVICE POLICY AND MOD 17. PERSONNEL FOUND TO BE MEDICALLY NON-DEPLOYABLE WHILE OUTSIDE OF THE CENTCOM AOR FOR ANY LENGTH OF TIME WILL NOT ENTER OR RE-ENTER THE THEATER UNTIL THE NON-DEPLOYABLE CONDITION IS COMPLETELY RESOLVED OR AN APPROVED WAIVER FROM A CENTCOM WAIVER AUTHORITY IS OBTAINED. SEE REF D, E, F, G, H. DOD CIVILIAN EMPLOYEES ARE COVERED BY THE REHABILITATION ACT OF 1973. AS SUCH, AN APPARENTLY DISQUALIFYING MEDICAL CONDITION NEVERTHELESS REQUIRES THAT AN INDIVIDUALIZED ASSESSMENT BE MADE TO DETERMINE WHETHER THE EMPLOYEE CAN PERFORM THE ESSENTIAL FUNCTIONS OF THEIR POSITION IN THE DEPLOYED ENVIRONMENT, WITH OR WITHOUT REASONABLE ACCOMMODATION, WITHOUT CAUSING UNDUE HARDSHIP. IN EVALUATING UNDUE HARDSHIP, THE NATURE OF THE ACCOMMODATION AND THE LOCATION OF THE DEPLOYMENT MUST BE CONSIDERED. FURTHER, THE EMPLOYEE'S MEDICAL CONDITION MUST NOT POSE A SUBSTANTIAL RISK OF SIGNIFICANT HARM TO THE EMPLOYEE OR OTHERS WHEN TAKING INTO ACCOUNT THE CONDITIONS OF THE RELEVANT DEPLOYED ENVIRONMENT. SEE REF I.

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

15.C.1.A. MEDICAL READINESS PROCESSING. THE MEDICAL SECTION OF THE DEPLOYMENT SCREENING SITE MAY PUBLISH GUIDANCE, IAW MOD17 AND SERVICE STANDARDS, TO ASSIST IN DETERMINING MEDICAL DEPLOYMENT FITNESS. DEPLOYING PERSONNEL MUST HAVE AN EVALUATION BY A MEDICAL PROVIDER TO DETERMINE IF THEY CAN SAFELY DEPLOY AND OBTAIN AN APPROVED WAIVER FOR ANY DISQUALIFYING MEDICAL CONDITION(S) FROM THE COMPONENT SURGEON OR CENTCOM SURGEON PRIOR TO DEPLOYING.

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

15.C.1.C. EXAMINATION INTERVALS. AN EXAMINATION WITH ALL MEDICAL ISSUES AND REQUIREMENTS ADDRESSED WILL REMAIN VALID FOR A MAXIMUM OF 15 MONTHS FROM THE DATE OF THE PHYSICAL, OR 12 MONTHS FOLLOWING DEPLOYMENT, WHICHEVER IS FIRST. SEE TAB A AND REF D, J, K, L FOR FURTHER GUIDANCE. GOVERNMENT CIVILIAN EMPLOYEES, VOLUNTEERS, AND DOD CONTRACTOR PERSONNEL DEPLOYED FOR MULTIPLE OR EXTENDED TOURS OF MORE THAN 12 MONTHS MUST BE RE-EVALUATED FOR FITNESS TO STAY DEPLOYED. ANNUAL IN-THEATER RESCREENING MAY BE FOCUSED ON HEALTH CHANGES, VACCINATION CURRENCY, AND MONITORING OF EXISTING CONDITIONS RATHER THAN BEING COMPREHENSIVE, BUT SHOULD CONTINUE TO MEET ALL MEDICAL GUIDANCE AS PRESCRIBED IN MOD 17. UNLESS SPECIFICALLY OBLIGATED BY CONTRACTUAL ARRANGEMENT, EXPEDITIONARY MILITARY MEDICAL ASSETS ARE NOT TO BE USED FOR RE-EVALUATION OF CONTRACTORS TO STAY DEPLOYED. IF INDIVIDUALS ARE UNABLE TO ADEQUATELY COMPLETE THEIR MEDICAL SCREENING EVALUATION IN THE AOR, THEY SHOULD BE

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REDEPLOYED TO ACCOMPLISH THIS YEARLY REQUIREMENT. PERIODIC HEALTH SURVEILLANCE REQUIREMENTS AND PRESCRIPTION NEEDS ASSESSMENTS SHOULD REMAIN CURRENT THROUGH THE DEPLOYMENT PERIOD.

15.C.1.D. SPECIALIZED GOVERNMENT CIVILIAN EMPLOYEES WHO MUST MEET SPECIFIC PHYSICAL STANDARDS (E.G., FIREFIGHTERS, SECURITY GUARDS, POLICE, AVIATORS, AVIATION CREW MEMBERS, AIR TRAFFIC CONTROLLERS, DIVERS, MARINE CRAFT OPERATORS, COMMERCIAL DRIVERS, ETC.) MUST MEET THOSE STANDARDS WITHOUT EXCEPTION, IN ADDITION TO BEING FOUND FIT FOR THE SPECIFIC DEPLOYMENT BY A MEDICAL AND DENTAL EVALUATION PRIOR TO DEPLOYMENT IAW MOD 17. CERTIFICATIONS MUST BE VALID AND RENEWED AS REQUIRED THROUGHOUT THE ENTIRETY OF THE DEPLOYMENT. IT IS UP TO THE INDIVIDUAL TO PLAN FOR AND RECERTIFY THEIR RESPECTIVE REQUIREMENTS.

15.C.1.E. DOD CONTRACTOR EMPLOYEES MUST MEET STANDARDS OF FITNESS FOR DEPLOYMENT AND MUST BE DOCUMENTED TO BE FIT FOR THE PERFORMANCE OF THEIR DUTIES, WITHOUT LIMITATIONS, BY MEDICAL AND DENTAL EVALUATION PRIOR TO DEPLOYMENT IAW MOD 17. CONTRACTORS MUST COMPLY WITH REF J AND SPECIFICALLY ENCLOSURE 3 FOR MEDICAL REQUIREMENTS. EVALUATIONS SHOULD BE COMPLETED PRIOR TO ARRIVAL AT THE DEPLOYMENT PLATFORM.

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

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

15.C.1.E.3. CONTRACTOR EXPENSE. IAW REF J, CONTRACTORS WILL PROVIDE PREDEPLOYMENT MEDICAL AND DENTAL EVALUATIONS. ANNUAL IN THEATER RESCREENING, IF REQUIRED, WILL BE AT CONTRACTOR EXPENSE. REQUIRED IMMUNIZATIONS OUTLINED IN THE FOREIGN CLEARANCE GUIDE ([HTTPS://WWW.FCG.PENTAGON.MIL](https://www.fcg.pentagon.mil)) FOR THE COUNTRIES TO BE VISITED, AS WELL AS THOSE OUTLINED IN PARAGRAPH 15.F. OF THIS MOD, WILL BE DONE AT CONTRACTOR EXPENSE. THE SOLE EXCEPTION TO THIS POLICY IS ANTHRAX VACCINE, WHICH WILL BE PROVIDED AT MILITARY EXPENSE. SEE REF C, J, O. A DISQUALIFYING MEDICAL CONDITION, AS DETERMINED BY AN IN-THEATER QUALIFIED MEDICAL PROVIDER, WILL BE IMMEDIATELY REPORTED TO THE CONTRACTOR EMPLOYEE'S CONTRACTING OFFICER WITH A RECOMMENDATION THAT THE CONTRACTOR BE IMMEDIATELY REDEPLOYED AND REPLACED AT CONTRACTOR EXPENSE UNLESS AN APPROVED WAIVER IS OBTAINED. ALL THE ABOVE EXPENSES WILL BE COVERED BY THE CONTRACTOR UNLESS OTHERWISE SPECIFIED IN THE CONTRACT.

15.C.1.F. LN AND TCN EMPLOYEES. MINIMUM SCREENING REQUIREMENTS ARE:

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15.C.1.F.1. PRE-EMPLOYMENT AND ANNUAL MEDICAL SCREENING OF LN AND TCN EMPLOYEES IS NOT TO BE PERFORMED IN MILITARY MTFs. LOCAL CONTRACTING AGENCIES MUST KEEP DOCUMENTATION FROM ALL REQUIREMENTS LISTED IN PARA. 15.C.1.E.1.

15.C.1.F.2. ALL LN AND TCN EMPLOYEES WHOSE JOB REQUIRES CLOSE OR FREQUENT CONTACT WITH NON-LN/TCN PERSONNEL (E.G., DINING FACILITY WORKERS, SECURITY PERSONNEL, INTERPRETERS, ETC.) MUST BE SCREENED FOR TUBERCULOSIS (TB) USING AN ANNUAL SYMPTOM SCREEN. A TUBERCULIN SKIN TEST (TST) IS UNRELIABLE AS A STAND-ALONE SCREENING TEST FOR TB DISEASE IN LN/TCN PERSONNEL AND SHOULD NOT BE USED. SPECIFIC QUESTIONS REGARDING APPROPRIATE SCREENING OF DETAINEES, PRISON GUARDS AND OTHER HIGHER RISK POPULATIONS SHOULD BE REFERRED TO THE THEATER PREVENTIVE MEDICINE CONSULTANT THROUGH UNIT MEDICAL PERSONNEL.

15.C.1.F.3. LN AND TCN EMPLOYEES INVOLVED IN FOOD SERVICE, WATER, AND ICE PRODUCTION MUST BE SCREENED ANNUALLY FOR SIGNS AND SYMPTOMS OF INFECTIOUS DISEASE. CONTRACTORS MUST ENSURE EMPLOYEES RECEIVE TYPHOID AND HEPATITIS A VACCINATIONS AND THIS INFORMATION MUST BE DOCUMENTED IN THE EMPLOYEES' MEDICAL RECORD / SCREENING DOCUMENTATION.

15.C.1.F.4. FURTHER GUIDANCE REGARDING MEDICAL SUITABILITY OR FORCE HEALTH PROTECTION MAY BE PROVIDED BY THE LOCAL TASK FORCE COMMANDER OR EQUIVALENT IN CONSULTATION WITH THEIR MILITARY MEDICAL ASSETS.

15.C.1.G. WORKING DOGS. ONLY THOSE ANIMALS FORMALLY CLASSIFIED AS A MILITARY WORKING DOG (MWD) OR CONTRACT WORKING DOG (CWD), AND DEPLOYED WITH APPROPRIATE HANDLERS FOR A SPECIFIC PURPOSE, ARE AUTHORIZED. ENSURE APPROPRIATE KENNELING, VETERINARY SUPPORT, AND FOOD PRIOR TO DEPLOYMENT. MWD DEPLOYING TO THE CENTCOM AOR MUST MEET THE FOLLOWING REQUIREMENTS.

15.C.1.G.1. MWDS/CWDS ARE SUBJECT TO THE IMPORT REQUIREMENTS OF THE COUNTRIES TO WHICH THEY TRAVEL. REQUIREMENTS ARE SUBJECT TO CHANGE WITHOUT OFFICIAL NOTICE TO DOD. VETERINARY CORPS OFFICERS (VCOS) RESPONSIBLE TO PREPARE DOGS FOR DEPLOYMENT WILL REVIEW HOST NATION IMPORT REQUIREMENTS FOR ANY COUNTRIES THE MWDS/CWDS MAY TRAVEL TO, OR TRANSIT THROUGH, TO ENSURE ASSOCIATED REQUIREMENTS ARE MET.

15.C.1.G.2. ONLY MWDS/CWDS ASSIGNED DEPLOYMENT CATEGORY 1 WILL DEPLOY INTO THE CENTCOM AOR. MWDS/CWDS ASSIGNED CATEGORIES 2-4 ARE ONLY AUTHORIZED TO DEPLOY INTO THE CENTCOM AOR AFTER RECEIVING A MEDICAL WAIVER FROM THE ARCENT VCO. MWD/CWD DEPLOYMENT CATEGORIES ARE DEFINED IN PARA 2.15 OF REF NN.

15.C.1.G.3. MWD DEPLOYING TO THE CENTCOM AOR MUST MEET THE FOLLOWING REQUIREMENTS.

15.C.1.G.3.A. BE IMPLANTED WITH A EUROPEAN UNION (EU) APPROVED 15 DIGIT ISO 11784/11785-307 COMPLIANT MICROCHIP.

15.C.1.G.3.B. CURRENT ON RABIES AND DISTEMPER/ADENO/PARVOVIRU (DAP) AND LEPTOSPIROSIS VACCINES, GIVEN WITHIN 2 MONTHS OF DEPLOYMENT.

15.C.1.G.3.C. THE RED SEMI-ANNUAL PHYSICAL EXAMINATION (RSAPE) WITH ALL NECESSARY LABORATORY TESTS COMPLETED PERFORMED PRIOR TO TRAVEL, AS WELL AS 4DX SNAP TESTS FOR DIROFILARIA AND TICK BORNE DISEASES, AND DETAILED ANESTHETIZED ORAL 313 EXAM TO INCLUDE ALL TEETH.

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LINKED TO THEIR 15 DIGIT ISO MICROCHIP, AND THEIR RABIES VACCINE COVERAGE HAS NEVER LAPSED SINCE THE FAVN WAS PERFORMED.

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

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

15.C.2. UNFIT PERSONNEL. CASES OF IN-THEATER/DEPLOYED PERSONNEL IDENTIFIED AS UNFIT, IAW THIS MOD 17, DUE TO CONDITIONS THAT EXISTED PRIOR TO DEPLOYMENT WILL BE FORWARDED TO THE APPROPRIATE COMPONENT SURGEON FOR DETERMINATION REGARDING POTENTIAL MEDICAL WAIVER OR REDEPLOYMENT. FINDINGS/ACTIONS WILL BE FORWARDED TO THE CENTCOM SURGEON AT CENCOM.MACDILL.CENCOM-HQ.MBX.CCSG-WAIVER@MAIL.MIL.

15.C.3. MEDICAL WAIVERS.

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

15.C.3.A.1. MEDICAL WAIVER APPROVAL AUTHORITY LIES AT THE COMBATANT COMMAND SURGEON LEVEL IAW REF I, K, M, AND IS DELEGATED TO THE USCENTCOM COMPONENT SURGEONS FOR ALL DEPLOYING PERSONNEL WITHIN THEIR RESPECTIVE COMPONENT FOR ALL HEALTH CONDITIONS. MWD/CWD WAIVERS WILL BE EVALUATED BY THE ARCENT VETERINARY CORPS OFFICER (VCO). SENDING UNIT COMMANDER OR DESIGNEE ENDORSEMENT OF UNIFORMED SERVICE MEMBER WAIVERS IS REQUIRED PRIOR TO SUBMISSION IN ORDER TO ENSURE COMMAND AWARENESS.

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

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

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

15.C.3.B.1. AUTHORIZED AGENTS (LOCAL MEDICAL PROVIDER, COMMANDER/SUPERVISOR, REPRESENTATIVE) WILL FORWARD A COMPLETED MEDICAL WAIVER REQUEST FORM (TAB C), TO BE ADJUDICATED BY THE APPROPRIATE SURGEON IAW PARAGRAPH 15.C.3.C. ADJUDICATION WILL ACCOUNT FOR SPECIFIC MEDICAL SUPPORT CAPABILITIES IN THE LOCAL REGION OF THE AOR, INCLUDING POSSIBLE MEDICATION UNAVAILABILITY. WAIVER SUBMISSION BY OR THROUGH A MEDICAL AUTHORITY IS STRONGLY ENCOURAGED TO AVOID UNNECESSARY ADJUDICATION DELAYS DUE TO INCOMPLETE INFORMATION. THE CASE SUMMARY PORTION OF THE WAIVER SHOULD INCLUDE A SYNOPSIS OF THE CONCERNING

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CONDITION(S) AND ALL SUPPORTING DOCUMENTATION TO INCLUDE THE PROVIDER'S ASSESSMENT OF ABILITY TO DEPLOY.

15.C.3.B.2. THE SIGNED WAIVER WILL BE RETURNED TO THE REQUEST ORIGINATOR FOR INCLUSION IN THE PATIENT'S DEPLOYMENT MEDICAL RECORD AND THE ELECTRONIC MEDICAL RECORD (EMR). DISAPPROVALS MUST BE DOCUMENTED AND SHOULD NOT BE GIVEN TELEPHONICALLY.

15.C.3.B.3. A CENTCOM WAIVER DOES NOT PRECLUDE THE NEED FOR SERVICE-SPECIFIC MEDICAL WAIVERS (E.G., SMALL ARMS WAIVERS) OR OCCUPATIONAL MEDICAL WAIVERS (E.G., AVIATORS, COMMERCIAL TRUCK DRIVERS, ETC.) IF REQUIRED.

15.C.3.B.4. APPEAL PROCESS. IF THE SENDING UNIT DISAGREES WITH THE COMPONENT SURGEON'S DECISION, AN APPEAL MAY BE SUBMITTED TO THE CENTCOM SURGEON. IF THE DISAGREEMENT IS WITH THE CENTCOM SURGEON'S DECISION, AN APPEAL MAY BE COORDINATED WITH THE INDIVIDUAL'S CHAIN OF COMMAND, THROUGH THE CENTCOM SURGEON, TO THE CENTCOM CHIEF OF STAFF FOR EXEMPTION TO POLICY CONSIDERATION.

15.C.3.B.5. WAIVERS ARE APPROVED FOR A MAXIMUM OF 15 MONTHS OR FOR THE TIMEFRAME SPECIFIED ON THE WAIVER (TAB C). WAIVER COVERAGE BEGINS ON THE DATE OF THE INITIAL DEPLOYMENT.

15.C.3.B.6. WAIVERS MAY BE APPROVED, AT THE WAIVER AUTHORITY'S SOLE DISCRETION, FOR PERIODS OF TIME (E.G. 90 DAYS) SHORTER THAN THE SCHEDULED DEPLOYMENT DURATION IN ORDER TO REQUIRE REASSESSMENT OF A MEDICAL CONDITION. SUCH WAIVERS WILL INCLUDE RESUBMISSION INSTRUCTIONS. ALL LABS, ASSESSMENTS, ETC. REQUIRED FOR RESUBMISSION ARE THE RESPONSIBILITY OF THE EMPLOYEE TO OBTAIN AND SUBMIT.

15.C.3.B.7. ALL ADJUDICATING SURGEONS WILL MAINTAIN A WAIVER DATABASE AND RECORD ALL WAIVER REQUESTS.

15.C.3.B.8. RECOMMEND ALL INITIAL WAIVER REQUESTS BE SUBMITTED AT LEAST, BUT NOT EARLIER THAN 60 DAYS PRIOR TO PLANNED DEPARTURE.

15.C.3.C. CONTACTS FOR WAIVERS

15.C.3.C.1. CENTCOM SURGEON.

CENTCOM.MACDILL.CENTCOM-HQ.MBX.CCSG-WAIVER@MAIL.MIL ;

CML: 813.529.0361; DSN: 312.529.0361

15.C.3.C.2. AFCENT SURGEON. SG.CLINOPS@AFCENT.AF.MIL;

CML: 803.717.7101; DSN: 313.717.7101

15.C.3.C.3. ARCENT SURGEON. USARMY.SHAW.USARCENT.MBX.SURG-WAIVER@ARMY.MIL;

CML: 803.885.7946; DSN: 312.889.7946

15.C.3.C.4. MARCENT SURGEON. MARCENT.WAIVERS@USMC.MIL;

CML: 813.827.7175; DSN: 312.651.7175

15.C.3.C.5. NAVCENT SURGEON. C5FMEDWAIVERS@US.NAVY.MIL;

CML: 011.973.1785.4558; DSN: 318.439.4558

15.C.3.C.6. SOCCENT SURGEON. SOCCENT.SG@SOCOM.MIL;

CML: 813.828.7351; DSN: 312.968.7351

15.D. PHARMACY.

15.D.1. SUPPLY. PERSONNEL WHO REQUIRE MEDICATION, REGARDLESS OF WAIVER NEED, AND WHO ARE DEPLOYING TO THE CENTCOM AOR WILL DEPLOY WITH NO LESS THAN A 180 DAY SUPPLY (OR APPROPRIATE AMOUNT FOR SHORTER DEPLOYMENTS) OF THEIR MAINTENANCE MEDICATIONS WITH ARRANGEMENTS TO OBTAIN A SUFFICIENT SUPPLY TO COVER THE REMAINDER OF THE DEPLOYMENT USING A FOLLOW-ON REFILL PRESCRIPTION. TRICARE ELIGIBLE PERSONNEL WILL OBTAIN FOLLOW-ON REFILL PRESCRIPTIONS FROM THE TRICARE MAIL ORDER PHARMACY (TMOP) DEPLOYED PRESCRIPTION PROGRAM (DPP) OR

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EXPRESS SCRIPTS. INFORMATION ON THIS PROGRAM MAY BE FOUND AT [HTTPS://WWW.EXPRESS-SCRIPTS.COM/TRICARE/TOOLS/DEPLOYEDRX.SHTML](https://www.express-scripts.com/tricare/tools/deployedrx.shtml) . THOSE ELIGIBLE FOR TMOP WILL COMPLETE ON-LINE ENROLLMENT AND REGISTRATION PRIOR TO DEPLOYMENT. IT IS THE PATIENTS RESPONSIBILITY TO PROVIDE A FOLLOW-ON PRESCRIPTION (DAY 180+ OR DAY 90+) TO TMOP PRIOR TO DEPLOYMENT. PHARMACIES AND MTFs IN THE AOR WILL NOT BE USED FOR MEDICATION RESUPPLY.

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

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

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

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

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

15.D.2.C. ALL DRUG ENFORCEMENT AGENCY (DEA) CONTROLLED SUBSTANCES (SCHEDULE I-V) ARE LIMITED TO A 90 DAY SUPPLY WITH NO REFILLS. AN APPROVED WAIVER MUST BE OBTAINED FROM THE CENTCOM WAIVER AUTHORITY PRIOR TO DEPLOYMENT. ALL RENEWALS WILL BE COMPLETED VIA TMOP. ALL SCHEDULE II MEDICATIONS REQUIRE A HARDCOPY PRESCRIPTION MAILED TO TMOP IF NOT UTILIZING MHS GENESIS. SCHEDULE III-IV CAN BE SUBMITTED VIA MHS GENESIS OR FAXED TO TMOP. SUBMISSION OF A DEA CONTROLLED SUBSTANCE TO TMOP REQUIRES AN INDIVIDUAL PROVIDER DEA NUMBER.

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

[HTTPS://HEALTH.MIL/ABOUT-MHS/OASDHA/DEFENSE-HEALTH-AGENCY/OPERATIONS/PHARMACY-DIVISION/POD-ANALYTICS-SUPPORT/D-MART](https://health.mil/about-mhs/oasdha/defense-health-agency/operations/pharmacy-division/pod-analytics-support/d-mart) THE CURRENT

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CENTCOM FORMULARY CAN BE REQUESTED FROM THE USCENTCOM PHARMACIST AT USARMY.ARIFJAN.USARCENT.LIST.TF-MED-PHARMACY@MAIL.MIL.

