



Medical Services
DEPLOYMENT FORCE HEALTH PROTECTION

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SUMMARY OF REVISIONS

CCR 40-5 replaces CCR 220-1. “220- series” regulations reference field organizations while “40-series” regulations reference medical services. This CCR specifies processes that must be initiated by medical service assets. This CCR is revised to reflect updates in Joint Publication 4-02 (26JUL12); deployment requirements specified in DoDD 6490.02E (03OCT13), DoDI 6200.03 (02OCT13), DoDI 6490.03 (30SEP11) and MCM 0017-12 (07DEC12); and synchs requirements in CCR 10-6 (23MAY14), CCR 200-1 (03APR14), CCR 200-2 (23MAY13), CCR 415-1(18JUL14), and CCR 700-3 (01MAY13). Significant revisions include addressing all the medical functional areas under Force Health Protection, adding deployed immunization requirements, malaria risk assessment and guidelines, and detailing the systems of record for electronically documenting OEHSA (Appendix D), POEMS (Appendix E), DNBI (Appendix F), RME (Appendix G), OEH Exposure Incident (Appendix I) and animal bites (Appendix J).

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CHAPTER 1 - GENERAL

1-1. PURPOSE

This regulation consolidates Department of Defense (DoD) policies and Chairman Joint Chiefs of Staff memorandums (MCM) into USCENTCOM specific deployment force health protection requirements. Joint medical capabilities are grouped into force health protection (FHP) and health service support (HSS) (Reference JP 4-02). Force health protection includes all measures taken by commanders, leaders, individuals, and the health care system to promote, improve or conserve the behavioral and physical well-being of military personnel, DoD civilians, and Contractors Authorized to Accompany the Force (CAAF). Force health protection falls under the joint function of protection (Reference JP 3-0). Force health protection functional areas include: casualty prevention, preventive medicine, health surveillance, combat and operational stress control, preventive dentistry, vision readiness, environmental laboratory services, and veterinary services (Reference JP 4-02).

1-2. APPLICABILITY

a. This regulation applies to all United States Central Command (USCENTCOM) Service Components, Combined and other Joint Task Forces (CJTFs/JTFs), and all other United States military forces operating under Title 10 authorities within the geographic area of responsibility (AOR) assigned to USCENTCOM by the Command Plan as well as Department of Defense (DoD) civilian employees and DoD contractor personnel deploying with United States (U.S.) forces (hereafter referred to as “DoD personnel”) consistent with DoD and Service-specific guidance. DoD personnel in the USCENTCOM AOR operating under Title 22 authorities receive force health protection support from the Department of State (DoS) IAW the DoS Foreign Affairs Manual Volume 15, Overseas Building Operations, 960 Safety, Occupational Health, and Environmental Management (SHEM) Program Requirements.

b. This regulation focuses primarily on the deployment health activities required during deployment operations. Pre- and post- deployment activities are addressed in the following guidance:

(1) Pre-Deployment. Due to limited deployed joint medical capabilities, USCENTCOM requires the supporting Services and JTFs to accomplish the pre-deployment activities described in the Chairman Joint Chief of Staff Memorandum Procedures for Deployment Health Surveillance (Reference MCM 0017-12), Department of Defense Instruction (DoDI) for Deployment Health (Reference DoDI 6490.03), Individual Medical Readiness (Reference DODI 6025.19), and meet pre-deployment requirements stipulated in USCENTCOM’s Individual and Individual/Unit Deployment Policy (Reference Modification 12).

(2) Post-Deployment. Post-deployment health activities are described in Deployment Health (Reference DoDI 6490.03) and are a Service responsibility.

c. For OCONUS deployments greater than 30 days with non-fixed U.S. medical treatment facilities (MTFs), all of the deployment health activities described by this regulation apply. For OCONUS deployment of 30 days or less, and OCONUS deployment with fixed U.S. MTFs,

deployment health activities are based on the health threats identified during the deployment, health risk assessments, and the decisions of the COCOM commander, Service component commander, or commander exercising operational control (Reference DoDI 6490.03).

d. For information related to environmental surveys, environmental reports, and the environmental criteria for establishing, operating, maintaining, closing and/or transferring base camps refer to The Sand Book (Reference CCR 415-1), Protection and Enhancement of Environmental Assets (Reference CCR 200-1), and CENTCOM Contingency Environmental Standards (Reference CCR 200-2).

1-3. REFERENCES

See Appendix A.

1-4. TERMS AND DEFINITIONS

Terms used in the regulation not found in Joint Publication 1-02 are defined in Appendix B.

1-5. POLICY

It is USCENTCOM policy to effectively anticipate, recognize, evaluate, control, and mitigate health threats to deployed forces in the USCENTCOM AOR, and to maximize electronic reporting and archiving of Force Health Protection surveillance activities.

CHAPTER 2 - RESPONSIBILITIES

2-1. COMMANDER, USCENTCOM (CDRUSCENTCOM)

- a. Establish Command deployment force health protection policies and programs for all DOD personnel (military and civilian), contractors, and other assigned personnel traveling within the USCENTCOM AOR.
- b. Support Occupation and Environmental Health (OEH) and Force Health Protection (FHP) requirements in accordance with the references listed in Appendix A.

2-2. DEPUTY COMMANDER, USCENTCOM (DCDRUSCENTCOM)

- a. Provide Command deployment force health protection guidance and direction to USCENTCOM Command Surgeon.
- b. Oversee staff coordination of deployment force health protection issues within the
- c. USCENTCOM AOR.
- d. Meet reporting requirements IAW this regulation and DoD policy.

2-3. USCENTCOM DIRECTOR FOR MANPOWER AND PERSONNEL (CCJ1)

Ensure that Service Components and JTFs have a process in place to record and report once-daily individual service member locations through Service-specific personnel management systems (Reference DoDI 6490.03).

2-4. USCENTCOM DIRECTOR OF INTELLIGENCE (CCJ2)

- a. Coordinate medical intelligence information with USCENTCOM Command Surgeon to incorporate into medical threat products.
- b. Review plans to ensure they describe procedures for collecting and analyzing intelligence information that potentially impacts the health and safety of deployed personnel.
- c. Disseminate health threat and hazard information to all units in the USCENTCOM AOR.
- d. Ensure medical intelligence is made available to all DOD activities and Chiefs of Mission (COM) located within the AOR and to Military Departments, supporting unified commands, and DOD agencies in support of their deployment health surveillance responsibilities.
- e. In coordination with the Defense Intelligence Agency and the National Center for Medical Intelligence (NCMI), provide intelligence information specific to the USCENTCOM AOR pertaining to DOD activities for Military Departments, supporting unified commands, and DOD agencies, in support of their deployment health surveillance responsibilities.

2-5. USCENTCOM DIRECTOR FOR OPERATIONS (CCJ3)

- a. Assist USCENTCOM Director for Strategic Planning and Policy (J5) in ensuring deliberate and crisis action plans address force health protection and deployment health surveillance requirements.
- b. Provide the Command Surgeon and Service Health Surveillance Centers known forward deployment sites for medical intelligence preparation of the operational environment (MIPOE) and intelligence preparation of the battle space (IPB) assessments.
- c. Coordinate with the USCENTCOM Command Surgeon regarding suspected and confirmed OEH/ Chemical, Biological, Radiological, and Nuclear (CBRN) incident exposures to facilitate personnel tracking of exposed or potentially exposed personnel, such as significant activity (SIGACT) numbers to facilitate updates to the designated CENTCOM SIGACT Database (e.g. combined information data network exchange (CIDNE) supported battle update assessment (BUA) SIGACT Events Database) and push information to Level IV medical assets.
- d. Incorporate food and water security into force protection vulnerability assessments.

2-6. USCENTCOM DIRECTOR OF LOGISTICS (CCJ4)

- a. Factor preventive medicine personnel and equipment requirements into time-phased force and deployment data (TPFDD) planning in support of deployment health surveillance and force health protection for all DoD deployed personnel.
- b. Coordinate with the USCENTCOM Surgeon to field qualified personnel or teams to perform Environmental Baseline Surveys (EBSs), Occupational and Environmental Health Site Assessments (OEHSAs) and/or other environmental surveys related to infrastructure, construction or demolition projects and base camp closures/transfers (Reference CCR 200-1).
- c. Coordinate with supporting medical personnel to approve water, ice, and food sources prior to consumption.
- d. Upon request, provide deployment site locations and other available relevant information to support Force Health Protection mission planning.

2-7. USCENTCOM DIRECTOR FOR STRATEGIC PLANNING AND POLICY (CCJ5)

Ensure deliberate and crisis action plans address force health protection and Occupational and Environmental Health Surveillance (OEHS) requirements specifically food/water vulnerability assessments, infectious disease, OEHSAs, CBRN and OEH incidents, and reportable medical event reporting and documentation.

2-8. USCENTCOM DIRECTOR OF COMMAND, CONTROL, COMMUNICATIONS, AND COMPUTER SYSTEMS (CCJ6)

- a. Provide appropriate communication capability to medical units within the USCENTCOM AOR to fulfill medical reporting requirements and medical intelligence dissemination.

b. Develop guidance and allow for the protection of operationally sensitive information while ensuring the widest distribution of OEHS information.

2-9. USCENTCOM COMMAND SURGEON (CCSG)

a. Monitor and enforce the implementation of this regulation for the USCENTCOM AOR.

b. Specify reporting requirements for Disease and Non-Battle Injury (DNBI) (Appendix F), Reportable Medical Events (RMEs) (Appendix G), Occupational and Environmental Health Site Assessments (OEHSAs) (Appendix D), Periodic Occupational and Environmental Monitoring Summaries (POEMS) (Appendix E), and OEH/CBRN incident documentation and reporting requirements (Appendix H) in Contingency and Operational Plans and Orders, as applicable.

c. Identify USCENTCOM OEHS program critical shortfalls and assist Service Components and JTFs with developing solutions to meet compliance.

d. Establish a Joint FHP planning team to meet at least monthly to support the USCENTCOM Medical Coordination Working Group (Reference CCR 10-6). The planning team will update running estimates, FHP concept of support, contact information, FHP capabilities, DNBI trends, RME investigations, deployment site assessment statuses, request for information submission, and identify lessons learned. The group will develop and recommend changes to this regulation.

e. Develop, implement, monitor, and assess the USCENTCOM OEHS Program.

f. Work with the Public Affairs, Strategic Communications, and/or Communications Integration Office(s) to identify appropriate communications channels, develop messages, and implement media plans supporting health risk communication efforts.

g. In coordination with J2, J3, J4, and J5, ensure that deliberate and crisis action plans address FHP and OEHS (including risk communication) requirements.

h. In the event of an exposure incident that involves weapons of mass destruction (WMD), to include CBRN agents or toxic industrial chemicals or materials (TICs/TIMs), coordinate with J3 and ensure the proper documentation and dissemination of information (per Appendices G and H) and facilitate tracking casualties to final disposition. Ensure use of SIGACT numbers from the designated CENTCOM SIGACT Database (e.g. CIDNE supported BUA SIGACT Events Database).

i. Serve as USCENTCOM's final approval for Periodic Occupational and Environmental Monitoring Summaries, unless otherwise delegated in writing to Service Component/JTF Surgeons (Reference DoDI 6490.03).

j. In support of CCJ3 security office, provide subject matter expertise on country-specific food and water vulnerabilities.

k. Implement and submit changes to medical travel restrictions to the DOD Foreign Clearance

l. Guide through HQ United States Air Force as needed, at fcg@pentagon.af.mil.

m. Send a Surgeon representative to the following USCENTCOM Boards, Bureaus, Centers, Cells, and Working Groups (B2C2WGs) (Reference CCR 10-6): Anti-Terrorism Executive Committee, Anti-Terrorism Working Group, Threat Working Group, and Joint Intelligence Center.

n. Monitor the Armed Forces Health Surveillance Center, World Health Organization, and International Society for Infectious Diseases Program for Monitoring Emerging Diseases (ProMED) products to identify disease non-battle injury (DNBI) trends, submit requests for studies, and develop strategies to reduce DNBI rates.

