

Army Regulation 40-5

Medical Services

Preventive Medicine

**Headquarters
Department of the Army
Washington, DC
25 May 2007**

UNCLASSIFIED

SUMMARY of CHANGE

AR 40-5
Preventive Medicine

This rapid action revision, dated 25 May 2007--

- o Includes the definition of "deployment" from Joint Publication 1-02 and Department of Defense Instruction 6490.03 (para 1-5d).
- o Introduces the 10 essential national public health services established by the American Public Health Association (para 1-6d).
- o Establishes acquired immunodeficiency syndrome as a specific disease of military concern, separate from a sexually transmitted disease (para 1-7a(2)).
- o Clarifies responsibilities of The Surgeon General with respect to developing medical criteria for exposure to chemical/biological/radiological/nuclear warfare agents (para 2-8b).
- o Emphasizes the role of military audiologists as the managers of installation hearing clinical and conservation services (para 2-18j).
- o Incorporates the change in name of the U.S. Army Safety Center to the U.S. Army Combat Readiness Center (para 2-19b(2)).
- o Updates the mission parameters of the Department of Defense Serum Repository (para 2-19m).
- o Adds new responsibility paragraph for the Commander, U.S. Army Medical Research and Materiel Command (para 2-24).
- o Adds the following new related publications: Department of Defense Directive 5400.11 (para 2-19m), Department of Defense Regulation 4500.9-R (para 2-19x), Department of Defense Directive 5134.8 (app A, sec II), and an Institute of Medicine Report entitled Noise and Military Service: Implications for Hearing Loss and Tinnitus (app A, sec II).
- o Adds definitions to the glossary for the following terms: direct reporting unit; garrison; and hearing readiness, clinical, operational, and conservation services (glossary, sec II).
- o Changes "operational risk management" to "composite risk management" (throughout).
- o Incorporates the name changes for Army commands, Army service component commands, and direct reporting units (throughout).

- o Incorporates changes in acronyms and capitalization of words based on guidance from the U.S. Army Records Management and Declassification Agency (throughout).

This regulation is a comprehensive and substantive revision of the 1990 policy and responsibilities relating to preventive medicine. Specifically, this major revision, dated 22 July 2005--

- o Redefines preventive medicine and preventive medicine services (chap 1, section II).
- o Requires the incorporation of health threats into the Army's operational risk management process (chap 1, para 1-5e).
- o Revises the list of the preventive medicine components of the Army Occupational Health Program (chap 1, para 1-7d).
- o Incorporates the concepts of the Joint Staff's Force Health Protection strategy (chaps 1 and 2).
- o Adds medical surveillance and occupational and environmental health and exposure surveillance policies and responsibilities (chaps 1 and 2).
- o Incorporates measures to decrease the risk and improve the management of communicable disease outbreak on an installation (chaps 1 and 2).
- o Implements Department of Defense Directive 6490.2 and Department of Defense Instruction 6490.3 policy and procedures for medical surveillance (chaps 1 and 2).
- o Implements Department of Defense Instruction 6055.1 policy and procedures for ergonomics (chaps 1 and 2).
- o Requires the addition of programs and services for vision conservation and readiness, deployment occupational and environmental health threat management, health risk assessment, medical and occupational and environmental health surveillance, surety programs, ergonomics, population health management, and health risk communication (chaps 1 and 2).
- o Redefines responsibilities for preventive medicine programs and services (chap 2).
- o Adds additional Army Secretariat and Army Staff responsibilities (chap 2).
- o Incorporates the U.S. Army Medical Department Functional Proponent for Preventive Medicine and the Proponency Office for Preventive Medicine (chap 2, para 2-8b).
- o Requires the use of the Reportable Medical Events System (chap 2).

- Identifies responsibilities for commanders of regional medical commands (chap 2).
- Provides guidance and responsibilities for using the Defense Health Program activity structure and codes for preventive medicine budget execution tracking and program analysis and review (chap 2).
- Establishes an installation-level ergonomics subcommittee and a vision conservation and readiness team (chap 2).
- Rescinds Requirement Control Symbol, Medical-3 (RCS MED-3) command health report requirement, DA Form 3075 (Occupational Health Daily Log), and DA Form 3076 (Army Occupational Health Report (RCS MED-20)).
- No longer prescribes DD Form 2215 (Reference Audiogram) and DD Form 2216 (Hearing Conservation Data), which are now prescribed by Department of the Army Pamphlet 40-501.
- No longer prescribes DD Form 2493-1 (Asbestos Exposure, Part I-Initial Medical Questionnaire) and DD Form 2493-2 (Asbestos Exposure, Part II-Periodic Medical Questionnaire), which are now prescribed by Department of the Army Pamphlet 40-11.
- No longer prescribes DA Form 3897-R (Tuberculosis Registry), which is now prescribed by Department of the Army Pamphlet 40-11.
- No longer prescribes DA Form 5402-R (Barber/Beauty Shop Inspection), which is now prescribed by Department of the Army Pamphlet 40-11.
- Eliminates the term "installation medical authority" and replaces it with "medical commander" throughout this regulation.
- Removes detailed roles, functions, procedural guidance, and technical standards and criteria throughout this regulation for inclusion in other appropriate Army publications.

Effective 25 June 2007


Medical Services

Preventive Medicine

By Order of the Secretary of the Army:

GEORGE W. CASEY, JR.
General, United States Army
Chief of Staff

Official:


JOYCE E. MORROW
Administrative Assistant to the
Secretary of the Army

History. This publication is a rapid action revision. The portions affected by this rapid action revision are highlighted in the Summary of Change.

Summary. This regulation establishes practical measures for the preservation and promotion of health and the prevention of disease and injury. This regulation implements Executive Order 12196; Department of Defense 1400.25–M; Department of Defense 6055.5–M; Department of Defense Directives 1000.3, 1010.10, 4715.1, 6000.12, 6050.16, and 6490.2; Department of Defense Instructions 1322.24, 4150.7, 6050.5, 6055.1, 6055.5, 6055.7, 6055.8, 6055.11, 6055.12, 6060.2, 6060.3, 6205.2, 6205.4, and 6490.3, and Presidential Review Directive 5.

Applicability. This regulation applies to all elements of the Army across the full spectrum of military operations from peacetime through major theater warfare. This regulation applies to all Army personnel to include the Active Army; the Army National Guard/Army National Guard of the United States and United

States Army Reserve personnel on active duty or in drill status; United States Military Academy cadets; United States Army Reserve Officer Training Corps cadets, when engaged in directed training activities; foreign national military personnel assigned to Army components; and civilian personnel and nonappropriated fund personnel employed by the Army worldwide. Except for those preventive medicine services defined in Department of Defense Instruction 6055.1 for supporting Department of Defense contractor personnel during outside continental United States force deployments or specifically provided for in contracts between the Government and a contractor, this regulation does not generally apply to Army contractor personnel and contractor operations. This regulation is applicable during mobilization.

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

Army management control process.

This regulation contains management control provisions and identifies key management controls that must be evaluated (see appendix B).

Supplementation. Supplementation of this regulation and establishment of command and local forms are prohibited without prior approval from HQDA (DASG–PPM–NC), 5109 Leesburg Pike, Falls Church, VA 22041–3258.

Suggested improvements. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) directly to HQDA (DASG–HS), 5109 Leesburg Pike, Falls Church, VA 22041–3258.

Committee Continuance Approval.

The Department of the Army Committee Management Officer concurs in the establishment of an installation-level ergonomics subcommittee.

Distribution. This publication is available in electronic media only, and is intended for command level C for the Active Army, the Army National Guard/Army National Guard of the United States, and the United States Army Reserve.

*This regulation supersedes AR 40–5, dated 22 July 2005.

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Glossary

Chapter 1 Introduction

Section I General

1-1. Purpose

This regulation—

- a. Establishes policies for preventive medicine.
- b. Defines preventive medicine and directs the establishment of preventive medicine programs and services.
- c. Assigns responsibilities for—
 - (1) Improving and sustaining health throughout the Army and across the spectrum of military operations, including joint and combined operations.
 - (2) Developing and implementing preventive medicine programs and services.
 - (3) Providing preventive medicine resources, services, and technical support.
 - (4) Providing preventive medicine guidance, strategy, doctrine, and oversight.
 - (5) Conducting comprehensive, coordinated military health surveillance activities to include medical surveillance and occupational and environmental health (OEH) surveillance for Army personnel throughout their time in service.
 - (6) Identifying or developing military-unique OEH standards, criteria, and guidelines.
 - (7) Identifying, developing, and providing military-specific force health preparedness, protection, sustainment and recovery interventions and measures.
 - (8) Implementing Department of Defense Directives (DODDs) and Department of Defense Instructions (DODIs), including those listed in appendix A.

1-2. References

Required and related publications and prescribed and referenced forms are listed in appendix A.

1-3. Explanation of abbreviations and terms

Abbreviations and special terms used in this regulation are explained in the glossary.

1-4. Responsibilities

Responsibilities are listed in chapter 2.

1-5. Preventive medicine policies

The Army will—

- a. Enhance and sustain optimal levels of health and fitness of all Army personnel by applying the principles of population medicine to promote health and prevent and minimize the impacts of diseases and injuries as defined in paragraph 1-7, below.
- b. Protect Army personnel from potential and actual harmful exposures to chemical/biological/radiological/nuclear (CBRN) warfare agents; endemic communicable diseases; food-, water-, and vector-borne diseases; ionizing and nonionizing radiation; combat and operational stressors; heat, cold, and altitude extremes; environmental and occupational hazards; toxic industrial materials (TIMs); and other physical agents.
- c. Adhere to Federal, state, and host nation laws, regulations, and guidance governing OEH during peacetime in nondeployed situations and during training exercises, except for uniquely military equipment, systems, and operations as authorized in Executive Order 12196. These statutes and regulations also apply during military operational deployments and war unless specifically exempted by appropriate authority based on the tactical situation. Contractors whose personnel are using Government-furnished facilities will similarly adhere to Federal, state, and host nation laws, regulations, and guidance governing OEH.
- d. Strive to adhere to peacetime United States (U.S.) or host nation health standards, whichever are more stringent, during military operational deployments.
 - (1) Deployment is defined as the relocation of forces and materiel to desired operational areas. Deployment encompasses all activities from origin or home station through destination, specifically including intracontinental United States, intertheater, and intratheater movement legs, staging, and holding areas (Joint Publication 1-02, definition no. 4; DODI 6490.03).
 - (2) When the mission or the overall health of deployed personnel warrant risk decisions that may require overriding the peacetime health standards, such decisions should be made by the first general officer (or colonel frocked to the grade of brigadier general) in the chain of command or as specified in the operational plans and orders.
 - (3) These decisions must be based on a complete consideration of operational as well as health risks and available

contingency guidance and criteria so that the total risk to our Soldiers and civilians is minimized. This decisionmaking will be deliberate, documented, and archived.

e. Use the composite risk management process to minimize the total health threat and risk to personnel in garrison, training, contingency operations, and war. Army health policies are intended to allow commanders to execute the full spectrum of military operations while minimizing the total health risk to Soldiers and civilian employees, according to applicable Department of Defense (DOD)/Army policies, implementing instructions, and regulations.

f. Have Army leaders make informed risk decisions about OEH risks and consider, in all risk decisions, health risks to personnel arising from short-term and long-term exposures across the full spectrum of operations.

g. Operate a system of medical, behavioral, and OEH surveillance to—

- (1) Provide preventive medicine assessments supporting composite risk management decisionmaking.
- (2) Identify health threats to Army personnel and other Military Health System beneficiaries.
- (3) Assist in establishing military public health and health promotion goals and targets.
- (4) Monitor and assess the health status of all Army personnel throughout their service.
- (5) Report the health status of Army units and the impact on readiness.
- (6) Archive data for future analyses.

h. Incorporate Army preventive medicine information management and information technology requirements into military health information systems.

i. Inform Army personnel and co-located contractor personnel of health threats, risks, and appropriate unit and individual preventive countermeasures using health risk communication techniques.

j. Provide pre-placement, job transfer, periodic, and termination medical examinations for military personnel and civilian employees potentially exposed to health hazards in the work environment.

k. Ensure all preventive medicine laboratories are accredited or abide by accepted quality assurance procedures to guarantee the accuracy and quality of the data.

l. Ensure all new equipment and materials acquired by the Army are subjected to a health hazard assessment (HHA).

m. Ensure that all new chemicals and materials being added to the Army Supply System have a toxicity clearance.

n. Procure and use in any military operation within the continental U.S. (CONUS) and outside the continental U.S. (OCONUS) only those pesticide active ingredients that are not cancelled by the U.S. Environmental Protection Agency for use within the U.S.

o. Acquire, archive, and store health-related data using only approved military health information systems and procedures that will comply, when applicable, with the provisions of the Health Insurance Portability and Accountability Act, codified in Part 201 et seq., Title 42, United States Code (42 USC 201 et seq.); and the Act's regulations, Parts 160, 162, and 164, Title 45, Code of Federal Regulations (45 CFR Parts 160, 162, and 164).

