This form must be completed electronically when possible. Handwritten forms will be accepted.

EBOLA VIRUS DISEASE REDEPLOYMENT RISK ASSESSMENT AND MEDICAL CLEARANCE

OMB No. 0720-
OMB approval expires

PRIVACY ACT STATEMENT

This statement serves to inform you of the purpose for collecting the personal information requested by this form and how it may be used.

AUTHORITY: 10 U.S.C. 1074f, Medical Tracking System for Members Deployed Overseas; 42 U.S.C. 264-272, Quarantine and Inspection, Executive Order 13295, Revised List of Quarantinable Communicable Diseases; 42 CFR Part 70, Interstate Quarantine; 42 CFR Part 71, Foreign Quarantine; DoDI 6490.03, Deployment Health; and E.O. 9397 (SSN), as amended.

PRINCIPAL PURPOSE(S): Your information may be used for the purpose of collecting certain communicable disease(s) data IAW regulations providing for the apprehension, detention, or conditional release of individuals to prevent the introduction, transmission, or spread of suspected communicable diseases, pursuant to section 361(b) of the Public Health Service Act. Your information will be collected in order to identify any health concerns and, if necessary, refer you for additional assessment and/or care.

ROUTINE USE(S): Use and disclosure of your records outside of DoD may occur in accordance with the DoD Blanket Routine Uses published at: http://dpclo.defense.gov/privacy/SORNsIndex/BlanketRoutineUses.aspx and as permitted by the Privacy Act of 1974, as amended (5 U.S.C. 552a(b)).

Any protected health information (PHI) in your records may be used and disclosed generally as permitted by the HIPAA Privacy Rule (45 CFR Parts 160 and 164), as implemented within DoD. Permitted uses and disclosures of PHI include, but are not limited to, treatment, payment, healthcare operations, and the containment of certain communicable diseases.

DISCLOSURE: Mandatory. To protect the health of the public from Ebola, a highly infectious virus of significant public health threat, you are hereby required to provide the requested information. Care will not be denied if you decline to provide the requested information, but you may not receive the care you deserve and may face administrative delays.

INSTRUCTIONS: **All DoD personnel are required to complete this form within 12 hours prior to departure from an Ebola outbreak country or region.** You are required to truthfully answer all questions. Failure to disclose the requested medical information regarding potention EVD contact or exposure risk while deployed to an Ebola outbreak area may result in UCMJ and/or criminal punishment. If you do not understand a question, please discuss the question with a healthcare provider.

DEMOGRAPHICS

Last Name: _____ **First Name:** _____ **Middle Initial:** _____

Social Security Number: _____ **Today's Date (dd/mmm/yyyy):** _____

Date of Birth (dd/mmm/yyyy): _____ **Gender:** ◯ Male ◯ Female

Service Branch:
- ◯ Air Force
- ◯ Army
- ◯ Navy
- ◯ Marine Corps
- ◯ Coast Guard
- ◯ Civilian Expeditionary Workforce
- ◯ USPHS
- ◯ Other Defense Agency (List): _____
- ◯ Other (List): _____

Component:
- ◯ Active Duty
- ◯ National Guard
- ◯ Reserves
- ◯ Civilian Government Employee
- ◯ Contractor

Pay Grade:

◯ E1	◯ O1	◯ W1
◯ E2	◯ O2	◯ W2
◯ E3	◯ O3	◯ W3
◯ E4	◯ O4	◯ W4
◯ E5	◯ O5	◯ W5
◯ E6	◯ O6	
◯ E7	◯ O7	
◯ E8	◯ O8	◯ Other
◯ E9	◯ O9	
	◯ O10	

Home Station/Unit: _____

Current Contact Information:

Phone: _____

Cell: _____

DSN: _____

Email: _____

Address: _____

Point of contact who can always reach you:

Name: _____

Phone: _____

Email: _____

Address: _____

Deployment location(s): ◯ Liberia ◯ Sierra Leone ◯ Guinea ◯ Senegal ◯ Nigeria ◯ Other: _____

Deployed Station/Unit: _____ **Duties while deployed:**

Theater departure location (airport): _____

EBOLA VIRUS DISEASE REDEPLOYMENT RISK ASSESSMENT AND MEDICAL CLEARANCE

Deployer's SSN (Last 4 digits): _____

PART I: Individual Ebola Virus Disease Exposure Questionnaire
[To be completed by all redeploying DoD personnel.]