15.D.4. TRICARE MAIL ORDER PHARMACY (TMOP). PERSONNEL REQUIRING ONGOING PHARMACOTHERAPY WILL USE THE TMOP/DPP SYSTEM (TO INCLUDE MEDICATIONS LISTED IN 15.D.2.B AND 15.D.2.C). TMOP DOES NOT SUPPLY TEMPERATURE SENSITIVE MEDICAL PRODUCT (TSMP) MEDICATIONS VIA MAIL. THOSE ELIGIBLE FOR TMOP WILL COMPLETE ON-LINE ENROLLMENT AND REGISTRATION PRIOR TO DEPLOYMENT. INSTRUCTIONS CAN BE FOUND AT [HTTPS://WWW.EXPRESS-SCRIPTS.COM/TRICARE/TOOLS/DEPLOYEDRX.SHTML](https://www.express-scripts.com/tricare/tools/deployedrx.shtml)

15.E. MEDICAL EQUIPMENT.

15.E.1. PERMITTED EQUIPMENT. PERSONNEL WHO REQUIRE MEDICAL EQUIPMENT (E.G., CORRECTIVE EYEWEAR, HEARING AIDS) MUST DEPLOY WITH ALL REQUIRED ITEMS IN THEIR POSSESSION TO INCLUDE TWO PAIRS OF EYEGLASSES, PROTECTIVE MASK EYEGGLASS INSERTS, BALLISTIC EYEWEAR INSERTS, AND HEARING AID BATTERIES. SEE REF D

15.E.2. NON-PERMITTED EQUIPMENT. PERSONAL DURABLE MEDICAL EQUIPMENT (NEBULIZERS, SCOOTERS, WHEELCHAIRS, CATHETERS, DIALYSIS MACHINES, INSULIN PUMPS, IMPLANTED DEFIBRILLATORS, SPINAL CORD STIMULATORS, CEREBRAL IMPLANTS, ETC.) IS NOT PERMITTED. MEDICAL MAINTENANCE, LOGISTICAL SUPPORT, AND INFECTION CONTROL PROTOCOLS FOR PERSONAL MEDICAL EQUIPMENT ARE NOT AVAILABLE AND ELECTRICITY IS OFTEN UNRELIABLE. A WAIVER FOR A MEDICAL CONDITION REQUIRING PERSONAL DURABLE MEDICAL EQUIPMENT IS APPLICABLE TO THE EQUIPMENT, AND VICE VERSA. DURABLE MEDICAL EQUIPMENT USED FOR RELIEF OR MAINTENANCE OF A MEDICAL CONDITION REQUIRES A WAIVER. WAIVER REQUESTS MUST DESCRIBE DEPLOYER'S ABILITY TO MEET MISSION REQUIREMENTS IN THE EVENT OF FAILURE OF THE EQUIPMENT. MAINTENANCE AND RESUPPLY OF EQUIPMENT IS THE RESPONSIBILITY OF THE INDIVIDUAL.

15.E.3. CONTACT LENSES. PERSONNEL WILL NOT DEPLOY WITH CONTACT LENSES EXCEPT IAW SERVICE POLICY. AUTHORIZED PERSONNEL DEPLOYING WITH CONTACT LENSES MUST RECEIVE PRE-DEPLOYMENT EDUCATION IN THE SAFE WEAR AND MAINTENANCE OF CONTACT LENSES IN THE DEPLOYED ENVIRONMENT AND DEPLOY WITH TWO PAIRS OF EYEGLASSES AND A SUPPLY OF CONTACT LENS MAINTENANCE ITEMS (E.G., CLEANSING SOLUTION) ADEQUATE FOR THE DURATION OF THE DEPLOYMENT.

15.E.4. MEDICAL WARNING TAGS. DEPLOYING PERSONNEL REQUIRING MEDICAL WARNING TAGS (MEDICATION ALLERGIES, G6PD DEFICIENCY, DIABETES, SICKLE CELL DISEASE, ETC.) WILL DEPLOY WITH RED MEDICAL WARNING TAGS WORN IN CONJUNCTION WITH THEIR PERSONAL IDENTIFICATION TAGS.

15.E.4.A. MEDICAL PERSONNEL WILL IDENTIFY NEED FOR MEDICAL WARNING TAGS AND PREPARE DOCUMENTATION.

15.E.4.B. INSTALLATION OR ORGANIZATION COMMANDERS WILL DIRECT EMBOSSING ACTIVITIES TO PROVIDE TAGS IAW SERVICE PROCEDURES.

15.F. IMMUNIZATIONS.

15.F.1. ADMINISTRATION. ALL IMMUNIZATIONS WILL BE ADMINISTERED IAW REF N. REFER TO THE DHA-IMMUNIZATION HEALTHCARE BRANCH WEBSITE [HTTPS://WWW.HEALTH.MIL/MILITARY-HEALTH-TOPICS/HEALTH-READINESS/IMMUNIZATION-HEALTHCARE/VACCINE-RECOMMENDATIONS/VACCINE-RECOMMENDATIONS-BY-AOR](https://www.health.mil/military-health-topics/health-readiness/immunization-healthcare/vaccine-recommendations/vaccine-recommendations-by-aor) OR CONTACT THE CENTCOM DHA-IMMUNIZATION HEALTHCARE BRANCH ANALYST BRIAN.D.CANTERBURY.CIV@HEALTH.MIL FOR QUESTIONS AND CLARIFICATIONS.

15.F.2. REQUIREMENTS. ALL PERSONNEL (TO INCLUDE PCS AND SHIPBOARD PERSONNEL) TRAVELING FOR ANY PERIOD OF TIME TO THE THEATER WILL BE CURRENT WITH ADVISORY COMMITTEE ON IMMUNIZATION PRACTICES (ACIP) IMMUNIZATION GUIDELINES AND SERVICE

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INDIVIDUAL MEDICAL READINESS (IMR) REQUIREMENTS IAW REF C. PERSONNEL WITH MEDICAL EXEMPTIONS DO NOT REQUIRE SEPARATE WAIVERS FOR ROUTINE ASSIGNMENTS, BUT MAY NOT BE ELIGIBLE FOR POSITIONS WHERE THE EXEMPTED VACCINE IS REQUIRED TO ADDRESS A SPECIFIC OCCUPATIONAL OR PUBLIC HEALTH THREAT. CURRENT DOD IMMUNIZATIONS REQUIREMENTS AND RECOMMENDATIONS CAN BE FOUND AT THE DEFENSE HEALTH AGENCY WEBSITE, ON THE CENTCOM TAB, AT [HTTPS://WWW.HEALTH.MIL/MILITARY-HEALTH-TOPICS/HEALTH-READINESS/IMMUNIZATION-HEALTHCARE/VACCINE-RECOMMENDATIONS/VACCINE-RECOMMENDATIONS-BY-AOR](https://www.health.mil/military-health-topics/health-readiness/immunization-healthcare/vaccine-recommendations/vaccine-recommendations-by-aor) . IN ADDITION, ALL TDY PERSONNEL MUST COMPLY WITH FOREIGN CLEARANCE GUIDELINES FOR THE COUNTRIES TO OR THROUGH WHICH THEY ARE TRAVELING. MANDATORY VACCINES FOR DOD PERSONNEL (MILITARY, CIVILIAN & CONTRACTORS) TRAVELING FOR ANY PERIOD OF TIME IN THEATER ARE:

15.F.2.A. TETANUS/DIPHThERIA. RECEIVE A ONE-TIME DOSE OF TDAP IF NO PREVIOUS DOSE(S) RECORDED. RECEIVE TETANUS (TD) IF \geq 10 YEARS SINCE LAST TDAP OR TD BOOSTER.

15.F.2.B. VARICELLA. REQUIRED DOCUMENTATION OF ONE OF THE FOLLOWING: BORN BEFORE 1980 (HEALTH CARE WORKERS MAY NOT USE THIS EXEMPTION), DOCUMENTED PREVIOUS INFECTION (CONFIRMED BY EITHER EPIDEMIOLOGIC LINK OR LABORATORY RESULT), SUFFICIENT VARICELLA TITER, OR DOCUMENTED ADMINISTRATION OF VACCINE (2 DOSES).

15.F.2.C. MEASLES / MUMPS / RUBELLA. REQUIRED DOCUMENTATION OF ONE OF THE FOLLOWING: BORN BEFORE 1957, DOCUMENTATION OF EFFECTIVE IMMUNITY BY TITER FOR ALL THREE VACCINE COMPONENTS, OR DOCUMENTED ADMINISTRATION OF 2 LIFETIME DOSES OF MMR.

15.F.2.D. POLIO. REQUIRED FOR TRAVEL TO/THROUGH **AFGHANISTAN OR PAKISTAN FOR \geq 4 WEEKS.** VACCINE MUST BE ADMINISTERED WITHIN 12 MONTHS OF DEPARTING AFGHANISTAN OR PAKISTAN.

15.F.2.D.1 IMMUNIZATION SHOULD BE DOCUMENTED ON THE CDC-731 CERTIFICATE OF VACCINATION OR PROPHYLAXIS (YELLOW SHOT RECORD) IN ADDITION TO THE DD2766C TO MEET INTERNATIONAL STANDARDS.

15.F.2.D.2. MEDICAL ASSUMED (MA) AND MEDICAL IMMUNE (MI) EXEMPTIONS ARE NOT ACCEPTED FOR THIS REQUIREMENT.

15.F.2.D.3. IAW WORLD HEALTH ORGANIZATION (WHO) OR ACIP DISEASE OUTBREAK GUIDANCE, MORE STRINGENT VACCINATION REQUIREMENTS MAY BE RECOMMENDED.

15.F.2.E. SEASONAL INFLUENZA (INCLUDING EVENT-SPECIFIC INFLUENZA, E.G., H1N1).

15.F.2.F. HEPATITIS A. AT LEAST ONE DOSE PRIOR TO DEPLOYMENT WITH SUBSEQUENT COMPLETION OF SERIES IN THEATER.

15.F.2.G. HEPATITIS B. AT LEAST ONE DOSE PRIOR TO DEPLOYMENT WITH SUBSEQUENT COMPLETION OF SERIES IN THEATER.

15.F.2.H. TYPHOID. BOOSTER DOSE OF TYPHIM VI VACCINE IF GREATER THAN TWO YEARS SINCE LAST VACCINATION WITH INACTIVATED / INJECTABLE VACCINE OR GREATER THAN FIVE YEARS SINCE RECEIPT OF LIVE / ORAL VACCINE. ORAL VACCINE IS AN ACCEPTABLE OPTION ONLY IF TIME ALLOWS FOR RECEIPT AND COMPLETION OF ALL FOUR DOSES PRIOR TO DEPLOYMENT.

15.F.3. ANTHRAX. PERSONNEL WITHOUT A MEDICAL CONTRAINDICATION TRAVELING IN THE CENTCOM THEATER FOR 15 DAYS OR MORE WILL COMPLY WITH THE MOST CURRENT DOD ANTHRAX REQUIREMENTS, CURRENTLY A SERIES OF 5 VACCINES AND ANNUAL BOOSTER. SEE REF O, P, Q AND EXCEPTIONS FOR VACCINATION IN 15.F.6. NOTE THIS IS A DOD REQUIREMENT, AND CANNOT BE WAIVED BY CENTCOM.

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15.F.3.A. MILITARY PERSONNEL. REQUIRED.

15.F.3.B. DOD CIVILIANS. REQUIRED AT GOVERNMENT EXPENSE, FOR EMERGENCY-ESSENTIAL AND NON-COMBAT-ESSENTIAL, OR EQUIVALENT, PERSONNEL IAW REF O.

15.F.3.C. DOD CONTRACTORS. REQUIRED AT GOVERNMENT EXPENSE AS DIRECTED IN THE CONTRACT AND IAW REF J AND O.

15.F.3.D. VOLUNTEERS. VOLUNTARY AT GOVERNMENT EXPENSE.

15.F.4. SMALLPOX. AS OF 16 MAY 2014, SMALLPOX VACCINATION IS NO LONGER REQUIRED FOR THE CENTCOM AOR. SEE REF O.

15.F.5. RABIES. PRE-EXPOSURE VACCINATION WILL BE ACCOMPLISHED AS BELOW, OR OTHERWISE CONSIDERED FOR PERSONNEL WHO ARE NOT REASONABLY EXPECTED TO RECEIVE PROMPT MEDICAL EVALUATION AND RISK-BASED RABIES POST-EXPOSURE PROPHYLAXIS WITHIN 72 HOURS OF EXPOSURE TO A POTENTIALLY RABID ANIMAL. FOR ALREADY-VACCINATED PERSONNEL, SERUM SAMPLES SHOULD BE TESTED EVERY TWO YEARS FOR VIRUS NEUTRALIZING ANTIBODIES, WITH BOOSTER DOSES REQUIRED WHEN TITERS FALL BELOW THE MINIMUM STANDARD LEVELS. EXCEPTIONS MAY BE IDENTIFIED BY UNIT SURGEONS.

15.F.5.A. HIGH RISK PERSONNEL: PRE-EXPOSURE VACCINATION IS REQUIRED FOR VETERINARY PERSONNEL, MILITARY WORKING DOG HANDLERS, ANIMAL CONTROL PERSONNEL, CERTAIN SECURITY PERSONNEL, CIVIL ENGINEERS AT RISK OF EXPOSURE TO RABID ANIMALS, AND LABORATORY PERSONNEL WHO WORK WITH RABIES SUSPECT SAMPLES.

15.F.5.B. SPECIAL OPERATIONS FORCES (SOF)/SOF ENABLERS: ALL PERSONNEL DEPLOYING IN SUPPORT OF SOF WILL BE ADMINISTERED THE PRE-EXPOSURE RABIES VACCINE SERIES AS INDICATED BELOW.

15.F.5.B.1. PAKISTAN. ALL PERSONNEL.

15.F.5.B.2. OTHER AREAS. PER USSOCOM SERVICE-SPECIFIC POLICIES. CONTACT USSOCOM PREVENTIVE MEDICINE OFFICER AT DSN (312) 299-5051 FOR MORE INFORMATION.

15.F.6. CHOLERA. ORAL CHOLERA VACCINE IS OF LIMITED OPERATIONAL USE AND NOT RECOMMENDED OR REQUIRED FOR MOST PERSONNEL. THOSE SPECIFICALLY DESIGNATED BY THEIR UNIT OR MISSION REQUIREMENTS TO RECEIVE THE VACCINE SHOULD TAKE THE FOLLOWING INTO ACCOUNT WHEN PLANNING:

15.F.6.A. ORAL CHOLERA VACCINE RECIPIENTS SHOULD NOT BE ON ORAL ANTIBIOTICS FOR FOURTEEN DAYS PRIOR TO, AND TEN DAYS AFTER, VACCINATION, TO INCLUDE MALARIA CHEMOPROPHYLAXIS. RISK FROM MALARIA DUE TO THIS COURSE OF ACTION MUST BE CONSIDERED DURING PLANNING. SEE 15.L.1. AND REF R.

15.F.6.B. ALLOW FOR TEN DAYS FOR ORAL CHOLERA VACCINE TO BE EFFECTIVE.

15.F.6.C. EFFICACY OF ORAL CHOLERA VACCINE IS UNKNOWN PAST 90 DAYS, AND REVACCINATION MAY NEED TO OCCUR WITH SAME PROVISIONS AS 15.F.6.A. TO ENSURE EFFECTIVENESS.

15.F.6.D. FOLLOW STORAGE AND RECONSTITUTION REQUIREMENTS DESCRIBED IN LABELING INCLUDED WITH PRODUCT PACKAGING FOR ORAL CHOLERA VACCINE.

15.F.7. COVID-19. MUST MEET A HOST NATION DEFINITION OF VACCINATED WHEN DEPLOYING TO COUNTRIES WITH A COVID-19 VACCINATION REQUIREMENT. FOR COUNTRY SPECIFIC COVID-19 REQUIREMENTS REFERENCE THE FOREIGN CLEARANCE GUIDE AND/OR U.S. EMBASSY WEBSITE.

15.F.8. MWD VACCINATIONS ARE COVERED IN SECTION 15.C.1.G.2.

15.F.9. EXCEPTIONS. REQUIRED IMMUNIZATIONS WILL BE ADMINISTERED PRIOR TO DEPLOYMENT, WITH THE FOLLOWING POSSIBLE EXCEPTIONS:

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15.F.9.A. THE FIRST VACCINE IN A REQUIRED SERIES MUST BE ADMINISTERED PRIOR TO DEPLOYMENT WITH ARRANGEMENTS MADE FOR SUBSEQUENT IMMUNIZATIONS TO BE GIVEN IN THEATER.

15.F.9.B. IAW REF Q, ANTHRAX MAY BE ADMINISTERED UP TO 120 DAYS PRIOR TO DEPLOYMENT. IT IS HIGHLY ADVISABLE TO GET THE FIRST TWO ANTHRAX IMMUNIZATIONS OR SUBSEQUENT DOSE/BOOSTER PRIOR TO DEPLOYMENT IN ORDER TO AVOID UNNECESSARY STRAIN ON THE DEPLOYED HEALTHCARE SYSTEM.

15.F.10. ADVERSE MEDICAL EVENTS RELATED TO IMMUNIZATIONS SHOULD BE REPORTED THROUGH REPORTABLE MEDICAL EVENTS (RME) IF CASE DEFINITIONS ARE MET. ALL IMMUNIZATION RELATED UNEXPECTED ADVERSE EVENTS WILL BE REPORTED THROUGH THE VACCINE ADVERSE EVENTS REPORTING SYSTEM (VAERS) AT [HTTP://WWW.VAERS.HHS.GOV](http://www.vaers.hhs.gov). QUESTIONS OR CONCERNS MAY BE DIRECTED TO THE DHA-IMMUNIZATION HEALTHCARE BRANCH AT (1-877-438-8222).

15.F.11. USCENTCOM AND COMPONENTS WILL MONITOR IMMUNIZATION COMPLIANCE VIA THE CCMDIMMUNIZATION REPORTING DATABASE. SUBORDINATE COMMANDS WILL REQUEST ACCESS TO THE CCMDIMMUNIZATION REPORTING DATABASE BY CONTACTING CCSG AT BRIAN.D.CANTERBURY.CIV@HEALTH.MIL OR CCSG-PMO@CENTCOM.SMIL.MIL.

15.G. MEDICAL / LABORATORY TESTING.

15.G.1. HIV TESTING. HIV LAB TESTING, WITH DOCUMENTED NEGATIVE RESULT, WILL BE WITHIN 120 DAYS PRIOR TO DEPLOYMENT OR DEPARTURE FOR ANY REQUIRED DEPLOYMENT TRAINING IF TRAINING IS EN ROUTE TO DEPLOYMENT LOCATION. IAW REF I,S, OO THE CENTCOM COMMAND SURGEON SHALL BE DIRECTLY CONSULTED IN ALL INSTANCES OF HIV SEROPOSITIVITY BEFORE MEDICAL CLEARANCE FOR DEPLOYMENT. **INDIVIDUALS MAY BE DENIED ENTRY TO THE AOR SECONDARY TO HOST NATION PROHIBITIONS REGARDING HIV.**

15.G.2. SERUM SAMPLE. SAMPLE WILL BE TAKEN WITHIN THE PREVIOUS 365 DAYS. IF THE INDIVIDUAL'S HEALTH STATUS HAS RECENTLY CHANGED OR HAS HAD AN ALTERATION IN OCCUPATIONAL EXPOSURES THAT INCREASES HEALTH RISKS, A HEALTH CARE PROVIDER MAY CHOOSE TO HAVE A SPECIMEN DRAWN CLOSER TO THE ACTUAL DATE OF DEPLOYMENT. SEE REF T.

15.G.3. G6PD TESTING. DOCUMENTATION OF ONE-TIME GLUCOSE-6-PHOSPHATE DEHYDROGENASE (G6PD) DEFICIENCY TESTING IS IAW REF U. ENSURE RESULT IS IN MEDICAL RECORD OR DRAW PRIOR TO DEPARTURE. PRE-DEPLOYMENT MEDICAL SCREENERS WILL RECORD THE RESULT OF THIS TEST IN THE SERVICE MEMBER'S PERMANENT MEDICAL RECORD, DEPLOYMENT MEDICAL RECORD (DD FORM 2766) AND SERVICE SPECIFIC ELECTRONIC MEDICAL RECORD. IF AN INDIVIDUAL IS FOUND TO BE G6PD-DEFICIENT, THEY SHOULD BE ISSUED MEDICAL WARNING TAGS (SEE 15.E.4.) THAT STATE "G6PD DEFICIENT: NO PRIMAQUINE". IF PRIMAQUINE IS GOING TO BE ISSUED TO A DOD CIVILIAN OR DOD CONTRACTOR, COMPLETE THE TESTING AT GOVERNMENT EXPENSE.

15.G.4. HCG. REQUIRED WITHIN 30 DAYS OF DEPLOYMENT FOR ALL WOMEN, AS WELL AS THOSE FEMALE TO MALE TRANSGENDERED INDIVIDUALS WHO HAVE RETAINED FEMALE ANATOMY. ABOVE INDIVIDUALS WITH A DOCUMENTED HISTORY OF HYSTERECTOMY ARE EXEMPT.

15.G.5. DNA SAMPLE. REQUIRED FOR ALL DOD PERSONNEL, INCLUDING CIVILIANS AND CONTRACTORS. OBTAIN SAMPLE OR CONFIRM SAMPLE IS ON FILE BY CONTACTING THE DOD DNA SPECIMEN REPOSITORY (COMM: 301.319.0366, DSN: 285; FAX 301.319.0369); [HTTP://WWW.AFMES.MIL](http://www.afmes.mil) . SEE REF D.

15.G.6. TUBERCULOSIS (TB) TESTING. SEE REF V.

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15.G.6.A. TUBERCULOSIS TESTING FOR SERVICE MEMBERS WILL BE PERFORMED AND DOCUMENTED IAW SERVICE POLICY. CURRENT POLICY IS TO AVOID UNIVERSAL TESTING, AND INSTEAD USE TARGETED TESTING BASED UPON RISK ASSESSMENT, USUALLY PERFORMED WITH A SIMPLE QUESTIONNAIRE. TB TESTING FOR DOD CIVILIANS, CONTRACTORS, VOLUNTEERS, AND OTHER PERSONNEL SHOULD BE SIMILARLY TARGETED IAW CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC) GUIDELINES, WITH TESTING FOR TB TO BE ACCOMPLISHED WITHIN 90 DAYS OF DEPLOYMENT IF INDICATED. IF TESTING IS PERFORMED TUBERCULIN SKIN TEST (TST) OR AN INTERFERON-GAMMA RELEASE ASSAY MAY BE USED UNLESS OTHERWISE INDICATED.