Section II

The Preventive Medicine Functional Area

1–6. Background

a. Preventive medicine is one of the functional areas of Army health care delivery for which The Surgeon General (TSG) is the Army functional proponent. It is the application of many of the principles of public health and preventive medicine practice to military situations and populations. A component of force health protection, preventive medicine is the anticipation, prediction, identification, surveillance, evaluation, prevention, and control of disease and injuries. These include—

- (1) Communicable diseases.
- (2) Vector-, food-, air-, and water-borne diseases.
- (3) OEH-related diseases and injuries.
- (4) Disease and non-battle injuries (DNBIs).
- (5) Training injuries.

b. Core public health functions as applied to military preventive medicine include assessment, policy development, and assurance. Assessment includes the key capabilities of general health evaluation of the beneficiary populations, medical surveillance, occupational and environmental health surveillance, investigation of outbreaks, and determination of risk factors and causes of major disease and injury syndromes. Policy development includes advocacy, prioritization of needs, development of plans and policies, and provision of resources to implement programs, plans, and policies. The assurance function includes the direct provision and assurance of delivery of services; it entails implementing programs, plans and policies; management of resources; and monitoring outcomes. A key aspect of all public health practice is effective communication and education with all affected populations.

c. Preventive medicine supports the concept of population health management within the Military Health System. Population health management is the intentional and proactive use of a variety of individual, organizational, and population interventions to help improve patterns of disease and injury burdens, health status, and the health care demand of defined populations. Preventive medicine support includes individual and community health risk and needs

assessments, surveillance, program planning, defined responses, and health outcome evaluation for the entire beneficiary community.

d. Army preventive medicine will include relevant and appropriate capabilities and functions of the following 10 essential national public health services established by the American Public Health Association:

- (1) Monitoring health status to identify community health problems.
- (2) Diagnosing and investigating health problems and health hazards in the community.
- (3) Informing, educating, and empowering people about health issues.
- (4) Mobilizing community partnerships to identify and solve health problems.
- (5) Developing policies and plans to support individual and community health efforts.
- (6) Ensuring compliance with laws and regulations that protect health and ensure safety.
- (7) Linking people to needed health services.
- (8) Assuring a competent public health and personal health care work force.
- (9) Evaluating effectiveness, accessibility, and quality of personal and population-based health services.
- (10) Researching new insights and innovative solutions to health problems.

e. Effective preventive medicine will meet the following objectives:

- (1) Improvement in beneficiary health.
- (2) Reduction in short- and long-term health risks.
- (3) Reduction of health care costs due to chronic disease and conditions caused by injury.
- (4) Improved performance through reduced morbidity.
- (5) Improvement in Soldier and other beneficiary self-care capabilities and activities.
- (6) Mitigation of the impact of large-scale public health emergencies.

f. The process for providing effective preventive medicine services consists of the following actions:

- (1) Identification of requirements and objectives.
- (2) Allocation of resources to accomplish objectives.
- (3) Development of policies, plans, and implementing guidance.
- (4) Accomplishment of objectives.
- (5) Demonstration of accomplishments using process and outcome measurements.

g. Knowledge and application of the principles of obtaining and executing resources through the Military Planning, Programming, Budgeting, and Execution System are essential skills for Army preventive medicine personnel. Without such skills, preventive medicine personnel responsible and accountable for obtaining and executing resources will not be able to perform those functions.

1-7. Preventive medicine programs and services

This paragraph broadly describes the components and scope of the Army preventive medicine functional areas. It directs the development and implementation of a wide range of specific preventive medicine/military public health programs and services. Health surveillance and epidemiology; toxicology and laboratory services; health risk assessment; and health risk communication are foundation components of Army preventive medicine that directly support and must be integrated into the other components of preventive medicine. The detailed implementing guidance and instructions for each of the required programs and services in this regulation are provided in Department of the Army Pamphlet (DA Pam) 40-11. The publication of new Army documents with guidance and instructions specific to any of the required individual programs and services is authorized. The following describe the Army preventive medicine functional areas:

a. Disease prevention and control.

(1) Primary care, preventive medicine, and other health care providers in both tables of distribution and allowances (TDA) and tables of organization and equipment (TOE) medical organizations deliver disease prevention and control services. These services, delivered in clinical and nonclinical settings, are initiated to prevent the occurrence and reduce the severity and consequences of diseases in individuals and populations. Examples include screening and monitoring procedures for early detection of disease (using a variety of clinical examinations and laboratory tests), immunizations to prevent disease, chemoprophylaxis for individuals exposed to infectious diseases, infection control, and preventive medicine counseling.

(2) Disease prevention and control programs and services will be provided according to the detailed implementing instructions and guidance published in DA Pam 40-11, chapter 2. Specific programs, services, and capabilities will be established and provided for the following areas:

(a) Communicable disease prevention and control to include—

1. Immunization and chemoprophylaxis.
2. Acute respiratory disease.
3. Meningococcal infection.
4. Malaria.

5. Viral hepatitis.
 6. Sexually transmitted diseases.
 7. Acquired immunodeficiency syndrome.
 8. Rabies.
 9. Tuberculosis.
 10. Biowarfare threat.
- (b) Travel medicine.
 - (c) Population health management.
 - (d) Hospital-acquired infection control.
- b. Field preventive medicine.*

(1) The principles and practices of Army preventive medicine will apply to all Army individuals and units in all field-training environments and across the full spectrum of military operations. Field preventive medicine services will focus on the health and fitness components of force medical readiness and on the operational management and effective communication of health risks.

(2) The overall objectives of field preventive medicine are to provide commanders with healthy and fit deployable forces; to sustain the health and fitness in any military operation; and to prevent casualties from DNBI and stress reactions.

(3) Field preventive medicine services will include capabilities from the following U.S. Army Medical Department (USAMEDD) functional areas, as described in Field Manual (FM) 4-02, chapter 5:

- (a) Preventive medicine services.
- (b) Veterinary services.
- (c) Combat and operational stress control.
- (d) Dental services (preventive dentistry).
- (e) Laboratory services (those supporting the above four USAMEDD functional areas).

(4) Field preventive medicine services will be provided according to Army doctrine published in FM 4-02, FM 4-02.17, FM 4-02.18, FM 4-02.19, FM 4-25.12, FM 8-51, FM 8-55, and their supporting references, as well as in DA Pam 40-11, chapter 3.

(a) Soldiers will apply the basic individual preventive medicine measures prescribed in FM 8-55, paragraph 11-5, and FM 21-10/MCRP 4-11.1D, chapter 2. Unit leaders will motivate, train, and equip subordinates prior to and during field training exercises and all deployments to defeat the medical threat through the use of individual and unit preventive measures as described in FM 4-25.12, chapters 1-2 and appendixes A-D, and FM 21-10/MCRP 4-11.1D, chapters 2 through 4 and appendix A.

(b) Company-sized units will establish and employ manned, trained, and equipped unit field sanitation teams (FSTs), according to the Army doctrine published in FM 4-02.17, chapter 2 and appendix A, and FM 4-25.12, chapters 1-2 and appendixes A-D.

(c) Medical and OEH surveillance will be provided for each Soldier from accession through the entire length of each Soldier's service commitment. Such surveillance will be provided according to the doctrinal principles defined in FM 4-02.17, chapters 3, 4, 6 through 9, and appendixes A, C, E, and F. Additional guidance can be found in DA Pam 40-11, chapter 6.

(d) Field preventive medicine information management needs will be met using standard military medical and nonmedical information and communication systems, and tactics, techniques and procedures prescribed by doctrine (for example, FM 4-02.16, chapters 1 through 5 and appendixes A-H).

(e) Health risk communication will be provided in the field through planning and implementation using proven processes and tools.

c. Environmental health.

(1) In Army preventive medicine, environmental health consists of those capabilities and activities necessary to anticipate, identify, assess, and control risks of immediate and delayed-onset DNBI to personnel from exposures encountered in the environment. These exposures include risks from chemical, biological, radiological, and physical hazards. These risks will be evaluated using standardized risk assessment principles and procedures.

(2) Environmental health programs and services will be provided according to the detailed implementing instructions and guidance published in DA Pam 40-11, chapters 3 and 4. Environmental health programs, services, and capabilities will be established and provided for the following specific areas:

- (a) Drinking water.
- (b) Recreational waters.
- (c) Ice manufacture.
- (d) Wastewater.
- (e) Pest and disease vector prevention and control.
- (f) Solid waste.

- (g) Hazardous waste.
- (h) Groundwater and subsurface release of hazardous constituents.
- (i) Regulated medical waste.
- (j) Waste disposal guidance.
- (k) Spill control.
- (l) Air quality.
- (m) Environmental noise.
- (n) Climatic injury prevention and control.
- (o) Sanitation and hygiene, including the following topics:
 1. Troop housing sanitation.
 2. Barber and beauty shops.
 3. Dry cleaning operations.
 4. Mobile home parks.
 5. Child development services facilities.
 6. Recreational areas.
 7. Laundry operations.
 8. Confinement facilities.
 9. Food service sanitation.
 10. Sports facilities, gymnasiums, and fitness centers.
 11. Tattooing and piercing businesses.
- d. *Occupational health.*

(1) In Army preventive medicine, occupational health consists of those capabilities and activities necessary to anticipate, identify, assess, communicate, mitigate, and control occupational disease and injury threats. This includes management of the risks to personnel from exposures encountered at their worksite in garrison and field settings. Occupational health hazards include risks from chemical, biological, radiological, physical, and psychological threats. These risks will be evaluated using standardized risk assessment methodologies.

(2) The Army Occupational Health Program's medical components will be developed and provided consistent with the Defense Safety and Occupational Health Program and implemented according to the detailed instructions and guidance published in DA Pam 40-11, chapter 5. Occupational health programs, services, and capabilities will be established and provided for the following specific areas:

- (a) Medical surveillance examinations and screening.
- (b) Health hazard education.
- (c) Surety programs.
- (d) Reproductive hazards.
- (e) Bloodborne pathogens.
- (f) Hearing readiness, clinical, operational, and conservation services.
- (g) Vision conservation and readiness.
- (h) Workplace epidemiological investigations.
- (i) Ergonomics.
- (j) Radiation exposure and medical surveillance.
- (k) Industrial hygiene.
- (l) Personal protective equipment.
- (m) Respiratory protection.
- (n) Asbestos exposure control and surveillance.
- (o) Injury prevention and control.
- (p) Occupational illness and injury prevention and mitigation.
- (q) Work-related immunizations.
- (r) Recordkeeping and reporting.
- (s) Worksite evaluations.
- (t) Other Federal programs (for example, Department of Labor (DOL), Office of Workers' Compensation).
- (u) Evaluation of occupational health programs and services.

(3) Other occupational health-related programs and services that are not listed above will also be provided according to the detailed instructions and guidance published in DA Pam 40-11, chapter 5. These programs and services will include—

- (a) Army aviation medicine.
- (b) HHA of Army equipment and materiel.
- (c) Medical facility and systems safety, health, and fire prevention.

(d) Nonoccupational illness and injury.

(4) Where local commanders establish and resource a command Prevention of Violence in the Workplace Program, preventive medicine will assist upon request.

e. Health surveillance and epidemiology.

(1) Health surveillance is defined to be those capabilities and activities necessary to effectively collect, analyze, report, and archive information pertaining to the—

(a) Health status of Army personnel throughout their time in service.

(b) Health hazards, risks, and exposures to Army personnel.

(c) Preventive medicine and health risk communication measures necessary to counter those hazards and reduce risks.

(d) Diseases, injuries, and behavioral problems that result from those hazards.

(2) Epidemiology will consist of those capabilities and activities necessary to effectively identify Army populations at risk of disease, injury, or behavioral difficulties and the associated risk factors to—

(a) Identify and characterize morbidity and mortality in Army populations.

(b) Identify the causes of occupational, environmental, and infectious diseases.

(3) Health surveillance and epidemiology programs and services are critical to the success of preventive medicine activities in disease prevention and control; field preventive medicine; occupational health; environmental health; and Soldier, family, and community health and health promotion. Programs and services will be developed and implemented according to the detailed implementing instructions and guidance published in DA Pam 40–11, chapter 6. Health surveillance and epidemiology programs, services, and capabilities will be established and provided for the following specific areas:

(a) OEH surveillance in deployment, training, and in garrison.

(b) Defense Occupational and Environmental Health Readiness System (DOEHRS).

(c) Occupational Health Management Information System.

(d) Medical surveillance.

(e) Epidemiology.

f. Soldier, family, community health, and health promotion.

(1) Soldier, family and community health programs and services consist of activities necessary to anticipate, identify, assess, and communicate health needs across a continuum of home, school, and work environments as well as specific communicable and chronic disease prevention and control activities. Soldier readiness is a priority in the development and execution of these programs. They are intended to address and improve the level of population health. The cornerstone of these programs and services is a comprehensive community health needs assessment. This assessment is the basis for a program document that plans, implements, evaluates, and prioritizes local health needs, resource agencies, and program implementation.

(2) Soldier, family, and community health programs and services will be developed and implemented according to the detailed implementing instructions and guidance published in DA Pam 40–11, chapter 7. Community health programs, services, and capabilities will be provided to support the following areas:

(a) Soldier medical readiness.

(b) Soldier dental readiness.

(c) Community health support of Army operations.

(d) Communicable disease prevention and control.

(e) Community health needs assessment.

(f) Community health referrals.

(g) Chronic disease prevention and control.

(h) Case management.

(i) Child and youth services.

(j) Health of school-age children.

(k) Childhood lead poisoning prevention.

(l) Spousal and child abuse.

(m) Family safety.

(n) Women's health.

(o) Health assessment.

(p) Tobacco use cessation.

(q) Nutrition.

(r) Stress management.

(s) Alcohol and substance abuse prevention and control.

(t) Suicide prevention.

(u) Spiritual health and fitness.

(v) Oral health.

(3) Health promotion is concerned with the promotion of wellness through health education and related activities designed to facilitate behavioral and environmental changes that will improve and maintain health as prescribed in AR 600–63, chapters 1–5.

(4) USAMEDD health promotion services to support the Army Health Promotion Program will be developed and implemented according to the detailed instructions and guidance published in DA Pam 40–11, chapter 7.

g. Preventive medicine toxicology and laboratory services.

(1) Preventive medicine toxicology and laboratory services provide for the analytical needs of all elements of preventive medicine.

(2) Toxicology programs and services will be developed and implemented according to the detailed instructions and guidance published in DA Pam 40–11, chapter 8. Toxicology programs, services, and capabilities will be established and provided for the following specific areas:

(a) Toxicological assessments of potentially hazardous materials.

(b) Toxicity clearances for Army chemicals and materiel.

(c) Toxicologically based assessments of health risks.

(3) Laboratory programs and services will be developed and implemented according to the detailed instructions and guidance published in DA Pam 40–11, chapter 9. In addition to the necessary analytical capabilities, laboratory programs and services will be established and provided for the following specific areas:

(a) Certification and accreditation.