2-10. USCENTCOM SERVICE COMPONENT AND JTF COMMANDERS AND DIRECTORS OF SEPARATE OPERATING AGENCIES

a. As specified in specific plans, orders or the CCJ4 Base Operating Support – Integrator (BOS-I) matrix: serve as BOS-I for medical management (Reference CCR 700-3). Ensure medical concepts of support for each deployment site address access to each medical functional area, whether organic to the site or not, IAW JP 4-02.

b. Provide a risk based, safe and healthy environment for all assigned personnel. Work closely with supporting force health protection assets to minimize the threats of DNBI.

c. Resource subordinates with appropriate countermeasures and personnel protective equipment.

d. Integrate OEHS requirements into deployment plans, orders, and exercises.

e. Submit requests for assistance to meet the requirements of this regulation to the appropriate Service Headquarters.

2-11. CJTF AND SERVICE COMPONENT COMMAND SURGEONS

a. Develop medical concepts of support to clarify how every deployment site accesses each medical functional area IAW JP 4-02. Initiate requests for assistance/support to fill gaps in medical capabilities, functional areas, programs, and services.

b. Ensure compliance with and execution of deployment health surveillance and FHP requirements for all operations and contingencies. Develop processes to address each of the deployment activities and reporting requirements directed in Appendix C. Specifically:

(1) Conduct baseline and vulnerability assessments, OEHSAs (Appendix D), POEMS (Appendix E), DNBI surveillance (Appendix F), RME reports (Appendix G), CBRN/OEH exposure incident reports (Appendix H), Animal Bite Reporting (Appendix J), and ensure documentation and archival (Appendix I) in accordance with the requirements of this regulation.

(2) Assess and manage medical threats and health risks within the area of responsibility IAW established military risk assessment and risk management doctrine.

(3) Ensure that health risk communication plans and/or tools are available to address OEH exposures and any associated concerns over medical risks.

c. Institute appropriate OEHS measures and provide Preventive Medicine (PVNTMD) support for identified hazards consistent with level of risk, mission and available resources.

d. Establish processes to submit and monitor health surveillance reports for forces ashore by geographic location, to include RMEs and DNBI Surveillance Reports through Medical Situational Awareness Tool (MSAT)/Joint Medical Workstation (JMeWS), Disease Reporting System Internet (DRSi) and other Service-specific health surveillance activities. See Appendices C-J for further details.

(1) Ensure all locations (medical units, medical treatment facilities, etc.) that provide medical care complete joining and departure reports within MSAT/JMeWS.

(2) Establish naming conventions and filters to monitor surveillance rates by appropriate geographical location: forward operating base, country, etc.

(3) Monitor data entry quality and conduct periodic continuing medical education (CME) training to standardize clinical interpretation of the disease codes associated with the surveillance categories listed in Appendix F.

e. Institute appropriate OEHS measures and provide PVNTMED support for health risk assessment of residual hazards during decontamination of CBRN contaminated equipment and human remains.

f. Identify critical shortfalls and capability gaps required to meet the requirements of this regulation. Initiate requests for assistance to meet the requirements of this regulation to the appropriate Service Headquarters.

g. Develop processes to ensure:

(1) Force Health Protection assets enter into DOEHRS or submit OEH monitoring data, food/water, PVNTMED and Veterinary Service survey and inspection reports, OEHSA, and POEMS in accordance with the references and guidance listed in Appendices C, D, and E.

(2) Locations (medical units, medical treatment facilities, etc.) that provide medical care enter DNBI data, reportable medical events, initiate Occupational and Environmental Exposure Incident Reports, and animal bite reports in accordance with the references and guidance listed in Appendices C, F, G, H, and J.

(3) Report all OEH/CBRN agents or TICs/TIMs OEH exposure incidents IAW procedures in Appendices H and I.

(4) Health risk communication plans are prepared to inform deployed personnel of known and perceived health risks. This includes use of Medical Threat Briefs (MTBs) and other products such as facts sheets, or information cards that describe the USCENTCOM country, and when applicable, area or base camp-specific health threats/medical risks and associated

countermeasures. Coordinate with Service-specific public health activities/centers for assistance with products.

h. Geographic specific malaria risk assessments are developed or implement the guidelines specified in Appendix K.

i. Deployed personnel maintain immunization requirements as specified in Appendix L.

j. Assign a Force Health Protection (FHP) Officer responsible for:

(1) Oversight of and compliance with the OEHS program and reporting/record keeping requirements in this regulation. Initiate JTF and deployment site specific policies and procedures to support the requirements of this regulation.

(2) Participating in the Joint Force Health Protection planning team. This team is chaired by the USCENTCOM Force Health Protection Officer and meets on a monthly basis via teleconference in support of the USCENTCOM Medical Coordination Working Group (Reference CCR 10-6). The planning team is comprised of representatives from the CCSG, Service Components, JTFs, National Center for Medical Intelligence (NCMI), Armed Forces Health Surveillance Center (AFHSC), and Service public health centers.

(3) Implementing procedures to develop, document, and track OEHSAs for all deployment sites within the respective AOR (Appendix D). Coordinate with Service Public Health Centers for reach back assistance and technical support.

(4) The Defense Occupational and Environmental Health Readiness System (DOEHRs) (Appendix I) is the system of record for documenting unclassified OEHSAs. Submit a monthly report of deployment sites with completed OEHSAs that are not accurately reflected in DOEHRs to the USCENTCOM Surgeon Force Health Protection Officer.

(5) Implementing procedures to ensure completion of the Periodic Occupational and Environmental Monitoring Summaries (POEMS) for all camps, sites, forward operating base locations within respective AOR (Appendix E).

(6) Staffing and coordination review for documents such as draft POEMS and related assessments where the component has identified equities.

(7) Tracking, staffing, and coordination of incident reports and associated documentation required for all OEH exposure incidents as described in Appendix H.

(8) Support deployment site and Command safety offices in the development of radiation safety programs and policies.

(9) Monitor vector control programs and provide input into deployment site integrated pest management plans.

(10) Identify regions where cold weather injuries (55 degrees and below), heat injuries, and altitude illness (over 9,888 feet) may occur and implement illness mitigation strategies.

2-12. INDIVIDUAL MILITARY PERSONNEL, DOD CIVILIANS, AND DOD CONTRACTORS TRAVELING OR DEPLOYING TO THE CENTCOM AOR AND WORKING UNDER THE AUSPICES OF THE DOD

- a. Apply personal protective measures and use protective clothing and equipment as required.
- b. Avoid contact with domestic and wild animals (Reference General Order Number 1C).
- c. Practice good field sanitation to maintain a healthy force by conducting: frequent hand washing, proper dental care, clean and dry clothing, and bathing.
- d. Implement the DoD insect repellent system which includes the application of extended duration deet lotion to exposed skin, application of permethrin to the field uniform, and wear the treated uniform properly to minimize exposed skin.
- e. Share the responsibility for ensuring a safe and healthy work environment by following administrative and engineering hazard controls.
- f. Report unsafe conditions, hazardous exposures, and occupational injury or illness.
- g. Seek medical care at the appropriate medical treatment facility for injuries, animal bites/scratches and illness received during deployment.

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CHAPTER 3 - PROCEDURES

3-1. SCOPE

This regulation focuses on force health protection activities that are required during deployment operations. A summary of the procedures for the key required activities are described below. Additional details regarding the associated documents and reporting responsibilities are summarized in Appendix C. Detailed guidance is also provided in Appendix D (OEHSA), Appendix E (POEMS), Appendix F (DNBI), Appendix G (RME), Appendix H (OEH/CBRN Incident reporting), Appendix I (DOEHRs), and Appendix J (Animal Bite Reporting).

3-2. PREDEPLOYMENT AND BASELINE DOCUMENTS

Deployment health activities are based on the pre-deployment and baseline health threat and risk assessment documents for the area or areas of operations and the specific deployment location. These documents, and early site reconnaissance should be reviewed by incoming site PVNTMD personnel and updated as the deployment proceeds.

- a. Pre deployment threat assessment information is documented in the IPB/MIPOE and
- b. Preliminary Health Assessments/Phase 1 reports.
- c. OEHSAs, site reconnaissance, environmental baseline surveys (EBSs), food and water vulnerability assessments and surveys are conducted to identify and assess actual or potential health threats, evaluate and identify potentially complete exposure pathways, and determine courses of action and countermeasures to control or reduce the health threats and protect the health of deployed personnel. These documents, especially the OEHSA, are critical baseline documents that establish a conceptual site model that identifies key hazards and affected populations. The OEHSAs for the CENTCOM AOR are the responsibility of, and finalized under, the authority of CJTF and Service Component designated FHP personnel. They may be drafted in coordination with U.S. Army Public Health Command (USAPHC), U.S. Air Force School of Aerospace Medicine (USAFSAM), or U.S. Navy and Marine Corps Public Health Center (NMCPHC) with assistance from preventive medicine assets/units in theater. The designated FHP personnel should use OEHSAs to direct and prioritize follow-on OEH activities such as routine sampling/monitoring, or focused sampling of a specific hazard or high risk areas, or to address significant information data gaps. Information based on follow-on and incident-driven monitoring and sampling and health risk assessments must be submitted to the applicable DOD-approved system of record listed in Appendix C. This information also serves as much of the source data from which POEMS are generated.
- d. At established base camps, review previously published public health related documents for potential use and familiarity with that location's documented health hazards, to include base camp OEHSAs, POEMS, deployment specific hazard and incident factsheets, Deployment Health Guide trifolds, and risk communication documents such as medical threat assessments.

3-3. RISK COMMUNICATION PLANS AND TOOLS

It is critical that personnel be provided education and training prior to deployment to an area, during the deployment, and are also made aware of information he/she can access post deployment regarding potential site hazards/exposures. Information should be up to date, appropriate for the audience and cleared through appropriate technical and command channels to include Public Affairs, Strategic Command (STRATCOM), and/or Communications Integration when applicable. See Appendices C and D.