15.G.6.B. POSITIVE TB TESTS WILL BE HANDLED IAW SERVICE POLICY AND CDC GUIDELINES.

15.G.6.C. UNIT-BASED / LARGE GROUP OR INDIVIDUAL LTBI TESTING SHOULD NOT BE PERFORMED IN THE AOR EXCEPT AMONG CLOSE CONTACTS OF CASES OF KNOWN TB DISEASE.

15.G.6.D. U.S. FORCES AND DOD CIVILIANS WITH TB DISEASE WILL BE EVACUATED FROM THEATER FOR DEFINITIVE TREATMENT. EVALUATION AND TREATMENT OF TB AMONG U.S. CONTRACTORS, LOCAL NATIONALS (LN) AND THIRD COUNTRY NATIONAL (TCN) EMPLOYEES WILL BE AT CONTRACTOR EXPENSE. EMPLOYEES WITH SUSPECTED OR CONFIRMED PULMONARY TB DISEASE WILL BE EXCLUDED FROM WORK AND OTHERWISE RESTRICTED AS DIRECTED BY THE THEATER PREVENTIVE MEDICINE CONSULTANT UNTIL CLEARED BY THE THEATER PREVENTIVE MEDICINE CONSULTANT FOR RETURN TO WORK.

15.G.7. OTHER LABORATORY TESTING. OTHER TESTING MAY BE PERFORMED AT THE CLINICIAN'S DISCRETION COMMENSURATE WITH RULING OUT OR MONITORING NON-DEPLOYABLE CONDITIONS AND ENSURING PERSONNEL MEET STANDARDS OF FITNESS IAW PARAGRAPH 15.C.2.

15.H. HEALTH ASSESSMENTS.

15.H.1. HEALTH ASSESSMENTS AND EXAMS. PERIODIC HEALTH ASSESSMENTS MUST BE CURRENT IAW SERVICE POLICY AT TIME OF DEPLOYMENT AND SPECIAL DUTY EXAMS MUST BE CURRENT FOR THE DURATION OF TRAVEL OR DEPLOYMENT PERIOD. SEE REF D, J. FOR MWD, SEE SECTION 15.C.1.G.3.

15.H.2. PRE-DEPLOYMENT HEALTH ASSESSMENT (DD FORM 2795).

15.H.2.A. ALL DOD PERSONNEL (MILITARY, CIVILIAN, CONTRACTOR) TRAVELING TO THE THEATER FOR MORE THAN 30 DAYS WILL COMPLETE OR CONFIRM AS CURRENT A PRE-DEPLOYMENT HEALTH ASSESSMENT WITHIN 120 DAYS OF THE EXPECTED DEPLOYMENT DATE. THIS ASSESSMENT WILL BE COMPLETED ON A DD FORM 2795 IAW REF C, W. THIS DOES NOT APPLY TO PCS PERSONNEL, SHIPBOARD PERSONNEL, OR PERSONNEL LOCATED WITH A DHP FUNDED FIXED MEDICAL TREATMENT FACILITY (E.G. BAHRAIN) IAW REF C.

15.H.2.A.1. PERSONNEL TRAVELING TO THE THEATER FOR 15 TO 30 DAYS MAY CONSIDER COMPLETING A PRE-DEPLOYMENT HEALTH ASSESSMENT IN ORDER TO DOCUMENT THEIR HEALTH STATUS AND ADDRESS ANY HEALTH CONCERNS PRIOR TO TRAVEL TO THEATER. THIS IS ESPECIALLY RELEVANT TO THOSE WHOSE POSITION REQUIRES FREQUENT TRAVEL TO THE AOR. THESE INDIVIDUALS ARE ENCOURAGED TO COMPLETE AT LEAST ONE PRE-DEPLOYMENT HEALTH ASSESSMENT EACH YEAR, ALONG WITH A CORRESPONDING POST-DEPLOYMENT HEALTH ASSESSMENT FOR THE SAME YEAR.

15.H.2.B. FOLLOWING COMPLETION OF THE DEPLOYER PORTION OF THE DD FORM 2795, THE DEPLOYER WILL HAVE A PERSON-TO-PERSON DIALOGUE WITH A TRAINED AND CERTIFIED HEALTH CARE PROVIDER (PHYSICIAN, PHYSICIAN ASSISTANT, NURSE PRACTITIONER, ADVANCED PRACTICE NURSE, INDEPENDENT DUTY CORPSMAN, SPECIAL FORCES MEDICAL SERGEANT, INDEPENDENT DUTY MEDICAL TECHNICIAN, OR INDEPENDENT HEALTH SERVICES

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TECHNICIAN) TO COMPLETE THE ASSESSMENT.

15.H.2.C. THE COMPLETED ORIGINAL DD FORM 2795 WILL BE PLACED IN THE DEPLOYER'S PERMANENT MEDICAL RECORD, A PAPER COPY IN THE DEPLOYMENT MEDICAL RECORD (DD FORM 2766), AND AN ELECTRONIC COPY TRANSMITTED TO THE DEFENSE MEDICAL SURVEILLANCE SYSTEM (DMSS) AT THE ARMED FORCES HEALTH SURVEILLANCE CENTER (AFHSC). CONTRACT PERSONNEL ARE NOT REQUIRED TO ELECTRONICALLY SUBMIT THE DD FORM 2795; A PAPER VERSION WILL SUFFICE.

15.H.3. AUTOMATED NEUROPSYCHOLOGICAL ASSESSMENT METRIC (ANAM).

ALL SERVICE MEMBERS AS DESIGNATED IN REF X WILL UNDERGO ANAM TESTING WITHIN 12 MONTHS PRIOR TO DEPLOYMENT. ANAM TESTING WILL BE RECORDED IN APPROPRIATE SERVICE DATABASE AND ELECTRONIC MEDICAL RECORD. CONTRACTORS, PCS AND SHIPBOARD PERSONNEL ARE NOT REQUIRED TO UNDERGO ANAM TESTING.

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

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

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

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

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

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

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

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

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

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

15.H.6. POST-DEPLOYMENT HEALTH RE-ASSESSMENT (DD FORM 2900). ALL PERSONNEL WHO WERE REQUIRED TO COMPLETE A PRE- AND POST-DEPLOYMENT HEALTH ASSESSMENT WILL COMPLETE A POST-DEPLOYMENT HEALTH REASSESSMENT (DD FORM 2900) 90 TO 180 DAYS AFTER RETURN TO HOME STATION. SEE WWW.PDHEALTH.MIL FOR ADDITIONAL INFORMATION ON PRE- AND POST-DEPLOYMENT HEALTH ASSESSMENTS. CONTRACT PERSONNEL ARE NOT REQUIRED TO ELECTRONICALLY SUBMIT THE DD FORM 2900; A PAPER VERSION WILL SUFFICE.

15.I. MEDICAL RECORD. SEE REF C.

15.I.1. DEPLOYED MEDICAL RECORD. THE DD FORM 2766, ADULT PREVENTIVE AND CHRONIC CARE FLOWSHEET, OR EQUIVALENT, WILL BE USED INSTEAD OF DEPLOYING AN INDIVIDUAL'S ENTIRE MEDICAL RECORD. THE DEPLOYED DD FORM 2766 SHOULD BE RE-INTEGRATED INTO THE MAIN MEDICAL RECORD AS PART OF THE REDEPLOYMENT PROCESS.

15.I.1.A. DEPLOYED PERSONNEL (MORE THAN 30 DAYS). DD2766 IS REQUIRED.

15.I.1.B. TDY PERSONNEL (15 – 30 DAYS). DD FORM 2766 IS HIGHLY ENCOURAGED, ESPECIALLY FOR THOSE WHO TRAVEL FREQUENTLY TO THEATER, TO DOCUMENT THEATER-SPECIFIC VACCINES AND CHEMOPROPHYLAXIS, AS REQUIRED.

15.I.1.C. TDY PERSONNEL (LESS THAN 15 DAYS). DD2766 IS NOT REQUIRED.

15.I.1.D. PCS PERSONNEL. FOLLOW SERVICE GUIDELINES FOR MEDICAL RECORD MANAGEMENT.

15.I.2. MEDICAL INFORMATION. THE FOLLOWING HEALTH INFORMATION MUST BE PART OF AN ACCESSIBLE ELECTRONIC MEDICAL RECORD FOR ALL PERSONNEL (SERVICE MEMBERS, CIVILIANS AND CONTRACTORS), OR BE HAND-CARRIED AS PART OF A DEPLOYED MEDICAL RECORD:

15.I.2.A. ANNOTATION OF BLOOD TYPE AND RH FACTOR, G6PD, HIV, AND DNA.

15.I.2.B. CURRENT MEDICATIONS AND ALLERGIES. INCLUDE ANY FORCE HEALTH PROTECTION PRESCRIPTION PRODUCT (FHPPP) PRESCRIBED AND DISPENSED TO AN INDIVIDUAL.

15.I.2.C. SPECIAL DUTY QUALIFICATIONS.

15.I.2.D. ANNOTATION OF CORRECTIVE LENS PRESCRIPTION.

15.I.2.E. SUMMARY SHEET OF CURRENT AND PAST MEDICAL AND SURGICAL CONDITIONS.

15.I.2.F. MOST RECENT DD FORM 2795, PREDEPLOYMENT HEALTH ASSESSMENT.

15.I.2.G. DOCUMENTATION OF DENTAL STATUS CLASSES I OR CLASS II.

15.I.2.H. IMMUNIZATION RECORD. MEDICAL DEPLOYMENT SITES WILL ENTER IMMUNIZATION DATA INTO SERVICE ELECTRONIC TRACKING SYSTEMS, (ARMY-MEDPROS, AIR FORCE-AFCITA, COAST GUARD-MRRS, NAVY-MRRS (ASHORE) OR SAMS (AFLOAT) AND MARINE CORPS-MRRS).

15.I.2.I. ALL APPROVED MEDICAL WAIVERS.

15.J. PRE-DEPLOYMENT TRAINING. SEE REF Z.

15.J.1. SCOPE. GENERAL ISSUES TO BE ADDRESSED: INFORMATION REGARDING KNOWN AND SUSPECTED HEALTH RISKS AND EXPOSURES, HEALTH RISK COUNTERMEASURES AND THEIR PROPER EMPLOYMENT, PLANNED ENVIRONMENTAL AND OCCUPATIONAL SURVEILLANCE MONITORING, AND THE OVERALL OPERATIONAL RISK MANAGEMENT PROGRAM.

15.J.2. CONTENT. SHOULD INCLUDE, BUT NOT BE LIMITED TO, THE FOLLOWING AREAS:

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COMBAT/OPERATIONAL STRESS CONTROL AND RESILIENCE; TACTICAL COMBAT CASUALTY CARE (TCCC), POST-TRAUMATIC STRESS AND SUICIDE PREVENTION; MILD TRAUMATIC BRAIN INJURY RISK, IDENTIFICATION AND TRACKING; NUCLEAR, BIOLOGICAL, CHEMICAL THREATS; ENDEMIC PLANT, ANIMAL, REPTILE AND INSECT HAZARDS AND INFECTIONS; COMMUNICABLE DISEASES; VECTORBORNE DISEASES; ENVIRONMENTAL CONDITIONS; SAFETY; OCCUPATIONAL HEALTH.

15.K. MEDICAL CBRN DEFENSE MATERIEL (MCDM) / CHEMICAL BIOLOGICAL RADIOLOGICAL NUCLEAR (CBRN) RESPONSE. SEE TAB D

15.L. THEATER FORCE HEALTH PROTECTION.

15.L.1. DISEASE RISK ASSESSMENT.

15.L.1.A. MALARIA RISK ASSESSMENT AND GUIDELINES. IN THE ABSENCE OF A LOCAL RISK ASSESSMENT CONDUCTED IAW THE GUIDANCE PROVIDED IN PARAGRAPH 15.L.1.B., THE FOLLOWING COUNTRIES AND TIMEFRAMES REQUIRE CHEMOPROPHYLAXIS. THESE ARE MINIMUM REQUIREMENTS.

15.L.1.A.1. AFGHANISTAN: YEAR ROUND.

15.L.1.A.2. PAKISTAN: YEAR ROUND.

15.L.1.A.3. TAJIKISTAN: APRIL THROUGH OCTOBER.

15.L.1.A.4. YEMEN: YEAR ROUND.

15.L.1.B. LOCAL COMPONENT/JTF SURGEONS ARE ENCOURAGED TO CONDUCT EVIDENCE-BASED ENTOMOLOGICAL AND EPIDEMIOLOGICAL ASSESSMENTS OF MALARIA RISK AT FIXED BASES WHERE SIGNIFICANT NUMBERS OF PERSONNEL ARE ASSIGNED FOR PROLONGED PERIODS. IN CONDUCTING SUCH A RISK ASSESSMENT, SURGEONS SHOULD REVIEW THE MOST RECENT ASSESSMENTS AND RISK MAPS PRODUCED BY THE NATIONAL CENTER FOR MEDICAL INTELLIGENCE (NCMI) AT [HTTPS://WWW.NCMI.DETRICK.ARMY.MIL/](https://www.ncmi.detrick.army.mil/) (UNCLASSIFIED) OR [HTTPS://WWW.NCMI.DIA.SMIL.MIL](https://www.ncmi.dia.smil.mil/) (CLASSIFIED).

15.L.1.B.1. BASED ON NCMI RISK ASSESSMENTS AND IN CONSULTATION WITH THE THEATER PREVENTIVE MEDICINE CONSULTANT, RECOMMENDATIONS FOR MODIFIED CHEMOPROPHYLAXIS POLICY MAY BE PROVIDED TO COMMANDERS USING REF AA OR SIMILAR RISK ANALYSIS.

15.L.1.B.2. MANEUVER FORCES WITH INTERMITTENT AND UNPREDICTABLE EXPOSURES TO RISK AREAS SHOULD EMPLOY CHEMOPROPHYLAXIS BASED ON THE HIGHEST RISK AREAS. UNITS AND INDIVIDUALS WITH VERY SHORT TERM EXPOSURE (I.E., AIRCREW NOT STATIONED IN THE AOR) SHOULD HAVE RISK AND CHEMOPROPHYLAXIS USE DETERMINED IAW SERVICE POLICY.

15.L.1.B.3 ASSESSMENT OF DISEASE THREATS AND NEAR REAL-TIME DISEASE OUTBREAK INFORMATION SHOULD BE OBTAINED PRIOR TO DEPLOYMENT BY ACCESSING THE DHA'S ARMED FORCES HEALTH SURVEILLANCE CENTER'S HEALTH SURVEILLANCE EXPLORER (HSE) DYNAMIC MAP APPLICATION. THE HSE IS FOUO AND IS LOCATED ON A CAC-ENABLED SITE AS FOLLOWS: NIPR: [HTTPS://WWW.HEALTH.MIL/HSE](https://www.health.mil/hse) OR [HTTPS://PORTAL.GEO.NGA.MIL/PORTAL/HOME/](https://portal.geo.nga.mil/portal/home/) SIPR: [HTTPS://PORTAL.GEO.NGA.SMIL.MIL/PORTAL/HOME](https://portal.geo.nga.smil.mil/portal/home/) OR [HTTPS://PORTAL/GEO.NGA.SMIL.MIL/PORTAL/APPS/WEBAPPVIEWER/INDEX.HTML?ID=53258902FF2E4D9587C7FF379B22A39B](https://portal/geo.nga.smil.mil/portal/apps/webappviewer/index.html?id=53258902ff2e4d9587c7ff379b22a39b)

15.L.2. MALARIA CHEMOPROPHYLAXIS UTILIZATION.

15.L.2.A. ALL THERAPEUTIC/CHEMOPROPHYLACTIC MEDICATIONS, INCLUDING ANTIMALARIALS AND MCDM WILL BE PRESCRIBED IAW FDA GUIDELINES, REF AA, BB, AND CC.

15.L.2.B. DOXYCYCLINE OR ATOVAQUONE/PROGUANIL ARE GENERALLY ACCEPTABLE AS A PRIMARY MALARIA CHEMOPROPHYLACTIC AGENT. MEFLOQUINE SHOULD BE CONSIDERED

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THE DRUG OF LAST RESORT FOR PERSONNEL WITH CONTRAINDICATIONS TO DOXYCYCLINE ORATOVAQUONE/PROGUANIL, SHOULD BE USED WITH CAUTION IN PERSONS WITH A HISTORY OF TBI OR PTSD, AND IS CONTRAINDICATED IN PERSONNEL WITH SOME BEHAVIORAL HEALTH DIAGNOSES. EACH MEFLOQUINE PRESCRIPTION WILL BE ISSUED WITH A WALLET CARD AND CURRENT FDA SAFETY INFORMATION INDICATING THE POSSIBILITY THAT THE NEUROLOGIC SIDE EFFECTS MAY PERSIST OR BECOME PERMANENT IAW REF DD. OTHER FDA-APPROVED AGENTS MAY BE USED TO MEET SPECIFIC SITUATIONAL REQUIREMENTS.

15.L.2.C. PERSONNEL SHOULD DEPLOY WITH EITHER THEIR ENTIRE PRIMARY PROPHYLAXIS COURSE IN HAND (EXCLUDING TERMINAL PRIMAQUINE) OR WITH ENOUGH MEDICATION TO COVER HALF OF THE DEPLOYMENT WITH PLANS TO RECEIVE THE REMAINDER OF THEIR MEDICATION IN THEATER BASED ON UNIT PREFERENCE. TERMINAL PROPHYLAXIS (PRIMAQUINE) SHOULD BE DISTRIBUTED UPON REDEPLOYMENT AND ONLY AFTER VERIFYING G6PD STATUS (SEE 15.G.3.). A COMPLETE COURSE OF PRIMARY PROPHYLAXIS BEGINS 2 DAYS PRIOR TO ENTERING THE RISK AREA FOR DOXYCYCLINE AND ATOVAQUONE/PROGUANIL (2 WEEKS FOR MEFLOQUINE) AND COMPLETES AFTER 4 WEEKS OF DOXYCYCLINE OR MEFLOQUINE AFTER LEAVING THE AT RISK AREA, OR (1 WEEK OF ATOVAQUONE/PROGUANIL). TERMINAL PROPHYLAXIS IS REQUIRED AND CONSISTS OF TAKING PRIMAQUINE FOR 2 WEEKS AFTER LEAVING THE RISK AREA. INDIVIDUALS WHO ARE NOTED TO BE G6PD-DEFICIENT, IAW PARAGRAPH 15.G.3., WILL NOT BE PRESCRIBED PRIMAQUINE.

15.L.2.D. MISSING ONE DOSE OF MEDICATION OR NOT USING THE DOD INSECT REPELLENT SYSTEM WILL PLACE PERSONNEL AT INCREASED RISK FOR MALARIA.

15.L.2.E. COMMANDERS AND SUPERVISORS AT ALL LEVELS WILL ENSURE THAT ALL INDIVIDUALS FOR WHOM THEY ARE RESPONSIBLE HAVE TERMINAL PROPHYLAXIS ISSUED TO THEM IMMEDIATELY UPON REDEPLOYMENT FROM THE AT RISK MALARIA AREA(S).

15.L.3. PERSONAL PROTECTIVE MEASURES. A SIGNIFICANT RISK OF DISEASE CAUSED BY INSECTS AND TICKS EXISTS YEAR-ROUND IN THE AOR. THE THREAT OF DISEASE WILL BE MINIMIZED BY USING THE DOD INSECT REPELLANT SYSTEM AND BED NETS; [HTTPS://WWW.ACQ.OSD.MIL/EIE/AFPMB/](https://www.acq.osd.mil/eie/afpmb/). SEE REF Q, DD

15.L.3.A. PERMETHRIN TREATMENT OF UNIFORMS. UNIFORMS ARE AVAILABLE FOR ISSUE WHICH ARE FACTORY-TREATED WITH PERMETHRIN. THE UNIFORM LABEL INDICATES WHETHER IT IS FACTORY TREATED. UNIFORMS WHICH ARE NOT FACTORY TREATED SHOULD BE TREATED WITH THE INDIVIDUAL DYNAMIC ABSORPTION (IDA) KIT (NSN: 6840-01-345-0237) OR 2 GALLON SPRAYER PERMETHRIN TREATMENT. BOTH ARE EFFECTIVE FOR APPROXIMATELY 50 WASHINGS. A MATRIX OF WHICH UNIFORMS MAY BE EFFECTIVELY TREATED IS AVAILABLE ON THE AFPMB WEBSITE AT [HTTP://WWW.AFPMB.ORG](http://www.afpmb.org).

15.L.3.B. APPLY DEET CREAM (NSN: 6840-01-284-3982) TO EXPOSED SKIN. ONE APPLICATION LASTS 6-12 HOURS; MORE FREQUENT APPLICATION IS REQUIRED IF HEAVY SWEATING AND/OR IMMERSION IN WATER. A SECOND OPTION IS 'SUNSECT CREAM' (20% DEET/SPF 15), NSN: 6840-01-288-2188.

15.L.3.C. WEAR TREATED UNIFORM PROPERLY TO MINIMIZE EXPOSED SKIN (SLEEVES DOWN AND PANTS TUCKED INTO BOOTS).

15.L.3.D. USE PERMETHRIN TREATED BEDNETS PROPERLY IN AT RISK AREAS TO MINIMIZE EXPOSURE DURING REST/SLEEP PERIODS. PERMETHRIN TREATED POP UP BEDNETS ARE AVAILABLE. SEE DOD PEST MANAGEMENT MATERIEL OTHER THAN PESTICIDES AT [HTTPS://WWW.ACQ.OSD.MIL/EIE/AFPMB/PEST_EQUIPLISTS.HTML](https://www.acq.osd.mil/eie/afpmb/pest_equiplists.html)

15.L.4. HEALTH SURVEILLANCE. SEE REF C AND EE.

15.L.4.A. AUTOMATED INFORMATION DISCOVERY ENVIRONMENT (AIDE) MEDICAL COMMON OPERATION PICTURE (MEDCOP)

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15.L.4.A.1. DEPLOYED UNITS WILL USE AIDE MECOP, SIPR ACCESS REQUIRED, AS THE PRIMARY DATA ENTRY POINT FOR DISEASE AND INJURY (DI) REPORTING. UNITS WILL ENSURE ALL SUBORDINATE UNITS COMPLETE JOINING AND DEPARTING REPORTS AS REQUIRED WITHIN MEDCOP. SHIPBOARD UNITS SHOULD UTILIZE SAMS OR TMIP-M FOR DI REPORTING AND FIXED MTF'S SHOULD UTILIZE AHLTA.

15.L.4.A.2. UNITS WILL COORDINATE AIDE MEDCOP TRAINING PRIOR TO DEPLOYMENT FOR APPROPRIATE PERSONNEL TO THE MAXIMUM EXTENT POSSIBLE. COORDINATION FOR TRAINING CURRENTLY CAN BE MADE THROUGH JOMIS AT: DHA.NCR.PEO-IPO.MBX.JOMIS-TRAINING@MAIL.MIL; PLEASE ALSO CC MEDCOP FSE, MR. JOHNNY ARIAS AT JOHNNY.ARIAS2.CTR@MAIL.MIL

15.L.4.B. DI SURVEILLANCE, SEE REF FF.