(b) Quality control and quality management.

(c) DOD Cholinesterase Monitoring Program.

h. Health risk assessment.

(1) Health risk assessment is those capabilities and activities necessary to identify and evaluate a health hazard to determine the associated health risk (probability of occurrence and resulting outcome and severity) of potential exposure to the hazard.

(2) Health risk assessment programs and services will be developed and implemented according to the detailed implementing instructions and guidance in DA Pam 40–11, chapter 10. Health risk assessment programs, services, and capabilities will be established and provided for all preventive medicine programs and service areas.

i. Health risk communication.

(1) Health risk communication is defined to be those capabilities and activities necessary to identify who is affected by potential or actual health and safety threats, to determine the interests and concerns those people have about the threats, and to develop strategies for effectively communicating the complexities and uncertainties associated with the scientific processes of determining risk. Effective risk communication can only be accomplished through building and maintaining relationships that provide a framework of credibility for the message and the messenger.

(2) Health risk communication programs and services will be developed and implemented according to the detailed implementing instructions and guidance in DA Pam 40–11, chapter 11. Health risk communication programs, services, and capabilities will be established and provided for all preventive medicine program and service areas.

1–8. Technical and consultative assistance

Technical assistance will be available through preventive medicine units, U.S. Army medical centers (USAMEDCENs), U.S. Army medical department activities (USAMEDDACs), regional medical commands (RMCs), and U.S. Army Center for Health Promotion and Preventive Medicine (USACHPPM). All technical assistance will be coordinated with the appropriate commands. Consultative assistance may be obtained from command surgeons, the U.S. Army Medical Department Center and School (USAMEDDC&S), U.S. Army Medical Research and Materiel Command (USAMRMC), veterinary commanders, and U.S. Army Dental Command (USADENCOM).

Chapter 2 Responsibilities

2–1. The Assistant Secretary of the Army (Installations and Environment)

The Assistant Secretary of the Army (Installations and Environment) (ASA(I&E)) will—

a. Provide executive leadership at the Army Secretariat level to ensure timely—

(1) Integration of DOD directives and policies concerning Army OEH with Army policies, doctrine, and guidance.

(2) Compliance with the Army OEH requirements.

b. Establish goals, policies, priorities, and oversight for Army OEH.

c. Provide Army OEH input to the defense planning guidance and the defense medical planning guidance in coordination with the Assistant Secretary of the Army (Manpower and Reserve Affairs) (ASA(M&RA)).

d. Provide policy, goals, guidance, and management oversight of the Army Occupational Health Program, as the Army component of the DOD Safety and Occupational Health Program.

2-2. The Assistant Secretary of the Army (Manpower and Reserve Affairs)

The ASA(M&RA) will—

- a.* Provide executive leadership at the Army Secretariat level—
 - (1) To ensure timely integration of DOD directives and policies concerning health and fitness with Army policies, doctrine, and guidance.
 - (2) For the development and implementation of Army health and fitness policies.
- b.* Oversee the integration of Army health and fitness policy with Army activities, operations, policies, and doctrine.
- c.* Provide preventive medicine input to the defense planning guidance and the defense medical planning guidance in coordination with the ASA(I&E).

2-3. The Assistant Secretary of the Army (Acquisition, Logistics, and Technology)/The Army Acquisition Executive

The Assistant Secretary of the Army (Acquisition, Logistics, and Technology)/Army Acquisition Executive (AAE) will plan, program, and budget for the integration of preventive medicine factors with the Army's acquisition programs. This includes but is not limited to—

- a.* The HHA of Army materiel and systems throughout the full life cycle of these items (see AR 40-10, para 2-1; AR 70-1, para 2-10; AR 200-1, para 1-8; and AR 385-16, para 4a(2)).
- b.* The development of nonmedical material (such as instruments, equipment) in conjunction with the USAMEDD to rapidly identify and assess the short- and long-term health risks to Army personnel presented by deployment OEH threats.
- c.* The establishment of procedures to assure that program managers and other individuals authorized to add chemicals and chemical-based materiel to the Army Supply System request toxicity clearances for those products.

2-4. The Deputy Chief of Staff, G-1

The Deputy Chief of Staff, G-1 will—

- a.* Provide executive leadership at the Army staff level for the integration of health and fitness policies and doctrine with Army personnel policies and doctrine.
- b.* Ensure that Army personnel data in support of designated major joint deployments are provided to the Defense Manpower Data Center. Data will include daily strength by unit and total deployed, grid location of each unit (company size and higher), and inclusive dates of individual Army personnel deployment. These personnel data provide denominators for deployment medical surveillance analyses as well as location information for identifying potential exposures for OEH surveillance.
- c.* Ensure that the Deputy Chief of Staff, G-1 information systems, which include medical data, are compatible with Army medical information systems.

2-5. The Deputy Chief of Staff, G-2

The Deputy Chief of Staff, G-2 will—

- a.* Advise the ASA(I&E) and TSG on medical intelligence.
- b.* Provide functional policy and guidance on collection and dissemination of medical intelligence.
- c.* Serve as Army liaison with DOD intelligence agencies on all matters regarding medical intelligence.

2-6. The Deputy Chief of Staff, G-3/5/7

The Deputy Chief of Staff, G-3/5/7 will exercise Army general staff responsibility for the integration of preventive medicine into Army planning and training.

2-7. The Deputy Chief of Staff, G-4

The Deputy Chief of Staff, G-4 will ensure the—

- a.* Integration of preventive medicine factors into—
 - (1) The transportation, storage, handling, and disposal of hazardous material or hazardous waste.
 - (2) Deployable housing, food preparation, water purification, mortuary affairs, laundry, and shower operations.
- b.* Coordination of field sanitation activities.

2-8. The Surgeon General

a. The Surgeon General will execute and provide oversight of preventive medicine activities as outlined in this regulation and will—

- (1) Provide leadership, proponentcy, policy, prioritization, oversight, and coordination for Army-wide preventive medicine programs and services.

- (2) Plan, program, budget, and oversee the execution of resourcing in support of preventive medicine and health promotion activities consistent with—
 - (a) DOD and Department of the Army (DA) policies and guidance.
 - (b) The resourcing provided in the Defense Health Program by the Office of the Assistant Secretary of Defense for Health Affairs.
 - (c) The resourcing provided in the operations and maintenance, Army (OMA) account.
- (3) Determine and direct the use of appropriate preventive measures, pharmaceuticals, and biologics for disease and injury control.
- (4) Ensure that prevention is integrated with the practice of Army medicine at all levels and in all settings.
- (5) Determine if Army medical and nonmedical materiel presents a health hazard to personnel, according to AR 40–10, paragraph 2–6, and AR 70–1, paragraph 2–18, and provide medical policies, health standards and guidance, and recommendations to protect personnel from the health hazard presented by that materiel.
- (6) Develop functional policy and guidance for the medical components of Army deployment OEH threat policies.
- (7) Develop guidance that allows commanders to quantify and mitigate the health risks resulting from exposures to occupational and environmental hazards.
- (8) Develop policy for medical care to prevent disability from occupational injuries and illnesses.
- (9) Execute the medical aspects of the Army Occupational Health Program.
- b. The USAMEDD Functional Proponent for Preventive Medicine will serve as TSG’s principal advisor on preventive medicine issues. The Proponency Office for Preventive Medicine will provide staff support to the USAMEDD Functional Proponent for Preventive Medicine. The USAMEDD Functional Proponent for Preventive Medicine will—
 - (1) Have TSG authority for preventive medicine policies, standards, regulations, and directives to protect and promote health, improve effectiveness, communicate health risks, and enhance the environment of Army personnel.
 - (2) Provide strategic direction, guidance, and prioritization for preventive medicine activities that take into account USAMEDD strategies and validated medical threat assessments.
 - (3) Provide staff support and consultative services for preventive medicine to the Army staff and to U.S. Army Medical Command (USAMEDCOM) and Office of The Surgeon General (OTSG) staffs.
 - (4) Execute TSG’s responsibilities, as specified in AR 200–1, paragraph 1–18, functioning as the Army executive point of contact for all OEH aspects of the Army’s Environmental Program and as TSG’s reviewing authority for all environmental documents submitted by DA activities.
 - (5) Execute TSG’s responsibilities in implementing the preventive medicine components of Army deployment OEH threat policies by—
 - (a) Developing policy and guidance for the medical surveillance and the OEH surveillance aspects of those Army policies, as well as policies developed by the Assistant Secretary of Defense for Health Affairs or the Assistant to the Secretary of Defense for Nuclear and Chemical and Biological Defense Programs. Specifically, the Functional Proponent for Preventive Medicine will be responsible for the development of chemical, biological, and radiological health criteria and guidelines to support Army deployment OEH threat policies. This includes criteria and guidance on long-term acceptable levels of exposures and risks resulting from exposures to low levels of OEH threat agents for various exposure scenarios, consistent with the policies and guidance provided by the Assistant Secretary of Defense for Health Affairs or the Assistant to the Secretary of Defense for Nuclear and Chemical and Biological Defense Programs.
 - (b) Developing consistent guidance that allows commanders to quantify and mitigate, through their medical or other appropriately qualified assets, the health risks resulting from exposures to OEH threats during deployments. This guidance may include other aspects of identifying, quantifying, and communicating risks, such as direct and indirect bioassay measurements in addition to the monitoring of ambient exposure levels.
 - (c) Supporting and advocating the preventive medicine requirements for adequate Defense Health Program and other appropriate funding to ensure timely and effective implementation of Army deployment OEH threat policies and procedures.
 - (6) Execute TSG’s responsibilities for The Army Chemical Agent Safety Program and Biological Defense Safety Program according to AR 385–61, paragraph 1–4i, and AR 385–69, paragraph 1–4e, respectively.
 - (7) Execute TSG’s responsibilities for the Army Ergonomics Program.
 - (8) Coordinate with the Director of Army Safety to ensure Army compliance with Occupational Safety and Health Act (Public Law 91–596, as amended) health standards.
 - (9) Provide preventive medicine representation and liaison as appropriate.
 - (10) Coordinate with the USAMEDDC&S and USAMRMC concerning doctrine, organizations, training, materiel, leadership and education, personnel, and facilities (DOTMLPF) solutions to Army preventive medicine issues.
 - (11) Coordinate with U.S. Army Training and Doctrine Command (USATRADO) concerning the prevention and control of injuries and communicable diseases in recruit and other training populations.
 - (12) Coordinate with the Assistant Surgeon General for Force Projection on clinical preventive medicine policies.
 - (13) Coordinate the inclusion of preventive medicine in medical information management and information technology initiatives.

- (14) Provide staff oversight including process and outcome metrics for execution of preventive medicine activities.
- (15) Coordinate with the U.S. Army Materiel Command (USAMC) Logistic Civil Augmentation Program concerning combat service support contracts written in support of contingency operations.
- c. The USAMEDD professional consultants will advise and assist the USAMEDD Functional Proponent for Preventive Medicine.

2-9. The Director of Army Safety

The Director of Army Safety will—

- a. Coordinate with TSG and the USAMEDD Functional Proponent for Preventive Medicine on occupational safety and health issues including medical aspects of safety policy regarding hazard communication and hazardous materials program requirements.
- b. Exchange accidental injury data with TSG for an accurate assessment of the Army health status.
- c. Provide support to commanders in developing and implementing installation ergonomics programs.
- d. Advance partnership initiatives that prevent workplace injuries and illnesses.

2-10. The Commander, U.S. Army Corps of Engineers/Chief of Engineers

The U.S. Army Corps of Engineers (USACE) and the Chief of Engineers, in addition to the responsibilities in paragraph 2-11, below, will—

- a. Coordinate with TSG and the USAMEDD Functional Proponent for Army Preventive Medicine on the health aspects of environmental issues including environmental compliance, environmental baseline surveys, environmental health site assessments, pollution prevention, hazardous waste minimization, risk assessment, and risk communication program requirements.
- b. Ensure coordination of environmental program data with TSG for an accurate assessment of the impact of environmental conditions on the Army health status.
- c. Ensure that health risk assessments are submitted to TSG for review and approval.

2-11. Commanders, Army commands, Army service component commands, and direct reporting units

Commanders, Army commands (ACOMs), Army service component commands, and direct reporting units will provide command emphasis, resources, policy implementation, guidance, and oversight to subordinate commands and activities to execute preventive medicine activities within their commands.

2-12. The Director, Army National Guard/Army National Guard of the United States

The Director, Army National Guard/Army National Guard of the United States, will—

- a. Provide emphasis, resources, policy, and implementation guidance to each state and territory adjutant general.
- b. Appoint the Army National Guard/Army National Guard of the United States Surgeon to coordinate with TSG and the USAMEDD Functional Proponent for Preventive Medicine on preventive medicine issues.

2-13. The Commanding General, U.S. Army Forces Command

The Commanding General, U.S. Army Forces Command, in addition to the responsibilities in paragraph 2-11, above, will—

- a. Coordinate with the USAMEDDC&S to identify the required force structure and capabilities to implement the preventive medicine aspects of combat health support according to military doctrine.
- b. Coordinate with OTSG in planning, programming, and budgeting for required capabilities to implement the preventive medicine aspects of combat health support according to Army and Joint doctrine.
- c. Coordinate with USAMEDCOM, USATRADO, and the Army Deputy Chief of Staff, G-3/5/7 to provide in-theater medical analytical capability (using organic or augmented medical assets) for theater-level, rapid nuclear (and radiological), biological, chemical, environmental and infectious disease risk identification and assessment to support operational health risk management.

2-14. The Commanding General, U.S. Army Training and Doctrine Command

The Commanding General, USATRADO, in addition to the responsibilities in paragraph 2-11, above, will—

- a. Develop, in coordination with USAMEDCOM, doctrine, tactics, techniques, and procedures; implementation plans; operational requirements; and appropriate training and education for leaders and others to use in assessing, managing, and countering deployment OEH threats.
- b. Incorporate training in deployment OEH into USATRADO leadership schools as appropriate.
- c. Develop and implement, through the U.S. Army Chemical School and in close cooperation with the USAMEDCOM, the doctrinal, training, organizational, and materiel solutions to the risks presented by chemical and biological agents, toxic industrial hazards, and radiation.
- d. Coordinate with USAMEDCOM and OTSG regarding health issues in the training base.