3-4. ROUTINE OEHS MONITORING DOCUMENT

OEHS surveillance includes monitoring and assessment of air, water, soil, food, vectors, noise, heat/cold and other potential hazards/exposures that can affect the short or long term health of troops. Routine monitoring and many individual surveys and reports are necessary to comprise a complete and effective OEHS program. OEHS related documents will be sent by the completing unit IAW DoD guidance for archiving to the DOD- approved system of record listed in Appendix C or entered into DOEHS in accordance with Appendix I.

3-5. MEDICAL DATA SUPPORTING DOCUMENTATION

a. DNBI surveillance shall be collected, reported, distributed, and archived within MSAT/JMEWS and per Appendices F (DNBI) and G (RME).

b. All deployment patient encounters, including those resulting from CBRN or OEHS exposures, must be documented in the electronic medical record, or alternatively on a SF600 if the electronic system is not available, using applicable International Classification of Diseases (ICD)-9 codes per Appendix G.

c. RMEs that meet the requirements described in Appendix G, to include CBRN OEHS incidents, shall be collected, reported, distributed, and archived according to Appendices H and I of this regulation, as well as DOD and Service specific policies.

d. Once-Daily Location Tracking of Personnel. During deployments, service components and JTFs ensure once-daily individual service member locations are recorded and reported through Service-specific personnel reporting systems to the Defense Manpower Data Center (DMDC).

CHAPTER 4 - PROPONENT PAGE

4-1. PROPONENT

The proponent for this regulation is the Command Surgeon (CCSG). Units are invited to submit comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) directly to HQ USCENTCOM Attn: CCSG, 7115 South Boundary Boulevard, MacDill AFB, Florida 33621-5101.

4-2. ACCESSIBILITY

Publications and Forms are available on the USCENTCOM SIPRNet Releasable (REL) Portal Index for downloading at the following link:

http://rel.centcom.smil.mil/sites/CCJ6/R_DIV/RD/RDR/SitePages/Publications.aspx.

4-3. RELEASABILITY

There are no releasability restrictions on this publication.



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APPENDIX A - REFERENCES

1. Department of Defense policies and Chairman of the Joint Chiefs of Staff memorandums.
 - a. DoDD 3000.10, Contingency Basing Outside the United States, 10 JAN 13.
 - b. DoDD 6200.04, Force Health Protection, 23 APR 07.
 - c. DoDD 6490.02E, Comprehensive Health Surveillance, 03 OCT 13.
 - d. DoDD 8320.03, Unique Identification (UID) Standards for aNet-Centric Department of Defense, 23 MAR 07.
 - e. DoDI 1100.22, Policy and Procedures for Determining Workforce Mix, 12 APR 10.
 - f. DoDI 3020.41, Operational Contract Support (OCS), 20 DEC 11.
 - g. DoDI 4150.07, DoD Pest Management Program, 29 MAY 08.
 - h. DoDI 6025.19, Individual Medical Readiness (IMR), 09 JUN 14.
 - i. DoDI 6055.05, Occupational and Environmental Health, 11 NOV 08.
 - j. DoDI 6200.03, Public Health Emergency Management within the Department of Defense, 02 OCT 13.
 - k. DoDI 6420.01, National Center for Medical Intelligence, 20 MAR 09.
 - l. DoDI 6490.03, Deployment Health, 30 SEP 11.
 - m. DoD Federal Acquisition Regulation Supplement, Clause 252.225-7040, Contractor Personnel Support U.S. Armed Forces Deployed Outside the United States, MAY 14
 - n. Secretary of Defense Memorandum, Guidance for Containment of Varicella Outbreaks, 15 OCT 08
 - o. Deputy Secretary of Defense Memorandum, Expansion of Force Health Protection Anthrax and Smallpox Immunization Programs for DoD Personnel, 28 JUN 04
 - p. Assistant Secretary of Defense for Health Affairs Memorandum, Notification for Healthcare Providers of Mefloquine Box Warning, 12 AUG 13
 - q. Assistant Secretary of Defense for Health Affairs Memorandum, Exception to Policy Guidance to the Mandatory Smallpox Vaccination Program in the U.S. Central Command Area of Responsibility, 16 MAY 14
 - r. Chairman of the Joint Chiefs of Staff Memorandum, MCM 0017-12 Procedures for Deployment Health Surveillance, 07 DEC 12

CCR 40-2, 29 August 2014

2. Joint Publications

- a. JP 1-02, Department of Defense Dictionary of Military and Associated Terms, 15 MAR 14.
- b. JP 3-0, Joint Operations, 11AUG11.
- c. JP 4-02, Health Service Support, 26 JUL 12.
- d. JP 4-10, Operational Contract Support, 17 OCT 08.

3. HQ USCENTCOM Publications

- a. CCR 10-6, Command Boards, Bureaus, Centers, Cells, and Working Groups (B2C2WG), 23MAY14
- b. CCR 200-1, Protection and Enhancement of Environmental Assets, 03 APR 14
- c. CCR 200-2, CENTCOM Contingency Environmental Guidance, 23 MAY 13
- d. CCR 380-14, Classification Guide, 15 MAR 14
- e. CCR 415-1, Construction and Base Camp Development in the USCENTCOM AOR “The Sand Book”, 18 JUL 14
- f. CCR 700-3, Base Operating Support, 01 MAY 13.
- g. General Order Number 1C (GO-1C), 21 MAY 13.
- h. GENADMIN Rabies Exposure Identification, Notification, and Treatment While Deployed to the USCENTCOM AOR, 16 SEP 11
- i. Modification 12 to United States Central Command Individual Protection and Individual, Unit Deployment Policy, 02 DEC 13

4. Service Publications

- a. AFI 44-170, Preventive Health Assessment, 30 JAN 14
- b. AFI 48-101, Aerospace Medicine Enterprise, 19 OCT 11
- c. AFI 48-105, Surveillance, Prevention, and Control of Diseases and Conditions of Public Health or Military Significance, 17 OCT 11.
- d. AFI 48-145, Occupational and Environmental Health Program, 15 SEP 11
- e. AFTTP 3-2.82_IP, ATP 4-02.82, NTRP 4-02.9, Occupational and Environmental Health Site Assessment, APR 12

f. AFMAN 48-138-IP/TB MED 577, Sanitary Control and Surveillance of Field Water Supplies, 01 MAY 10.

g. AR 40-5, Preventive Medicine, 25 MAY 07

h. AR 40-562, BUMEDINST 6230.15B, AFI 48-110 IP, CG COMDTINST M6230.4G, Immunizations and Chemoprophylaxis for the Prevention of Infectious Disease, 07 OCT 13

i. BUMEDINST 6220.12C, Medical Surveillance and Medical Reporting, 27 SEP 11

j. FM 3-11.21, MCRP 3-37.2C, NTTP 3-11.24, AFTTP(I) 3-2.37, Multiservice Tactics, Techniques, and Procedures for Chemical, Biological, Radiological and Nuclear Consequence Management Operations, 01 APR 08

k. FM 4-02, Army Health System, 26 AUG 13

l. NAVMED P-5010-10, Sanitary Control and Surveillance of Field Water Supplies, 01 MAY 10

5. Other References

a. Armed Forces Pest Management Board Technical Guide No 36, Personal Protective Measures Against Insects and Other Arthropods of Military Significance, October 2009

b. Armed Forces Reportable Medical Events Guidelines & Case Definitions, Armed Forces Health Surveillance Center, March 2012

c. American Society for Testing and Materials (ASTM) International, E 2318-03 Standard Guide for Environmental Health Site Assessment Process for Military Deployments, DEC 03.

d. Assistant Secretary of Defense for Health Affairs, Policy Memorandum – Human Rabies

e. Prevention During and After Deployment, 14 NOV 11

f. NMCPHC-TM-PM 6220.12, Medical Surveillance and Medical Reporting Technical Manual, September 2013

g. USACHPPM TG 188, US Army Food and Water Vulnerability Assessment Guide, July 2008

h. USACHPPM TG 195, Safety and Health Guidance for Mortuary Affairs Operations: Infectious Materials and CBRN Handling, May 2009.

i. USACHPPM TG 244, Medical CBRN Battle book, October 2008.

j. USACHPPM TG 248, Guide for Deployed Preventive Medicine on Health Risk Assessment, August 2001.

CCR 40-2, 29 August 2014

k. USAPHC TG 230, Environmental Health Risk Assessment and Chemical Exposure Guidelines for Deployed Military Personnel, June 2013.

l. USAPHC TG 355, Installation Food Vulnerability Assessment Program Handbook, November 2012.

m. U.S. Department of State Foreign Affairs Manual, Volume 15 Overseas Building Operations, 960 Safety, Occupational Health, and Environmental Management (SHEM) Program Requirements, 28 FEB 14.

APPENDIX B - TERMS AND DEFINITIONS

1. All DoD Personnel - Department of Defense (DoD) civilian employees and DoD contractor personnel deploying with United States (U.S.) forces (hereafter referred to as “DoD personnel”) consistent with DoD and Service-specific guidance, these contractors are also called CAAF, see definition below.
2. Boards, Bureaus, Centers, Cells, and Working Groups (B2C2WGs). B2C2WGs and other semi-permanent or temporary organizations (e.g., Councils, Elements and Planning Teams) facilitate cross-functional coordination, synchronization, planning and information sharing between principal staff directorates and enable the Commander’s Decision Cycle. (Reference CCR 10-6).
3. Base Operating Support – Integrator (BOS-I) – For each deployment location, the base operating support matrix designates a component, sub-unified command, or CJTF Headquarters with the responsibility to plan, coordinate, integrate, manage or provide necessary BOS Management, Airfield Management, and Communications Management functions for all tenant units. It further designates the role of BOS Integrator (BOS-1) for its sub-functions (Reference CCR 700-3). The component, sub-unified command, or CJTF Headquarters should clearly identify the BOS-I for medical management at each location.
4. Casualty Prevention – Supports military personnel by applying prevention and protection capabilities. Casualty prevention includes all measures taken by commanders, leaders, individual military personnel, and the health care system to promote, improve, or conserve the mental and physical well-being of military personnel.
5. Combat & Operational Stress Control – Includes programs and actions to be taken by military leadership to prevent, identify, and manage adverse combat and operational stress reactions in units.
6. Contractors Authorized to Accompany the Force (CAAF)- Contingency contractor employees and all tiers of subcontractors who are specifically authorized through their contract (via Letter of Authorization (LOA) they are required to carry with them and provide to JROSI upon arrival) to accompany the force and have protected status in accordance with international conventions. Generally all US citizens and TCN contingency contractor and subcontractor employees of US forces who do not reside within the operational area and who routinely reside with US forces (especially in uncertain and hostile environments) are considered CAAF. CAAF may also include some mission essential host nation (HN) and local national (LN) contractor employees (i.e. linguists) who reside with US forces and receive Government-Furnished support such as billeting and access to dining facilities (Reference JP 4-10).
7. Defense Occupational and Environmental Health Readiness System (DOEHRS) – DoD Military Health System’s (MHS’s) maintained informatics system for entering standardized sample and survey collection forms and reporting associated sample laboratory results and survey data. The DOEHRS system has multiple modules which include: Industrial Hygiene (IH); Environmental Health (EH); Radiation (R); and Incident Reporting (IR). Access to each of these modules is managed by an individual’s roles within the system. DOEHRS also provides

the ability to search and report across all data entered. DOEHRS is the foundation for the Individual Longitudinal Exposure Record (ILER).