15.L.4.B.1. THE LIST OF DI REPORTING CATEGORIES, THEIR DEFINITIONS, AND THE ESSENTIAL ELEMENTS OF THE STANDARD DI REPORT CAN BE FOUND IN ENCLOSURE C OF REF EE.

15.L.4.B.2. COMPONENT AND JTF SURGEONS ARE RESPONSIBLE FOR ENSURING UNITS WITHIN THEIR AOR ARE COLLECTING THE PRESCRIBED DI DATA AND REPORTING THAT DATA THROUGH THE JMEWS OR OTHER STANDARDIZED REPORTING PROCESSES ON A WEEKLY BASIS.

15.L.4.B.3. MEDICAL PERSONNEL AT ALL LEVELS WILL ANALYZE THE DI DATA FROM THEIR UNIT AND THE UNITS SUBORDINATE TO THEM AND MAKE CHANGES AND RECOMMENDATIONS AS REQUIRED TO REDUCE DI AND MITIGATE THE EFFECTS OF DI UPON OPERATIONAL READINESS.

15.L.4.C. OCCUPATIONAL AND ENVIRONMENTAL HEALTH SURVEILLANCE (OEHSA)

15.L.4.C.1. AUTHORITY. AN OEHSA IS A JOINT APPROVED PRODUCT USED TO PROVIDE A COMPREHENSIVE ASSESSMENT OF BOTH OCCUPATIONAL AND ENVIRONMENTAL HEALTH HAZARDS ASSOCIATED WITH DEPLOYMENT LOCATIONS AND ACTIVITIES AND MISSIONS THAT OCCUR THERE ESTABLISHED BY REF D AND EE.

15.L.4.C.2 TIMEFRAME. AN OEHSA IS INITIATED WITHIN 30 DAYS OF DATE OF ESTABLISHMENT AND COMPLETED WITHIN THREE MONTHS FOR ALL PERMANENT AND SEMI-PERMANENT BASE CAMPS. OEHSA ARE CONDUCTED TO VALIDATE ACTUAL OR POTENTIAL HEALTH THREATS, EVALUATE EXPOSURE PATHWAYS, AND DETERMINE COURSES OF ACTION AND COUNTERMEASURES TO CONTROL OR REDUCE THE HEALTH THREATS AND PROTECT THE HEALTH OF DEPLOYED PERSONNEL.

15.L.4.C.3. CLASSIFICATION/PUBLICATION/ACCESS. OEHSA WILL BE SENT BY THE COMPLETING UNIT THROUGH THE DESIGNATED SERVICE COMPONENT OR JTF PM/FHP OFFICER FOR REVIEW AND SUBMITTED DIRECTLY TO THE DEFENSE OCCUPATIONAL AND ENVIRONMENTAL READINESS SYSTEM (DOEHR) AT [HTTPS://DOEHR-IH.CSD.DISA.MIL/](https://DOEHR-IH.CSD.DISA.MIL/). SEE APPENDIX J TO REFERENCE DD FOR DOEHR REQUIREMENTS. IF THE SUBMITTER DOES NOT HAVE ACCESS TO DOEHR SUBMIT THE OEHSA TO THE MILITARY EXPOSURE SURVEILLANCE LIBRARY (MESL) [HTTPS://MESL.APGEA.ARMY.MIL/MESL/](https://MESL.APGEA.ARMY.MIL/MESL/). IF THE MESL IS NOT AVAILABLE, EMAIL THE DOCUMENT TO OEHS.DATA@US.ARMY.MIL. CLASSIFIED EXPOSURE DATA SHOULD BE SUBMITTED DIRECTLY TO MESL-S [HTTPS://MESL.CSD.DISA.SMIL.MIL](https://MESL.CSD.DISA.SMIL.MIL). IF ACCESS TO THE MESL-S IS NOT AVAILABLE, EMAIL THE DOCUMENT TO [HTTPS://PHC.ARMY.SMIL.MIL](https://PHC.ARMY.SMIL.MIL).

15.L.4.C.4. RESPONSIBILITIES. SERVICE COMPONENTS AND JTFs ARE RESPONSIBLE FOR APPROVING OEHSA COMPLETION AND WILL SUBMIT A MONTHLY REPORT IAW PROCEDURES OUTLINED IN REFERENCE FF.

15.L.4.D. PERIODIC OCCUPATIONAL AND ENVIRONMENTAL MONITORING SUMMARY (POEMS).

15.L.4.D.1. AUTHORITY. POEMS IS A JOINT APPROVED PRODUCT USED TO ADDRESS ENVIRONMENTAL EXPOSURE DOCUMENTATION REQUIREMENTS ESTABLISHED BY REF D AND EE.

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15.L.4.D.2. TIMEFRAME. POEMS WILL BE CREATED AND VALIDATED FOR EVERY MAJOR DEPLOYMENT SITE AS SOON AS SUFFICIENT DATA IS AVAILABLE. IN GENERAL, POEMS ARE A SUMMARY OF INFORMATION REFLECTING A YEAR OR MORE OF ENVIRONMENTAL AND OCCUPATIONAL HEALTH DATA TO ENSURE ADEQUATE COLLECTION OF EXPOSURE INFORMATION.

15.L.4.D.3. CLASSIFICATION/PUBLICATION/ACCESS. POEMS WILL BE UNCLASSIFIED BUT POSTED ON THE PASSWORD PROTECTED DEPLOYMENT OCCUPATIONAL AND ENVIRONMENTAL HEALTH SURVEILLANCE DATA PORTAL AT <HTTPS://MESL.APGEA.ARMY.MIL/MESL> WHERE JOINT OCCUPATIONAL AND ENVIRONMENTAL HEALTH SURVEILLANCE DATA AND REPORTS ARE STORED. THE POEMS TEMPLATE CAN BE FOUND AT <HTTP://PHC.AMEDD.ARMY.MIL>.

15.L.4.D.4. RESPONSIBILITIES. SERVICE COMPONENTS AND JTFS ARE RESPONSIBLE FOR ENSURING POEMS ARE COMPLETED FOR SITES IN THEIR RESPECTIVE AOR. THEY SHOULD DEVELOP SITE PRIORITIZATION LISTS AND ENLIST THE SUPPORT OF SERVICE PUBLIC HEALTH ORGANIZATIONS (E.G., U.S. ARMY PUBLIC HEALTH CENTER (USAPHC)) TO DRAFT THE CONTENT OF A SITE POEMS. THE USAPHC OVERSEES THE DATA ARCHIVAL WEBSITE FOR PUBLICATION OF FINAL POEMS AND ASSOCIATED DOCUMENTS; HOWEVER, APPROVAL OF "FINAL" POEMS MUST COME FROM THE SERVICE COMPONENT/JTF FHP OFFICER WITH INPUT FROM PREVENTIVE MEDICINE RESOURCES IN DIRECT OR GENERAL AREA SUPPORT.

15.L.5. REPORTABLE MEDICAL EVENT (RME) SURVEILLANCE. SEE REF M, FF.

15.L.5.A. THE LIST OF DISEASES AND CONDITIONS THAT MUST BE REPORTED CAN BE FOUND IN THE TRI-SERVICE REPORTABLE EVENTS GUIDELINES AND CASE DEFINITIONS AT <HTTP://WWW.AFHSC.MIL> OR REF GG.

15.L.5.B. COMPONENT AND JTF SURGEONS ARE RESPONSIBLE FOR ENSURING UNITS WITHIN THEIR AO ARE COLLECTING THE APPROPRIATE RME DATA AND REPORTING THAT DATA THROUGH THEIR SERVICE SPECIFIC REPORTING MECHANISMS.

15.L.5.B.1. IT IS ONLY REQUIRED TO COPY CCSG FOR THE FOLLOWING RMES AT <CCSG-PMO@CENTCOM.SMIL.MIL> OR <CENTCOM.MACDILL.CENTCOM-HQ.MBX.CCSG-WAIVER@MAIL.MIL>: ANTHRAX; BOTULISM; CBRN AND TOXIC INDUSTRIAL CHEMICAL/MATERIAL (TIC/TIM) EXPOSURE; SEVERE COLD WEATHER/HEAT INJURIES; DENGUE FEVER; HANTAVIRUS DISEASE; HEMORRHAGIC FEVER; HEPATITIS B OR C, ACUTE; HIV; MALARIA; MEASLES; MENINGOCOCCAL DISEASE; MIDDLE EASTERN RESPIRATORY SYNDROME CORONAVIRUS (MERS-COV); NOROVIRUS; OUTBREAK OR DISEASE CLUSTER; PLAGUE; PNEUMONIA, EOSINOPHILIC; Q- FEVER; RABIES, HUMAN; SEVERE ACUTE RESPIRATORY INFECTIONS (SARI); STREPTOCOCCUS, INVASIVE GROUP A; TETANUS; TUBERCULOSIS, ACTIVE; TULAREMIA; TYPHOID FEVER; VARICELLA

15.L.5.C. RME REPORTING IS TO OCCUR AS SOON AS REASONABLY POSSIBLE AFTER THE EVENT HAS OCCURRED. EVENTS WITH BIOTERRORISM POTENTIAL OR RAPID OUTBREAK POTENTIAL ARE CONSIDERED URGENT RME AND IMMEDIATE REPORTING IS REQUIRED (WITHIN FOUR HOURS).

15.L.6. HEALTH RISK COMMUNICATION. SEE REF C.

15.L.6.A. DURING ALL PHASES OF DEPLOYMENT, PROVIDE HEALTH INFORMATION TO EDUCATE, MAINTAIN FIT FORCES, AND CHANGE HEALTH RELATED BEHAVIORS FOR THE PREVENTION OF DISEASE AND INJURY DUE TO RISKY PRACTICES AND UNPROTECTED EXPOSURES.

15.L.6.B. CONTINUAL HEALTH RISK ASSESSMENTS ARE ESSENTIAL ELEMENTS OF THE HEALTH RISK COMMUNICATION PROCESS DURING THE DEPLOYMENT PHASE. MEDICAL PERSONNEL AT ALL LEVELS WILL PROVIDE WRITTEN AND ORAL RISK COMMUNICATION PRODUCTS TO

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COMMANDERS AND DEPLOYED PERSONNEL FOR MEDICAL THREATS, COUNTERMEASURES TO THOSE THREATS, AND THE NEED FOR ANY MEDICAL FOLLOW-UP.

15.L.6.C. DI, RME, AND OCCUPATIONAL AND ENVIRONMENTAL HEALTH (OEH) RISK ASSESSMENTS WITH RECOMMENDED COUNTERMEASURES WILL BE PROVIDED TO COMMANDERS AND DEPLOYED PERSONNEL ON A REGULAR BASIS AS WELL AS A SITUATIONAL BASIS WHEN A SIGNIFICANT CHANGE IN ANY ASSESSMENT OCCURS.

15.L.7. HEALTH CARE MANAGEMENT.

15.L.7.A. JOINT TRAUMA SYSTEM (JTS) CLINICAL PRACTICE GUIDELINES (CPGS) MAY BE OBTAINED HERE HTTPS://JTS.AMEDD.ARMY.MIL/INDEX.CFM/PI_CPGS/CPGS .

15.L.7.B. DOCUMENTATION OF ALL MEDICAL AND DENTAL CARE RECEIVED WHILE DEPLOYED WILL BE IAW CENTCOM MEDICAL INFORMATION MANAGEMENT GUIDELINES. SEE REF C, HH.

15.L.7.C. IT IS A COMMANDER'S RESPONSIBILITY TO ENSURE THAT ALL PERSONNEL POTENTIALLY AFFECTED BY A BLAST OR OTHER POTENTIALLY CONCUSSIVE EVENT ARE EVALUATED FOR TRAUMATIC BRAIN INJURY (TBI) BY A MEDICAL PROVIDER AND DOCUMENTATION IS COMPLETED IAW REF II. JOINT TRAUMA ANALYSIS & PREVENTION OF INJURY IN COMBAT (JTAPIC) TBI REPORTING LINK:

<HTTPS://INTELSHARE.INTELINK.GOV/SITES/JTAPIC/>

15.L.8. UNIT MASCOTS AND PETS.

15.L.8.A. PER CENTCOM GENERAL ORDER 1.C., DEPLOYED PERSONNEL WILL AVOID CONTACT WITH LOCAL ANIMALS (E.G., LIVESTOCK, CATS, DOGS, BIRDS, REPTILES, ARACHNIDS, AND INSECTS) IN THE DEPLOYED SETTING AND WILL NOT FEED, ADOPT, OR INTERACT WITH THEM IN ANY WAY.

15.L.8.B. ANY CONTACT WITH LOCAL ANIMALS, WHETHER INITIATED OR NOT, THAT RESULTS IN A BITE, SCRATCH OR POTENTIAL EXPOSURE TO THE ANIMAL'S BODILY FLUIDS (SALIVA, VENOM, ETC.) WILL BE IMMEDIATELY REPORTED TO THE CHAIN OF COMMAND AND MEDICAL PERSONNEL FOR EVALUATION AND FOLLOW-UP.

15.L.9. FOOD AND WATER SOURCES.

15.L.9.A. ALL WATER (INCLUDING ICE) IS CONSIDERED NON-POTABLE UNTIL TESTED AND APPROVED BY APPROPRIATE MEDICAL PERSONNEL (ARMY OR NAVY PREVENTIVE MEDICINE, AIR FORCE BIOENVIRONMENTAL ENGINEERING, INDEPENDENT DUTY MEDICAL TECHNICIAN/CORPSMAN). COMMERCIAL SOURCES OF DRINKING WATER MUST ALSO BE APPROVED BY THE U.S. ARMY PUBLIC HEALTH CENTER.

15.L.9.B. NO FOOD SOURCES WILL BE UTILIZED UNLESS INSPECTED AND APPROVED BY U.S. ARMY PUBLIC HEALTH CENTER (I.E. VETERINARY PERSONNEL).

15.L.9.C. COMMANDERS WILL ENSURE THE NECESSARY SECURITY TO PROTECT WATER AND FOOD SUPPLIES AGAINST TAMPERING BASED ON RECOMMENDATIONS PROVIDED IN FOOD/WATER VULNERABILITY ASSESSMENTS. MEDICAL PERSONNEL WILL PROVIDE CONTINUAL VERIFICATION OF QUALITY AND PERIODIC INSPECTION OF STORAGE AND PREPARATION FACILITIES.

15.L.10. ENVIRONMENTAL EXPOSURES OF CONCERN.

15.L.10.A. COLD INJURY RISK WILL DEPEND ON THE SPECIFIC REGION. HYPOTHERMIA, A LIFE-THREATENING CONDITION, MOSTLY OCCURS UP TO 55 DEGREES FAHRENHEIT AIR TEMPERATURE. RISK OF COLD INJURY INCREASES FOR PERSONS WHO ARE IN POOR PHYSICAL CONDITION, DEHYDRATED, WET, OR AT INCREASED ALTITUDE. COUNTERMEASURES INCLUDE PROPER WEAR OF CLOTHING AND COVER. EXPOSED SKIN IS MORE LIKELY TO DEVELOP FROSTBITE. ENSURE CLOTHING IS CLEAN, LOOSE, LAYERED, AND DRY. COVER THE HEAD TO CONSERVE HEAT.

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15.L.10.B. HEAT STRESS/ SOLAR INJURIES/ILLNESS. HEAT INJURIES MAY BE THE GREATEST OVERALL THREAT TO MILITARY PERSONNEL DEPLOYED TO WARM CLIMATES. ACCLIMATIZATION TO INCREASED TEMPERATURE AND HUMIDITY MAY TAKE 10 TO 14 DAYS. HEAT INJURIES CAN INCLUDE DEHYDRATION, SUNBURN, HEAT SYNCOPE, HEAT EXHAUSTION AND HEAT STROKE. ENSURE PROPER WORK-REST CYCLES, ADEQUATE HYDRATION, AND COMMAND EMPHASIS ON HEAT INJURY PREVENTION. ENSURE AVAILABILITY AND USE OF INDIVIDUAL PROTECTION SUPPLIES AND EQUIPMENT SUCH AS SUNSCREEN, LIP BALM, SUN GOGGLES/GLASSES, AND POTABLE WATER.

15.L.10.C. ALTITUDE. OPERATIONS AT HIGH ALTITUDES (OVER 9888 FT) CAN CAUSE A SPECTRUM OF ILLNESSES, INCLUDING ACUTE MOUNTAIN SICKNESS; HIGH ALTITUDE PULMONARY EDEMA, HIGH ALTITUDE CEREBRAL EDEMA, OR RED BLOOD CELL SICKLING IN SERVICE MEMBERS WITH SICKLE CELL TRAIT. ASCEND GRADUALLY, IF POSSIBLE. TRY NOT TO GO DIRECTLY FROM LOW ALTITUDE TO >9,888 FT (3,013 M) IN ONE DAY. A HEALTH CARE PROVIDER MAY PRESCRIBE ACETAZOLAMIDE (DIAMOX) OR DEXAMETHASONE (DECADRON) TO SPEED ACCLIMATIZATION IF ABRUPT ASCENT IS UNAVOIDABLE. TREAT AN ALTITUDE HEADACHE WITH SIMPLE ANALGESICS; MORE SERIOUS COMPLICATIONS REQUIRE OXYGEN AND IMMEDIATE DESCENT.

15.L.10.D. GOOD FIELD SANITATION PRACTICES ARE ESSENTIAL TO MAINTAIN FORCE HEALTH. THEY INCLUDE: FREQUENT HANDWASHING, PROPER DENTAL CARE, CLEAN AND DRY CLOTHING (ESPECIALLY SOCKS, UNDERWEAR, AND BOOTS), BATHING AND DENTAL CARE WITH WATER FROM A POTABLE SOURCE. CHANGE SOCKS FREQUENTLY, FOOT POWDER HELPS PREVENT FUNGAL INFECTIONS.

15.M. ALL OTHER INSTRUCTIONS AND GUIDANCE SPECIFIED IN INITIAL POLICY MESSAGE REMAIN IN EFFECT. MOD SIXTEEN IS NOW INVALID.

15.N. THE USCENCOM POC FOR PREVENTIVE MEDICINE/FORCE HEALTH PROTECTION IS CCSG, DSN 312-529-0345; COMM: 813-529-0345; SIPR: ANDREW.B.HALL14.MIL@MAIL.SMIL.MIL; NIPR: CENTCOM.MACDILL.CENTCOM-HQ.MBX.CCSG-WAIVER@MAIL.MIL//

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MOD17-TAB A: AMPLIFICATION OF THE MINIMAL STANDARDS OF FITNESS FOR DEPLOYMENT TO THE CENTCOM AOR; TO ACCOMPANY MOD 17 TO USCENTCOM INDIVIDUAL PROTECTION AND INDIVIDUAL/UNIT DEPLOYMENT POLICY

1. General. This TAB A accompanies MOD 17, Section 15.C. and provides amplification of the minimal standards of fitness for deployment to the CENTCOM area of responsibility (AOR). Individuals possessing a disqualifying medical condition must obtain an exception to policy in the form of a medical waiver prior to being medically cleared for deployment. The list of deployment-limiting conditions is not comprehensive; there are many other conditions that may result in denial of medical clearance for deployment based upon the totality of individual medical conditions and the medical capabilities present at that individual's deployed location. "Medical conditions" as used here also include those health conditions usually referred to as dental and behavioral health.

- A. Uniformed Service Members must meet Service standards of fitness according to Service regulations and policies, in addition to the guidance in the parent MOD 17. See MOD 17 REF E, F, G, H, I, JJ.
- B. DoD civilian personnel with disqualifying medical conditions could still possibly deploy based upon an individualized medical assessment and approved medical waiver from the appropriate CENTCOM waiver authority. All personnel must be able to perform the duties of their position.
- C. DoD Contract personnel will be evaluated for fitness according to MOD 17 and DoDI 3020.41 (REF J).
- D. The final authority of who may deploy to the CENTCOM AOR rests with the CENTCOM Surgeon and/or the Service Component Surgeons' waiver authority, not the individual's medical evaluating entity, deploying platform, or Commander.
- E. Regardless of underlying diagnosis, waivers for disqualifying medical conditions will be considered only if all the following general conditions are met:
 - 1. The condition is not of such a nature or duration that an unexpected worsening or physical trauma is likely to have a grave medical outcome or negative impact on mission execution.
 - 2. The condition is stable and reasonably anticipated not to worsen during the deployment in light of the physical, physiological, psychological, and nutritional effects of assigned duties and location.
 - 3. The condition does not require frequent clinical visits (more than quarterly), ancillary tests, or significant physical limitations, and does not constitute an increased risk of illness, injury, or infection.
 - 4. There is no anticipated need for routine evacuation out of theater for continuing diagnostics or evaluations.
 - 5. The condition is expected to remain stable without consistent medication resupply. The CENTCOM formulary is a deployed formulary, and not all medications are available in theater. Medication resupply can be delayed in Theater and is fulfilled through the Tricare Mail Order Program (TMOP). If the medication is a Controlled

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Substance, delays in medication resupply are common. 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 (i.e. heat or cold stress, sunlight, etc.) and should not cause significant side effects in the setting of moderate dehydration.

6. Individuals must be able to perform all essential functions of their position in the deployed environment, with or without reasonable accommodation, without causing undue hardship. In evaluating undue hardship, the nature of the accommodation and workplace environment must be considered. Further, the member's medical condition must not pose a significant risk of substantial harm to the member or others taking into account the condition of the relevant deployed environment, with particular consideration of areas of armed conflict in the AOR. See REF I.
7. The medical condition does not prevent the wear of personal protective equipment, including protective mask, ballistic helmet, body armor, and chemical/biological protective garments.
8. The medical condition does not prohibit required theater immunizations or medications.
9. The medical condition is not anticipated to significantly impair duty performance during the duration of the deployment.
10. The diagnosis, management, and/or treatment of medical conditions does not place an unreasonable burden on deployed medical assets, operational assets, or complicate the evaluation of other reasonably-anticipated illnesses or injuries.
11. The individual has not been previously medically evacuated for the same condition.

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

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

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

5. Shipboard operations which are not anticipated to involve operations ashore are exempt from the deployment-limiting medical conditions listed below and will generally follow Service specific guidance.

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However, sovereign laws of some nations within the CENTCOM AOR may prohibit entry of individuals with certain medical conditions. Contingency plans for emergency evacuation of individuals with diagnoses that could result in or complicate medical care in theater following evacuation should be coordinated with and approved by the CENTCOM Surgeon prior to entering the AOR.

6. Per general guidance from MOD 17, section 15.C:

A. All personnel (uniformed service members, government civilian employees, volunteers, and DoD contractor employees) deploying to theater must meet medical, dental, and behavioral health fitness standards for deployment and possess a current Periodic Health Assessment (PHA) or physical. Fitness specifically includes the ability to accomplish tasks and duties unique to a particular operation and the ability to tolerate environmental and operational conditions of the deployed location.