- e. Incorporate deployment and garrison risk mitigation of communicable diseases and injuries into cadre training.

2–15. The Commanding General, U.S. Army Materiel Command

The Commanding General, USAMC, in addition to the responsibilities in paragraph 2–11, above, will—

- a. Support the AAE in developing the nonmedical materiel (such as instruments, equipment) in conjunction with the USAMEDD to rapidly identify and assess the short- and long-term health risks presented by deployment OEH threats.
- b. Support the AAE, program executive officers, and program managers in analyzing all emerging Army systems for environmental effects, including noise and toxic and hazardous wastes associated with normal system testing, operation, use, maintenance, and disposal.

2–16. The Commander, U.S. Army Medical Command

The Commander, USAMEDCOM, in addition to the responsibilities defined in paragraph 2–11 above, will—

- a. Provide health care services and resources of the Army within CONUS, Europe, Pacific, Alaska, Puerto Rico, Hawaii, and Guam and other territories.
- b. Develop and execute installation, regional, and worldwide preventive medicine programs to support the entire spectrum of military operations.
- c. Plan and program for OMA, Army and Defense Health Program funding requirements. Prioritize, budget, and resource all USAMEDCOM subordinate command assets necessary to support preventive medicine. Use the Defense Health Program activity structure and codes for effective Defense Health Program budget execution tracking and program analysis and review (see Defense Finance and Accounting Service—Indianapolis Center (DFAS–IN) Manual 37–100–FY). Track execution of OMA resources provided for preventive medicine programs and services.
- d. Coordinate with the DA staff and appropriate medical organizations OCONUS to provide preventive medicine augmentation support when directed or requested.
- e. Provide command guidance and oversight including program evaluation of the priorities, services, and direction for preventive medicine with the assistance of the USAMEDD Functional Proponent for Preventive Medicine.
- f. Monitor the obligation of funds for USAMEDCOM preventive medicine assets against the Defense Health Program activity structure to ensure that expenditures coincide with priorities.
- g. Provide command guidance to the USAMEDDC&S and to the USAMRMC for preventive medicine issues and needs for DOTMLPF solutions.
- h. Ensure the development of doctrine, implementation plans, procedures, capabilities, and training relative to medical and OEH surveillance to address exposures to Soldiers and civilian employees throughout their time in service.
- i. Ensure that deployment OEH training is incorporated into the USAMEDDC&S curriculum.
- j. Include preventive medicine in Army medicine strategic and mid-term planning activities.
- k. Establish chemical, biological, radiological, and nuclear advisory medical teams at appropriate locations.
- l. Establish a performance improvement program for preventive medicine.
- m. Develop appropriate strategies and processes to ensure the availability of adequate information management and information technology support to implement the prevention-related objectives and requirements of Army deployment OEH threat policies.
- n. Develop the procedures and guidance for USAMEDCOM subordinate commands to obtain intelligence products regarding medical, industrial, and other environmental threats.
- o. Prepare the production requirements for valid intelligence product requests to the USAMEDCOM supporting intelligence office as defined in the Department of Defense Intelligence Production Program.
- p. Ensure that any requests for reimbursable preventive medicine services (from either Active Army or Reserve Component organizations) are assessed by preventive medicine staff in coordination with RMC or USAMEDCOM resource management staff and program analysis and evaluation staff prior to accepting any additional missions or program growth. Such requests will be evaluated for impact on existing programs and resources and, if approved, will be provided according to Army principles encoded in the Economy Act (31 USC 1535 and 1536).
- q. Provide periodic evaluation of installation occupational health programs along with a plan to ensure appropriate followup and resolution of corrective actions. A copy of the evaluation along with the plan for resolution should be provided to the installation commander.

2–17. Commanders, regional medical commands

Commanders of regional medical commands (RMCs) will—

- a. Provide command and operational guidance, oversight, mentorship, coordination, and consultative support for effective preventive medicine programs and services within the region based on this regulation and the guidance provided in DA Pam 40–11.
- b. Plan, program, prioritize, budget, and resource all RMC assets necessary to support preventive medicine based on priorities, policy, and guidance from TSG. Use the Defense Health Program activity structure and codes for effective Defense Health Program budget execution tracking and program analysis and review (see DFAS–IN Manual

37–100–FY). Track execution of Defense Health Program and OMA resources provided for preventive medicine programs and services.

c. Develop, train, staff, equip, and operate augmentation response teams to support the full spectrum of military operations, including the stability and support operations defined and described throughout FM 8–42.

d. Coordinate support for Army Reserve and Army National Guard/Army National Guard of the United States units requiring preventive medicine services according to established memorandum of agreement/understanding, this regulation, and the guidance provided in DA Pam 40–11.

e. Ensure that any requests for reimbursable preventive medicine services (from Active Army or Reserve Component organizations) are assessed by preventive medicine staff in coordination with RMC resource management staff before accepting any additional missions or program growth. Such requests will be evaluated for impact on existing programs and resources and, if approved, will be provided according to Army reimbursable policy (see 31 USC 1535 and 1536).

f. Review and consolidate environmental program requirements submitted from military treatment facilities (MTFs) within the region for transmission to USAMEDCOM.

g. Conduct a formal evaluation of each installation Occupational Health Program within the region at least once every 3 years. Evaluation officials may come from occupational health assets within the region or from other USAMEDCOM assets. Results of these evaluations will be forwarded to USAMEDCOM along with formal plans for corrective actions. Correction of identified deficiencies also will be forwarded to USAMEDCOM when completed.

2–18. Commanders, U.S. Army medical centers and U.S. Army medical department activities

Commanders of USAMEDCENs and USAMEDDACs, as the local medical authorities, will—

a. Establish and provide effective installation and clinical preventive medicine programs and services, designating a chief of preventive medicine to execute the commander’s installation and clinical preventive medicine responsibilities. The primary purpose of preventive medicine services is to support installation commanders in preventing disease and injury throughout the health services support area, not to function solely as an in-house clinical service.

(1) Preventive medicine services will be resourced accordingly for the installation support mission—

(*a*) Personnel.

(*b*) Funding.

(*c*) Office and laboratory space.

(*d*) Equipment and supplies.

(*e*) Transportation and communication.

(2) The chief of preventive medicine, on behalf of the medical commander, is responsible for establishing, implementing, and directing the preventive medicine programs and services described in this regulation. The chief of preventive medicine, or his or her designee, will—

(*a*) Serve as consultant and provide preventive medicine liaison to the installation commander and staff and tenant activities.

(*b*) Establish and maintain liaison with appropriate Federal, state, and local public health authorities.

(*c*) Serve as the medical representative on installation boards, councils, and committees.

b. Plan, program, prioritize, budget, and resource all assets necessary to support installation and clinical preventive medicine programs and services based on the priorities, policy, and guidance from TSG. Use the Defense Health Program activity structure and codes for effective budget execution tracking and program analysis and review (see DFAS–IN Manual 37–100–FY). Track execution of Defense Health Program and OMA resources provided for preventive medicine programs and services (see DA Pam 40–11, para 1–6).

c. Provide local implementing guidance for installation and clinical preventive medicine programs and services described in this regulation.

d. Ensure that medical events on the current tri-Service list are reported through the Reportable Medical Events System (RMES) as soon as possible after the diagnosis has been made or within 48 hours. This includes case reports from subordinate clinics and clinics at satellite locations.

(1) The U.S. Army Medical Surveillance Activity (USAMSA) maintains the current tri-Service list of reportable medical events on the USAMSA Web site (<http://amsa.army.mil>). The staff at USAMSA can provide current versions of the RMES software for use at each preventive medicine service. Technical assistance may be obtained from USAMSA, USACHPPM, ATTN: MCHB–TS–EDM, Bldg. T20, 6900 Georgia Avenue, Washington, D.C. 20307–5001; or through the USAMSA Web site (http://amsa.army.mil/AMSA/amsa_home.htm).

(2) Commanders must also comply with all Federal, state and local medical reporting requirements including applicable Occupational Safety and Health Administration (OSHA) requirements for work-related injuries and illnesses.

e. Participate on Armed Forces disciplinary control boards and coordinate with representatives of civil agencies concerned with health and welfare as prescribed in AR 190–24/OPNAVINST 1620.2A/AFI 31–213/MCO 1620.2C/COMDTINST 1620.1D, chapter 2.

f. Coordinate with medical departments of other military services; appropriate representatives of international,

Federal, state, and local public health organizations; and those organizations responsible for developing consensus standards.

g. Ensure complete documentation of workload for all installation and clinical preventive medicine programs and services.

h. Provide a health consultant to the local installation child development services according to AR 608–10, paragraph 2–3c.

i. Provide preventive medicine representation to installation boards, councils, and committees, as directed by published instructions establishing such boards, councils, and committees.

j. Ensure that assigned military audiologists have the primary duty title of Installation Hearing Program Manager; that their primary responsibility is to manage the installation hearing clinical and conservation services; and that they are afforded at least 50 percent of their available time to accomplish the installation hearing conservation mission, for example, health education, unit visits, command inspections, and range inspections.

k. Ensure that the job series codes for all supported civilian employees are entered into medical surveillance databases.

l. Establish a Hospital Infection Control Program and a hospital infection control committee to oversee and guide efforts to prevent and control hospital-acquired infections according to the implementing guidance provided in DA Pam 40–11, chapter 2.

m. Ensure that any requests for reimbursable preventive medicine services (from either Active Army or Reserve Component organizations) are assessed by preventive medicine staff in coordination with USAMEDCEN or USAMED-DAC resource management staff prior to accepting any additional missions or program growth. Such requests will be evaluated for impact on existing programs and resources and, if approved, will be provided according to Army reimbursable policy (see 31 USC 1535 and 1536).

n. Serve as or appoint a director of health services as principal medical advisor to the installation commander and staff on health care delivery matters, including installation and clinical preventive medicine programs and services for the installation commander's area of responsibility. The director of health services, in coordination with the chief of preventive medicine services, will—

(1) Notify unit and installation commanders of special or potentially serious health problems. The initial telephonic or electronic notification will be followed by a written report within 72 hours. The purpose is to inform commanders of serious sanitary deficiencies, OEH hazards, potential epidemic conditions, or other serious situations that may affect the health of the command.

(2) Provide preventive medicine information along with other health-related input to the Installation Status Report according to AR 210–14, paragraphs 9 and 11, and implementing instructions as published by the DA Assistant Chief of Staff for Installation Management.

(3) Work with the installation safety manager to provide the installation commander with a comprehensive Safety and Occupational Health Program that includes, but is not limited to, ergonomics, injury prevention and control, respiratory protection, industrial hygiene, hearing conservation, vision conservation and readiness, hazard communication, laboratory safety, and occupational health surveillance.

(4) Provide technical and quality assurance oversight of the OEH Program, and provide qualifications and competency oversight for preventive medicine and occupational health service providers.

(5) Advise the installation commander on the health aspects of the installation Environmental Program, and arrange for medical consultation and support services.

(6) Work with the installation pest management coordinator on prevention and control of medically important pests and OEH exposures from pest management operations.

o. Coordinate with field units within the area of responsibility to provide any required or requested supplemental preventive medicine support.

p. Maintain a deployable medical augmentation team to reinforce the medical response team on installations having a chemical surety mission.

q. Designate physicians to provide required physician support to each Occupational Health Program supported by the command, including supported installations where no physician is assigned.

2–19. The Commander, U.S. Army Center for Health Promotion and Preventive Medicine

The Commander, USACHPPM, will—

a. Provide worldwide support of Army preventive medicine activities through consultations, program evaluations, supportive services, program development, development of best practices, investigations, and training in the areas of disease and injury prevention and control; field preventive medicine; environmental health; occupational health; health surveillance and epidemiology; Soldier, family, and community health, and health promotion; preventive medicine toxicology and laboratory services; health risk assessment; and health risk communication.

b. Provide support for comprehensive health surveillance for the Army and DOD, and develop and maintain data analysis and archiving for worldwide military health surveillance activities such as the Defense Medical Surveillance System and DOEHRS. This will include, at a minimum—