8. Deployment – For medical purposes, travel to or through the USCENTOM area of responsibility with expected or actual time in country for a period of greater than 30 days, excluding shipboard operations (Reference DoDI 6490.03).

9. Environmental Baseline Survey (EBS): An EBS establishes a snapshot of existing conditions of a location at the time occupied, documents any health risks and environmental risks, and provides guidance on environmental abatement or risk management necessary to protect the health of US personnel. EBSs are required if a site is occupied or expected to be occupied for 30 or more calendar days after initial occupation. EBSs will be completed by units during training exercises either before the exercise begins or during the exercise. If the exercise is a recurring exercise in the same locations, the EBS will not be repeated (Reference CCR 200-1).

10. Environmental Laboratory Services – Deployable environmental laboratory services include capabilities in identification and field confirmation of endemic diseases, occupational and environmental health hazards, and CBRN agents. The focus of the laboratory is the total health environment of the JOA, not individual patient care.

11. Health Risk – Potential for adverse health impact to an exposed population or individuals – the consequences associated with military actions and resources. The risk may be due to acute health effects or chronic long-term health effects.

12. Health Risk Communication Plan – A specific plan that documents means of delivery and development of key messages on deployment health threats and risks (including actual and potential exposures), associated countermeasures, and any necessary medical follow-up for deployed personnel. The plan should document how OEHSA data and industrial hazard assessments (IHA) information will be used to develop appropriate written and oral materials to communicate deployment health risks. The plan should identify how health risk communications will be updated as new information about health risks becomes available (Reference MCM 0017-12).

13. Health Surveillance – Includes identifying the population at risk; identifying and assessing their potentially hazardous exposures (such as medical, food/water, occupational and environmental, psychological, and chemical, biological, radiological, and nuclear [CBRN]); using health risk communications practices to communicate the risk; employing specific countermeasures to eliminate or mitigate exposures; and utilizing medical surveillance procedures to monitor and report DNBI/battle injury rates and other measures of health outcomes to higher authority in a timely manner.

14. Health Threat – A composite of ongoing or potential enemy actions; adverse environmental, occupational, and geographic and meteorological conditions; endemic diseases; and employment of nuclear, biological, and chemical weapons (to include weapons of mass destruction) that have the potential to affect the short- or long-term health (including psychological impact) of personnel.

15. Industrial Hazard Assessments – Reports developed by the intelligence community (i.e., National Center for Medical Intelligence) that identify potential local industrial operations and the hazards normally associated with those operations.

16. Low Level Exposures – Low-level exposures are occupational and environmental health exposures that do not produce acute health effects of significant clinical or physiological impact and, thus, will not pose significant operational (mission) impact. This involves a range of exposures and points along a hazard's dose-response continuum to include a) potential for mild non-impairing, minimally noticeable reversible acute effects and, b) for certain hazards, some limited possibility of latent (post-deployment onset) and/or non-clinical effects (reversible or non-reversible), and c) levels associated with no anticipated effects of any kind. Low-level exposures are generally assigned a negligible hazard severity.

17. Medical Surveillance – The ongoing, systematic collection, analysis, and interpretation of data derived from instances of medical care and the reporting of population-based information for characterizing and countering threats to a population's health, well-being, and performance.

18. Occupational and Environmental Health (OEH)/Exposure Incident – In general may be defined as an unexpected significant OEH (to include CBRN) exposure event that results in an acute illness, that has the potential to cause latent illness to those individuals affected or possibly exposed, or an event that was perceived as an unexpected significant exposure event though no exposure occurred. Several variables, including event perception and data confidence limitations, may factor into the determination of whether an event constitutes an 'incident'. See Appendix H of this document for more details.

19. Occupational and Environmental Health Risks – The likelihood of health effects associated with:

a. The accidental or deliberate release of non-weaponized TICs/TIMs; hazardous physical agents; ionizing or nonionizing radiation; or residue from CBRNE.

b. Environmental contaminants, to include 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, local national governments, or local national agricultural, industrial, or commercial activities.

c. The TICs/TIMs or hazardous physical agents currently being generated as a by-product of the activities of U.S. forces or other concerns, such as non-U.S. military forces, local national governments, or local national agricultural, industrial, or commercial activities.

d. Endemic diseases, deployment related stress, and climatic and/or environmental extremes.

e. Noise induced hearing injury as a result of hazardous noise exposure.

20. Occupational and Environmental Health (OEH) Significant Exposure – Exposure to OEH hazard that will plausibly result in some clinically-relevant adverse health outcome to exposed individuals as determined by an appropriate medical/health professional. These include situations where specific OEH hazards are determined to:

a. Present a Moderate or higher level of operational risk based on quantified OEH data that indicate acute effects are anticipated;

b. Be plausibly and causally associated with actual observed (acute) clinical health outcomes that are reported and/or treated (e.g., complaints of headaches, dizziness, respiratory problems, ocular effects, nausea, seizures, etc.) even in the absence of quantitative exposure data and/or an actual OEH risk assessment being performed);

c. Present a “Low Risk” because onset of associated health outcomes would occur post-deployment but where the confidence is High that such a latent long term (chronic) health impact has been strongly associated with exposures of similar magnitude and duration. For example:

(1) The use of facilities with substantial friable asbestos as the official (1-year) living/working quarters for a deployed unit may be a “Low risk” relative to the acute impacts to the mission. However, the asbestos exposure could be deemed significant if toxicological and or epidemiological scientific evidence supports High confidence exposures of similar magnitude and duration are strongly associated with the development of disease (e.g., asbestosis or mesothelioma).

(2) Most Low risk exposures associated with potential long-term chronic health effects will not be considered significant because available scientific data does not support extrapolation of the dose- response curve to low exposures with any degree of confidence in the predictive value.

21. Occupational and Environmental Health Site Assessment (OEHSA) – Documents the OEH conditions found at a site (e.g., base camp, bivouac site or outpost, or other permanent or semi-permanent basing location). The assessment, done by Service preventive medicine personnel, includes site history; environmental health surveys for air, water, soil, and noise; entomological surveys; occupational and industrial hygiene surveys; and ionizing and non-ionizing radiation hazard surveys, if indicated. Its purpose is to identify hazardous exposure agents with complete or potentially complete exposure pathways that may affect the current or future health of deployed personnel (see Appendix D).

22. Occupational and Environmental Health Surveillance – The regular or repeated collection, analysis, archiving, interpretation, and dissemination of OEH-related data for monitoring the health of, or potential health hazard impact on, a population and individual personnel, and for intervening in a timely manner to prevent, treat, or control the occurrence of disease or injury when determined necessary.

23. Occupational and Environmental Health Threat – Threats to the health of military personnel and to military readiness created by exposure to hazardous agents, environmental contamination, or toxic industrial materials.

24. Periodic Occupational and Environmental Monitoring Summary (POEMS) – A POEMS is a document that summarizes the DoD medical interpretation of existing occupational and environmental health (OEH) exposure information/data for deployment sites (e.g. base camps). Specifically, a POEMS describe the types of exposure hazards identified at a site (e.g., airborne pollutants, water pollutants, infectious disease, noise, heat/cold), summarizes data/information collected about those hazards, assesses mitigation measures that have been implemented to

address the hazard, and then provides an assessment of the significance of any known or anticipated potential acute (short term) and long-term (post deployment) health effects to the personnel population deployed to the site. The POEMS concludes with a summary of the key acute and chronic hazards/risks. If a specific recommendation for follow-up is indicated, this must be coordinated with a health care provider before inclusion to the POEMS (Appendix E).

25. Preventive Dentistry – Incorporates primary, secondary, and tertiary measures to reduce or eliminate conditions that may decrease military personnel fitness in performing their mission and which could result in being removed from their unit for treatment.

26. Preventive Medicine – The anticipation and prevention, control of communicable diseases, illnesses, and exposure to endemic, occupational, and environmental threats. Preventive Medicine includes FHP measures taken against infectious, endemic, environmental, occupational, industrial, and operational health risks.

27. Reportable Medical Event (RME) – May represent an inherent, significant threat to public health and military operation. These events have the potential to affect large numbers of people, to be widely transmitted within a population, to have severe/life threatening clinical manifestations, and to disrupt military training and deployment. Timely, accurate reporting of probable, suspected or confirmed cases ensures proper identification, treatment, control, and follow-up of cases.

28. Risk Communication – The timely process of adequately and accurately communicating the nature of actual, potential, and perceived OEH hazards, risks (probability and severity), countermeasures, health outcomes, and other health-related information associated with pre-, during, and post-deployment operations to all personnel (especially commanders) and other individuals/groups directly affected by, or highly interested in, the health risks. Health risk communication efforts must be understandable and foster trust. They may involve multiple techniques and should allow for timely two-way communications between subject matter experts (medical personnel) and those individuals and groups who have concerns.

29. Veterinary Services – The United States Army (USA) is the DOD executive agent for veterinary support for the Services. USA veterinary units are task-organized and tailored in order to support government-owned animal health care, veterinary PVNTMED, and food safety and security programs.

30. Vision Readiness – Encompasses the Service member having optimal visual clarity in order to most effectively and efficiently complete their assignments as well as the optical devices needed for vision correction (if required) and for eye protection of all service members during hazardous activities, including deployment.

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APPENDIX C - SUMMARY OF DEPLOYMENT HEALTH ACTIVITIES AND REPORTING REQUIREMENTS

a. This Appendix summarizes the key deployment health activities and associated documents/products discussed in this regulation. It summarizes responsible parties and timelines for key deployment health activities and documents.

Activity Description	CC Cdr	CCJ2	CCJ3	CCJ4	CCJ5	CCSG	Component & JTF Cdr	Component & JTF SG	Supporting PM Assets	Location BOS-I for Medical Management	Diagnostic Labs	Units providing medical care
DNBI Surveillance Appendix F	BPT request assistance from non-DoD agencies	Determine if outbreak is tied to intentional threat	Notify CCSG of SIGACTs which document any illness	BPT provide food and water from alternate sources	Monitor phase 0 conditions of the PI&ID OPLAN	Monitor DNBI surveillance throughout the AOR	BPT submit RFAs if outbreak mitigation exceeds capabilities	Standardize reporting process throughout the JTF / country	Review surveillance reports. BPT investigate / assist	Standardize reporting by deployment site	BPT send specimens to reference laboratory	Submit MSAT "Joining" Reports.
Reportable Medical Event Appendix G	BPT request assistance from non-DoD agencies	Determine if RME is tied to intentional threat	Notify CCSG of SIGACTs which document any illness		Monitor phase 0 conditions of the PI&ID OPLAN	Monitor RMEs across all Components and systems	BPT submit RFAs if RME mitigation exceeds capabilities	Standardize reporting process throughout the JTF / country	Review RME reports. BPT investigate / assist	Establish RME documentation processes by deployment site	Update RME report based on analysis	Document suspect cases in MSAT or DRSi. Update cases based on lab results.