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

1. An approved medical waiver, IAW Section 15.C.3, is documented in the medical record.

OR

2. The conditions in Para. 1.D.1-1.D.10 are met. To determine stability and assess need for further care, for most conditions 60 days is considered a reasonable timeframe, subject to the examining provider's judgment. The exception to this is noted in paragraph 7.G. Behavioral Health Conditions.

7. Documented medical conditions precluding medical clearance. A list of all possible diagnoses and their severity that may cause an individual to be non-deployable would be too expansive. *The medical evaluator must carefully consider whether the climate, altitude, nature of available food and housing, availability of medical, behavioral health, dental, surgical, and laboratory services, or whether other environmental and operational factors may be hazardous to the deploying person's health.* The following list of conditions should not be considered exhaustive. Other conditions may render an individual medically non-deployable (see paragraph 6). Medical clearance to deploy with any of the following documented medical conditions may be granted, except where otherwise noted, IAW MOD 17, Section 15.C. If an individual is found deployed with a pre-existing non-deployable condition and without a waiver for that condition, a waiver request to remain deployed should be submitted to the respective Component Surgeon. If the waiver request is denied, the individual will be redeployed out of the CENTCOM AOR. **Individuals with the following conditions and/or therapeutic interventions will not deploy without an approved waiver:**

A. Specific Medical Conditions / Restrictions:

1. Moderate or severe persistent asthma, or other respiratory conditions that have a Forced Expiratory Volume 1 Second (FEV1) \leq 50% of predicted, that have required hospitalization or emergency room visit in the past 12 months, or that require daily systemic (not inhaled) steroids. Mild intermittent and mild persistent asthma with an Asthma Control Test >19 does not require waiver.

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- 2.** Seizure disorder, either within the last year or currently on anticonvulsant medication for prior seizure disorder/activity. Persons on a stable anticonvulsant regimen, who have been seizure-free for one year, may be considered for waiver.
- 3.** Diabetes mellitus, type 1 or 2, on pharmacotherapy or with HgA₁C > 7.0.
 - a.** Type 1 diabetes or insulin-requiring type 2 diabetes.
 - b.** Type 2 diabetes, on oral agents only, with no change in medication within the last 60 days and HgA₁C ≤ 7.0 does not require a waiver if a calculated 10-year coronary heart disease risk percentage (see paragraph 7.B.7) is less than 15%. If the calculated 10-year risk is 15% or greater, further evaluation is required prior to waiver submission. See 7.B.7.
 - c.** Newly diagnosed diabetics will require demonstrated stability, either on oral medications or with lifestyle changes, before a waiver will be considered. Confirmation of complete initial diabetic evaluation (eye exam, foot exam, nutrition counseling, etc.) is required.
- 4.** History of heat stroke or rhabdomyolysis. Those without multiple episodes, persistent sequelae or organ damage, or episodes within the preceding 24 months may be considered for waiver. Waiver should include circumstances of the event(s), and functional assessment of current ability to perform rigorous duties in an environment similar to the deployed location.
- 5.** Meniere's disease or other vertiginous/motion sickness disorder, unless well controlled on medications available in theater.
- 6.** Recurrent syncope for any reason. Waiver request should include the etiology and diagnosis of the condition.
- 7.** History of stinging insect allergy causing generalized symptoms, IAW Ref JJ.
 - a.** Local swelling, itching, or redness contiguous with the sting site and exhibiting no signs of anaphylaxis or systemic reaction do not require waiver. Generalized cutaneous-only reactions that occurred prior to the 16th birthday also do not require waiver.
 - b.** Severe systemic and anaphylactic reactions, as well as cutaneous reactions – defined as generalized rash or swelling in locations not contiguous with sting site - occurring after the 16th birthday, should be referred to an allergist for testing.
 - c.** Negative testing results indicate no further therapeutic action is required, however a waiver should still be submitted for review.
- 8.** Endocrine conditions that are unstable, require laboratory monitoring or specialty consultation, or require more than routine follow-up. Waiver is not required if condition is stable, treatment medications are within clinically appropriate dose and effect parameters, have no special storage requirements, and do not produce side effects which interfere with the normal performance of duties or require additional medications to manage side effects. If treatment consists of CSA schedule I-V, such as testosterone, a waiver for that medication is required, see section I, 8 below.
- 9.** Any musculoskeletal condition that significantly impairs performance of duties or activities of daily living in a deployed environment. If there are concerns, an official functional capacity exam (FCE) should be performed and results included with the waiver request.
- 10.** Migraine headache, when frequent or severe enough to disrupt normal performance of duties. Waiver submission should note history, frequency, severity, and functional impact of headaches, with or without treatment, success of abortive therapies, as well previous and current treatment regimens. Neurology evaluation and endorsement encouraged.

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11. Nephrolithiasis, requiring clinical evaluation or intervention in the preceding 12 months, or with most recent imaging showing multiple stones or a single stone >5mm in size, or a history of more than two episodes in a 12 month period in the last 3 years.
12. Chronic Kidney Disease. A documented prolonged period of stability for Stage I and Stage II is expected prior to granting a waiver.
13. Pregnancy.
14. Obstructive sleep apnea (OSA). Should be diagnosed with polysomnography (PSG), with a minimum of 2 hours of total sleep time. For moderate and severe OSA, a compliance report demonstrating at least 4 hours of use per night for greater than 70% of nights over a 30-day period must be documented. Individuals treated with an oral appliance require polysomnography that indicates OSA is controlled with its use. Complex OSA, central sleep apnea, or OSA that requires advanced modes of ventilation such as adaptive servo-ventilation (ASV) or average volume assured pressure support (AVAPS) is non-deployable.
 - a. Mild OSA (diagnostic AHI and RDI < 15/hr): **No waiver required.**
 - b. Individuals using PAP therapy should deploy with a machine that has rechargeable battery back-up and sufficient supplies (air filters, tubing and interfaces/masks) for the duration of the deployment.
15. History of clinically diagnosed traumatic brain injury (mTBI/TBI) of any severity, including mild. Waiver may not be required, but pre-deployment evaluation, which may include both neurological and psychological components, is required per ref X.
 - a. Individuals who have a history of a single mild Traumatic Brain Injury may deploy once released by a medical provider after 24-hours symptom free.
 - b. Individuals who have sustained a second mTBI within a 12-month period, may deploy after seven days symptom free and release by a medical provider.
 - c. Individuals who have had three clinically diagnosed TBIs (of any severity, including mild) must have neurological and psychological evaluation completed prior to deployability determination.
16. Weight > 136 kg (300 lb)
17. Asplenia, either actual or functional secondary to other medical condition. Waiver request should include verification of immunization against encapsulated bacterial pathogens (pneumococcus, meningococcus, Haemophilus influenza).
18. Gout, with two or more flares in the preceding year.
19. Multiple Sclerosis. Waiver requests should address stability of condition, current limitations, increased vulnerability to heat injury, and possible requirement for medication waiver.
20. Any medical condition (except OSA-see 14 above) that requires durable medical equipment or appliances (e.g., nebulizers, catheters, spinal cord stimulators), or that requires periodic evaluation/treatment by medical specialists not readily available at any theater location.
21. Conditions requiring service animals or comfort animals. Does not apply to Military Working Dogs/Contract Working Dogs (see MOD 17, section 15.C.1.G.). Animals deployed to support behavioral health operations must deploy from CONUS as part of an official program with full logistic support and uniformed handlers.

B. Cardiovascular Conditions:

1. Symptomatic coronary artery disease.
2. Myocardial infarction within one year of deployment.

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3. Coronary artery bypass graft, coronary artery angioplasty, carotid endarterectomy, other arterial stenting, or aneurysm repair within one year of deployment.
4. Cardiac dysrhythmias or arrhythmias, either symptomatic or requiring medication, electro-physiologic control, or automatic implantable cardiac defibrillator or other implantable cardiac devices.
5. Heart failure or history of heart failure.
6. Blood pressure and lipids should be considered and treated in the context of overall cardiac risk, for which a waiver may be required (see B. 7). Isolated hypertension or lipids do not require separate waiver except in the following circumstances:
 - a. Hypertensive urgency or emergency within previous 90 days.
 - b. 3 day average SBP > 140, DBP > 90.
 - c. Total Cholesterol >300, or Triglycerides >1000.
7. Non-uniformed personnel who are 50 years of age or older must have a 10-year CHD risk percentage calculated (online calculator is available at <http://tools.acc.org/ASCVD-Risk-Estimator/>). If the individual's calculated 10-year CHD risk is 15% or greater, the individual should be referred for further cardiology work-up and evaluation, to include some form of functional assessment (i.e. graded exercise stress test with a myocardial perfusion scintigraphy (SPECT scan) or stress echocardiography as determined by the evaluating cardiologist). Results of the evaluation and testing, along with the evaluating cardiologist's recommendation regarding suitability for deployment, should be included in the waiver request.

C. Infectious Disease:

1. Confirmed Blood-borne diseases (i.e. Hepatitis B, Hepatitis C) which may be transmitted to others in a deployed environment. Waiver requests for persons testing positive for a blood borne disease, including positive antigens and viral load positive members, should include a full test panel for the disease, including all antigens, antibodies, viral load, and appropriate tests for affected organ systems.
2. Confirmed HIV infection. Individuals that are asymptomatic with undetectable viral load may deploy dependent on host nation requirements.
 - a. Host nation entry or residence requirements can be found at: <http://travel.state.gov>
 - b. ~~Hep~~ through the MOD17 waiver process
3. History of active tuberculosis (TB). Must have documented completion of full treatment course prior to deployment. Those currently on treatment for TB disease may not deploy.
4. A CENTCOM waiver cannot override host or transit nation infectious disease or immunization restrictions. Active duty must comply with status of forces agreements; civilian deployers should contact the nation's embassy for up-to-date information.

D. Eye, Ear, Nose, Throat, Dental Conditions:

1. Vision loss. Best corrected visual acuity which does not meet minimum occupational requirements to safely perform duties. Bilateral blindness or visual acuity that is unsafe for the combat environment per the examining provider.
2. Refractive eye surgery. Personnel who have had laser refractive surgery must have a satisfactory period for post-surgical recovery before deployment. There is a large degree

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of patient variability which prevents establishing a set timeframe for full recovery. The attending ophthalmologist or optometrist will determine when recovery is complete.

- a. Personnel are non-deployable while still using ophthalmic steroid drops post-procedure.
 - b. Personnel are non-deployable for three months following uncomplicated photorefractive keratectomy (PRK) or laser epithelial keratomileusis (LASEK), or one month for laser-assisted in situ keratomileusis (LASIK) unless a waiver is granted.
 - c. Waiver request should include clearance from treating ophthalmologist or optometrist.
3. Hearing loss. Service members must meet all Service-specific requirements or have completed a medical board and found fit for duty do not require a waiver. Individuals with sufficient unaided hearing to perform duties safely, hear and wake up to emergency alarms unaided, and hear instructions in the absence of visual cues such as lip reading do not require waiver. If ability to perform duties is in question, Speech Recognition In Noise Test (SPRINT) or equivalent testing should be included to verify this ability.
 4. Tracheostomy or aphonia.
 5. Patients without a dental exam within 12 months of deployment, or those who are likely to require evaluation or treatment during the period of deployment for oral conditions that are likely to result in a dental emergency. Individuals being evaluated by a non-DoD civilian dentist should use a DD Form 2813, or equivalent, as proof of dental examination.
 6. Orthodontics requiring follow-up or adjustment while deployed. Those with wires in neutral force and are cleared by the treating orthodontist do not require waiver.

E. Cancer:

1. Cancer for which the individual is receiving continuing treatment or which requires any subspecialist examination and/or laboratory/imaging testing during the anticipated duration of the deployment.
2. Precancerous lesions that have not been treated and/or evaluated and that require treatment/evaluation during the anticipated duration of the deployment.
3. Cancers which have not been in complete remission for at least a year

F. GASTROINTESTINAL SYSTEM:

1. Inflammatory bowel disease, including, but not limited to: Crohn's disease; ulcerative colitis; ulcerative proctitis; regional enteritis; granulomatous enteritis.
2. Chronic hepatitis with impairment of liver function.
3. The presence of any ostomy (gastrointestinal or urinary).

G. Surgery:

1. Any medical condition that requires surgery or for which surgery has been performed and the patient requires ongoing treatment, rehabilitation or additional surgery/revision.
2. Individuals who have had surgery requiring follow up during the deployment period or who have not been cleared/released by their surgeon (excludes minor procedures).

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3. Individuals who have had surgery (open or laparoscopic) within 6 weeks of deployment.
4. Special dietary and hygienic requirements resulting from surgery cannot be reliably accommodated and may be independently disqualifying.

H. Behavioral Health Conditions: Diagnostic criteria and treatment plans should adhere to the current Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5 as of writing) and current professional standards of care. Waiver submission should include information on applicant condition, including history and baseline symptoms of known disorders, severity of symptoms with and without treatment, and likelihood to recur or deteriorate in theater if exposed to operational activity. The deployed operational environment is notable for lack of support systems, inability to practice external coping mechanisms, unpredictability, long and stressful work periods, sleep disruption, lack of privacy, lack of control, and exposure/re-exposure to traumatic and life-threatening events. See reference KK. Waiver required for all conditions listed below (list is not inclusive).

1. Behavioral health disorders without demonstrated clinical stability of at least 3 months, as defined by unchanged treatment, well controlled symptoms, and no expectation of incapacitation if the condition should relapse or recur.
2. Psychotic and bipolar-spectrum disorders are strictly disqualifying.
3. Any DSM 5-diagnosed behavioral health disorder, to include personality disorders, with residual symptoms, or medication side effects, which impair social and/or occupational performance.
4. Any behavioral health condition that poses a substantial risk for deterioration and/or recurrence of impairing symptoms in the deployed environment.
5. Any behavioral health condition that requires periodic (beyond quarterly) counseling or therapy.
6. Chronic insomnia that requires regular or long-term use of any sedative hypnotics / amnestics, benzodiazepines, and/or antipsychotics. PRN, or as needed, use of medication for this diagnosis must clarify frequency of actual use.
7. Anxiety disorders requiring use of benzodiazepines for management, or featuring symptoms of panic or phobia.
8. Post-Traumatic Stress Disorder, when causing impairment or not completely treated, or when therapy includes use of benzodiazepines without additional anxiety diagnosis. Waiver submission should note if condition is combat-related, and, if so, comment on impact that return to the operational environment could have on applicant well-being and performance.
9. Gender dysphoria, when distressing enough to require treatment. Transgender without history of, or current requirement for, transition, and not associated with significant gender dysphoria is not disqualifying and does not require waiver. Underlying behavioral health, endocrine, and/or surgical issues (as applicable) should be stable and resolved, and all Service requirements must be met, to include the involvement of, and clearance by, Service Central Coordination Cell if transition is required. See Ref LL. Transitioning personnel's treatment course should be complete, with DEERS marker change, and an adequate Real Life Experience (RLE) period should have occurred to ensure stability. Due to complex needs, those requiring or actively undergoing gender

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transition are generally disqualified until the process, including all necessary follow-up and stabilization, is completed.

10. Bulimia and anorexia nervosa.

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

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

13. Suicidal Ideation, behavior or suicide attempt with the last 12 months is strictly disqualifying.

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

a. A post-treatment period of demonstrated stability is required, the length of which will depend on individual patient factors.

b. Substance use disorders (SUD), not in remission and/or actively enrolled in Service Specific substance abuse programs are not eligible for waiver.

c. SUD requiring regular use of reversal agents or antagonists (Naloxone, Suboxone, Methadone) cannot be supported. Single-dose issuances of Naloxone are not intrinsically disqualifying, but require clarification of underlying SUD issues.

d. Alcohol use disorder requiring pharmacotherapy for maintenance (Disulfiram, Naltrexone, Acamprosate) cannot be supported.

e. Alcohol use disorders requiring random testing or other monitoring are disqualifying.

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

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

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

onest opportunity via medical evacuation with appropriate escorts and per TRANSCOM guidelines.

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

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I. Medications – Recently discontinued medications are considered to have had valid clinical indications, and should include verification of control of underlying conditions and reason for cessation. Medications included as “PRN”, or as needed, must include a description of typical use. Any of the following medications (specific medication or class of medication) is disqualifying for deployment, unless a waiver is granted:

1. Any medication which, if lost, misplaced, stolen, destroyed, or unable to be resupplied, would result in significant worsening or grave outcome for the affected individual before the medication could be reasonably replaced.
2. Any medication requiring periodic laboratory monitoring, titrated dosing, or special handling/storage requirements, or which has documented side effects, when used alone or in combination with other required therapy, which are significantly impairing, or which impose an undue risk to the individual or operational objectives.
3. Blood modifiers:
 - a. Therapeutic Anticoagulants: warfarin (Coumadin), rivaroxaban (Xarelto), apixaban (Eliquis).
 - b. Platelet Aggregation Inhibitors or Reducing Agents: clopidogrel (Plavix), anagrelide (Agrylin), Dabigatran (Pradaxa), Aggrenox, Ticlid (Ticlopidine), Prasugrel (Effient), Pentoxifylline (Trental), Cilostazol (Pletal), Ticagrelor (Brilinta). Note: Aspirin use in theater is to be limited to individuals who have been advised to continue use by their healthcare provider for medical reasons; such use must be documented in the medical record.
 - c. Hematopoietics: filgrastim (Neupogen), sargramostim (Leukine), erythropoietin (Epoen, Procrit).
 - d. Antihemophilics: Factor VIII, Factor IX, Factor Xa.
4. Antineoplastics (oncologic or non-oncologic use): e.g., antimetabolites (methotrexate, hydroxyurea, mercaptopurine, etc.), alkylators (cyclophosphamide, melphalan, chlorambucil, etc.), antiestrogens (tamoxifen, etc.), aromatase inhibitors (anastrozole, exemestane, etc.), medroxyprogesterone (except use for contraception), interferons, etoposide, bicalutamide, bexarotene, oral tretinoin (Vesanoid).
5. Immunosuppressants: e.g., chronic systemic steroids.
6. Biologic Response Modifiers (immunomodulators): e.g., abatacept (Orencia), adalimumab (Humira), anakinra (Kineret), etanercept (Enbrel), infliximab (Remicade), leflunomide (Arava), azathioprine (Imuran), etc.
7. Any CSA Schedule I-V controlled substance, including but not limited to the following:
 - a. Benzodiazepines: lorazepam (Ativan), alprazolam (Xanax), diazepam (Valium), flurazepam (Dalmane), clonazepam (Klonopin), etc.
 - b. Stimulants: methylphenidate (Ritalin, Concerta), amphetamine/dextroamphetamine (Adderall), dextroamphetamine (Dexedrine), dexmethylphenidate (Focalin XR), lisdexamfetamine (Vyvanse), modafinil (Provigil), armodafinil (Nuvigil), etc.
 - c. Sedative Hypnotics/Amnestics: zolpidem (Ambien, Ambien CR), eszopiclone (Lunesta), zaleplon (Sonata), estazolam (Prosom), triazolam (Halcion), temazepam (Restoril), etc. Note: single pill-count issuances for operational transition do not require a waiver.
 - d. Narcotics/narcotic combinations: oxycodone (Oxycontin, Percocet, Roxicet), hydrocodone (Lortab, Norco, Vicodin), hydromorphone (Dilaudid), meperidine (Demerol), tramadol (Ultram), etc.

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- e. Cannabinoids: marijuana, tetrahydrocannabinol (THC), dronabinol (Marinol), cannabidiol (CBD oil), etc. Note that possession or use may be a criminal offense in the CENTCOM AOR.
- f. Anorexiant: phendimetrazine (Adipost), phentermine (Zantryl, Adipex-P), etc.
- g. Androgens and Anabolic Steroids: testosterone (Axiron, AndroGel, Fortesta, Testim), oxymetholone (Anadrol-50), methyltestosterone (Methitest), etc.
- 8. Antipsychotics, including atypical antipsychotics: haloperidol (Haldol), fluphenazine (Prolixin), quetiapine (Seroquel), aripiprazole (Abilify), lurasidone (Latuda), ziprasidone (Geodon), olanzapine (Zyprexa), etc.
- 9. Antimanic (bipolar) agents: e.g., lithium.
- 10. Anticonvulsants, used for seizure control or behavioral health diagnoses.
 - a. Anticonvulsants (except those listed below) which are used for *non-behavioral health* diagnoses, such as migraine, chronic pain, neuropathic pain, and post-herpetic neuralgia, are not intrinsically deployment-limiting as long as treated conditions meet the criteria set forth in this document and accompanying MOD 16. No waiver required. Exceptions include:
 - b. Valproic acid (Depakote, Depakote ER, Depacon, divalproex, etc.).
 - c. Carbamazepine (Tegretol, Tegretol XR, etc.).
 - d. Lamotrigine (Lamictal)
- 11. Dopamine agonists: Ropinirole (Requip), pramipexole (Mirapex), etc.
- 12. Botulinum toxin (Botox): Current or recent use to control severe pain.
- 13. Insulin
- 14. Injectable medications of any type require waiver, excluding medroxyprogesterone acetate (Depo-Provera) and EpiPens. Strongly recommend requesting waiver over modifying route of administration when treatment is stable and effective.

8. CONTACTS FOR WAIVERS (See also MOD 17, Para. 15.C.3.C.)

- A. CENTCOM. CENCOM.MACDILL.CENCOM-HQ.MBX.CCSG-WAIVER@MAIL.MIL; CML: 813.529.0361/0348; DSN: 312.529.0361/0348
- B. AFCENT. SG.CLINOPS@AFCENT.AF.MIL; CML: 803.717.7101; DSN: 313.717.7101
- C. ARCENT. USARMY.SHAW.USARCENT.MBX.SURG-WAIVER@ARMY.MIL; CML: 803.885.7946; DSN: 312.889.7946
- D. MARCENT. MARCEN.WAIVERS@USMC.MIL; CML: 813.827.7175; DSN: 312.651.7175
- E. NAVCENT. C5FMEDWAIVERS@US.NAVY.MIL; CML: 011.973.1785.4558; DSN: 318.439.4558
- F. SOCCENT. SOCENT.SG@SOCOM.MIL; CML: 813.828.7351; DSN: 312.968.7351

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EXHIBIT E

Berman, Keri L. (CIV)

From: Peter Perkowski <peter@perkowskilegal.com>
Sent: Wednesday, May 31, 2023 7:29 PM
To: Berman, Keri L. (CIV)
Cc: 'Scott Schoettes'; Abbuhl, Joshua (CIV); Wynosky, Kevin J. (CIV); Barghaan, Dennis (USAVAE)
Subject: RE: [EXTERNAL] Re: Harrison v. Austin, 18-cv-641

Hi Keri,

We will be filing the declarations as soon as signatures are received. We would not be opposed to Defendants filing evidentiary objections within a reasonable time of that filing.