- (1) Summarizing reportable medical events, injuries, and conditions across installations and commands, and notifying all reporting sites at least monthly.
- (2) Assuring injury data are synchronized with Army accidental injury data and with AR 385-40 reporting requirements by direct coordination with the U.S. Army Combat Readiness Center.
- (3) Updating and distributing, as needed through official preventive medicine channels, the tri-Service list of reportable medical events, and maintaining the current reportable medical events list on the USAMSA Web site.
- (4) Providing timely and useful feedback to assist garrison and field commanders in reducing OEH risks.
 - c. Provide reference laboratory support for OEH surveillance. These programs include but are not limited to the laboratory quality assurance for the DOD Cholinesterase Monitoring Program; radiological bioassay for the Army; and toxicity clearances and toxicological profiles for chemicals, radiological materials, and unregulated substances commonly found in the military.
 - d. Develop, train, staff, equip, and operate preventive medicine augmentation response teams to support the full spectrum of military operations as defined and described throughout FM 4-02 and FM 8-42.
 - e. Provide additional preventive medicine material and personnel augmentation and Preventive Medicine Level V support to deployed forces, including theater medical laboratory support when requested.
 - f. Serve as the lead agent and the Army liaison for the DOD in executing the Memorandum of Understanding between the Agency for Toxic Substances and Disease Registry and the DOD.
 - g. Augment local preventive medicine assets by providing installation-level preventive medicine services as directed or as approved by Commander, USAMEDCOM. Such installation-level support may require regionally established memoranda of understanding and close coordination with the medical commander for the region in which support services are provided.
 - h. Plan, program, budget, and resource USACHPPM preventive medicine capabilities according to priorities set by the USAMEDCOM using the Defense Health Program activity structure and codes for tracking and accountability of Defense Health Program resources. Track execution of any Defense Health Program and OMA resources provided to USACHPPM for preventive medicine programs and services.
 - i. Provide support to commanders in developing and implementing installation ergonomics and occupational health programs.
 - j. Conduct periodic evaluations of regional and local preventive medicine programs and services in support of USAMEDCOM oversight responsibilities.
 - k. Ensure that any requests for reimbursable preventive medicine services (from either Active or Reserve Component military organizations) are assessed by USACHPPM technical staff in coordination with USACHPPM resource management staff prior to accepting any additional missions or program growth. Such requests will be evaluated for impact on existing programs and resources and, if approved, will be provided according to Army reimbursable policy (see 31 USC 1535 and 1536).
 - l. Provide the following pest management programs and services:
 - (1) Provide consultative, field, and laboratory services to monitor, evaluate, and support the USAMEDD's role in the Army Pest Management Program. These include—
 - (a) The Pesticide Regulatory Action System to include the operation of the DOD Pesticide Hotline.
 - (b) The DOD Lyme Disease Program and other tick-borne disease prevention programs.
 - (2) Field a Pesticide-Use Reporting System to Army preventive medicine units.
 - (3) Serve as the DA repository for the archiving of pesticide use reports generated by deployed forces.
 - (4) Maintain laboratories for the surveillance, identification, and analyses of vector-borne diseases.
 - m. Operate and maintain the DOD Serum Repository for medical surveillance for clinical diagnosis and epidemiology studies. According to DODD 6490.2, paragraphs 4.12 and 4.13, the serum repository will be used for the identification, prevention, and control of diseases associated with military service. The serum repository and other systems of records containing health surveillance information will comply with the DOD Privacy Program, as defined in DODD 5400.11.
 - n. Provide OEH guidance to assist commanders in applying the Army risk management process to OEH hazards.
 - o. Establish and maintain a capability to provide a comprehensive support for the conduct of OEH operational health risk assessments for garrison activities and deployments.
 - p. Provide the capability to support the TSG responsibility to review and approve human health risk assessments.
 - q. Provide the capability to support the TSG responsibility to review ecological risk assessments.
 - r. Provide technical sustainment training to installation preventive medicine organizations and field (TOE) preventive medicine units upon request or as directed.
 - s. Coordinate with USATRADOC to develop training aids for cadre training on mitigating deployment and garrison risks for communicable diseases and injuries.
 - t. Provide epidemiologic consultation services to RMCs, ACOMs, Army service component commands, and direct reporting units upon request. These services may include informal or formal analysis, reports, and recommendations.

As needed to support this service, the Commander, USACHPPM, will deploy teams to on-site locations to conduct or assist in field investigations of disease or injury outbreaks or clusters.

u. Review, interpret, and respond to assessment and surveillance data, as needed, to identify, prevent, and control newly identified or evolving health problems. Response capabilities will include regular communication with preventive medicine staffs at the RMCs, ACOMs, Army service component commands, and direct reporting units.

v. Provide technical consultation on Federal Employees' Compensation Act (Sections 8101–8193, Title 5, United States Code (5 USC 8101–8193)), perform review and analysis of available civilian lost-day data, and provide recommendations for targeted interventions to prevent and mitigate work-related injuries and illnesses.

w. Partner with the Director of Army Safety to support the Army Safety and Occupational Health Program.

x. Provide DOD certification training to personnel who sign shipping papers for the transport of medical specimens to include infectious substances, select agents, and regulated medical waste. (See DOD 4500.9-R, chapter 204, part II.)

2–20. The Director, DOD Veterinary Service Activity

The Director, DOD Veterinary Service Activity will—

a. Coordinate with the USAMEDD Functional Proponent for Preventive Medicine on veterinary preventive medicine issues.

b. Develop standards, criteria, and methods to determine the safety of—

- (1) Foodstuffs contaminated with chemical or biological material.
- (2) Subsistence and equipment damaged by man-made or natural disasters.

2–21. Veterinary commanders

Veterinary commanders will, when requested, provide veterinary assets, as resources permit—

a. To support preventive medicine installation and field food sanitation programs, the screening and approval of pets in child development centers and family child care homes, and public health education activities.

b. To support and coordinate zoonotic disease surveillance and control efforts with preventive medicine epidemiology assets.

c. To support theater preventive medicine surveillance by providing any analytical results obtained during a foodborne illness investigation and from the sampling and analysis of all locally procured (within the theater of operations) bottled water, food, and ice to the USACHPPM Deployment Environmental Surveillance Program at USACHPPM, ATTN: MCHB–TS–RDE, 5158 Blackhawk Road, Aberdeen Proving Ground, MD 21010–5403, for database archiving.

2–22. The Commander, U.S. Army Dental Command

The Commander, USADENCOM will coordinate with the USAMEDD Functional Proponent for Preventive Medicine concerning the health promotion and disease prevention aspects of dental services.

a. Initiatives that support oral health include, but are not limited to, nutrition counseling, tobacco use cessation, delivery of dental sealants and mouth guards, and other preventive medicine program components supporting oral health such as fluoridation of drinking water supplies.

b. The semiannual Community Oral Health Protection Report (formerly the Preventive Dentistry Report) data are submitted through the USADENCOM's Web-based reporting system termed the Corporate Data Application located at <https://conus.dencom.army.mil/>. The data and accompanying narrative provide documentation of activities and outcomes of the Clinical Oral Health and Health Promotion Program as well as the Community Health Promotion and Disease Prevention Program.

2–23. The Commander, U.S. Army Medical Department Center and School

The Commander, USAMEDDC&S, will—

a. Identify, develop, and validate Active Army and Reserve Component preventive medicine requirements. Develop and provide doctrine, training, leader development, organization, and Soldier system solutions to those requirements. Coordinate, through USAMEDCOM, with USAMRMC in the development of materiel solutions to preventive medicine requirements.

b. Coordinate, through the appropriate chain of command, with USAMEDCOM subordinate commands and Reserve Component organizations for participation in and technical support of the preventive medicine components of the training mission and functions of the Academy of Health Sciences.

c. Coordinate, through the appropriate chain of command, with USAMEDCOM subordinate commands and Reserve Component organizations for preventive medicine participation in, and support of, force integration activities, such as—

- (1) Combat and doctrine development.
- (2) Force structure and analysis.
- (3) Theater medical information management.

- (4) Technology insertion.
- (5) War fighting experimentation.
- (6) USAMEDD systems integration.
- (7) Operational test and evaluation.
- (8) Strategic planning and force management.

d. Coordinate, through the appropriate chain of command, with USAMEDCOM subordinate commands and Reserve Component organizations for planning and providing preventive medicine sustainment training for individuals and units.

e. Coordinate, through USAMEDCOM, with the USAMEDD Functional Proponent for Preventive Medicine concerning USAMEDD preventive medicine personnel proponent issues.

f. Coordinate, through the appropriate chain of command, with USATRADO to incorporate preventive medicine principles into officer and enlisted training manuals and Soldier common task training manuals.

g. Represent and advocate through USATRADO, and in coordination with USAMRMC, preventive medicine-related Army science and technology objectives.

h. Provide preventive medicine doctrine and training on reportable medical events, the use of the RMES software, pesticide use reporting and recordkeeping, and the North Atlantic Treaty Organization disease and injury reporting procedures.

i. Incorporate appropriate preventive medicine training in command surgeon preparation courses such as brigade/division surgeons' courses, USAMEDD Officer Basic Course, U.S. Army School of Aviation Medicine's Army Flight Surgeons' Primary Course to include deployment surveillance requirements and procedures, OEH-related diseases and injuries, travel medicine, and field preventive medicine.

j. Train health care providers on the principles of preventive medicine and the basics of OEH threats, their potential for health effects, and requirements for treatment and/or medical surveillance.

k. Establish, maintain, and disseminate lessons learned from deployment OEH-related issues from previous and ongoing deployments.

l. Update training support packages for mitigating risk of communicable diseases, injuries, combat and operational stress reactions, and suicide.

2-24. The Commander, U.S. Army Medical Research and Materiel Command

The Commander, USAMRMC, will—

a. Provide biomedical materiel and information solutions for military public health capabilities to enhance, sustain, and protect health, fitness, and performance.

b. Provide capabilities to support DOD and joint surveillance and laboratory diagnosis of emerging and reemerging infectious diseases of military significance.

c. Provide capabilities to support the surveillance for early notification of disease outbreaks of military importance..

d. Support the graduate medical education residency training programs in preventive medicine and occupational medicine through the Walter Reed Army Institute of Research, in collaboration with USACHPPM.

2-25. Health care providers

Health care providers will—

a. Promote the health and fitness of their patients by integrating appropriate and current prevention strategies in their delivery of primary care services.

b. Support and participate in the advocacy of approved Army health promotion and preventive medicine and population health improvement activities.

c. Inform the supporting preventive medicine service of—

(1) All incidences of disease and injury on the Tri-Service Reportable Events list as well as any other incidences that must be reported to local civilian public health authorities, using the guidance provided in DA Pam 40-11 (<http://amsa.army.mil>).

(2) Disease or injury hazards that may require preventive medicine assessment and intervention.

2-26. Commanders at all levels

Commanders at all levels are responsible and accountable for the health of their command. They will—

a. Ensure that the health of all personnel in their command is sustained and protected in all military activities through aggressive implementation of preventive medicine activities. Command Preventive Medicine Program responsibilities should include—

(1) Training.

(2) Hazard control.

(3) Proper use of personal protective measures and protective clothing and equipment.

(4) Immunization and chemoprophylaxis.

- (5) Health risk and hazard communication.
- (6) Worksite, occupational health, and environmental health surveillance.
- (7) Workplace violence prevention.
- b.* Program and budget for resources, and provide training to comply with individual and unit responsibilities for improving and maintaining health and fitness.
- c.* Implement health surveillance requirements ensuring that Soldiers and civilian employees under their command who are enrolled in an Occupational Medicine Surveillance Program comply with the occupational medicine surveillance requirements including pre-placement, periodic, and outprocessing or termination medical evaluation (see DA Pam 40–11, chap 5, and FM 4–02.17, chap 9).
- d.* Provide leadership and personal example in improving and sustaining individual and unit health and fitness.
- e.* Ensure that contingency and operational plans include the appropriate elements of preventive medicine.
- f.* Minimize health risks using Army composite risk management principles (see FM 5–19).
- g.* Adhere to Federal, state, and host nation statutory and regulatory laws, directives, licenses, and guidance governing OEH in garrison and during training exercises. These statutes and regulations will also apply during military operational deployments and war unless specifically exempted by appropriate authority based on the tactical situation.
- h.* Ensure that contracts provide for adherence to occupational health laws and regulations.

2–27. Installation commanders and state and territory adjutants general

- a.* Installation commanders and state and territory adjutants general are responsible and accountable for providing a safe and healthy environment for all assigned and supported military personnel. They will also ensure that required preventive medicine programs and services are provided to all personnel under their command and all other military personnel they support, such as tenant organizations. Such preventive medicine support will be provided in coordination with the supporting medical commander and that commander’s preventive medicine assets. Preventive medicine support of tenant organizations and other supported military personnel will be established through local installation or other type of support agreement. (See DA Pam 40–11, chaps 1–11 and apps B–G, for implementing guidance.)
- b.* Installation commanders are responsible for resourcing and implementing the preventive medicine components of installation infrastructure and services in coordination with the director of health services and the chief of preventive medicine services. Installation commanders provide the safe and healthy living and work environments and services such as drinking water, food, safe worksites, and recreational activities. Preventive medicine personnel provide the medical oversight and monitoring of installation infrastructure and services that may pose health threats. They provide the technical advice and assistance to installation commanders to minimize risks from such threats.
- c.* Installation occupational health programs and services that will include, but are not limited to the following:
 - (1) Safety and Occupational Health Program according to AR 385–10, chapter 4, and 29 CFR Part 1960.
 - (2) Ergonomics Program with an ergonomics subcommittee and an installation ergonomics officer according to DA Pam 40–21, chapters 1–7 and appendix B.
 - (3) Respiratory Protection Program according to AR 11–34, chapters 1–3.
 - (4) Hearing Conservation Program according to DA Pam 40–501, chapters 1–10.
 - (5) Vision Conservation and Readiness Program according to DA Pam 40–506, chapters 1–6 and appendixes B–H.
 - (6) Health Promotion Program according to AR 600–63, paragraph 1–19 and chapters 2–3.
 - (7) The Army Industrial Hygiene Program according to DA Pam 40–503, chapters 1–7 and appendixes B–D.
 - (8) The Army Radiation Safety Program according to AR 11–9, paragraph 1–4j, chapters 2–6 and appendixes A–C.

2–28. Unit and command surgeons

Unit and command surgeons, as the senior USAMEDD officers present for duty within a headquarters (other than medical), will—

- a.* Advise the command on all preventive medicine matters pertaining to the command.
- b.* Provide staff and technical oversight of all preventive medicine assets of the command.
- c.* Provide implementing guidance for field preventive medicine programs and services.
- d.* Ensure that medical events on the current Tri-Service Reportable Events list are reported through the RMES as soon as possible after the diagnosis has been made or within 48 hours.
- e.* Coordinate preventive medicine support provided to the command by installation medical assets with the medical asset commander or installation director of health services and the chief of preventive medicine services of the supporting USAMEDCEN or USAMEDDAC.

2–29. Unit commanders and leaders

Unit commanders and leaders will—

- a.* Inform, motivate, train, and equip subordinates and work closely with Army preventive medicine personnel to defeat the threat of DNBI. Broad categories of DNBI include—
 - (1) Heat injuries caused by heat stress and insufficient water consumption.