<p>Animal Bite Report Appendix J</p>	<p>Prohibit contact with domestic and wild animals in GO#1</p>	<p>BPT provide guidance for vector control contracts</p>		<p>Review recommendations from rabies advisory boards</p>	<p>Prohibit contact with domestic & wild animals</p>	<p>Conduct investigation IAW Appendix J</p>	<p>Assess deployment site vector control actions</p>	<p>Coordinate deployment site vector control actions</p>	<p>BPT send specimens to reference laboratory</p>	<p>Initiate the DD 2341, Animal Bite Report IAW Appendix J</p>
<p>Occupational & Environmental Health, CBRN Exposure Incident Reporting (IR) Appendix H</p>	<p>BPT request assistance from non-DoD agencies</p>	<p>Determine if incident is tied to intentional threat</p>	<p>Notify CCSG of SIGACTs which document any exposure</p>	<p>Monitor the incident and update DoD and Joint Staff</p>	<p>BPT submit RFAs if incident mitigation exceeds capabilities</p>	<p>Ensure incidents are documented in DOEHS</p>	<p>Conduct investigation, prepare IR, document in DOEHS</p>	<p>Request support if assets are not organic to the site</p>		<p>Notify supporting PM assets of suspected exposure incidents</p>
<p>Field Data Sheet Documentation</p>				<p>Monitor PM support throughout the AOR</p>	<p>Resource mitigation actions.</p>	<p>Ensure each deployment site receives PM support</p>	<p>Enter field data sheets for each site into DOEHS</p>	<p>Request PM support for each deployment site</p>		
<p>Occupational & Environmental Health Site Assessment Appendix D</p>				<p>Verify OEHS documentation in DOEHS for each site</p>	<p>Resource mitigation actions.</p>	<p>Ensure each deployment site receives an annual OEHS</p>	<p>Document an initial and annual for each site</p>	<p>Request PM support for each deployment site</p>		

<p>Periodic Occupational & Environmental Monitoring Summary Appendix E</p>	<p>Delegates USCENCOM POEMS approval to CCSG</p>		<p>Review to ensure it is consistent with CBRN records</p>	<p>Review to ensure it is consistent with environmental records</p>		<p>Review and approve POEMS for sites within USCENCOM</p>	<p>Submit RFA to Component Public Health Center to author</p>	<p>Author deployment site POEMS or submit RFA</p>	<p>Author deployment site POEMS or submit RFA</p>	<p>Request PM support for each deployment site</p>		
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**APPENDIX D - OCCUPATIONAL AND ENVIRONMENTAL HEALTH SITE
ASSESSMENT (OEHSA)**

1. The OEHSA, done by Component preventive medicine personnel, documents the overall OEH conditions and documents complete or potentially complete exposure pathways at the deployment site (Reference MCM 0017-12). It includes a reconnaissance of the site history and potential or actual hazards from air, soil, water, noise, entomological vectors, occupational, and ionizing and non-ionizing radiation (Reference ASTM E 2318-03). The template can be found at the following web link, under the drop down menu for 'Survey Forms': <https://mesl.apgea.army.mil/mesl/doehrsResources/initialize.do>
2. The initial OEHSA for a deployment site will be initiated within 30 days of date of establishment and completed and marked "Approved by quality analysis" (when added to DOEHRS) within 3 months for all contingency basing (Reference DoDD 3000.10). Based on the risks assessments of the exposure pathways within the OEHSA, future deployment health activities will be directed by the USCENTCOM Commander, JTF Commander, or Commander exercising operational control of the deployment site (Reference DoDI 6490.03). The deployment site's BOS-I for medical management must review the OEHSAs annually to ensure they are current and request assistance as necessary to complete a reassessment.
3. OEHSAs are conducted to identify actual or potential health threats, evaluate exposure pathways, and recommends courses of action and countermeasures to control or reduce the health threats and protect the health of all deployed DoD personnel.
4. OEHSA related documents will be sent by the completing unit through the Component PM/FHP officer for review and submitted directly to the DOEHRS-IH (EH) module. Classified portions of the OEHSA should be submitted to the USAHPC SIPR (oehs@usaphc.army.smil.mil)
5. Service Components and JTFs are responsible for approving OEHSA completion (i.e. ensuring it is marked Approved by QA) and will review the DOEHRS-IH (EH) module to ensure each deployment site receives a reassessment at least annually. Components should contact their Service specific Public Health Centers for assistance with OEHSAs.

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APPENDIX E - PERIODIC OCCUPATIONAL AND ENVIRONMENTAL MONITORING SUMMARY

1. While OEHSAs document the assessment at a specific point in time, the POEMS are the official DoD approved documents that summarize population based health risks and associated medical implications resulting from occupational and environmental health (OEH) exposures identified at major contingency bases (e.g. base camps) over a period of time. Specifically, POEMS describe the types of exposure hazards (e.g., airborne pollutants, water pollutants, infectious disease, noise, heat/cold), summarize site data/information collected, and provide an assessment of the significance of any known or potential short term (during deployment) and long-term (post deployment) health risks to the personnel population deployed to the site.
2. POEMS have been developed to address requirements of DoDI 6490.03, DoDI 6055.05, and MCM 0017-12. The POEMS replaces the DoDI requirement to prepare “periodic occupational and environmental monitoring summaries on a SF 600 for each permanent or semi-permanent basing location.” POEMS are to be created and validated/updated for every major deployment site as soon as sufficient site data is available, but no later than one year after occupation. In general, POEMS should reflect data and information collected from a year or more time at a site in order to adequately evaluate potential risks from long term exposures. In USCENTCOM, POEMS should be reevaluated at least every three years or more frequently if environmental exposure conditions change.
3. The Component or JTF Commander approves the location of deployment sites. Therefore, the deployment site’s BOS-Integrator for medical management must prepare the POEMS or submit a request for assistance through their chain to author the summary. Components should submit their request for assistance to their Service Public Health Center. The POEMS author, whether in theater or Service Public Health Center, will submit the draft POEMS to CCSG for staffing within USCENTCOM. The CCSG will consolidate USCENTCOM comments and provide feedback to the author. The author will incorporate comments and post the POEMS in DOEHRS. By the authority of this regulation, the USCENTCOM Surgeon is the USCENTCOM approval authority for POEMS in the AOR.
4. The primary audience of the POEMS is military public health personnel and health care providers (military, VA, as well as private sector). To the extent that the available data allows, the POEMS describes the general ambient conditions at the deployment site and surrounding area, and characterizes the risks at the population-level. While useful to inform providers and others of potential health effects and associated medical implications, it does not represent an individual exposure profile. Actual individual exposures and specific resulting health effects depend on many variables and should be addressed in individual medical records by providers as appropriate at the time of an evaluation of a unique exposure. The intent of POEMS is to satisfy the need for such population-level health surveillance information to be available, should service personnel have OEH exposure-related concerns. For additional assessment of potential individual exposures, Service members are also required to complete pre- and post- deployment questionnaires regarding their individual health status and any occupational or environmental exposures that they believe that they experienced while deployed.

5. The template for the POEMS is located at:

<https://mesl.apgea.army.mil/mesl/healthSummary.jsp> .

6. Completed approved POEMS are available via NIPRNET on the Defense Occupational and Environmental Health Readiness System at <https://doehrs-ih.csd.disa.mil/>

APPENDIX F - DISEASE AND NON-BATTLE INJURY (DNBI) SURVEILLANCE

1. Purpose and Processes for DNBI surveillance

a. DNBI surveillance (Reference MCM 0017-12) , can reveal abnormal patterns and trends that may signal a serious, widespread health problem that could negatively impact the mission. The causes of these types of health problems include environmental health threats, inadequate sanitation and hygiene and monitoring programs, inadequate use of preventive and/or protective measures, and unhealthy behaviors and practices.

b. The purpose of DNBI surveillance is to promote and maintain the health and fitness of deployed forces and maximize force health protection through monitoring illness and injury rates, and instituting interventions as required. Surveillance is not a report card tool to capture work load trends. Surveillance focuses on initial encounters and diagnosis. Specific objectives include:

(1) Communicable disease outbreak detection.

(2) Sentinel event detection, primarily related to reportable medical events (Appendix G).

(3) Evaluating the effectiveness of systems to provide healthy food, clean water, safe sanitation and adequate shelter in the deployed environment.

c. DNBI surveillance is based on information from healthcare visits at every level of the combat healthcare system. Once locations providing medical care complete the appropriate joining report, information will flow from the NIPRNET-based health care information system to the Medical Situational Awareness Tool (MSAT). MSAT is a SIPRNET-based application that facilitates the monitoring of DNBI trends throughout the AOR. Deployed forces ashore will use JMEWS as the primary data entry point for DNBI reporting.

(1) Surveillance will focus on diagnosis of initial cases in the following categories: mental disorders, dermatological, respiratory, recreational injury, ophthalmologic, gastrointestinal, work related injury, dental, gynecological, unexplained fever, motor vehicle injuries, neurological, combat/operational stress reaction, sexually transmitted diseases, and heat/cold injuries.

(2) Sites operating without NIPRNET in their healthcare areas must maintain a spreadsheet containing the counts of their local healthcare visits (Reference MCM 0017-12).

(3) Sites without SIPRNET must transmit their weekly reports to the next higher medical activity or surgeon in their chain of command for entry into MSAT/JMeWS. Every physically distinct medical activity (Role I through III), including those conducting split-base operations, must provide a report.

d. The weekly DNBI report through MSAT/JMeWS indicates the number of cases of disease or injury (Reference MCM 0017-12) along with the size of the population at that location. Command Surgeons should assist the BOS-Integrator for medical management at each deployment site to establish naming conventions and filters to consolidate surveillance data appropriate geographical location.

(1) Populations in the battlespace often overlap. Medical activities should report, to the best of their abilities, the number of personnel directly eligible for primary healthcare at their location.

(2) At locations where there is a significant overlap in the population under care, medical personnel must coordinate to reduce the amount of “double-counting” of individuals.

e. Using MSAT/JMeWS, Command Surgeons at all levels can aggregate weekly reports by UIC (or a similar location- specific code) in order to survey deployed forces ashore within their specific AOR.

(1) It is the responsibility of each medical treatment facility using MSAT/JMeWS to establish, maintain and hand-over DNBI baseline rates for their location. This may entail maintaining legacy files (spreadsheets) with DNBI data for the last 1-2 years. MSAT/JMeWS does not currently support the archiving and reporting of baseline data. It is not necessary to maintain DNBI data beyond 24 months.