Best,

Peter E. Perkowski (*he/him, Mr./Mx.*)

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peter@perkowskilegal.com | [web](#)

Admitted in CA, DC, and NY

From: Berman, Keri L. (CIV) <Keri.L.Berman@usdoj.gov>
Sent: Wednesday, May 31, 2023 7:06 AM
To: Peter Perkowski <peter@perkowskilegal.com>
Cc: 'Scott Schoettes' <sschoettes@gmail.com>; Abbuhl, Joshua (CIV) <Joshua.Abbuhl@usdoj.gov>; Wynosky, Kevin J. (CIV) <Kevin.J.Wynosky@usdoj.gov>; Barghaan, Dennis (USAVAE) <Dennis.Barghaan@usdoj.gov>
Subject: RE: [EXTERNAL] Re: Harrison v. Austin, 18-cv-641

Hi Peter,

We have not had an opportunity to review and consider the alleged similarity of the contents of future affidavits, which in any event is not our only concern. We've explained our position and cannot accept your proposition. Your declaration contains improper and inadmissible information and we intend to object to it as part of our opposition. Our opposition is due in two days so your filing of additional evidence between then and now certainly would not cure the defective filing or the prejudice to Defendants.

Best,

Keri

From: Peter Perkowski <peter@perkowskilegal.com>
Sent: Saturday, May 27, 2023 9:45 PM
To: Berman, Keri L. (CIV) <Keri.L.Berman@usdoj.gov>
Cc: 'Scott Schoettes' <sschoettes@gmail.com>; Abbuhl, Joshua (CIV) <Joshua.Abbuhl@usdoj.gov>; Wynosky, Kevin J. (CIV) <Kevin.J.Wynosky@usdoj.gov>; Barghaan, Dennis (USAVAE) <DBarghaan@usa.doj.gov>
Subject: RE: [EXTERNAL] Re: Harrison v. Austin, 18-cv-641

Hi Keri. I'm afraid that the way that I phrased my prior response has caused a misunderstanding. Let me clarify.

The declarations we proposed submitting from affected service members would be substantively the same, containing the same information, as that which is already in my declaration. We would not be adding (or even subtracting) details. The language I used (“as closely as possible”) was meant to account for the need to change the perspective of the narrative, where necessary—that is, from my perspective to the service members’ perspective.

Given this clarification, we do not believe that Defendants would suffer any prejudice at all. To further limit any prejudice, we could endeavor to submit these declarations within a week, possibly by Friday, June 2. We do not believe a modification of the briefing schedule is necessary—Defendants have had the submission since May 3, and has been tracking the service members’ factual circumstances for some six months—but if you disagree, please let us know.

Thank you.

V/r,

Peter E. Perkowski (*he/him, Mr./Mx.*)

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Admitted in CA, DC, and NY

From: Berman, Keri L. (CIV) <Keri.L.Berman@usdoj.gov>

Sent: Thursday, May 25, 2023 6:51 PM

To: Peter Perkowski <peter@perkowskilegal.com>

Cc: Scott Schoettes <sschoettes@gmail.com>; Abbuhl, Joshua (CIV) <Joshua.Abbuhl@usdoj.gov>; Wynosky, Kevin J. (CIV) <Kevin.J.Wynosky@usdoj.gov>; Barghaan, Dennis (USAVAE) <Dennis.Barghaan@usdoj.gov>

Subject: Re: [EXTERNAL] Re: Harrison v. Austin, 18-cv-641

Hi Peter,

Thank you for your response. Unfortunately your main proposal will not cure the prejudice to the Defendants.

Federal Rule of Civil Procedure 6(c)(2) requires that “[a]ny affidavit supporting a motion must be served with the motion.” The purpose of this rule is to permit the opposing party a fair opportunity to respond to the evidence presented. Therefore, although “Rule 6(c)(2) does not preclude affidavits supporting a reply brief,” they are only permitted “when they respond to evidence supporting an opposition brief.” *See, e.g., Robinson v. Empire Equity Group, Inc.*, Case No. WDQ-09-1603, 2009 U.S. Dist. LEXIS 107607, at *2 & n.14 (D. Md. Nov. 18, 2009); *Aldridge v. Marion Cty. Coal Co.*, Case No. 1:17CV79, 2017 U.S. Dist. LEXIS 127733, at *5 (N.D. W. Va. Aug. 10, 2017) (“affidavits may accompany a reply brief if they support the reply rather than the original motion.”).

We understand that you are not proposing providing the sworn declarations as part of your reply per se, but the import is the same. Defendants would be precluded from responding, both procedurally and timewise, to the factual assertions of those declarations, which you admit may not contain all of the same information as your current improper declaration. *See Democracy N.C. v. N.C. State Bd. of Elections*, Case No. 1:20-CV-457, 2020 U.S. Dist. LEXIS 131980 at *15-16 (M.D.N.C. July 27, 2020); *see also id.* at * 17 (quoting *McGinnis v. Se. Anesthesia Assocs., P.A.*, 161 F.R.D. 41, 42

(W.D.N.C. 1995) (Rule 6(c)(2) “requires the supporting affidavits to be filed simultaneously with the motion it supports, affording the opposing party an opportunity to address the motion fully and squarely on its merits.”)).

Consequently if you follow your proposed route we will maintain our objection to the declaration and make any additional objections that become necessary. In light of your representation that you intend to cure the hearsay testimony issue within the declaration, we believe that issue could be properly resolved in two ways. First, the parties could agree to request a modification of the schedule to accommodate the amendment of your evidence. If you believe you can obtain the declarations by June 16 (the current date of your reply) we can jointly move the Court to stay the briefing schedule to accommodate your supplementation of the record. Since we asked you last Friday to correct this defect we would propose 2 weeks to respond beginning June 16, followed by your 2 weeks to reply as previously agreed. Second, to avoid the complications of gaining the Court’s approval, Plaintiffs could withdraw the motion and exhibits and refile when they deem the necessary attachments to be ready. The parties could then negotiate a new schedule.

We would not object to a supplemental declaration attaching published regulations to the extent its purpose was limited to introducing those documents for the record. However, given the above, we anticipate any action you would take as to that issue would be rolled into curing the inadmissible evidence.

Please let us know tomorrow how you intend to proceed.

Best,

Keri

On May 23, 2023, at 5:44 PM, Peter Perkowski <peter@perkowskilegal.com> wrote:

Hi Keri. Thanks for this update.

To address the hearsay issue in paragraphs 23-72, we will do our best to obtain and submit declarations from the service members involved in those paragraphs. Those declarations will restate the details of my declaration as closely as possible. We can do so as quickly as possible but in no event later than our reply.

We can also submit a supplemental declaration attaching the regulations discussed in paragraphs 10-20 (roughly, based on recollection), unless Defendants intend to submit them or do not intend to assert a best evidence objection under FRE 1002. Please advise.

We will not withdraw or revise paragraphs 7-9, which we believe are proper.

Thank you,

Peter E. Perkowski (he/him, Mr./Mx.)

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peter@perkowskilegal.com | [web](#)

Admitted in CA, DC, and NY

From: Berman, Keri L. (CIV) <Keri.L.Berman@usdoj.gov>

Sent: Tuesday, May 23, 2023 11:58 AM

To: Peter Perkowski <peter@perkowskilegal.com>; 'Scott Schoettes' <sschoettes@gmail.com>

Cc: Abbuhl, Joshua (CIV) <Joshua.Abbuhl@usdoj.gov>; Wynosky, Kevin J. (CIV)

<Kevin.J.Wynosky@usdoj.gov>; Barghaan, Dennis (USAVAE) <Dennis.Barghaan@usdoj.gov>

Subject: RE: [EXTERNAL] Re: Harrison v. Austin, 18-cv-641

Hi Peter,

As I stated we consider the large majority of the declaration to be objectionable and reserve all rights to object to it or oppose consideration of the evidence presented up to the time of the opposition and in the opposition.

I believe I was clear that we are particularly concerned with ¶¶ 7-9 and 23-72 which are based on unsworn statements of individuals who are not the declarant. We will object to the presentation of that evidence if it is not withdrawn. You indicated that you could obtain proper sworn affidavits of the various individuals whose information you are attempting to present. This is not a representation that we will not otherwise challenge those affidavits or the accuracy of the statements made within, but that would cure the principal defect of unsworn first order hearsay testimony.

As it concerns timing, I asked that you let us know by the end of the day yesterday whether you would cure these defects. Please let us know as soon as possible. If you indicate that you intend to cure some or all of the defective declaration we will then consider our next steps based on what you choose to do and when you actually do it.

Best,
Keri

From: Peter Perkowski <peter@perkowskilegal.com>

Sent: Tuesday, May 23, 2023 12:31 AM

To: Berman, Keri L. (CIV) <Keri.L.Berman@usdoj.gov>; 'Scott Schoettes' <sschoettes@gmail.com>

Cc: Abbuhl, Joshua (CIV) <Joshua.Abbuhl@usdoj.gov>; Wynosky, Kevin J. (CIV)

<Kevin.J.Wynosky@usdoj.gov>; Barghaan, Dennis (USAVAE) <DBarghaan@usa.doj.gov>

Subject: RE: [EXTERNAL] Re: Harrison v. Austin, 18-cv-641

Hi Keri.

So if I understand correctly, Defendants decline to identify which objections you intend to stand on—reserving your rights as to all of them—but insist that Plaintiffs identify which purported defects we intend to cure. I suppose that is your right, but it certainly is not a productive way to resolve disputes, as it leaves Plaintiffs in the dark about both the scope of what is actually in dispute and the best way to reach an agreement. But we appreciate the courtesy, I guess.

In order to answer your question—about which objections we intend to cure—we do in fact need some answers from you, not deflections. What would Defendants consider an acceptable cure, sufficient to obviate their objections, and in what time frame? Please advise.

Thank you,

Peter E. Perkowski (*he/him, Mr./Mx.*)

o: +1 (213) 340-5796 | m: +1 (323) 707-3154

peter@perkowskilegal.com | [web](#)

Admitted in CA, DC, and NY

From: Berman, Keri L. (CIV) <Keri.L.Berman@usdoj.gov>
Sent: Monday, May 22, 2023 3:44 PM
To: Peter Perkowski <peter@perkowskilegal.com>; 'Scott Schoettes' <sschoettes@gmail.com>
Cc: Abbuhl, Joshua (CIV) <Joshua.Abbuhl@usdoj.gov>; Wynosky, Kevin J. (CIV) <Kevin.J.Wynosky@usdoj.gov>; Barghaan, Dennis (USAVAE) <Dennis.Barghaan@usdoj.gov>
Subject: RE: [EXTERNAL] Re: Harrison v. Austin, 18-cv-641

Hi Peter,

We let you know that we intend to object to the consideration of the declaration you presented as a courtesy so that you can cure the defects if you choose to. We have not made any representations about which factual assertions we will dispute because that is irrelevant to the admissibility of the declaration. We reserve the right to make any and all objections to or other arguments against this declaration, any part of the declaration you choose not to withdraw, or any other evidence you have submitted or will submit in support of this motion.

In particular, as I mentioned, we object to your presentation of unsworn information from third parties of which you do not have personal knowledge. Contrary to your suggestion, hearsay, and hearsay within hearsay, are not mere technicalities and we will object to any consideration of that material.

Please let us know if you intend to cure some or all of the defects we have identified.

Best,
Keri

From: Peter Perkowski <peter@perkowskilegal.com>
Sent: Monday, May 22, 2023 4:12 PM
To: Berman, Keri L. (CIV) <Keri.L.Berman@usdoj.gov>; 'Scott Schoettes' <sschoettes@gmail.com>
Cc: Abbuhl, Joshua (CIV) <Joshua.Abbuhl@usdoj.gov>; Wynosky, Kevin J. (CIV) <Kevin.J.Wynosky@usdoj.gov>
Subject: RE: [EXTERNAL] Re: Harrison v. Austin, 18-cv-641

Hi Keri. Scott is traveling so I'm replying this time. Thank you for providing the additional information.

We disagree that the "entire declaration" is improper and inadmissible. First, testimony is the entire point of a declaration, and attorney declarations are an exceedingly common of presenting it when the information being provided is based on the attorney's personal experience and knowledge. Second, the

declaration is not argument—much less argument “outside the bounds of the brief.” The factual details about the contents and operation of the regulations do support arguments made in the brief.

If your argument regarding the few regulations that were not attached to the declaration is a “best evidence” objection under FRE 1002, Defendants are certainly free to submit copies of those regulations, which are—as you have pointed out—also publicly available, should the court wish to view them. Do Defendants insist that

We are still unsure about the basis of the objection to paragraphs 7-9, but we disagree that they are inadmissible under any theory. These paragraphs report factual information (things that I experienced and learned) and are not hearsay. Nor are they argument—which in any event isn’t really a basis for inadmissibility in this context.

As for paragraphs 23-72: We do not agree that all of the information in these paragraphs is hearsay, much less double hearsay, but we will not waste time arguing our position paragraph by paragraph. We acknowledge that some of the statements in paragraphs 23-72 are hearsay and don’t satisfy an exception. Because you reference footnote 3 of the brief, you know why we took this approach: the administrative burden was high, and we doubt that the truth of the information is in dispute (a question Scott put to you directly and you avoided answering).

You will recall that Plaintiffs took this same approach in the briefing on the preliminary injunction motion in *Roe*: factual information about a handful of other Airmen was set forth in an attorney declaration, to which defendants did not object. (See Declaration of Peter Perkowski in Support of Motion for a Preliminary Injunction, *Roe v. Shanahan*, No.1:18-cv-1565.) We concluded that proceeding here in the same way would be acceptable and would minimize burdens. Further, since Defendants know who these individuals are and were investigating their circumstances, we are confident that Defendants have verified the information in the declaration and do not dispute it.

Though it appears that Defendants do not dispute the truth of the matters asserted in those paragraphs, please let us know whether Defendants will nevertheless insist that Plaintiffs undergo the merely administrative and time-consuming exercise of putting those same statements in declarations from the persons involved, seeking the Court's permission, and filing them under seal.

Happy to discuss.

Best regards,

Peter E. Perkowski (*he/him, Mr./Mx.*)

o: +1 (213) 340-5796 | m: +1 (323) 707-3154

peter@perkowskilegal.com | [web](#)

Admitted in CA, DC, and NY

From: Berman, Keri L. (CIV) <Keri.L.Berman@usdoj.gov>

Sent: Monday, May 22, 2023 8:19 AM

To: Scott Schoettes <sschoettes@gmail.com>

Cc: Abbuhl, Joshua (CIV) <Joshua.Abbuhl@usdoj.gov>; peter@perkowskilegal.com; Wynosky, Kevin J. (CIV) <Kevin.J.Wynosky@usdoj.gov>

Subject: RE: [EXTERNAL] Re: Harrison v. Austin, 18-cv-641

Hi Scott,

We view the entire declaration as improper since your attorney is providing testimony and at times argument outside of the bounds of the brief, including about numerous publicly available documents which speak for themselves.

Additionally, paragraphs 7-9 and 23-72 contain inadmissible hearsay and hearsay within hearsay, all of which is being offered for the truth of the matter asserted. As you noted yourself in footnote 3 of the brief, your approach to providing this information is nonstandard and potentially objectionable. You also made clear that you can obtain more appropriate and probative evidence and have chosen not to do so.

As I previously stated, we intend to object to this declaration and oppose consideration of the evidence provided therein. Please let us know today if you will cure these defects.

Best,
Keri

From: Scott Schoettes <sschoettes@gmail.com>
Sent: Sunday, May 21, 2023 12:08 AM
To: Berman, Keri L. (CIV) <Keri.L.Berman@usdoj.gov>
Cc: Abbuhl, Joshua (CIV) <Joshua.Abbuhl@usdoj.gov>; peter@perkowskilegal.com
Subject: [EXTERNAL] Re: Harrison v. Austin, 18-cv-641

Dear Keri and Josh,

Thanks for reaching out. If you could provide a few more specifics, that would help us to evaluate the appropriate course of action.

Please explain why you believe the declaration is improper and identify each specific statement you claim is inadmissible hearsay, keeping in mind the definition of hearsay and the hearsay exceptions for admissions and statements against interest.

Recognizing that the hearsay rules are intended to give a party a chance to test the veracity of any out of court statement--and the parties joint obligation to narrow any areas of dispute before filing a motion-- please also identify any of the out of court statements (offered for the truth of the matter asserted) that Defendants contend are false.

If you will endeavor to supply this information by noon on Monday, we will endeavor to provide an answer regarding the need for a motion by the end of the day.

Thanks,
Scott

On Fri, May 19, 2023 at 7:05 PM Berman, Keri L. (CIV) <Keri.L.Berman@usdoj.gov> wrote:

Good Morning Peter and Scott,

In reviewing your Motion to Enforce the Judgment in Harrison/Roe we have determined that the Perkowski Declaration is improper and seeks to provide inadmissible evidence. If the declaration remains in the record, we intend to object to the declaration and oppose the consideration of that

evidence. Please let us know by 5pm est on Monday, May 22, if you intend to cure this defective declaration or if you will continue to rely on it.

Best,

Keri

Keri L. Berman

Trial Attorney, Civil Division

United States Department of Justice

Tel: 202-305-7538

Keri.L.Berman@usdoj.gov

--

Scott Schoettes (he/him)
HIV Advocate/Attorney/Consultant
Scott A. Schoettes, Esq.
773.474.9250

EXHIBIT 2

**IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
Alexandria Division**

NICHOLAS HARRISON, *et al.*,

Plaintiffs,

v.

MARK ESPER, Secretary of Defense,
et al.,

Defendants.

No. 1:18-cv-641 (LMB/IDD)

RICHARD ROE, *et al.*,

Plaintiffs,

v.

MARK ESPER, Secretary of Defense,
et al.,

Defendants.

No. 1:18-cv-1565 (LMB/IDD)

DECLARATION OF LIEUTENANT COLONEL AMBER ELLISON

I, Lieutenant Colonel Amber Ellison, do hereby state and declare as follows:

1. I currently serve as the Deputy G3 in the District of Columbia Army National Guard (DCARNG). I previously served as Recruiting and Retention Battalion Commander from August 2019 through April 2023. Over the course of my career, I have served as an enlisted Soldier, platoon leader, Battery Commander, Operations Officer, Secretary General Staff, Plans Officer, and Officer Strength Manager. As the Recruiting and Retention Battalion Commander I oversaw the processing of all accessions activities within the DCARNG, including SGT Nicholas Harrison's application for accession to the Army Judge Advocate

General's Corps (JAGC).

2. I submit this declaration in support of Defendants' opposition to Plaintiffs' motion to enforce judgment and for an order to show cause in the above-titled cases. I base this declaration upon my personal knowledge, as well as knowledge made available to me in the course of my official duties.

3. On or about June 30, 2022, my Battalion started working with SGT Harrison for his application into the JAGC. Because his previous application dated back to 2013, his new application required significant updating to ensure that all required documents would be valid and relevant before review from the JAGC accessions board. Some of those documents included an updated commissioning physical (required to be complete within two-years of the application), updated security clearance questionnaire (required within one year of the application), an age waiver request, a current statement of good standing from state in which he is admitted to practice law (required to be complete within sixty days of the application), and an updated statement of personal interest from SGT Harrison.

4. ARNG JAGC accession boards typically occur on average two-to-four times annually. Because there is no sitting board, the timing of the boards can vary. Ultimately, the assembly and composition of each board must be approved by The Judge Advocate General of the Army (TJAG) before the board can convene. There was a ARNG JAGC accessions board that convened at the end of July 2022, which had a document submission deadline of July 17, 2022. The next ARNG JAGC accessions board did not convene until mid-January 2023. Applications to the ARNG JAGC are accepted on a rolling basis, but will only be reviewed once a board has been properly convened.

5. SGT Harrison did not complete the requirements for his accessions packet prior to the July 17, 2022 deadline for the July 2022 accessions board. Because his term of enlistment was set to expire on July 19, 2022, DCARNG offered and SGT Harrison accepted an extension of his term of service for six months. At his request, SGT Harrison was also given an accommodation that excused him from participating in scheduled military unit training

assemblies during his extension. The DCARNG received all of SGT Harrison's required documentation by November 6, 2022, and subsequently submitted to the National Guard Bureau for forwarding to the ARNG JAGC accessions board.

6. SGT Harrison's packet was considered by the January 2023 ARNG JAGC accessions board—the first board convened since the July 2022 board. The board recommended approval of his application for appointment as a JAG in the DCARNG. TJAG approved the board's recommendation on or around March 23, 2023, and SGT Harrison was informed of his selection to access as a Judge Advocate in the DCARNG on or around April 4, 2023. The DCARNG convened a Federal Recognition Board on May 23, 2023, and found that SGT Harrison met all the federal recognition requirements to be appointed as a First Lieutenant JAGC officer within the DCARNG. All documents have been submitted for processing and SGT Harrison is only awaiting orders to effectuate his appointment.

In accordance with 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct. Executed this 2nd day of June 2023.

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AMBER L. ELLISON
LTC, Air Defense Artillery
United States Army

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EXHIBIT 3

**IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
Alexandria Division**

NICHOLAS HARRISON, *et al.*,
Plaintiffs,
v.
MARK ESPER, Secretary of Defense,
et al.,
Defendants.

No. 1:18-cv-641 (LMB/IDD)

RICHARD ROE, *et al.*,
Plaintiffs,
v.
MARK ESPER, Secretary of Defense,
et al.,
Defendants.

No. 1:18-cv-1565 (LMB/IDD)

DECLARATION OF MAJOR SERENA STAPLES

I, Major Serena Staples, do hereby state and declare as follows:

1. I am an Active-Duty Army Public Health Nurse with a Master of Public Health and nationally certified in Public Health through the National Board of Public Health Examiners. I currently serve as the Health Promotion and Policy Officer for the Department of the Army, Deputy Chief of Staff, G-1, Army Resilience Directorate. I have been in the position since September 2022. As part of my duties, I am responsible for the oversight of Army Regulation 600-110: Identification, Surveillance, and Administration of Personnel Infected with Human Immunodeficiency Virus (AR 600-110), to include updating the regulation, and processing waivers to policies for the regulation.

2. Prior to my current position, I completed a fellowship with the Centers for Disease Control Headquarters in Atlanta, GA, served as a Public Health Nurse in Army medical centers, combat support hospitals/field hospitals, and remote deployments with Civil Affairs.

3. I submit this declaration in support of Defendants' opposition to Plaintiffs' motion to enforce the judgment and for an order show cause motion in the above-titled cases. I base this declaration upon my personal knowledge, as well as knowledge made available to me in the course of my official duties.

4. As the Army's Health Promotion and Policy Officer, I am familiar with the procedures by which the Army processes various personnel actions for individuals who have been infected with Human Immunodeficiency Virus (HIV). Since the June 6, 2022 memorandum outlining the change in DoD policy regarding "covered personnel" (the "covered personnel" policy), there is no categorical prohibition preventing deployment or appointment for commissioning of those Soldiers covered under the policy.