- (2) Cold injuries caused by combinations of low temperatures, wind, and wetness.
- (3) Diseases and injuries caused by arthropods, other animals, and hazardous plants.
- (4) Diarrheal diseases caused by drinking contaminated water, eating contaminated foods, and not practicing good personal and unit sanitation and hygiene measures.
- (5) Diseases, trauma, or injuries caused by poor health or fitness or injuries caused by training or sports.
- (6) Occupational and environmental diseases and injuries caused by physical, chemical, biological, and radiological hazards.
- (7) Disease threats resulting from exposure at high altitudes.
- (8) Communicable diseases and sexually transmitted diseases.
- (9) Noise-induced hearing injury.
- b.* Ensure compliance with preventive medicine guidance and the use of countermeasures.
- c.* Promote combat and operational stress control programs and procedures.
- d.* Ensure the establishment, manning, training, and equipping of unit FSTs at the company level, or obtain FST support from another unit, according to Army doctrine published in FM 4–02.17, chapters 1–2; FM 4–25.12, chapters 1–2 and appendixes A–D; and FM 8–55, paragraphs 11–1 through 11–6.
- e.* Execute the unit leader responsibilities defined in FM 4–02.17. U.S. Army Reserve Component unit commanders and leaders may request guidance and support from the local Active Army RMC, using the RMC point of contact for Reserve Component support.
- f.* Provide after-action reports after deployments and training exercises that include preventive medicine issues to the USAMEDDC&S as part of the Center for Army Lessons Learned Program (see AR 11–33).
- g.* Record and report all pesticide applications, except arthropod skin and clothing repellent applications, according to the guidance in DA Pam 40–11, chapter 4.
- h.* Ensure compliance with pre- and post-deployment surveillance procedures.

2–30. Managers and supervisors at all levels

- a.* Army managers and supervisors at all levels will—
 - (1) Ensure that the health of all personnel under their supervision is sustained and protected in all Army activities through aggressive implementation of preventive medicine activities, to include—
 - (*a.*) Training.
 - (*b.*) Hazard control.
 - (*c.*) Immunizations and chemoprophylaxis.
 - (*d.*) Health risk and hazard communication.
 - (*e.*) Worksite, OEH surveillance.
 - (2) Program and budget resources to—
 - (*a.*) Correct workplace deficiencies and control hazards.
 - (*b.*) Provide training to comply with individual and unit responsibilities according to FM 8–55, paragraphs 11–5 and 11–6, and FM 21–10/MCRP 4–11.1D, chapters 1–2 and appendix A.
 - (3) Implement health surveillance requirements, ensuring that personnel enrolled in an Occupational Medicine Surveillance Program comply with the occupational medicine surveillance requirements including pre-placement, periodic, and outprocessing or termination medical evaluations (see DA Pam 40–11, chap 5, and FM 4–02.17, chap 9).
 - (4) Provide leadership and personal example in improving and sustaining individual and unit health and fitness.
 - (5) Ensure that contingency and operational plans include the appropriate elements of preventive medicine.
 - (6) Minimize health risks using Army composite risk management principles (see FM 5–19).
 - (7) Adhere to Federal, state, and host nation statutory and regulatory laws, directives, licenses, and guidance governing OEH in garrison and during training exercises. These statutes and regulations will also apply during military operational deployments and war unless specifically exempted by appropriate authority based on the tactical situation.
 - (8) With respect to civilian employees—
 - (*a.*) Ensure that essential elements of the job and potential health hazards are identified in the job description.
 - (*b.*) Ensure that any requirements to undergo a medical examination; receive laboratory testing and immunization; and use protective clothing and equipment, including respiratory equipment, safety eye and foot wear, and hearing protection, are written in job descriptions and job announcements as conditions of employment.
 - (*c.*) Ensure that employees comply with the pre-placement, periodic, and outprocessing medical surveillance requirements of their employment.
 - (*d.*) Request an occupational health evaluation of personnel with an occupational illness or injury at the time of illness or injury and whenever new job restrictions are imposed or accommodations are required. Supervisors should refer employees who have a work-related injury or illness to the supporting occupational health services, or have the employees see their treating physicians, for periodic reevaluation of their ability to work until the employees return to full duty (see DOD 1400.25–M, subchap 810).

(e) Ensure that personnel enrolled in a Medical Surveillance Program complete a baseline, periodic, and outprocessing or termination medical evaluation.

(f) Provide to occupational health services a copy of the releasable portions of DOL Forms CA-1 (Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation), CA-2 (Federal Employee's Notice of Occupational Disease and Claim for Compensation), and CA-20 (Attending Physician's Report), if applicable.

(g) Refer all employees to occupational health services before they return to duty from any absence due to any illness or injury that could impair their job performance according to Equal Employment Opportunity Commission (EEOC) guidelines (see EEOC Notice Number 915.002).

(h) Refer food handlers and patient care personnel to occupational health services before they return to duty from any absence due to illness according to EEOC guidelines noted in paragraph (g), above.

(9) Be held personally accountable, by appropriate means, for preventive medicine compliance of their subordinates.

b. U.S. Army Reserve Component managers and supervisors may request guidance and support from the local Active Army RMC, using the appropriate chain of command and the RMC point of contact for Reserve Component support.

2-31. Civilian personnel or human resources managers

Local servicing civilian personnel support offices or human resources managers will take the following actions, subject to EEOC guidelines and U.S. Office of Personnel Management regulations, to assist medical personnel in implementing the Army Occupational Health and Safety Program:

a. Provide consultative assistance to managers and supervisors for their responsibilities described in paragraph 2-30.

b. Refer applicants for jobs with medical standards or physical requirements or that are part of a Medical Evaluation Program for preplacement physical examinations.

(1) Coordinate the scheduling of the exam with the employee, the supervisor, and the health clinic.

(2) Provide the examining medical officer the physical and psychological job requirements.

c. Ensure that all new personnel whose jobs have medical standards or physical requirements inprocess through the supporting occupational health services. New personnel whose jobs do not have medical standards or physical requirements may voluntarily inprocess through the supporting occupational health services.

d. During outprocessing or termination of employment—

(1) Assist management in ensuring that departing personnel enrolled in a Medical Surveillance Program complete an outprocessing or termination medical evaluation.

(2) Include occupational health services on all personnel outprocessing checklists for those personnel whose jobs have medical standards or physical requirements or are part of a Medical Evaluation Program.

(3) Offer voluntary outprocessing to those personnel whose jobs do not have medical standards or physical requirements or are not part of a Medical Evaluation Program.

e. Provide the supporting occupational health services a list of all local civilian personnel whose jobs have medical standards or physical requirements or are part of a Medical Evaluation Program and their job series codes within the supporting occupational health services' local areas of responsibility for use in medical surveillance planning and implementation.

2-32. Installation Federal Employee Compensation Act or Injury Compensation Program administrator

The installation Injury Compensation Program administrator, assisted by local or organizational personnel who are assigned injury compensation duties, will—

a. Provide consultative assistance to managers and supervisors for their responsibilities related to employee injury and illness compensation described in paragraph 2-30.

b. Advise and support the installation safety and occupational health advisory council, as established by AR 385-10, paragraph 2-1k, on injury compensation matters.

c. Make available to health care providers who treat employees with occupational injuries and illnesses the necessary forms for completion as well as job requirements and environmental conditions. Such forms will include DOL Forms CA-1, CA-2, CA-17 (Duty Status Report), and CA-20 or equivalent medical documentation.

d. Provide occupational health services a copy of the position description, the physical and environmental requirements of the position, and personnel-related questions for any fitness-for-duty medical examination recommended by management, in conjunction with the supporting civilian personnel or human resources office.

e. Refer personnel at the time of injury or illness, or when reasonably required, to occupational health services, or to their treating physicians, for a duty status determination when such personnel will be absent from work or have work limitations due to their work-related injuries or illnesses.

2-33. Military personnel officers

a. Military personnel officers for both TDA and TOE units will—

(1) Ensure all Soldier inprocessing and outprocessing checklists include occupational health services where such services are provided.

(2) Assist commanders in ensuring that Soldiers enrolled in an Occupational Medicine Surveillance Program comply with the occupational medicine surveillance requirements including a pre-placement and an outprocessing or termination medical evaluation.

(3) Provide a list of all Soldiers including their military occupational specialty codes to occupational health services, where such services are provided, for use in medical surveillance databases.

(4) Support the application of medical information management tools to document unit and individual Soldier medical readiness.

b. Military personnel officers at initial entry training installations will provide installation troop strength data weekly to the supporting medical commander.

c. U.S. Army Reserve unit personnel officers will contact the supporting Active Army RMC's Reserve Component support point of contact, through the appropriate chain of command, for guidance and assistance.

2-34. Army personnel

All Army personnel will—

a. Apply personal protective measures and use protective clothing and equipment when required.

b. Share the responsibility for ensuring a safe and healthy work environment by following administrative and engineering hazard controls.

c. Report unsafe conditions, hazardous exposures, and occupational injury or illness to their supervisors.

d. Report to the supporting occupational health services for medical examination or treatment for occupational injuries and illnesses as prescribed by established procedures.

Appendix A References

Section I

Required Publications

Except as noted below, Army regulations and DA pamphlets are available online from the U.S. Army Publishing Directorate Web site: <http://www.apd.army.mil/>. Field manuals are available online from the General Dennis J. Reimer Training and Doctrine Digital Library Web site: <http://www.train.army.mil/>. Technical bulletins, medical and USACHPPM technical guides are available online from the USACHPPM Web site: <http://chppm-www.apgea.army.mil>. DOD manuals, directives, and instructions are available online from the Washington Headquarters Services Web site: <http://www.dtic.mil/whs/directives>.

AR 11-9

The Army Radiation Safety Program. (Cited in para 2-27c(8).)

AR 11-34

The Army Respiratory Protection Program. (Cited in para 2-27c(3).)

AR 40-10

Health Hazard Assessment Program in Support of the Army Materiel Acquisition Decision Process. (Cited in para 2-8a(5).)

AR 70-1

Army Acquisition Policy. (Cited in paras 2-3a and 2-8a(5).)

AR 190-24/OPNAVINST 1620.2A/AFI 31-213/MCO 1620.2C/COMDTINST 1620.1D

Armed Forces Disciplinary Control Boards and Off-Installation Liaison and Operations. (Cited in para 2-18e.)

AR 200-1

Environmental Protection and Enhancement. (Cited in paras 2-3a and 2-8b(4).)

AR 210-14

The Army Installation Status Report Program. (Cited in para 2-18n(2).)

AR 385-10

The Army Safety Program. (Cited in paras 2-27c(1) and 2-32b.)

AR 385-16

System Safety Engineering and Management. (Cited in para 2-3a.)

AR 385-40

Accident Reporting and Records. (Cited in para 2-19b(2).)

AR 385-61

The Army Chemical Agent Safety Program. (Cited in para 2-8b(6).)

AR 385-69

Biological Defense Safety Program. (Cited in para 2-8b(6).)

AR 600-63

Army Health Promotion. (Cited in paras 1-7f(3) and 2-27c(6).)

AR 608-10

Child Development Services. (Cited in para 2-18h.)

DA Pam 40-11

Preventive Medicine. (Cited in paras 1-7, 1-7a(2), 1-7b(4), 1-7b(4)(c), 1-7c(2), 1-7d(2), 1-7d(3), 1-7e(3), 1-7f(2), 1-7f(4), 1-7g(2), 1-7g(3), 1-7h(2), 1-7i(2), 2-17a, 2-17d, 2-18b, 2-18l, 2-25c(1), 2-26c, 2-27a, 2-29g, and 2-30a(3).)

DA Pam 40-21

Ergonomics Program. (Cited in para 2-27c(2).)

DA Pam 40-501

Hearing Conservation Program. (Cited in para 2-27c(4).)

DA Pam 40-503

Industrial Hygiene Program. (Cited in para 2-27c(7).)

DA Pam 40-506

The Army Vision Conservation and Readiness Program. (Cited in para 2-27c(5).)

Executive Order 12196

Occupational and Safety Health Programs for Federal Employees. (Cited in para 1-5c.) (Available at <http://www.nara.gov/federal.register/index.html>.)

FM 4-02

Force Health Protection in A Global Environment. (Cited in paras 1-7b(3), 1-7b(4), and 2-19d.)

FM 4-02.16

Army Medical Information Management Tactics, Techniques, and Procedures. (Cited in para 1-7b(4)(d).)

FM 4-02.17

Preventive Medicine Services. (Cited in paras 1-7b(4), 1-7b(4)(b), 1-7b(4)(c), 2-26c, 2-29d, 2-29e, and 2-30a(3).)

FM 4-02.18

Veterinary Services Tactics, Techniques, and Procedures. (Cited in para 1-7b(4).)

FM 4-02.19

Dental Service Support In a Theater of Operations. (Cited in para 1-7b(4).)

FM 4-25.12

Unit Field Sanitation Team. (Cited in paras 1-7b(4), 1-7b(4)(a), 1-7b(4)(b), and 2-29d.)

FM 8-42

Combat Health Support in Stability Operations and Support Operations. (Cited in paras 2-17c and 2-19d.)

FM 8-51

Combat Stress Control in a Theater of Operations Tactics, Techniques, and Procedures. (Cited in para 1-7b(4).)

FM 8-55

Planning for Health Service Support. (Cited in paras 1-7b(4), 1-7b(4)(a), 2-29d, and 2-30a(2)(b).)

FM 21-10/MCRP 4-11.1D

Field Hygiene and Sanitation. (Cited in paras 1-7b(4)(a) and 2-30a(2)(b).)

FM 5-19

Composite Risk Management. (Cited in paras 2-26f and 2-30a(6).)

Public Law 91-596

Occupational Safety and Health Act of 1970, 84 Stat. 1590, as amended. (Cited in para 2-8b(8).) (Available at http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=OSHACT&p_id=2743.)

5 USC 8101-8193

Federal Employees' Compensation Act. (Cited in para 2-19v.) (Available at <http://uscode.house.gov/search/criteria.php> or <http://www.dol.gov/esa/regs/compliance/owcp/INDEXofResources.htm#bookmark2>.)

42 USC 201

Public Welfare, Department of Health and Human Services, Administrative and Miscellaneous Provisions. (Cited in paras 1-5o.) (Available at <http://uscode.house.gov/search/criteria.php>.)