(2) Preventive medicine personnel should develop methods for reporting DNBI information to their surgeons and commanders. At a minimum, preventive medicine personnel responsible for DNBI surveillance must review and analyze DNBI data on a weekly basis and BPT summarize the results of their latest analysis as needed.

(3) It is the responsibility of the Command Surgeons to determine when the command should be notified immediately about a certain case or condition. Indicators of potential emergencies include (but are not limited to) communicability, severity of disease, a fatality or a condition that suggests a failure in the established public health system.

f. Commanders should use the results of DNBI surveillance for composite risk management, when evaluating the health and fitness of the force, and in determining the needs for (and allocation of) preventive medicine and force health protection resources.

2. Specific Procedures.

a. MCM 0017-12 contains the latest requirements for conducting DNBI surveillance. Additional procedures designed to enhance DNBI surveillance in USCENTCOM are provided below.

b. Properly configure the MSAT/JMeWS “Joining Report.”

(1) The Joining Report establishes the data linkage between the NIPRNET health information system (MC4/AHLTA-T) and the SIPRNET MSAT/JMeWS. Every unique medical activity ashore, including those conducting split-base operations, must have a unique identifier, such as a version of their UIC. The medical activity identifier for MC4/AHLTA-T must exactly match the “UIC” in the MSAT/JMeWS Joining Report.

(2) Medical activities must report their unique identifier (or changes) to their next higher surgeon and their local FHP personnel.

(3) Medical activities that are assuming responsibilities at a location where the health information system (computers, servers, etc.) are not being redeployed should not attempt to submit a new Joining Report, but may change the description of their facility in the appropriate data field.

c. Ensure that reports conform to the established methods for counting cases. It is critical that DNBI surveillance at all levels follows the established case definitions. FHP personnel and surgeons are responsible for distributing copies of the Chairman's memorandum (Reference MCM 0017-12) throughout their AORs and conducting local training, as needed.

Example DNBI rate calculation:

$$\text{DNBI (\%)} = ((\# \text{ Patients})/(\text{Population at Risk})) * 100$$

$$\text{DNBI}_{\text{derm}} (\%) = (20/500) * 100$$

$$\text{DNBI}_{\text{derm}} (\%) = (0.04) * 100$$

$$\text{DNBI}_{\text{derm}} (\%) = 4\%$$

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APPENDIX G - CENTCOM REPORTABLE MEDICAL EVENT (RME) DATA PROCEDURES

1. Purpose and Process for RME reporting

a. RMEs are those diseases and conditions defined by the Armed Forces Reportable Medical Events Guidelines and Case Definitions that represent a special concern to the military leadership and public health authorities because they carry with them the potential for infectious disease outbreaks, or they may constitute sentinel events that indicate the failure of force health protection measures. Many are consistent with conditions that are reportable under U.S. federal or individual state laws.

b. Central reporting of RMEs ensures that commanders have timely visibility of medical situations that threaten the health of the force. Centralized reporting retains historical data, supports disease mapping, and enhances public awareness, treatment options and vector mitigation.

(1) Locations/Units providing medical care must:

(a) Ensure all providers are familiar with the list of RMEs.

(b) Establish internal procedures for electronically documenting the RME in the Service specific Disease Reporting System internet (DSRi) or MSAT. Once the electronic documentation is submitted, the reporting requirement is met.

(c) Follow up suspected cases with laboratory confirmation when feasible and update the electronic report as necessary.

(2) Medical personnel will maintain a regional approach for monitoring RMEs and to ensure that all geographic and command AORs are covered. The deployment site's BOS-Integrator for medical management must lead the effort to standardize the process for RME reporting. For locations without a Component specified at the BOS-I for medical management where multiple Services are performing health care operations, the medical treatment facility/unit from the Service with the preponderance of forces / population at risk will lead the efforts to standardize RME reporting and DNBI surveillance.

c. Certain conditions may represent a significant threat to public health and may require further investigation as determined by the local command surgeons. Reporting of cases should not be delayed by lack of confirmatory (definitive) laboratory testing or uncertain clinical criteria. In the deployed environment, rapid assessment and containment of communicable disease outbreaks is essential to maintaining force strength.

d. Units lacking direct access to one of the electronic RME data systems, or in unusual circumstances where the determination is made that initial details of a RME must be made via SIPR, will record the necessary information on the available RME form in this appendix and email or fax the report through the component surgeon to the CENTCOM Surgeon.

2. Specific procedures.

a. All locations/Units providing medical care in CENTCOM are required to develop internal procedures for electronically documenting the RME in Disease Reporting System internet (DSRi) or MSAT

(1) The U.S. Army, U.S. Air Force, and U.S. Navy have all mandated the use of DSRi as the system of record for electronically documenting RMEs at all fixed facility and deployed, locations/Units providing medical care. Once the RME is uploaded into DSRi the reporting requirement is met for all levels of notification. MTFs must coordinate directly with DSRi to ensure their facility is documented as a USCENTCOM reporting unit.

(2) Medical organizations assigned on orders to the USCENTCOM AOR can electronically document RMEs in MSAT if they don't have existing procedures for submitting RMEs into DSRi. MTFs must validate that their RME inputs are captured in the CENTCOM Reportable Conditions query, filter ID 1570.

b. Command Surgeons, Force Health Protection Officers, and Clinical Operations Officers will monitor and review DRSi and MSAT Reportable Conditions reports from their AOR for patterns indicative of a public health problem.

c. Components can request DRSi accounts through their respective Service public health center:

- (1) U.S. Air Force, episervices@wpafb.af.mil
- (2) <https://data.nmcphc.med.navy.mil/afdrsi/Login.aspx>
- (3) U.S. Army, usaphc.disease.epidemiology@us.army.mil
- (4) <https://data.nmcphc.med.navy.mil/adrsi/Login.aspx>
- (5) U.S. Navy, NDRS@nmcphc.med.navy.mil
- (6) <https://data.nmcphc.med.navy.mil/ndrsi/Login.aspx>

Sample RME form to facilitate submission into DSRi or MSAT

(U) PATIENT DATA:

Last Name		First Name	
Rank/Grade/Contractor	Social Security Number	Gender (M/F)	Date of Birth (DDMMYY)
Unit		Unit UIC	
Unit Location (Base, Camp, etc.)		Duty/Unit	
Country	APO Zip Code	Category***	Race:
			White
			Black
			Hispanic
			Asian
			Am. Indian
			Other

(U) DISEASE DATA (complete as much as possible): *See Armed Forces RMEs Chapter 7

Diagnosis Code*	Diagnosis Description			Onset of Symptoms
Confirmed	Method of Confirmation		Admitted	Date of Admission
YES	CLINICAL	BIOPSY	YES	
NO	CULTURE	SEROLOGY	NO	
PENDING	SLIDE	OTHER		
Pertinent Travel:	Yes	Country #1		
	No	Country #2		
Malaria Chemoprophylaxis:	Yes	Prophylaxis #1		
	No	Prophylaxis #2		

(U) FOR HEAT OR COLD INJURIES:

Ambient Air Temperature (F)	WBGT	Previous Heat or Cold Injury	Yes
Wind Speed (MPH)	Body Part or Organ System Affected:	Multi-system involvement:	No
Rectal Temperature (F)			Yes
Uniform: ACU/Armor/ MOPP/PT		Water Consumption:	No

(U) FOR CBRN/OEH TIC/TIM EXPOSURE INCIDENTS (send to ccs-gpmo@centcom.smil.mil):

Provide to extent possible: Substance and/ source description and exposure route; Approximate duration, estimated degree of exposure; signs & symptoms; treatment /other medical codes; disposition. EXAMPLE: (e.g. several minutes exposure to accidental release of vapor with ammonia-like odor from facility, coughing difficulty breathing (786.2); RTD.

(U) REPORTING SOURCE:

Healthcare Provider:	Preventive Medicine Officer (or person completing form)
Medical Unit/MTF:	
Phone #	Place additional notes/comments on next page

** For Chemical, Biological, Nuclear, Radiological (CBRN) and TIC/TIM OEH exposure – send this form to the CENTCOM FHP Officer within 48 hours of treatment: ccsg-gpmo@centcom.smil.mil.

CATEGORY
CODES ***

A11	Army active duty	F41	DEP Air Force Active Duty	N11	Navy Active Duty
A31	Army retired	F43	DEP Air Force Retired	N31	Navy Retired
A41	DEP Army Active Duty	M11	Marine Active Duty	N41	DEP Navy Active Duty
A43	DEP Army Retired	M31	Marine Retired	N43	DEP Navy Retired
F11	Air Force Active Duty	M41	DEP Marine Active Duty	K59	Civilian/DEP Civilian
F31	Air Force Retired	M43	DEP Marine Retired	K79	Local National

PRIVACY ACT INFORMATION

Authority: Section 133, Title 10, United States Code (10 USC 133)

Purpose: The purpose of this form is to compile relevant patient information concerning communicable diseases and injuries occurring among

Department of Defense personnel and family members stationed or operating in Europe.

Routine Uses: Used to monitor for the emergence of specific communicable diseases or outbreaks which pose a public health threat and to prepare data for inclusion in the U.S. Army Medical Surveillance System.

Disclosure: The requested information is mandatory for compliance with U.S., Host Nation and Army disease reporting laws and regulations. Failure to provide the requested information will prevent effective public health action and contribute to higher disease and injury rates.

**ALL COMPLETED FORMS WILL BE SUBMITTED TO THE COMPONENT
CJTF SURGEON FORCE HEALTH PROTECTION (FHP) OFFICER. DO NOT
DELAY REPORTING LABORATORY CONFIRMATION.**

**APPENDIX H - OCCUPATIONAL AND ENVIRONMENTAL (OEH)
EXPOSURE INCIDENT REPORTING**

1. PURPOSE

a. This appendix provides responsibilities and guidance related to OEH incident reporting (Reference DoDI 6490.03).

(1) DoD and Joint Staff policies require documentation of exposure incidents from OEH

(2) contaminants resulting from a significant exposure to any deployed individual(s), to include exposures from CBRN agents (USCENTCOM CCIR #CC-04 and JS-06) and acutely toxic industrial chemicals.

(3) What constitutes an OEH Exposure Incident? The determination of whether an OEH exposure is sufficient to warrant reporting as an exposure incident is somewhat subjective, but there are certain criteria to support a determination (e.g., it would be considered a CCSG medical friendly forces information requirement). Table I-A-1 provides a checklist of considerations that can be used to determine whether an OEH incident warrants documentation. The most obvious scenarios are those resulting in real-time health impacts that require medical countermeasures or treatment. If significant concerns or senior leadership interest trigger a specific investigation related to the potential presence of a OEH hazard, actions and circumstances surrounding the incident should be documented even when a determination is made of no notable exposure or significant impact to human health or mission. The resources required for such an investigation can also support justification for the Incident Reporting process and document the event. Documentation provides a record of the assessment and maximizes documentation for a service member’s longitudinal exposure record.