5. Current Department of Defense and Army regulations require such Soldiers to submit a waiver request. AR 600-110 is the governing regulatory guidance concerning HIV positive Soldiers in the Army. In its current form, AR 600-110 requires all HIV positive Soldiers to request a waiver of this regulation for transfer of Army Component, duty assignments over 30 days, any overseas assignment, or to commission as an Officer in the U.S Army. All requests to the waiver of requirements under this regulation must be approved by the Assistant Secretary of the Army (Manpower and Reserve Affairs) (ASA M&RA) for Reserve-Component Soldiers or Deputy Military Personnel Policy (DMPM) for Active-Duty Soldiers. The waiver requests include a justification providing an analysis of the expected benefits. Waivers are endorsed by the requesting Soldier's Commander or Senior Leader and forwarded through their higher headquarters to the Headquarters Department of the Army (HQDA), Deputy Chief of Staff, G-1, ARD policy proponent (my office). Since the June 6, 2022 memorandum outlining the change in DoD policy regarding "covered personnel," each waiver request has been processed consistent with the new "covered personnel" policy.

6. The processing of these waiver requests is also subject to Department of Defense Instruction (DoDI) 6490.07: Deployment-Limiting Medical Conditions for Service Members and DoD Civilian Employees, which expressly withholds the final approval authority to combatant commanders for any waiver requests to medical standards. Under DoDI 6490.07, the Combatant Command surgeon must be consulted prior to the granting of any waiver for the deployment of an HIV positive Soldier. Accordingly, any request for overseas deployments that are received by our office are still subject approval from the combatant commander or their delegee. Since the implementation of the “covered personnel” policy, our office has processed 9 waiver requests relevant to the above-titled case: 8 were for an Outside the Continental United States (OCONUS) deployment, temporary duty assignment, or permanent change of station (both from the reserve and active components) and 1 was for commissioning (this waiver and approval request was for SGT Nicholas Harrison). The only requested waiver that was ultimately denied was a request for deployment to the country of Kuwait; that denial was not made by the Army waiver authority, but rather by CENTCOM approval authority on the basis of country entry requirements.

7. The waiver request process takes approximately 90 days upon receipt of a completed waiver request packet by HQDA G-1 point of contacts. Waiver requests are processed for review by the Office of the Surgeon General and the Office of the Judge Advocate General before final review and action from the approval authority (ASA M&RA or DMPM as described in para. 4). Additional review and processing time is required for Soldiers requesting to switch between components (e.g., from Reserve to Active-Duty status).

In accordance with 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct. Executed this 2nd day of June 2023.

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SERENA K. STAPLES

MAJ, AN

United States Army

EXHIBIT 4

UNITED STATES DISTRICT COURT FOR THE EASTERN
DISTRICT OF VIRGINIA ALEXANDRIA DIVISION

NICHOLAS HARRISON, et al.,

Plaintiffs,

v.

LLOYD J. AUSTIN, Secretary of Defense, et al.,

Defendants.

Civil Action No. 1:18-cv-641 (LMB/IDD)

RICHARD ROE, et al.,

Plaintiffs,

v.

LLOYD J. AUSTIN, Secretary of Defense, et al.,

Defendants.

Civil Action No. 1:18-cv-1565 (LMB/IDD)

**DECLARATION OF CAPT KENNETH O BONAPARTE, USN IN SUPPORT OF
DEFENDANTS' OPPOSITION TO PLAINTIFFS' MOTION TO ENFORCE THE
INJUNCTION**

I, CAPT Kenneth O Bonaparte, do hereby declare as follows:

1. I currently serve as the Medical Waivers Division Head, Navy Recruiting Command.

I have held this position since June 2021. I act on behalf of Commander, Navy Recruiting Command. I am responsible for medical waiver recommendations for US Navy Enlisted and some Officer programs for the active and reserve force. I have previously served as board certified internal medicine physician, U.S. Navy, 2006 until present, Group Surgeon 3d Marine Logistics Group Okinawa 7/19-6/21, internal medicine physician Fort Belvoir hospital 10/15-6/19, Regimental/Group Surgeon 3d Marine Expeditionary Force Okinawa 9/12-9/15, internal

medicine physician, Naval hospital Okinawa 9/06-9/09.

2. In the exercise of my duties, I have been made aware of this motion to enforce the

revision of relevant Department of Defense policies to permit the commissioning of covered personnel with HIV.

5. As of June 1, 2023, and to the best of my knowledge, Navy Recruiting Command has received two applications from covered personnel requesting a commission via NROTC/in-service commissioning programs. Both of the applications were reviewed and both applicants were deemed to be medically cleared to commission.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge and belief.

EXECUTED this 1st day of June 2023, Millington, Tennessee.



KENNETH O. BONAPARTE

CAPTAIN, MC, U.S. Navy

EXHIBIT 5

**UNITED STATES DISTRICT COURT FOR THE EASTERN
DISTRICT OF VIRGINIA ALEXANDRIA DIVISION**

NICHOLAS HARRISON, et al.,

Plaintiffs,

v.

LLOYD J. AUSTIN, Secretary of Defense, et al.,

Defendants.

Civil Action No. 1:18-cv-641 (LMB/IDD)

RICHARD ROE, et al.,

Plaintiffs,

v.

LLOYD J. AUSTIN, Secretary of Defense, et al.,

Defendants.

Civil Action No. 1:18-cv-1565
(LMB/IDD)

**DECLARATION OF CAPT ANDREW HOUSE, JAGC, USN IN SUPPORT OF
DEFENDANTS' OPPOSITION TO PLAINTIFFS' MOTION TO ENFORCE THE
INJUNCTION**

I, CAPT Andrew R. House, JAGC, USN, do hereby declare as follows:

1. I currently serve as the Legal Advisor (Staff Judge Advocate) to the Superintendent of the U.S. Naval Academy. I have held this position since June 28, 2021. I provide legal advice, guidance, and support to the Superintendent of the Naval Academy and other Naval Academy senior leaders on a multitude of issues related to the execution of the Naval Academy's mission. I have previously served as a Legal Advisor (Staff Judge Advocate) to multiple senior Navy Commanders and their staffs.

2. In the exercise of my duties, I have been made aware of this motion to enforce the

injunction by counsel from the Office of the Judge Advocate General of the Navy, General Litigation Division.

3. I submit this declaration in support of Defendants' opposition to Plaintiffs' motion to enforce the judgment and for an order to show cause. I base this declaration on my personal knowledge and on information made available to me in the performance of my duties.

Commissioning of HIV Positive Midshipmen

4. On June 6, 2022, the Secretary of Defense issued a memorandum directing immediate revision of relevant Department of Defense policies to permit the commissioning of covered personnel with HIV. The U.S. Naval Academy adheres to this direction and the accession policy for Academy midshipmen seeking to commission thereby. Since June 6, 2022, there have been zero midshipmen seeking to commission under this policy.

5. However, prior to the issuance of the memorandum, on May 27, 2022, the U.S. Naval Academy received an exception to policy from the Under Secretary of Defense to allow an HIV-positive midshipman to commission upon graduation from the U.S. Naval Academy. As a result, this midshipman received his commission as an officer in the U.S. Navy. Since this date, no HIV-positive U.S. Naval Academy midshipmen have been denied a commission.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge and belief.

EXECUTED this 1st day of June 2023, Annapolis, Maryland.



ANDREW R. HOUSE
Captain
Judge Advocate General's Corps
U.S. Navy

EXHIBIT 6

**UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
ALEXANDRIA DIVISION**

NICHOLAS HARRISON, *et al.*,)
)
Plaintiffs,)

v.)

Civil Action No: 1:18-cv-641 (LMB/IDD)

LLOYD J. AUSTIN, in his official capacity)
as Secretary of Defense, *et al.*,)
)
Defendants.)

AND)

RICHARD ROE, et al.,)
)
Plaintiffs,)

v.)

Civil Action No: 1:18-cv-1565 (LMB/IDD)

LLOYD J. AUSTIN, in his official capacity)
as Secretary of Defense, *et al.*,)
)
Defendants.)

DECLARATION OF DOCTOR (LIEUTENANT COLONEL) JENNIFER STANGLE

I, Jennifer A. Stangle, declare and state as follows:

1. I am an active-duty Lieutenant Colonel (Lt Col) in the United States Air Force (USAF). I am also a licensed physician. I have been a member of the Department of the Air Force (DAF) since 2003, and a medical doctor since 2003. I have served in various roles while a USAF Service member, including clinical physician, medical director, associate professor, and board member of the Air Force Physical Evaluation Board (PEB).
2. My current role is Chief, Medical Retention Standards for the Air Force Personnel Center (AFPC). In this role I am responsible for the DAF branch charged with implementing USAF Surgeon

General policy on medical standards for continued active-duty service. The branch is the reviewing body for all active duty USAF and Space Force Review-in-Lieu-Of (RILO) Medical Evaluation Boards (MEBs), application and management of Assignment Limitation Code-Cs (ALC-Cs), approval of Airman Medical Transition Unit assignments, non-emergent surgery requests when in the final six months of service or undergoing Disability Evaluation System (DES) processing, and medical hold applications to retain a member on active duty beyond an approved date of separation or retirement for DES completion.

3. I am familiar with the general facts of the above-captioned case, and Department of Defense (DoD) and USAF policies for HIV positive Service members. I base this declaration upon my personal knowledge and information provided to me as part of my official duties.

4. To help manage medical conditions that require long-term medication, testing, and follow-up, the USAF uses Assignment Limitation Codes (ALCs). Accordingly, Service members with HIV receive an ALC. ALCs ensure appropriate higher-level review is given to the Service member's assignment. ALCs are designed to limit, not prevent, deployment and/or overseas assignments.

5. In accordance with DAF Manual (DAFMAN) 48-108, *Physical Evaluation Board Liaison Officer (PEBLO) Functions: Pre-Disability Evaluation System (DES) and Medical Evaluation Board (MEB) Processing*, 5 August 2021, the office of AFPC/DPMNR (formerly AFPC/DP2NP) retains sole authority to assign or remove the ALC on Active-Duty Service members. DPMNR assigns the appropriate ALC stratification code to the Service member based on risk and medical requirements. The ALC is valid indefinitely, and reviewed at least annually to renew the currency of the ALC, change to a different ALC, or remove the ALC. As described in DAFMAN 48-108, there are three levels of ALC stratifications.

6. Most service members who are HIV positive with an undetectable viral load receive an ALC stratification of C2. The C-code stratification is determined after an individualized review of the Service member's specific medical circumstances and the nature of medical care that will be

necessary. The C2 stratification is used for conditions in which specialized medical care and referral within one year is likely, but where the Service member could be deployed or reassigned outside the continental United States (OCONUS) or to non-fixed environments if appropriate specialty care is available or for short periods of time.

7. Service members may request a review of their ALC at any time. Moreover, Service members who receive an assignment and/or deployment to an overseas location will automatically have their case reviewed for a waiver of the ALC. The waiver process is described in DAFMAN 48-108. When a Service member receives an overseas assignment/deployment tasking, the member's home station Medical Treatment Facility (MTF) initiates the waiver process. The Service member's commander is not involved in the waiver process. In accordance with DAFMAN 48-108, paragraph 5.2.2, within 10 duty days of MTF notification of the Service member's assignment/deployment, the MTF forwards a waiver application to the waiver authority. The waiver review package contains various information, to include the most recent review-in-lieu of narrative, a current AF Form 469 that details all duty and deployment limitations, the most recent medical record entry that addresses the medical condition for which the Service member was issued an ALC, and a memorandum that includes information on the assignment. *See* DAFMAN 48-108, para. 5.2.1. The MTF may request an additional 10 duty days if additional testing or evaluation is required to fully assess the Service member's ability to meet the assignment requirements. If the primary care manager determines that the Service member's condition is of questionable stability, and requires a new specialty consult to assess the medical condition, the waiver package can be delayed up to 10 additional duty days before being submitted to the waiver authority, but only with the approval from the Chief of Medical Staff or the Chief of Aerospace Medicine. *See* DAFMAN 48-108, para. 5.2.2.1. The final waiver authority varies based on the specific ALC, pursuant to DAFMAN 48-108, paragraph 5.2.4. The deployment waiver authority generally rests with the gaining Geographic Combatant Command. *See* DAFMAN 48-108, para. 5.2.4.3. While the procedures outlined in this declaration are required by

USAF regulations, the decision to approve or disapprove medical waivers for deployment of individuals who are HIV-positive is made by the combatant commands, not the USAF.

8. In sum, no DAF Service member with an ALC is automatically determined to be non-deployable or ineligible for an overseas assignment. Rather, once the Service member receives a deployment and/or overseas assignment, the ALC triggers an individualized review of the Service member's medical condition and the medical resources available to the Service member at the gaining location. Service members who are HIV-positive are not non-deployable solely due to their HIV-positive status and are not disqualified for deployments based on such status, but rather undergo an individualized review to determine deployment eligibility. The substantive determination made for HIV-covered personnel under the Secretary of Defense's June 6, 2022 policy is made by the Geographic Combatant Command pursuant to DAFMAN 48-108 and this amended deployment guidance.

9. As the Chief of Medical Retention Standards, my branch holds the authority over all requests to commission a Service member with an ALC code and the application and management of ALC codes. Since June 6, 2022, we have received no waivers to commission by covered personnel with HIV under the Secretary of Defense's 2022 revised policy.

10. During that same period, based on information provided to me by the Air Force Medical Readiness Agency, there are 9 Service members who submitted 11 deployment waiver requests. Five waivers were approved; one waiver has not yet been submitted (the deployment requiring the waiver has already been assigned triggering the review); two waivers were not decided because the deployments were cancelled; one waiver was determined to be unnecessary for deployment under the applicable policy; and two waivers were denied, one for an unrelated medical disqualification and one based on host-country entry requirements.¹

¹ I am also aware that there are currently 21 additional Air Force Service Members with HIV who are stationed OCONUS. These positions are not considered deployments. I am not aware of whether there have been any other

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that to the best of my knowledge and belief the foregoing is true and correct.

Executed on June 2, 2023.

STANGLE.JENNIFER
.ANN. [REDACTED]

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Date: 2023.06.02 18:23:33 -05'00'

JENNIFER A. STANGLE, Lt Col, USAF, MC
Chief, Medical Retention Standards
AFPC/DPMNR
JBSA Randolph, TX

requests by Air Force Service Members with HIV to be assigned to non-deployment positions OCONUS since June 6, 2022.

EXHIBIT 7

**IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
Alexandria Division**

NICHOLAS HARRISON, et al.,)
)
Plaintiffs,)
)
v.)
)
LLOYD J. AUSTIN III, et al.,)
)
Defendants.)
)
_____)

No. 1:18-cv-641-LMB-IDD

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)
RICHARD ROE, et al.,)
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Plaintiffs,)
)
v.)
)
LLOYD J. AUSTIN III, et al.,)
)
Defendants.)
)
_____)

No. 1:18-cv-1565-LMB-IDD

**DECLARATION OF CAPTAIN MICHAEL T. CURR , USN IN SUPPORT OF
DEFENDANTS’ OPPOSITION TO PLAINTIFFS’ MOTION TO ENFORCE THE
INJUNCTION**

I, Captain Michael T. Curry, do hereby declare as follows:

1. I currently serve as the Director of the Enlisted Placement and Distribution Division, Navy Personnel Command. I have held this position since December 1, 2020. I act on behalf of the Chief of Naval Personnel. I am responsible for the assignment of Active Component and Training Active Reserve Enlisted Sailors throughout the Navy. I have previously served as

Helicopter Combat Support squadron EIGHT (HC-8) as a Detachment Maintenance Officer and subsequently served as the Maintenance Material Control Officer (MMCO). I then reported to the "FLEET ANGELS" of Helicopter Combat Support Squadron TWO (HC- 2) as the MMCO, Fleet Logistics Squadron FOUR ERO as a Detachment Maintenance Officer, USS CARL VINSON (CVN-70) as the Aircraft Intermediate Maintenance Department (AIMD) MMCO, and USS BATAAN (LHD-5) as the AIMD Maintenance Officer. Additionally, I have served as Naval Education and Training Command (N7) as the Training Project Coordinator; Naval Surface Forces, U.S. Atlantic Fleet as the Aviation Readiness Maintenance Officer; Center for Naval Aviation Technical Training Unit, Jacksonville FL, as the Executive Officer and Commanding Officer; and the U.S. Naval Air Forces as Project Training Coordinator for Carrier and Amphibious Operations. Again, I currently serve as the Director of Enlisted Distribution Division at Navy Personnel Command Millington, Tennessee.

2. In the exercise of my duties, counsel at the Office of the Judge Advocate General of the Navy, General Litigation Division made me aware of this motion to enforce the injunction.

3. I submit this declaration in support of Defendants' opposition to Plaintiffs' motion to enforce the judgment and for an order to show cause. I base this declaration on my personal knowledge and on information made available to me in the performance of my duties.

Navy Enlisted Detailing Process

4. Sailors negotiate for assignments via a detailing marketplace, known as MyNavy Assignment (MNA), which is a web-based process that is similar to Monster.com, USA Jobs, or other major advertising and hiring processes. MNA is a bi-monthly marketplace that consists of five phases: The first phase is the "scrub phase," which is used to review, prioritize, and advertise jobs. The second phase is the "application phase," where Sailors can review all

advertised jobs and submit up to seven applications. The third phase is the “command comment phase,” where the gaining command (the command advertising each assignment) will review resumes for applicants and rank the applicants. The commands also provide comments for consideration in the selection process. The fourth phase is the “selection phase,” where all of the prioritized jobs are reviewed and Sailors are selected for jobs. The fifth phase is the “results phase,” where the Sailors and gaining commands can see selections that were made in MNA. Certain assignments are identified as “priority jobs” and must be filled at the end of each cycle. Consequently, in the regular course of the assignment process, Sailors may be selected for positions for which they did not apply that fall into this priority category. Sailors may have up to three MNA cycles (two months per cycle) to negotiate for orders. No Sailor is entitled to any specific position and, as noted, Sailors are routinely assigned to positions for which they have not expressed any preference. Orders are assigned based on three factors, listed in order of importance: the needs of the Navy, career needs of the individual, and desires of the individual.

5. Sailors that require special consideration for distribution will have a flag on their record in the order writing system, known as the Enlisted Assignment Information System (EAIS). This flag enables either medical, legal, or policy staff to view the orders prior to releasing them to ensure that the area to which the Sailor is assigned can provide all required services for the Sailor and their family. These flags may include issues affecting overseas assignment and deployability, such as individual medical needs, exceptional family member medical needs, dual military co-location considerations, citizenship, legal considerations, or other policy-driven requirements that may impact the assignment process. In order to maintain medical privacy, Detailers are not made aware of the specific medical reasons that a Sailor may not be suitable for a position. Instead, such information is reviewed by the Deployability

Assignment and Assessment Office (hereafter “PERS-454”), including the Navy Blood Borne Pathogen Program Manager, who reviews all such orders for suitability.

6. PERS-454 involvement in the assignment process for Sailors with a blood borne pathogen begins when a Sailor’s orders appear in EAIS. In EAIS, Sailors with a blood borne pathogen are flagged in queue P203C1 and therefore are selected for review. For operational and overseas orders, PERS-454 further sends these cases to Navy Blood Borne Infection Management Center (NBIMC) for review of their medical record and decision. The NBIMC sends approval or disapproval recommendations back to PERS-454, who then approves or disapproves orders in EAIS. PERS-454 then contacts the commanding officer gaining the Sailor and informs them the Sailor has been screened and approved for orders in their command. If not approved for an assignment, and the sailor has questions about why they were not approved, the Sailor’s Detailer will refer the Sailor back to PERS-454. PERS-454 will explain the circumstances of denial because the Sailor’s Detailer will not be aware of the medical conditions affecting their assignment.

7. In practice, PERS-454 do not receive “requests to deploy”. Instead, they review Permanent Changes of Station (PCS) orders to ensure that they are in compliance with MILPERSMAN 1300-1300 (which governs the assignment process for sailors with a blood borne pathogen). This includes orders to operational platforms which may or may not deploy to any given area of responsibility (AOR). Moreover, these platforms may travel to various combatant command AOR in a single deployment, including Central Command (CENTCOM). When orders are in compliance with MIPERSMAN 1300-1300, PERS-454 sends them to the NBIMC Officer in Charge (OIC) for approval or disapproval based on their review of their medical record. Since June 6, 2022, PERS-454 has sent 68 sets of orders to NBIMC for review

(58 to operational platforms and 10 to overseas shore orders) and 58 have been approved. All 68 sets of orders were Sailors positive with HIV.¹ For the 10 sets of orders that were not approved, the following are the reasons: 1 set of orders is for a Sailor who passed away before NBIMC completed the review; 1 set of orders is for a Sailor who requested to stay on their current ship; 1 set of orders is for a case where the requested individual augment orders did not have a medical officer billet (this Sailor was subsequently detailed to an aircraft carrier); 2 sets of orders are due to Sailors being non-compliant with treatment; 3 sets of orders are due to poor viral control; 1 set of orders to Romania due to insufficient medical resources; and 1 set of orders to Italy, where duties included availability to operate in every nation within the CENTCOM AOR.

8. I understand that Plaintiffs' motion discusses a Sailor who applied to be a "defense courier." Defense courier duty is a general duty assignment, outside a Sailor's specific career path or "rate" (occupational specialty). A general duty assignment is one that can be filled by Sailors from any career field or rate. Every sailor has an assigned rate, and every rate has a defined career path demonstrating how to succeed and promote. In order to advance to a higher paygrade, enlisted sailors take an advancement exam, which tests them on sailor knowledge and knowledge from their occupational specialty. Sailors who fill jobs in-rate are getting on-the-job training and familiarization with the skills required by their rate. The mission of the defense courier is to "provide secure timely, and efficient end-to-end global distribution of classified and sensitive material for the United States and its allies." MILPERSMAN 1306-990. All personnel nominated to a defense courier station must meet additional requirements (such as no nonjudicial punishments within the last three years, etc.) and are medically screened as described in NAVMED P-117, Manual of the Medical Department (MANMED). This medical screening

¹ One other set of orders was considered for a different blood-borne illness.

process is not unique to defense couriers, but rather required for all sailors who are assigned to operational jobs or oversees duty stations. This screening is completed in order to ensure that the medical needs of the sailor can be met. In the case of sailors with HIV, PERS-454 additionally coordinates directly with the gaining commanding officer and, if applicable, the senior medical officer, in order to ensure those sailors will not be found medically unsuitable during the screening process after NBIMC has already screened the HIV status. Additionally, the defense courier billet located in Italy requires the Sailor assigned to have the ability to travel on limited notice to any nation within the CENTCOM AOR without restrictions.