29 CFR Part 1960

Basic Program Elements for Federal Employee Occupational Safety and Health Programs and Related Matters. (Cited in para 2-27c(1).) (Available at <http://www.gpoaccess.gov/cfr/index.html>.)

45 CFR Parts 160, 162, and 164

Health Insurance Reform: Modifications to Electronic Data Transactions Standards and Code Sets. (Cited in para 1-5o.) (Available at <http://www.gpoaccess.gov/cfr/index.html>.)

Section II

Related Publications

A related publication is a source of additional information. The user does not have to read it to understand this publication.

AR 5-22

The Army Proponent System

AR 10-5

Headquarters, Department of the Army

AR 10-88

Field Operating Agencies, Office of Chief of Staff, Army

AR 11-2

Management Control

AR 11-33

Army Lessons Learned Program: System Development and Application

AR 40-1

Composition, Mission, and Functions of the Army Medical Department

AR 40-3

Medical, Dental, and Veterinary Care

AR 40-35

Dental Readiness and Community Oral Health Protection

AR 40-216

Neuropsychiatry and Mental Health

AR 40-656/NAVSUPINST 4355.10/MCO 10110.45

Veterinary Surveillance Inspection of Subsistence

AR 40-657/NAVSUP 4355.4H/MCO P10110.31H

Veterinary/Medical Food Safety, Quality Assurance, and Laboratory Service

AR 40-905/SECNAVINST 6401.1A/ARI 48-131

Veterinary Health Services

AR 70-45

Scientific and Technical Information Program

AR 200-2

Environmental Effects of Army Actions

AR 200-5

Pest Management

AR 350-10

Management of Army Individual Training Requirements and Resources

AR 381-11

Productions Requirements and Threat Intelligence Support to the U.S. Army

AR 600-9

The Army Weight Control Program

AR 600-60

Physical Performance Evaluation System

AR 600-85

Army Substance Abuse Program (ASAP)

AR 600-110

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

AR 602-2

Manpower and Personnel Integration (MANPRINT) in the System Acquisition Process

AR 608-18

The Army Family Advocacy Program

AR 623-105

Officer Evaluation Reporting System

AR 690-300

Employment (Civilian Personnel)

AR 700-48

Management of Equipment Contaminated with Depleted Uranium or Radioactive Commodities.

AR 700-135

Soldier Support in the Field

AR 700-136

Tactical Land Based Water Resources Management in Contingency Operations

DA Pam 40-578

Health Risk Assessment Guidance for the Installation Restoration Program and Formerly Used Defense Sites

DA Pam 385-40

Army Accident Investigation and Reporting

DFAS-IN Manual 37-100-FY

The Army Management Structure. (Available at <http://www.asafm.army.mil/secretariat/document/dfas37-100/dfas37-100.asp>)

DOD 1400.25-M

Department of Defense Civilian Personnel Manual

DOD 4500.9-R

Defense Transportation Regulation

DOD 6055.5-M

Occupational Medical Surveillance Manual

DODD 1000.3

Safety and Occupational Health Policy for the Department of Defense

DODD 1010.10

Health Promotion and Disease/Injury Prevention

DODD 4715.1

Environmental Security

DODD 5134.8

Assistant to the Secretary of Defense for Nuclear and Chemical and Biological Defense Programs (ATSD(NCB))

DODD 5400.11

DOD Privacy Program

DODD 6000.12

Health Services Operations and Readiness

DODD 6050.16

DOD Policy for Establishing and Implementing Environmental Standards at Overseas Installations

DODD 6200.4

Force Health Protection (FHP)

DODD 6490.2

Comprehensive Health Surveillance

DODI 1322.24

Medical Readiness Training

DODI 1336.5

Automated Extracts of Active Duty Military Personnel Records

DODI 4150.7

DOD Pest Management Program

DODI 4715.7

Environmental Restoration Program

DODI 6050.5

DOD Hazard Communication Program

DODI 6055.1

DOD Safety and Occupational Health (SOH) Program

DODI 6055.5

Industrial Hygiene and Occupational Health

DODI 6055.7

Accident Investigation, Reporting, and Record Keeping

DODI 6055.8

Occupational Radiation Protection Program

DODI 6055.11

Protection of DOD Personnel from Exposure to Radiofrequency Radiation and Military Exempt Lasers

DODI 6055.12

DOD Hearing Conservation Program (HCP)

DODI 6060.2

Child Development Programs (CDPs)

DODI 6060.3

School-Age Care (SAC) Program

DODI 6205.2

Immunization Requirements

DODI 6205.4

Immunization of Other Than U.S. Forces (OTUSF) for Biological Warfare Defense

DODI 6490.03

Deployment Health

DOD Information Memorandum

Military and Veterans Health Coordinating Board (MVHCB) and Presidential Review Directive-5 (PRD-5). December 1999. (For information regarding this publication, contact the Assistant Secretary of the Army for Installations and Environment (ASA(I&E)), 110 Army Pentagon, Washington, DC 20310-0110.)

EEOC Notice Number 915.002

Enforcement Guidance: Disability-Related Inquiries and Medical Examinations of Employees Under the Americans With Disabilities Act (ADA). July 27, 2000. Equal Employment Opportunity Commission (EEOC). (Available at <http://www.eeoc.gov/policy/docs/guidance-inquiries.html>.)

Engineer Manual 385-1-1

Safety and Health Requirements Manual, USACE, latest edition. (Available at <http://www.usace.army.mil/inet/usace-docs/eng-manuals/em385-1-1/entire.pdf>.)

FM 3-11.34/MCWP 3-37.5/NTTP 3-11.23/AFTTP(I) 3-2.33

Multi-Service Procedures for Nuclear, Biological, and Chemical (NBC) Defense of Theater Fixed Sites, Ports, and Airfields

FM 3-100.4/MCRP 4-11B

Environmental Considerations in Military Operations

FM 4-02.33

Control of Communicable Diseases Manual

Force Health Protection Capstone Document

Available at <http://www.deploymentlink.osd.mil/pdfs/fhp2004.pdf>.

Joint Publication 1-0

Joint Doctrine for Personnel Support to Joint Operations. (Available at http://www.dtic.mil/doctrine/jel/new_pubs/jp1_0.pdf.)

Joint Publication 1-02

Department of Defense Dictionary of Military and Associated Terms. (Available at http://www.dtic.mil/doctrine/jel/new_pubs/jp1_02.pdf.)

Joint Publication 4-02

Doctrine for Health Service Support in Joint Operations. (Available at http://www.dtic.mil/doctrine/jel/new_pubs/jp4_02.pdf.)

Memorandum

Office of DASA (ESOH), 20 March 1998, subject: Agency for Toxic Substances and Disease Registry (ATSDR) Program Management Plan. (Available at <http://chppm-www.apgea.army.mil/atsdr/docs.aspx>.)

Memorandum of Understanding

The Agency for Toxic Substances and Disease Registry, U.S. Public Health Service, and the U.S. Department of Defense, The Development of Toxicological Profiles for Hazardous Substances and Public Health Assessments and Related Activities at DOD Facilities, 22 November 2004. (Available at <http://chppm-www.apgea.army.mil/atsdr/Documents/MOUfinal21Nov04ATSDR.pdf> and <http://chppm-www.apgea.army.mil/atsdr/Documents/ATSDRMOU2004signaturepage.pdf>.)

Institute of Medicine Report

Noise and Military Service: Implications for Hearing Loss and Tinnitus. (2006). National Academy of Sciences. (Available at <http://www.nap.edu>.)

Institute of Medicine Report

Potential Radiation Exposure in Military Operations: Protecting the Soldier Before, During and After. (1999). National Academy of Sciences. (Available at <http://www.nap.edu>.)

Institute of Medicine Report

Protecting Those Who Serve: Strategies to Protect the Health of Deployed U.S. Forces. (2000). National Academy of Sciences. (Available at <http://www.nap.edu>.)

Presidential Review Directive 5

Planning for Health Preparedness For and Readjustment of the Military, Veterans, and Their Families After Future Deployments. (Available at <http://www.fas.org/irp/offdocs/prd-5-report.htm>.)

TB MED 530

Occupational and Environmental Health Food Sanitation

Unified Facilities Guide Specifications

Available at <http://www.hnd.usace.army.mil/techinfo/gspec.htm>.

USACHPPM Technical Guide 230

Chemical Exposure Guidelines for Deployed Military Personnel. (Available from the U.S. Army Center for Health Promotion and Preventive Medicine, ATTN: MCHB-TS-EES, 5158 Blackhawk Road, Aberdeen Proving Ground, MD 21010-5403 or <http://chppm-www.apgea.army.mil>.)

USACHPPM Reference Document 230

A Companion Document to USACHPPM Technical Guide 230, Chemical Exposure Guidelines for Deployed Military Personnel. (Available from the U.S. Army Center for Health Promotion and Preventive Medicine, ATTN: MCHB-TS-EES, 5158 Blackhawk Road, Aberdeen Proving Ground, MD 21010-5403 or <http://chppm-www.apgea.army.mil>.)

USACHPPM Technical Guide 248

Guide for Deployed Preventive Medicine Personnel on Health Hazard Risk Management. (Available from the U.S. Army Center for Health Promotion and Preventive Medicine, ATTN: MCHB-TS-EES, 5158 Blackhawk Road, Aberdeen Proving Ground, MD 21010-5403 or <http://chppm-www.apgea.army.mil>.)

31 USC 1535 and 1536

Economy Act

50 USC 1522

Conduct of chemical and biological defense program. (Available at <http://uscode.house.gov/download/pls/50C32.txt>)

Section III**Prescribed Forms**

This section contains no entries.

Section IV**Referenced Forms****DA Form 11-2-R**

Management Control Evaluation Certification Statement. (Available at <http://www.apd.army.mil/>)

DOL Form CA-1

Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation. (Available at <http://www.dol.gov/esa/regs/compliance/owcp/ca-1.pdf>.)

DOL Form CA-2

Notice of Occupational Disease and Claim for Compensation. (Available at <http://www.dol.gov/esa/regs/compliance/owcp/ca-2.pdf>.)

DOL Form CA-17

Duty Status Report. (Available at <http://www.dol.gov/esa/regs/compliance/owcp/ca-17.pdf>.)

DOL Form CA-20

Attending Physician's Report. (Available at <http://www.dol.gov/esa/regs/compliance/owcp/ca-20.pdf>.)

**Appendix B
Management Control Evaluation****B-1. Function**

The function covered by this evaluation is preventive medicine.

B-2. Purpose

The purpose of this evaluation is to assist commanders in evaluating the key management controls as outlined below (with medical personnel evaluating these key controls or resulting evaluation certified by some medical officer/official). This evaluation should be used at the following levels: Headquarters, Department of the Army, field operating agency, ACOMs, Army service component commands, direct reporting units, major subordinate commands, installations, and TOE units. It is not intended to cover all controls, but you must evaluate all controls applicable to your activity.

B-3. Instruction

Answers must be based on the actual testing of key management controls (for example, document analysis, direct observation, sampling, simulation, other). Answers that indicate deficiencies *must* be explained and corrective action indicated in supporting documentation. These key management controls must be formally evaluated at least once every 5 years. Certification that this evaluation has been conducted must be accomplished on DA Form 11-2-R (Management Control Evaluation Certification Statement).

B-4. Test Questions

- a. Are practices and procedures in place and operating to determine adherence to health standards established in pertinent Federal, state, local and host Government statutes and regulations and in Army regulations?
- b. Were sufficient resources requested to accomplish all responsibilities designated in this regulation? Where actual resources received were insufficient, were those resources applied to the highest priority areas? Was the adverse impact of the unfunded requirements communicated to higher headquarters?
- c. Is medical and OEH surveillance performed as required?
- d. Are Army personnel informed of all health threats and risks and appropriate countermeasures?
- e. Is accreditation and quality assurance for preventive medicine laboratory services monitored?
- f. Are health hazards of new equipment and materiel assessed?
- g. Are the same preventive medicine support services provided to all personnel (for example, military, civilian, contractor) deployed for military operations?
- h. Are there standard process outcome metrics applied to evaluate preventive medicine activities?
- i. Are commanders, supervisors, and preventive medicine staff provided basic, specialized, and sustainment training that will enable them to properly execute their preventive medicine leadership and staff responsibilities?
- j. Are Defense Health Program structure codes used for preventive medicine budget execution tracking and program analysis review?
- k. Are preventive medicine issues addressed through the DOTMLPF process?
- l. Are preventive medicine workloads documented?
- m. Are preventive medicine principles incorporated into Army officer and enlisted training manuals and Soldier common task training manuals?
- n. Are medical events reported through a military Medical Event Reporting System in compliance with state and local medical reporting requirements?

B-5. Supersession

This evaluation replaces the checklists (DA Circular 11-88-7) previously published for this regulation.

B-6. Comments

Help make this a better tool for evaluating management controls. Submit comments to the Deputy Functional Proponent for Preventive Medicine, ATTN: DASG-PPM-NC, 5109 Leesburg Pike, Suite 684, Falls Church, VA 22041-3258.

Glossary

Section I

Abbreviations

AAE

Army Acquisition Executive

ACOM

Army Command

ASA(I&E)

Assistant Secretary of the Army (Installations and Environment)

ASA(M&RA)

Assistant Secretary of the Army (Manpower and Reserve Affairs)

ATSDR

Agency for Toxic Substances and Disease Registry

ATTN

attention

CBRN

chemical/biological/radiological/nuclear

CBRNE

chemical/biological/radiological/nuclear/explosives

CFR

Code of Federal Regulations

CONUS

continental U.S.

DA Pam

Department of the Army pamphlet

DFAS-IN

Defense Finance and Accounting Service—Indianapolis Center

DNBI

disease and non-battle injury

DODD

Department of Defense directive

DODI

Department of Defense instruction

DOEHRS

Defense Occupational and Environmental Health Readiness System

DOL

Department of Labor

DOTMLPF

doctrine, organizations, training, materiel, leadership and education, personnel, and facilities

EEOC

Equal Employment Opportunity Commission

eV

electron volt

FM

field manual

FST

field sanitation team

FY

fiscal year

HHA

health hazard assessment

MTF

military treatment facility

OCONUS

outside the continental U.S.