Y/N	Any one of the indicators for documentation of an OEH Exposure Incident through the Incident Reporting Process (e.g. per DOEHRS-IR module)
	The presence of an OEH hazard is plausibly associated with actual observed (acute) clinical health outcomes that are reported and/or treated (e.g., complaints of headaches, dizziness, skin/eye irritation/burning, coughing, nausea, etc.)
	The presence of an acute OEH hazard is indicated through positive detection using real-time field equipment. (e.g. M8/M256/ICAM detectors for chemical warfare agents)
	Evaluation of data/related information by an appropriate medical/health professional indicates that exposure to the OEH hazard could plausibly result in some significant (e.g., Moderate or higher risk level) clinically-relevant adverse health outcome (to include
	Visual/sensory cues indicating potential presence of a OEH hazard (e.g., smoke/cloud, odors, strange liquid/powers, etc.) are present
	Concern over a perceived or potential adverse health exposure leads to involvement of preventive medicine assets and military leadership for investigation, assessment, determination and response. Document these actions as an Incident Report even when there is a determination that no adverse exposures or impacts to human health are

Table H-A-1. Indicators suggesting **need to document an OEH Exposure Incident through the Incident Reporting Process (e.g. per DOEHRS-IH-IR module)**

b. Exposure Incident Investigations. Preventive medicine assets providing area support to the deployment site where the incident occurred will lead the investigation effort and submit the initial report in accordance with the following information requirements (Reference DoDI 6490.03):

- (1) Location, date, and time of incident;
- (2) Unit rosters of all personnel involved (affected or possibly exposed);
- (3) Acute or known/anticipated latent health outcomes and any medical follow-up required;
- (4) Documentation of personal protective equipment (PPE) or countermeasures used, effectiveness of and compliance with countermeasures, and any other exposure incident response activities;
- (5) Results of environmental monitoring; and
- (6) Attachment or description of any health risk communication materials provided to health care providers, patients, or the population at risk.
- (7) Initial reports are due to the Geographic Combatant Commands (USCENTCOM) within 7-days of the incident.
- (8) Final reports will be archived in DOEHRS.

APPENDIX I - DOEHRS

Purpose. Defense Occupational and Environmental Health Readiness System (DOEHRS) provides the ability to manage and report occupational and environmental health surveillance information. Information managed in DOEHRS includes site observation, field equipment results, and laboratory analysis supporting population and individual based OEH exposures. Occupational and environmental health operations conducted in CENTCOM should use DOEHRS forms whenever possible for data entry and archival.

a. DOEHRS is a CAC enabled web-based system (available via NIPR only) with multiple modules. The primary modules used for deployment OEH are Industrial Hygiene (IH), Environmental Health (EH), Radiation (R) and Incident Reporting (IR). Access to different modules is granted on an individual basis.

b. DOEHRS contains a variety of preventive medicine surveys and sample categories. Survey categories include Occupational and Environmental Health Site Assessment (OEHSA), food sanitation, general sanitation, water, entomology and waste management. The OEHSA serves as the foundation document for which potential hazards are identified and future sampling and surveillance plans are developed. Other surveys and samples in DOEHRS document follow-on surveillance activities to define, monitor and control identified hazards on the OEHSA.

c. Sample types in DOEHRS include various air methods, water, soil and thermal stress. Samples and surveys may relate to another document within this system; DOEHRS provides the ability to associate samples to surveys (to include Radiation surveys and Incident Report surveys), as well as associate both samples and surveys to the OEHSA.

d. Various reporting functionalities reside in DOEHRS that enable the user to view current and historical data either discretely or collectively, including access to laboratory results related to samples collected in theater, that have been sent to rear-area support organizations (such as USAPHC).

Responsibility. Deploying PM Commanders will ensure that their unit is trained on DOEHRS and that DOEHRS is used whenever possible as a routine business practice of the health surveillance mission.

Procedure: Whenever possible enter data collected on DOEHRS forms. These forms are available at: <https://mesl.apgea.army.mil/mesl/doehrsResources/initialize.do>.

a. Field personnel will establish a DOEHRS account. Surveys and samples should be entered into DOEHRS whenever a CAC enabled NIPR computer with internet connectivity is available.

b. Unclassified portions of the OEHSA will be entered into DOEHRS. Any classified portions of the OEHSA will be sent to the USAPHC SIPR, including the associated Survey ID of the unclassified OEHSA entered in DOEHRS. The unclassified portion within DOEHRS can be exported as a document using the "Other Actions" tool within the OEHSA survey in DOEHRS. Classified information can then be added to it, prior to submission to the USAPHC SIPR. A blank OEHSA survey can be downloaded from the DOEHRS resources page on the

MESL <https://mesl.apgea.army.mil/mesl/doehrsResources/initialize.do>. OEHSAs will be updated as site conditions change, and reviewed at least annually.

c. Environmental Health (EH) sample data will be entered by field personnel. This includes routine water monitoring (RWM) (e.g. samples not requiring laboratory analysis), as well as samples shipped to USAPHC laboratories, (e.g. air samples utilizing media; soil, ash, asbestos, and bulk samples collected in USAPHC kits; and water samples collected in USAPHC kits). RWM samples are distinctly different from samples sent to USAPHC. These results should be entered under a defined sampling profile (e.g. what field test was conducted) and a defined sampling point in DOEHRS. The procedure for samples shipped to USAPHC for analysis should be as follows:

(1) Document sample(s) on the field data sheet(s)(FDSs) at the time of sample collection. Adobe versions of FDSs are available on the DOEHRS resources page on the MESL. <https://mesl.apgea.army.mil/mesl/doehrsResources/initialize.do>

(2) Enter contents of hardcopy FDS into DOEHRS, including any documents or photos related to the sample as attachments.

(3) If possible, scan (IAW Reference CCR 380-8) hardcopy FDS and load as an attached in the DOEHRS sample.

(4) Notify USAPHC POC via email of DOEHRS Sample ID(s) and sample shipment information.

(5) Ship sample(s) and hard copy FDS to USAPHC.

This will enable timely laboratory analysis and results reporting. Once laboratory analysis is complete, USAPHC will load results in DOEHRS. The sample collector can immediately view laboratory results in DOEHRS after they are loaded.

d. General Sanitation, Food Establishment, Water, and Waste Surveys will be conducted by field personnel in support of OEHS and entered in DOEHRS. The surveys can be downloaded from the DOEHRS resources page on the MESL. [<https://mesl.apgea.army.mil/mesl/doehrsResources/initialize.do>] Field personnel should routinely notify USAPHC POCs of the surveys completed, and document issues as they arise to clarify the potential need to update an OEHSA or create an IR.

e. Entomology surveys include a General Entomology Survey, Vector Surveillance, Pest Surveillance and Pesticide Application Survey. Personnel conducting General Entomology Surveys, Vector or Pest Surveillance should enter survey results in DOEHRS. Pesticide application data should generally not be entered into DOEHRS as it is being provided directly to the USAPHC via an established by the Armed Forces Pest Management Board (AFPMB) reporting template (<http://www.afpmb.org/content/dd-form-1532-updated-pest-management-report>). However, DOEHRS can be used to view and report loaded pesticide application data.

Training. Training is required for familiarization with navigating, data entry, and retrieving information from DOEHRS. Training is offered through the following means:

e. The DOEHRS web site (<https://doehrs-ih.csd.disa.mil>) contains training material under the DOEHRS documentation tile. An account is required to access this material.

f. The DOEHRS Resources page (<https://mesl.apgea.army.mil/mesl/doehrsResources/initialize.do>) includes, but is not limited to, information on how to apply for a DOEHRS account and how to request training.

g. Individual or group training is offered through Defense Connect Online (DCO) webinar meetings or through personalized Training as requested through sending an email to: phc-esiprequests@amedd.army.mil

h. Training tutorial videos can be found on the DCO website [<https://www.dco.dod.mil>]. An account must first be created before the tutorial can be found by searching the Recordings, Public Recordings, and then search for “PHC-DOEHRS” to return numerous tutorials.

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APPENDIX J - ANIMAL BITE REPORTING

1. Endemic animal rabies exists in many countries within the CENTCOM AOR. Apply a higher index of suspicion when considering whether an animal may be rabid. Locations / Units providing medical care will document and report through their Component and JTFs all animal bites, scratches or instances of possible rabies exposure resulting from contact with wild, stray, feral, or domestic animals.

a. High risk personnel (veterinary personnel, military working dog handlers, animal control personnel, certain security personnel, civil engineers occupationally at risk of exposure to rabid animals, and laboratory personnel who work with rabies suspect samples) should receive rabies pre-exposure vaccination (Reference USCENTCOM GENADMIN Modification 12).

b. All U.S. personnel who are exposed to rabies or potentially exposed to rabies must report the animal exposure and seek medical treatment from a health care provider as soon as possible, preferably within 24 hours, for evaluation in accordance with the flowchart in figure J-1. Exposure events include a bite from an animal capable of spreading rabies, fluid contact with an open wound or mucous membranes, or possible contact with a bat.

c. Risk-based rabies post-exposure prophylaxis applies to all individuals after potential rabies exposure regardless of their pre-exposure immunization status. However, post-exposure prophylaxis schedules differ for unvaccinated vs. previously vaccinated persons, and for individuals considered to be immunosuppressed (Centers for Disease Control and Prevention Advisory Committee on Immunization Practices guidelines (www.cdc.gov/rabies/resources/index.html)).

2. Document a rabies risk assessment for all potential rabies exposures (Reference USCENTCOM GENADMIN 16SEP11).

a. Component/CJTF/JTF Rabies Advisory Boards (or Committees/Teams, as applicable). Rabies Advisory Boards will at a minimum be comprised of a U.S. military veterinarian and at least two U.S. military health care providers trained in rabies risk assessment or in preventive medicine. These teams provide a region-specific forum to evaluate bite reporting, post-exposure prophylaxis (PEP) administration, documentation, and other rabies prevention program initiatives.

b. The need for post-exposure prophylaxis will be based on a case-specific risk assessment by the attending provider, in consultation with the Rabies Advisory Teams/Boards, and as documented on DD Form 2341.

c. Completion of the DD Form 2341 ensures a multi-disciplinary review of the circumstances of each potential rabies exposure by the Component/CJTF/JTF Rabies Advisory Board, with a response that is tailored to each individual case. This review must occur as soon as possible following exposure. The individual case DD Form 2341 documents rabies infection risk assessment, management of the case, treatment recommendation, and case disposition.

3. Adhere to risk-based post-exposure rabies prophylaxis protocols in accordance with the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) guidance.
4. Treatment consists of appropriate wound care and, as indicated by the rabies risk assessment, complete CDC/ACIP rabies post-exposure prophylaxis. The CDC/ACIP rabies post-exposure prophylaxis schedule to be used depends upon the rabies immunization status and immunosuppression status of the individual. When rabies prophylaxis is initiated, measures will be in place to ensure the completion of the protocol without deviations. (www.cdc.gov/rabies/resources/index.html)
5. All DD Form 2341s should be reviewed within 30 days of the initiation of each report for final disposition of the case. Each report/case will be reviewed by the Rabies Advisory Board for proper disposition. To the maximum extent possible, ensure that all necessary measures have been taken to reduce any risk of rabies.
6. Ensure documentation of rabies pre- and or post-exposure prophylaxis (including lot numbers) in Service immunization databases as well as the individual's electronic medical record.