Petty Officer Second Class PO2 C.J.²

9. Petty Officer Second Class C.J. is an active duty enlisted Sailor. PO2 C.J.'s previous duty assignment was onboard an aircraft carrier from [REDACTED]. His projected rotation date (PRD), the date he was scheduled to leave his position and transfer to another position, was [REDACTED]. Sailors assigned to a sea duty activity, such as onboard an aircraft carrier, regularly transfer to their subsequent assignment after their PRD if there will be a gap in staffing coverage onboard a sea duty unit. This is because sea duty typically has a higher staffing priority than shore duty. C.J. entered his order negotiation window in [REDACTED] and submitted a total of three applications, ranked in the following order: Naval Air Station (NAS) Sigonella, Italy, [REDACTED] [REDACTED]. All of the jobs were within the Sailor's skillset, and the only job with an additional specialized skillset requirement was at NAS Sigonella, which would have required the Sailor to attend Disaster Preparedness Operations and Training Specialist training.

² Through counsel I have been made aware of the identity of "Petty Officer C.J." and will refer to this Sailor by Plaintiff's chosen pseudonym.

10. On or about [REDACTED], PO2 C.J. tentatively received general duty orders as a defense courier based out of Sigonella. These orders are listed as overseas shore orders. Following the procedures described in paragraph 8, the PERS-454 Navy Blood Borne Pathogen Program Manager, LCDR Ryan Peterson, sent the orders to NBIMC for review. NBIMC replied and approved the orders on [REDACTED]. On [REDACTED], LCDR Peterson approved the orders in EAIS. LCDR Peterson then looked to obtain the gaining commanding officer's contact information for notification; however, while researching the job in an attempt to identify the commanding officer, LCDR Peterson learned that this job was for "Defense Courier Duty" and would require the Sailor to be able travel on short notice to any country within the CENTCOM AOR. Of concern, some host nation locations within the CENTCOM AOR have travel restrictions for individuals with HIV. <http://travel.state.gov>.

11. Between [REDACTED] and [REDACTED], LCDR Peterson contacted C.J.'s Detailer, and the Special Programs Detailer to verify whether courier duty would require travel within all of CENTCOM. The Detailer confirmed that the assignment would and, therefore, LCDR Peterson advised the Detailer that C.J. would not be able to travel throughout all of CENTCOM. The Detailer then said they would find C.J. another job. LCDR Peterson advised that if C.J. had any questions, they could be directed to him. Shortly thereafter, C.J. contacted LCDR Peterson by telephone asking about the courier position and decision. LCDR Peterson explained the unique requirements of that job, including the potential need to travel to any country at any time, and that some countries in the CENTCOM AOR had entry restrictions.

12. On [REDACTED], C.J. contacted LCDR Peterson by email asking if he would be willing to speak with Mr. [REDACTED] on [REDACTED] about the decision. C.J. told LCDR Peterson that Mr. [REDACTED] "will be talking on my behalf. He is the liaison for people in

my situation at [REDACTED].” LCDR Peterson told C.J. that he would be happy to speak with Mr. [REDACTED]. Neither Mr. [REDACTED] nor C.J. reached out to discuss the decision with LCDR Peterson further on or after [REDACTED].

13. C.J. reentered his order negotiation process and on [REDACTED], C.J. received orders to a job within his designated career field in [REDACTED]. C.J.’s orders were to depart his duty station on the aircraft carrier within the month of [REDACTED], and report to his new duty station no later than [REDACTED]. C.J. did not apply for the job he currently holds; instead, he was nominated by his Detailer. This job is appropriate for his skillset and future promotion opportunities and, unlike the courier position, is “in-rate” meaning it will expose C.J. to the daily knowledge necessary for him to make further advancements in paygrade via the Navy-wide advancement exam—an exam that tests a sailor’s knowledge, including job-specific knowledge required for his or her rate (occupational specialty).

14. C.J.’s counsel was told that the Navy would send a waiver request to CENTCOM should C.J. wish to be considered for the courier position based in Italy. However, notwithstanding this offer, C.J. did not contact his Detailers or request that a waiver be submitted.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge and belief.

EXECUTED this 2nd day of June 2023.

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CURRY.MICHAEL.TORON
ON [REDACTED]
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MICHAEL T. CURRY
Captain, U.S. Navy

EXHIBIT 8

**IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
Alexandria Division**

NICHOLAS HARRISON, et al.,)
)
Plaintiffs,)
)
v.)
)
LLOYD J. AUSTIN III, et al.,)
)
Defendants.)
)
_____)

No. 1:18-cv-641-LMB-IDD

RICHARD ROE, et al.,)
)
Plaintiffs,)
)
v.)
)
LLOYD J. AUSTIN III, et al.,)
)
Defendants.)
)
_____)

No. 1:18-cv-1565-LMB-IDD

DECLARATION OF DR. ANDRE B. HALL

I, Andrew B. Hall, declare under penalty of perjury under the laws of the United States that the following is true and correct:

1. I am a board-certified surgeon who received my medical training at Saint Louis School of Medicine and Keesler AFB s general surgery residency program.

2. Since May 2021, I have worked for USCENCOM s Command Surgeon s Office. In that role, I am primarily responsible for many initial medical waiver adjudications and all initial waiver appeals after being adjudicated by component command surgeon offices. The USCENCOM Individual Protection and Individual-Unit Deployment Policy MOD-15, MOD-16

(now MOD-17) had provisions designed to help determine the deployment eligibility of HIV positive service members.

3. I reviewed waivers based on MOD-15 and was a primary author of MODs-16 and 17. When the Secretary of Defense's June 6, 2022, guidance was published regarding HIV-positive servicemembers and their deployment eligibility, USCENTCOM published a night order (a night order is a supplementation to a standing order) shortly afterwards. Consistent with the June 6 Memo and the supplemental night order, USCENTCOM has individually considered and approved HIV waivers for deployment to the area of operations consistent with the change in policy. The DoD guidance concerning the deployability of asymptomatic, undetectable viral load HIV-positive service members as well as the need to consider host nation requirements was memorialized in MOD-17.

4. The deployability restrictions on HIV-positive service members were eliminated in MOD-17 due to the inclusion of DoD guidance. However, the laws of certain countries within the USCENTCOM area of operations impose restrictions relating to HIV, including restrictions related to whether individuals with HIV may enter the country. If an individual living with HIV seeks a waiver to deploy to the USCENTCOM area of operations, those host-country restrictions are taken into account. Such restrictions, however, are not present in all countries in the USCENTCOM area of operations. That is, there are some countries within USCENTCOM that do not have restrictions that would prohibit the entry of individuals living with HIV.

5. The process by which USCENTCOM reviews an HIV waiver consists of:
 - a. Submission to and review of a deployer's case summary by a deployer's component
 - b. Determination that a deployer meets criteria published by DoD guidance
 - c. Determination of the country restrictions regarding HIV through sources such as <https://travel.state.gov> and
 - d. If a deployer fulfills DoD HIV guidance, and a review of host-nation restrictions does not counsel against HIV-positive persons from deploying to the country, then USCENTCOM will approve the deployment waiver.
6. It typically takes the USCENTCOM surgeon office less than 1 business day to review and decide on any medical waiver, including HIV waivers.

Date

Signature

1 Jun 2023

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Date: 2023.06.01 09:32:43 -04'00'

EXHIBIT 9

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
Alexandria Division

NICHOLAS HARRISON, *et al.*,

Plaintiffs,

v.

MARK ESPER, Secretary of Defense,
et al.,

Defendants.

No. 1:18-cv-641 (LMB/IDD)

RICHARD ROE, *et al.*,

Plaintiffs,

v.

MARK ESPER, Secretary of Defense,
et al.,

Defendants.

No. 1:18-cv-1565 (LMB/IDD)

DECLARATION OF LIEUTENANT COLONEL [REDACTED]

I, Lieutenant Colonel [REDACTED], do hereby state and declare as follows:

1. I currently serve as the [REDACTED] Commander, in the [REDACTED] Army National Guard. I have served in this capacity since [REDACTED] 2021 and have served as a commissioned Army officer in the [REDACTED] since [REDACTED], 2001. Over the course of my career, I have served as platoon leader, company commander, battalion executive officer, the deputy chief of staff for [REDACTED] [REDACTED], and the Assistant Chief of Staff for the [REDACTED] Army National Guard. In my current position, I oversee the manning and operations of all Soldiers assigned to

the [REDACTED]. The [REDACTED] is composed of [REDACTED] [REDACTED] and its Headquarters company. Our higher command is the [REDACTED] which is a part of the [REDACTED] Army National Guard. [REDACTED] are currently deployed to the U.S. Central Command (CENTCOM) area of operations, although not every member of those companies participated in the deployment. [REDACTED] did not deploy on our current mission, additionally a Rear Detachment was established at home station to manage all Soldiers from the other [REDACTED] companies that did not deploy.

2. I submit this declaration in support of Defendants' opposition to Plaintiffs' motion to enforce the judgment and for an order to show cause in the above-titled cases. I base this declaration upon my personal knowledge, as well as knowledge made available to me in the course of my official duties.

3. The [REDACTED] was notified, through the official Notice of Sourcing, on [REDACTED] [REDACTED] 2021, of the upcoming deployment to CENTCOM. The purpose of the deployment is to [REDACTED] supporting Department of the Defense and Department of the Army assets throughout the area of operations as part of the [REDACTED] [REDACTED] Specifically, our Battalion would not all be co-located in any one location, but would be sending individuals to Kuwait, [REDACTED], Saudi Arabia, [REDACTED] [REDACTED] in support of that mission. All of those countries are located in the CENTCOM area of operations.

4. The vast majority of the [REDACTED] deployed in one major movement to [REDACTED] [REDACTED], on [REDACTED] This movement consisted of [REDACTED] [REDACTED] Soldiers. There were [REDACTED] additional Soldiers who were identified as late deployers and did not mobilize with the rest of the [REDACTED] at [REDACTED], including the Soldier identified in Plaintiff's motion as A.J. The purpose of the mobilization at [REDACTED] was to ensure all deploying Soldiers of the [REDACTED] met all requirements for the deployment and completed their required training. Instead of mobilizing through [REDACTED], the [REDACTED] individuals that

were identified as late deployers mobilized individually through the CONUS Replacement Center (CRC) located at [REDACTED] on [REDACTED].¹ There, those individuals completed all the same pre-deployment training requirements that the rest of the [REDACTED] completed at [REDACTED].

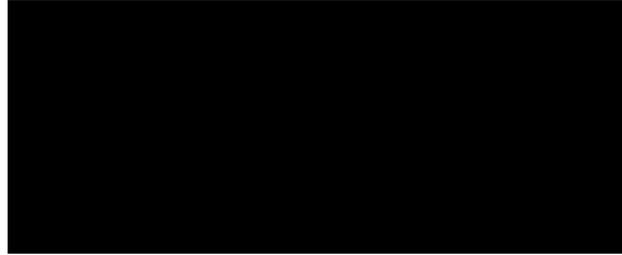
5. The unit deployed to the CENTCOM Area of Operations from [REDACTED] via government-chartered airline flights to Kuwait. These flights were on [REDACTED] and [REDACTED]. From Kuwait, members of the [REDACTED] dispersed to the various countries within CENTCOM. All individually mobilizing Soldiers deployed to CENTCOM directly from the [REDACTED]. The Soldier identified as A.J. left [REDACTED] and arrived in Saudi Arabia on [REDACTED]. The last of the late deployer Soldiers arrived in theater on [REDACTED]. There are no appreciable differences or impacts on the late deploying Soldiers and the rest of the [REDACTED]. Given the nature of the National Guard structure, having individuals deploy outside of the major unit movement is extremely common and there are no negative impacts or implications based on being an individually mobilized Soldier.

6. Throughout the Battalion, we had [REDACTED] Soldiers out of [REDACTED] [REDACTED] deploy. There were [REDACTED] Soldiers who did not deploy for a variety of reasons that included medical disqualifications or unresolvable family hardships.

While we encourage all our Soldiers to deploy when given the opportunity, Soldiers can and do have successful careers in the [REDACTED] Army National Guard without ever deploying. In other words, serving without a deployment does not have a negative impact or influence on a Soldier's career within the [REDACTED] Army National Guard. In fact, given the drawdown in recent years in Afghanistan and Iraq, it is becoming increasingly more common that Soldiers within our formations have not deployed.

¹ Individually mobilizing Soldiers, i.e. Soldiers mobilizing outside a major unit mobilization, are required by policy to mobilize through the [REDACTED].

In accordance with 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct. Executed this 2nd day of June 2023.



United States Army

EXHIBIT 10

UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
ALEXANDRIA DIVISION

NICHOLAS HARRISON, *et al.*,)
)
Plaintiffs,)

v.)

Civil Action No: 1:18-cv-641 (LMB/IDD)

LLOYD J. AUSTIN, in his official capacity)
as Secretary of Defense, *et al.*,)
)
Defendants.)

AND)

RICHARD ROE, *et al.*,)
)
Plaintiffs,)

v.)

Civil Action No: 1:18-cv-1565 (LMB/IDD)

LLOYD J. AUSTIN, in his official capacity)
as Secretary of Defense, *et al.*,)
)
Defendants.)

DECLARATION OF MASTER SERGEANT [REDACTED]

I, [REDACTED] declare and state as follows:

1. I am an active-duty Master Sergeant in the United States Air Force (USAF), and I have been a member of the Department of the Air Force (DAF) since [REDACTED]. During my time in the USAF, I have served in various roles, including Unit Deployment Manager, [REDACTED] and Acting First Sergeant, [REDACTED].

2. My current role is as the First Sergeant for the [REDACTED]. As the First Sergeant I am the unit focal point for all readiness, health, morale, welfare and quality of life issues. My primary responsibility is to build and maintain a mission-ready force. A First Sergeant also serves as a key advisor to the commander on matters relating to health, morale,

welfare, safety, legal, personnel, administrative issues and a variety of other issues. A First Sergeant works directly for and derives authority from the commander and serves a critical link for the commander within the unit.

3. I am familiar with the facts of this case and am aware that Richard Roe is currently serving in the [REDACTED]. There has not been a Service member tasked to deploy with HIV in the [REDACTED]. There also has not been a Service member who has volunteered or requested to be deployed out of the [REDACTED] with HIV. As the First Sergeant for the [REDACTED] I am familiar with the process by which members of our unit are selected for deployments. [REDACTED] currently has [REDACTED] military members assigned, [REDACTED] of whom are currently deployed in various locations across the world. Generally, when [REDACTED] receives a deployment tasking, the Group Unit Deployment Manager (UDM) sends the tasking information to the Senior Enlisted Leaders (SELs) in each squadron. Tasking information includes basic details about the assignment, such as the length of the deployment, location, required pre-deployment training, and any specific requirements for that assignment. Tasking specific requirements may include a particular grade, Air Force Specialty Code (AFSC), or skill level. Some deployments require specific AFSC or skill levels; others are open to all AFSCs and skill levels.

4. The SELs vet the information and provide the tasking information to their Flight Chiefs. Flight Chiefs then discuss the possible deployment with individual members. No Service members are excluded from the possibility of deploying based on an Assignment Limitation Code (ALC), Assignment Availability Code (AAC), or Deployment Availability Code (DAV). [REDACTED] generally does not have to require members to deploy as enough Service members volunteer. [REDACTED] has not received any requests to deploy or volunteers for deployment from any individuals who are HIV positive. After discussing with interested Service members, the Flight Chief does an initial check for restrictions that may prevent a Service member from deploying. Restrictions generally fall into two categories: mobility restrictions and duty limitations.

5. Duty limitations affect the amount or type of work an individual Service member can perform (e.g. no running, no lifting heavy objects, etc.). They do not automatically prevent a Service member from

deploying. If the duty limitation would prevent the Service member from performing the required tasks on the deployment, the Service member could work with their Primary Care Manager (PCM) to determine if the duty limits can be revised to allow them to fill the deployment tasking.

6. Mobility restrictions could prevent a Service member from deploying. They are typically related to medical reasons. Having a mobility restriction does not automatically make a Service member ineligible for a deployment. If a Service member with a mobility restriction is tasked to deploy or desires to volunteer for a deployment, they work with their PCM and any specialty medical providers for a waiver of the restriction before they would be set against the tasking.

7. The Flight Chiefs compile a list of interested Service members who meet the requirement for the deployment tasking, and provide this information to the SEL. The SEL works with the squadron commander to determine the Service member who will be tasked to deploy. The squadron command team considers many things before the commander makes a decision, including the Service member's deployment tempo band, which is their scheduled six-month window of vulnerability to deploy out of a twenty-four month cycle; the Service member's deployment history; the length of time since the Service member's last deployment; the nature of the deployment tasking; current manning levels at [REDACTED] the Service member's desires; impacts on unit cohesion, morale, and discipline; and mission accomplishment. Once a decision is made, the SEL sends the information to the UDM. The UDM confirms the member is not subject to a mobility restriction and sends the tasking up through the chain of command.

8. Sometimes Service members encounter medical issues after being selected, but before they are deployed (e.g. injured in training, discovery of a previously unknown medical condition, etc.). If so, a replacement from the previously compiled list of Service members is selected by the commander to fill the tasking unless a waiver of the restriction is approved

EXHIBIT 11

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
Alexandria Division

NICHOLAS HARRISON, *et al.*,

Plaintiffs,

v.

MARK ESPER, Secretary of Defense,
et al.,

Defendants.

No. 1:18-cv-641 (LMB/IDD)

RICHARD ROE, *et al.*,

Plaintiffs,

v.

MARK ESPER, Secretary of Defense,
et al.,

Defendants.

No. 1:18-cv-1565 (LMB/IDD)

DECLARATION OF LIEUTENANT COLONEL [REDACTED]

I, Lieutenant Colonel [REDACTED], do hereby state and declare as follows:

1. I currently serve as the field grade career manager for [REDACTED]

[REDACTED]

[REDACTED] I have served in this capacity since June 2021 and have been an [REDACTED] and commissioned officer in the [REDACTED] since 2006. Over the course of my career, I have served in a variety of [REDACTED] roles within Army

[REDACTED]

[REDACTED]

Department. Prior to my current assignment, I served as the [REDACTED] Program Director for the enlisted [REDACTED] [REDACTED]. In this role, I was responsible for curriculum development and trained entry level Soldiers and Airmen to be [REDACTED]. In my current position as career manager, I advise Army [REDACTED] on a variety of matters pertaining to professional development and career progression which includes enrolling officers in professional military education courses and schools, generating request for assignment orders, performing record scrubs and file updates, and assisting officers to navigate and compete for future assignments in the Assignment Interactive Module (AIM2) Marketplace.

2. In the exercise of my official duties, I have been made aware of this lawsuit by counsel from the Army Office of General Counsel. I am aware that the individual identified by Plaintiffs in their motion as B.J. is [REDACTED] [REDACTED]

3. I submit this declaration in support of Defendants' opposition to Plaintiffs' motion to enforce judgment and for an order to show cause motion in the above-titled cases. I base this declaration upon my personal knowledge, as well as knowledge made available to me in the course of my official duties.

Career progression of [REDACTED]

4. The Army utilizes [REDACTED] throughout its formation to drive [REDACTED] [REDACTED]. Currently, there are approximately [REDACTED] serving on Active Duty. The [REDACTED] [REDACTED] billets are considered non-deployable because the officers are providing [REDACTED] [REDACTED] Assignment to a deployable unit within the [REDACTED] community is not required. Indeed, [REDACTED]

[REDACTED] within Army Forces Command (FORSCOM) units¹ [REDACTED]. By way of example, I have spent 16 years as an Army [REDACTED], have been promoted through the ranks to Lieutenant Colonel, and [REDACTED]

5. Projecting out to October 2023, only about [REDACTED] [REDACTED] Despite being assigned to operational units it [REDACTED] [REDACTED] I am aware of only [REDACTED] currently serving on active duty that have deployed to a combat theater or in support of combat operations. Of these, the majority were not deployed as [REDACTED] and instead were utilized in another capacity outside of their primary area of concentrations (AOC).

6. The typical assignment pattern for [REDACTED] is to serve at a [REDACTED] [REDACTED] where they operate under the guidance of a more experienced practitioner and complete the requirements necessary for [REDACTED]. Additionally, an [REDACTED] assignment provides opportunities for the [REDACTED] to work in all aspects of [REDACTED] [REDACTED] [REDACTED], thus preparing the officer to advance to higher level leadership positions. By contrast, [REDACTED] [REDACTED] of Army policy and programs as well as [REDACTED]. These [REDACTED] must be able to operate independently and as a result, these positions tend to be filled by individuals with at least [REDACTED].

Ar Assi n en C le

7. Army dietitians are matched to assignments through participation in the Assignment

¹ FORSCOM is the largest United States Army command and provider of expeditionary, regionally engaged, campaign-capable land forces to combatant commanders. *ee* <https://www.army.mil/forscom> org-about. For [REDACTED] [REDACTED]

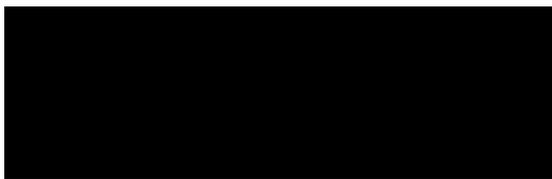
Interactive Module (AIM2) marketplace. Assignment Market places are built to allow officers the widest choice and preference of assignments consistent with Army readiness requirements. Officers can view and rank all available positions in their marketplace. Officers are instructed to preference deep, meaning they should rank all assignments in their marketplace. Units can see when an officer has ranked them in the top 3 or 10 (whichever is greater) of assignments and view the officer's AIM resume before submitting their final preferences. After the marketplace closes, the career manager runs the Army Talent Alignment Algorithm (ATAA), a mathematical algorithm that matches the Soldier to an assignment based on officer and unit preferences, to generate an initial assignment slate. The slate is then reviewed for accuracy and assignment considerations. Any deviations to the ATAA require justification and Director level approval.

8. Medical Readiness Codes (MRC) do not play a significant role in the initial matching or slating of officers with units. If an officer, who for example has a medical readiness code indicating they are non-deployable, is matched with a FORSCOM unit, the career manager will staff the assignment action to the appropriate higher level approval authority and/or process any applicable waivers.

9. The individual referred to as B.J. in the Plaintiff's May 3, 2023, motion participated in the [REDACTED] AIM2 assignment marketplace in the [REDACTED] for reassignment between [REDACTED] [REDACTED]. He ranked a total of 47 assignments, including FORSCOM units, and was matched with his number two preferred assignment. He was not matched to his first-choice assignment, a non-deployable position, because it had a higher market match to another officer (1:1). His top-6 preferred assignments were all [REDACTED] assignments. There was no consideration of B.J.'s MRC as part of this assignment process. Any waiver requests would have been processed had B.J. been in fact matched with a FORSCOM unit. Given his match with a [REDACTED] unit, which he had preferred over any FORSCOM unit, there was no need for any waiver processing.

In accordance with 28 U.S.C. § 1746, I declare under penalty of perjury that the

foregoing is true and correct. Executed this 1st day of June 2023.



LTC, SP

United States Army