	Please respond "Yes", "No", or "Don't Know" to all questions below.	Yes	No	Don't Know
1.	Over the past 21 days were you deployed to an area known or suspected of having and Ebola Virus Disease outbreak?	◯	◯	◯
2.	Over the past 21 days were you in contact with someone known or suspected of having Ebola Virus Disease?	◯	◯	◯
3.	Over the past 21 days did you have contact with, or exposure to, the blood or body fluids (e.g., vomit, diarrhea, saliva), of someone known or suspected of having Ebola Virus Disease?	◯	◯	◯
4.	Over the past 21 days did you handle any items that may have come in contact with an infected person's blood or body fluids?	◯	◯	◯
5.	Over the past 21 days did you touch the body or bodies of people who died from Ebola Virus Disease?	◯	◯	◯
6.	Over the past 21 days did you attend a funeral or burial ritual that required touching the body of someone who died from Ebola Virus Disease?	◯	◯	◯
7.	Over the past 21 days did you have contact with bats, nonhuman primates, blood fluids, or raw meat prepared from these animals?	◯	◯	◯
8.	Over the past 21 days were you in or assigned to a hospital where Ebola Virus Disease patients were being treated?	◯	◯	◯
9.	While deployed did you evaluate or treat patients known or suspected of having Ebola Virus Disease?	◯	◯	◯
10.	While deployed did your duties require the use of personal protective equipment [PPE] for the purpose of protecting against Ebola Virus Disease?	◯	◯	◯
11.	Are you a pilot or flight crew member traveling from an Ebola endemic area?	◯	◯	◯
12.	Are you a pilot or flight crew member involved in the transport of known or suspected Ebola Virus Disease patients from a country or region currently experiencing an Ebola outbreak?	◯	◯	◯
13.	**If "Yes" to any of the above questions, please explain. Please be sure to detail date of last possible exposure.**			

EBOLA VIRUS DISEASE REDEPLOYMENT RISK ASSESSMENT AND MEDICAL CLEARANCE

Deployer's SSN (Last 4 digits): _____

COMPLETED BY DESIGNATED MEDICAL PROVIDER ONLY – Provider Review, Interview, Assessment and Medical Clearance Recommendations

PART II-A: Ebola Virus Disease Clinical Evaluation [Mark all that apply.]

		Yes	No
1.	**Ask "Are you currently experiencing any of the following signs and symptoms?"**		
	a. Fever (temperature of >100.4°F) ◯ **Don't Know**	◯	◯
	b. Subjective fever (e.g., chills, night sweats)	◯	◯
	c. Severe headache	◯	◯
	d. Joint and muscle aches	◯	◯
	e. Abdominal/stomach pain	◯	◯
	f. Vomiting	◯	◯
	g. Diarrhea	◯	◯
	h. Unexplained bruising or bleeding	◯	◯
	i. New skin rash	◯	◯
	j. Other	◯	◯
2.	**Ask "Have you taken any fever reducing medications within the past twelve [12] hours?"** (e.g., aspirin, Tylenol, Motrin, Ibuprofen)	◯	◯
3.	**Conduct and record temperature check.** Temperature: _____ Time: _____		
4.	**Date and time of onset of symptoms** Date (dd/mmm/yyyy): _____ Time: _____ ◯ N/A		
5.	**Comments:**		

EBOLA VIRUS DISEASE REDEPLOYMENT RISK ASSESSMENT AND MEDICAL CLEARANCE

Deployer's SSN (Last 4 digits): _____

PART II-B: Ebola Virus Disease Risk Assessment [Mark all that apply. If "Yes" document date, time & type of MOST recent exposure.]