OEH

occupational and environmental health

OMA

operations and maintenance, Army

OSHA

Occupational Safety and Health Administration

OTSG

Office of The Surgeon General

RMC

regional medical command

RMES

Reportable Medical Events System

TDA

tables of distribution and allowances

TIM

toxic industrial material

TOE

tables of organization and equipment

TSG

The Surgeon General

USACHPPM

U.S. Army Center for Health Promotion and Preventive Medicine

USADENCOM

U.S. Army Dental Command

USAMC

U.S. Army Materiel Command

USAMEDCEN

U.S. Army medical center

USAMEDCOM

U.S. Army Medical Command

USAMEDD

U.S. Army Medical Department

USAMEDDAC

U.S. Army medical department activity

USAMEDDC&S

U.S. Army Medical Department Center and School

USAMRMC

U.S. Army Medical Research and Materiel Command

USAMSA

U.S. Army Medical Surveillance Activity

USATRADO

U.S. Army Training and Doctrine Command

USC

United States Code

Section II**Terms****Army installation**

A grouping of facilities located in the same vicinity supporting particular DA functions. Installations may include locations such as posts, camps, stations, or communities and land and improvements permanently affixed thereto that are under the DA control and used by Army organizations. Where installations are located contiguously, the combined property is designated as one installation and the separate functions are activities of that installation. In addition to those used primarily by troops, the term applies to installation real properties such as depots, arsenals, ammunition plants (both contractor and Government-operated), hospitals, terminals, and other special mission installations. An installation is a physical site uniquely identified by an Army Location Code. The Army National Guard/Army National Guard of the United States by state is equivalent to an installation and has a designated unique Army location code.

Army personnel

As used in this publication, includes Active Army; Army National Guard/Army National Guard of the United States and U.S. Army Reserve personnel on active duty or inactive duty for training status; U.S. Military Academy cadets; U.S. Army Reserve Officer Training Corps cadets, when engaged in directed training activities; other DOD and foreign national military personnel assigned to Army components; and civilian personnel and nonappropriated fund personnel employed by the Army worldwide. Except for those preventive medicine services defined in DODI 6055.1 for supporting DOD contractor personnel during OCONUS force deployments or specifically provided for in contracts between the Government and a contractor, Army contractor personnel are not included in this definition.

Augmentation response teams

Teams consisting of subject matter experts who are sufficiently trained and prepared to provide the appropriate level of response on order of Headquarters, Department of The Army Surgeon General/U.S. Army Medical Command, at the request of legitimate civil, Federal, or defense authorities. These teams provide short-duration medical augmentation to regional domestic, Federal and DOD agencies responding to disaster, civil-military, humanitarian, and emergency incidents.

Biologics

Medicinal preparations made from living organisms and their products, including serums, vaccines, antigens, and antitoxins.

Biological agent

A microorganism that causes disease in personnel, plants, or animals or causes the deterioration of materiel.

Biopsychosocial

A term combining biological, psychological, and social factors or aspects into one term for convenience, and to maintain the sense of complex interaction among these various aspects of human behavior.

Chemical warfare agent or chemical agent

A chemical substance intended for use in military operations to kill, seriously injure, or incapacitate people through its physiological effects. Deny or hinder the use of areas, facilities, or materials or defense against such use. Included are blood, nerve, choking, blister, and incapacitating agents. Excluded are riot control agents, chemical herbicides, and smoke and flame materials.

Combat and operational stress reactions

Acute, debilitating mental, behavioral or somatic symptoms thought to be caused by operational or combat stressors that are not adequately explained by physical disease, injury, or preexisting mental disorder and that can be managed with reassurance, rest, physical replenishment (such as, hydration, food, hygiene, sleep), and activities that restore confidence.

Communicable disease

Illness due to a specific infectious agent or its toxic products that arises through transmission of that agent or its products from an infected person, animal, or inanimate reservoir to a susceptible host, either directly or indirectly, through an intermediate plant or animal host, vector, or the inanimate environment. Synonymous with infectious disease.

Deployment

The relocation of forces and materiel to desired operational areas. Deployment encompasses all activities from origin or home station through destination, specifically including intracontinental United States, intertheater, and intratheater movement legs, staging, and holding areas.

Direct reporting unit

An Army organization comprised of one or more units with institutional or operational functions; designated by the Secretary of the Army; providing broad general support to the Army in a normally single, unique discipline not otherwise available elsewhere in the Army. Direct reporting units report directly to a Headquarters Department of the Army principal and/or Army command and operate under authorities established by the Secretary of the Army. Direct reporting units include the following 11 commands:

- a. U. S. Army Network Enterprise Technology Command/9th Signal Command.
- b. U.S. Army Medical Command.
- c. U.S. Army Intelligence and Security Command.
- d. U.S. Army Criminal Investigation Command.
- e. U.S. Army Corps of Engineers.
- f. U.S. Army Military District of Washington.
- g. U.S. Army Test and Evaluation Command.
- h. U.S. Military Academy.
- i. U.S. Army Reserve Command.
- j. U.S. Army Acquisition Support Center.
- k. U.S. Army Installation Management Command.

Director of health services

The principal medical advisor to the installation commander and staff on health care delivery matters, including installation and clinical preventive medicine programs and services for the installation commander's areas of responsibility. Commanders of USAMEDCENs and USAMEDDACs, as the local medical authority, either serve as the director of health services on the installation staff, or more commonly, appoint a representative.

Disease and non-battle injury

Preventable diseases and injuries that are not a result of hostile action by or against an organized enemy, but of non-battle conditions that render a Soldier combat-ineffective. These diseases and injuries include infectious diseases, arthropod-borne diseases, food- and water-borne diseases, environmental injury/illness (such as, heat, cold, altitude,

toxic materials), and occupational injury/illness (such as noise-induced hearing loss). Non-battle injuries include self-inflicted wounds and all injuries that occur during peacetime.

Ergonomics

The field of study that seeks to fit the job to the person, rather than the person to the job. This is achieved by the evaluation and design of workplaces, environments, jobs, tasks, equipment, and processes in relationship to human capabilities and interactions in the workplace.

Force Health Protection

The medical portion of Force Protection; all measures taken by commanders, leaders, individual Service members, and the Military Health System to promote, improve, conserve, or restore the mental and physical well-being of Service members across the range of military activities and operations. These measures enable the fielding of a healthy and fit force, prevention of injuries and illness, protection of the force from health hazards, and provision of excellent medical and rehabilitative care to those who become sick or injured anywhere in the world.

Garrison

The basic organizational structure for providing programs, services and management to an installation and its resident community. An Army garrison is a TDA organization that commands, controls, and manages Army installations. Garrison command is the execution arm of the Installation Management Agency. It delivers the majority of installation management services to both resident and nonresident organizations. The garrison's mission is linked to the installation's purpose. As the execution arm of the Installation Management Agency, the garrison's mission is to provide installation management programs and services for mission activity commanders, Soldiers, civilians, family members, and retirees.

Health hazard assessment

The application of biomedical knowledge and principles to document and quantitatively determine the health hazards of Army systems. This assessment identifies, evaluates, and recommends controls to reduce risks to the health and effectiveness of personnel who test, use, or service Army systems. This assessment includes—

- a. The evaluation of hazard severity, hazard probability, risk assessment, consequences, and operational constraints.
- b. The identification of required precautions and protective devices.
- c. Training requirements.

Health risk assessment

The identification and evaluation of a health hazard to determine the associated health risk (probability of occurrence and resulting outcome and severity) of potential exposure to hazard.

Health risk communication

The process of building and maintaining strategic partnerships that is the foundation for information exchange, dialogue, and collaborative problem solving among interested stakeholders about health and safety issues.

Hearing readiness, clinical, operational, and conservation services

The four elements that embody the leadership policies, strategies, and processes to prevent noise-induced hearing loss among military and civilian personnel. Together these elements constitute The Army Hearing Program. The hearing readiness element provides for audiometric monitoring and the tracking of individual and unit hearing readiness status for deployability. The clinical services element provides for treatment of hearing injury in garrison and deployed settings, as well as audiological diagnostic capabilities in fixed facilities. The operational services element focuses on preventing or mitigating noise-induced hearing loss during military operations while maintaining or enhancing the ability to communicate. This element includes risk communication, training, communication enhancement and hearing protection devices, sound-level monitoring, noise abatement control measures, and evaluation of effectiveness of countermeasures. The hearing conservation element focuses on protecting military and civilian personnel from hearing loss due to occupational/industrial noise exposures in fixed facilities.

Industrial hygiene

The science and art devoted to anticipation, recognition, evaluation, and control of those environmental factors or stresses, arising in or from the workplace, that may cause sickness, impaired health and well-being, or significant discomfort and inefficiency among workers.

Initial entry training

Training presented to new enlistees with no prior military service. It is designed to produce disciplined, motivated,

physically fit Soldiers ready to take their place for the Army in the field. This training includes basic combat training, one station unit training, and advanced individual training.

Ionizing radiation

Charged subatomic particles and ionized atoms with kinetic energies greater than 12.4 electron volt (eV), electromagnetic radiation with photon energies greater than 12.4 eV, and all free neutrons and other uncharged subatomic particles (except neutrinos and antineutrinos).

Medical surveillance

The ongoing systematic collection, analysis, and interpretation of medical data essential to evaluating, planning, and implementing public health practice and prevention that is closely integrated with the timely dissemination of this data to those who need to know. In particular, it means the medical data related to individual patient encounters and the summary of portions of the data in the calculation of DNBI rates for a defined population for the primary purposes of prevention and control of health and safety hazards.

Medical Surveillance System

An integrated set of information management capabilities, information technologies, databases, and procedures for the collection, analysis, archiving, and dissemination of information in support of preventive medicine activities.

Military treatment facility

A civilian or uniformed services medical center, hospital, clinic, or other facility that is authorized to provide medical, dental, or veterinary care.

Nonionizing radiation

Electromagnetic radiation with photon energies less than 12.4 eV.

Occupational and environmental health surveillance

The continuous process of assessing potential exposures and health effects, recommending health risk reduction options, and evaluating the effectiveness of health risk reduction methods for chemicals of concern, weapons of mass destruction, pathogens, disease vectors (such as, arthropods and rodents), and radioactive materials in air, soil, water, and food. It also includes surveillance of health effects from heat, cold, nonionizing radiation (such as, radio frequency, microwave and laser), ionizing radiation sources, noise, and psychological stressors. It includes coordination and information transfer with agencies responsible for surveillance of safety hazards (such as, ground, vehicle, and aviation) and environmental management actions to comply with U.S. or host nation environmental compliance, cleanup, and pollution prevention laws and regulations.

Occupational and environmental health threat

Any condition that could result in exposures of any Army personnel to chemical, biological, radiation, and physical hazards in any aspect of military operations in garrison and during deployments. In deployments, occupational and environmental health threats include but are not limited to—

a. Accidental or deliberate release of non-weaponized TIMs, hazardous physical agents, ionizing and nonionizing radiological hazards, as well as direct hazard effects from weaponized chemical/biological/radiological/nuclear/explosive (CBRNE) devices, and the residue from the use of CBRNE devices.

b. Environmental hazards to include physical hazards and vector- and arthropod-borne threats, residues, or agents naturally occurring or resulting from previous activities of U.S. forces or other concerns, such as non-U.S. military forces, enemy forces, local national governments, or local national agricultural, industrial, or commercial activities.

c. The TIMs or hazardous physical agents, such as noise or ionizing and nonionizing radiation hazards, currently being generated as a by-product of the activities of U.S. forces or other concerns, such as non-U.S. military forces, enemy forces, local national governments, or local national agricultural, industrial, or commercial activities.

d. Combat and operational stress.

Pharmaceuticals

Pertaining to pharmacy or to medicinal drugs.

Preventive medicine level V support

One of the five levels of support for preventive medicine. In the theater of operation, preventive medicine support is tailored and phased to enhance mission requirements, counter the medical threat, and provide preventive medicine support as far forward as the tactical situation will permit. Level V support is provided by preventive medicine units in CONUS. Home station operations centers, such as USAMEDDACs and USAMEDCENs, in the CONUS-sustaining base will provide technical support for preventive medicine issues and support to the force during pre- and post-deployment surveillance. The USACHPPM and its subordinate activities provide definitive laboratory analysis, serve as

the technical center of expertise, and are the ultimate repository of all medical surveillance data collected within the theater.

Principles of population medicine

A systematic approach to healthcare delivery for a beneficiary population. Such an approach includes self-care; community-based public health health care activities; and medical interventions to render primary, secondary, and tertiary comprehensive care, taking into consideration the determinants of health.

Reimbursable preventive medicine services

Those services that fall beyond the normal mission area of the servicing organization but within that organization's technical competency; these services are provided to a requesting agency under a fund cite from that requesting agency.

Risk management

The process of identifying, assessing, and controlling risks arising from operational factors and making decisions that balance risk cost with mission benefits.

Toxic industrial materials (TIMs)

Materials such as chemicals and radioactive material that pose hazards to individuals. TIMs are generally in one of the following categories:

- a.* Agriculture—includes insecticides, herbicides, fertilizers.
- b.* Industrial—chemical and radiological materials used in manufacturing processes or for cleaning.
- c.* Production and research—chemicals and biologicals produced or stored in a facility.
- d.* Radiological—nuclear power plants, medical facilities/laboratories, uranium mining and refining operations, nuclear fuel fabrication, transportation, and radiological waste storage operations (see FM 3-11.34/MCWP 3-37.5/NTTP 3-11.23/AFTTP(I) 3-2.33).

Weapons of mass destruction

In arms control usage, weapons that are capable of a high order of destruction and/or of being used in such a manner as to destroy large numbers of people. Can be nuclear, chemical, biological, or radiological weapons but excludes the means of transporting or propelling the weapon where such means is a separable and divisible part of the weapon.

Section III

Special Abbreviations and Terms

This section contains no entries.

UNCLASSIFIED

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