	SOME RISK OF EXPOSURE: One or more of the following within the past 21 days.	Yes	No
1.	**Close contact with an Ebola Virus Disease (EVD) patient in any of the following settings: household, living quarters, workplace, or community? If yes, document date, time and type of contact and/or exposure.** Date (dd/mmm/yyyy): _____ Time: _____ Type: _____ **Close contact is defined as:** a. Being within approximately 3 feet (1 meter) of an EVD patient for a prolonged period of time while not wearing recommended personal protective equipment (PPE) or PPE was compromised. b. Having direct brief contact (e.g., shaking hands) with an EVD patient while not wearing recommended personal protective equipment (PPE) or PPE was compromised. **(Brief interactions, such as walking by a person, do not constitute close contact.)**	◯	◯
2.	**Other close contact with EVD patients in healthcare facilities? If yes, document date, time and type of contact and/or exposure.** Date (dd/mmm/yyyy): _____ Time: _____ Type: _____ **Close contact is defined as:** c. Being within approximately 3 feet (1 meter) of an EVD patient or within the patient's room or care area for a prolonged period of time (e.g., health care personnel, household members) while not wearing recommended personal protective equipment (PPE) (standard droplet and contact precautions) or PPE was compromised. d. Having direct brief contact (e.g., shaking hands) with an EVD patient while not wearing recommended personal protective equipment (PPE) or PPE was compromised. **(Brief interactions, such as walking by a person or moving through a hospital, do not constitute close contact.)**	◯	◯
	HIGH RISK OF EXPOSURE: One or more of the following within the past 21 days.	**Yes**	**No**
3.	**Percutaneous (e.g., needle stick) or mucous membrane exposure to blood or body fluids of an EVD patient? If yes, document date, time and type of contact and/or exposure.** Date (dd/mmm/yyyy): _____ Time: _____ Type: _____	◯	◯
4.	**Direct skin contact with, or exposed to, blood or body fluids of an EVD patient without appropriate personal protective equipment (PPE) or PPE was compromised? If yes, document date, time and type of contact and/or exposure.** Date (dd/mmm/yyyy): _____ Time: _____ Type: _____	◯	◯
5.	**Processing blood or body fluids of a confirmed EVD patient without appropriate personal protective equipment (PPE), standard biosafety precautions, or PPE was compromised? If yes, document date, time and type of contact and/or exposure.** Date (dd/mmm/yyyy): _____ Time: _____ Type: _____	◯	◯
6.	**Direct contact with a dead body without appropriate personal protective equipment (PPE), or PPE was compromised in a country where an EVD outbreak is occurring? If yes, document date, time and type of contact and/or exposure.** Date (dd/mmm/yyyy): _____ Time: _____ Type: _____	◯	◯

EBOLA VIRUS DISEASE REDEPLOYMENT RISK ASSESSMENT AND MEDICAL CLEARANCE

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PART II-C: EBOLA VIRUS DISEASE RISK CATEGORY [Mark ONLY one.]

Disposition Guidance: Document patient's risk category in the individual's medical record.

◯ **No Known Exposure**	**Asymptomatic:** • Trained personnel at home station must perform twice daily face-to-face review of symptoms and temperature check for 21 days. • Upon return to home station, leave or TDY/TAD is NOT authorized outside the local area during the 21 day monitoring period. **Symptomatic: (Fever WITH or WITHOUT other symptoms)** • Evaluation by medical authorities. • Implement infection control precautions.
◯ **Some Risk of Exposure** **("Yes" to questions 1 or 2, PART II-B)**	**Asymptomatic:** • Evaluation by medical authorities. • Transfer to a DoD designated facility to monitor for signs and symptoms of EVD for 21 days IAW official policy. **Symptomatic: (Fever or other symptoms)** • Evaluation by medical authorities. • **Isolate and separate from "High Risk" individuals**. Implement infection control precautions. • **Transfer via regulated movement** to a DoD designated **medical** facility capable of providing care for EVD patients IAW official policy.
◯ **High Risk Exposure** **("Yes" to questions 3, 4, 5, or 6, PART II-B)**	**Asymptomatic:** • Evaluation by medical authorities. • **Transfer via regulated movement** to a DoD designated **medical** facility capable of monitoring for signs and symptoms and/or providing care for EVD patients IAW official policy. **Symptomatic: (Fever or other symptoms)** • Evaluation by medical authorities. • **Isolate and separate from "Some Risk" individuals.** Implement infection control precautions. • **Transfer via regulated movement** to a DoD designated **medical** facility capable of providing care for EVD patients IAW official policy.

Medical Disposition	**Patient is cleared to travel.**	**Patient is NOT cleared to travel. Requires further medical evaluation.**	**Patient must be transferred via regulated movement.**
	◯	◯	◯

Provider's Name: _____ **Date (dd/mmm/yyyy):** _____ **Time:** _____

Title: ◯ MD ◯ DO ◯ PA ◯ Nurse Practitioner ◯ Adv Practice Nurse ◯ Other: _____

◯ **I certify this assessment process has been completed. Provider's Signature:** _____