Health Care Provider
Initiate a DD 2341 for U.S. personnel

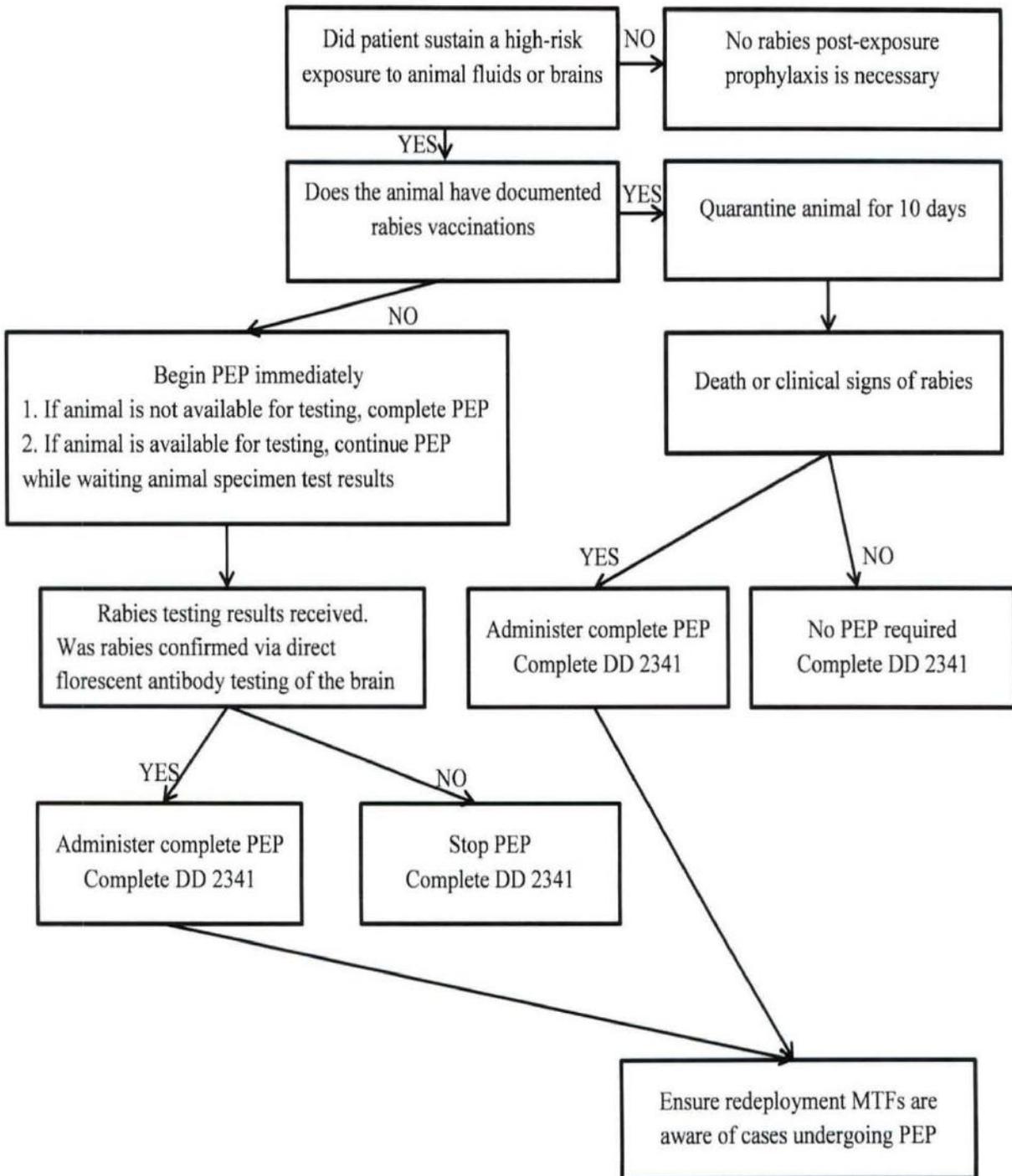


Figure J-1. Rabies Post-Exposure Prophylaxis (PEP) Treatment Flow

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APPENDIX K - IMMUNIZATION REQUIREMENTS

1. Immunizations will be given in accordance with Service specific requirements which are constantly updated. Contact the Military Vaccine Agency for the latest guidance.

2. Requirements. All personnel (to include Permanent Change of Station (PCS) and shipboard personnel) traveling for any period of time to the theater will be current with advisory committee on immunization practices immunization guidelines and service individual medical readiness (IMR) requirements IAW Service specific requirements. In addition, all temporary duty personnel must comply with the foreign clearance guide for the countries to which they are traveling. Mandatory vaccines for DoD personnel (military, civilian and contractors) traveling for any period of time within the USCENTCOM theater are:

a. Tetanus/diphtheria. Receive a one-time dose of TDAP if no previous dose(s) recorded. Receive tetanus TD if greater than or equal to 10-years since last TDAP or tetanus TD booster.

b. Varicella. Required documentation of one of the following: born before 1980 (assumed immunity except for health care workers), documented history of disease by the provider who treated the number at the time (either by an epidemiologic link or laboratory confirmation), sufficient varicella titer, or administration of vaccine, 2 doses (Reference ASD(HA) memo 15OCT08).

c. Measles, mumps, rubella. It is to be assumed that all individuals born before 1957 are immune and do not require the immunizations. Documentation of immunity by titer or immunization records of 2 adult doses are required for all other deployers. Immunity against mumps is not necessary as a military requirement, but may be appropriate in exceptional clinical circumstances such as outbreaks.

d. Polio-IPV. Single adult booster is required for travel only to Afghanistan or Pakistan. Both OPV or IPV qualify as an adult booster. It is to be assumed that all post-accession military personnel are immune and do not require this booster. Documentation by titer or immunization records is required for all civilian deployers.

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APPENDIX L - IMMUNIZATION REQUIREMENTS

1. Immunizations will be given in accordance with Service specific requirements which are constantly updated. Contact the Military Vaccine Agency for the latest guidance.

2. Requirements. All personnel (to include Permanent Change of Station (PCS) and shipboard personnel) traveling for any period of time to the theater will be current with advisory committee on immunization practices immunization guidelines and service individual medical readiness (IMR) requirements IAW Service specific requirements. In addition, all temporary duty personnel must comply with the foreign clearance guide for the countries to which they are traveling. Mandatory vaccines for DoD personnel (military, civilian and contractors) traveling for any period of time within the USCENTCOM theater are:

a. Tetanus/diphtheria. Receive a one-time dose of TDAP if no previous dose(s) recorded. Receive tetanus TD if greater than or equal to 10-years since last TDAP or tetanus TD booster.

b. Varicella. Required documentation of one of the following: born before 1980 (assumed immunity except for health care workers), documented history of disease by the provider who treated the number at the time (either by an epidemiologic link or laboratory confirmation), sufficient varicella titer, or administration of vaccine, 2 doses (Reference ASD(HA) memo 15OCT08).

c. Measles, mumps, rubella. It is to be assumed that all individuals born before 1957 are immune and do not require the immunizations. Documentation of immunity by titer or immunization records of 2 adult doses are required for all other deployers. Immunity against mumps is not necessary as a military requirement, but may be appropriate in exceptional clinical circumstances such as outbreaks.

d. Polio-IPV. Single adult booster is required for travel only to Afghanistan or Pakistan. Both OPV or IPV qualify as an adult booster. It is to be assumed that all post-accession military personnel are immune and do not require this booster. Documentation by titer or immunization records is required for all civilian deployers.

e. Seasonal influenza (including event specific influenza, E.G. H1N1).

f. Hepatitis A. At least one dose prior to deployment with subsequent completion of series in theater.

g. Hepatitis B. At least one dose prior to deployment with subsequent completion of series in theater.

h. Typhoid. Booster dose of typhim VI vaccine if greater than two years since last vaccination with inactivated, injectable vaccine or greater than five years since receipt of live, oral vaccine. Oral vaccine (VIVOTIF) is an acceptable alternative if time allows for receipt and completion of all four doses prior to deployment.

i. Anthrax. Personnel without a medical contraindication traveling in the USCENTCOM theater for 15-days or more will comply with the most current DoD anthrax requirements, currently a series of 5 vaccines and annual boosters.

(1) Military personnel, required.

(2) DoD civilians, required at government expense for emergency essential personnel IAW Reference SECDEF memo 28JUN04.

(3) DoD contractors, required at government expense as directed in the contract.

(4) Volunteers, voluntary at government expense.

j. Rabies pre-exposure vaccination series may be considered for personnel who are not expected to be able to receive prompt medical evaluation and risk based rabies post-exposure prophylaxis (PEP) within 72-hours of exposure to a potentially rabid animal. Booster doses are required every two years or when titers indicate exceptions may be identified by unit surgeons.

(1) High risk personnel. Pre-exposure vaccination is required for veterinary personnel, military working dog handlers, animal control personnel, certain security personnel, civil engineers occupationally at risk of exposure to rabid animals, and laboratory personnel who work with rabies suspect samples.

(2) Special operations forces (SOF)/SOF enablers. All personnel deploying in support of SOF will be administered the pre-exposure rabies vaccine series as indicated below:

(a) Afghanistan. Personnel with primary duties outside of fixed bases.

(b) Pakistan. All personnel.

(c) Other areas. Per USSOCOM Service specific policies, contact USSOCOM preventive medicine officer at DSN 312-299-5051 for more information.

3. Immunization exceptions. Required immunizations will be administered prior to deployment with the following possible exceptions:

a. The first vaccine in a required series must be administered prior to deployment with arrangement made for subsequent immunizations to be given in theater.

b. Anthrax vaccinations may be administered up to 120 days prior to deployment. It is highly advisable to get the first two anthrax immunizations or subsequent dose/booster prior to deployment in order to avoid unnecessary strain on the deployed healthcare system.

4. Adverse medical events related to immunization should be reported IAW Appendix G if case definitions are met. All immunization related unexpected adverse events are to be reported through the vaccine adverse events reporting system (VAERS) at <http://www.vaers.hhs.gov>.

5. USCENTCOM and Components will monitor immunization compliance via the COCOM immunization reporting database.

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APPENDIX M - MALARIA RISK ASSESSMENT AND GUIDELINES

1. In the absence of a local risk assessment, the following are the minimum malaria chemoprophylaxis requirements by country:

- a. Afghanistan: year round.
- b. Pakistan: year round.
- c. Tajikistan: April through October.
- d. Yemen: Year round.

2. The Component with BOS-I for medical management/JTF Surgeons are encouraged to conduct evidence based entomological and epidemiological assessment of malaria risk at fixed bases where significant numbers of personnel are assigned for prolonged periods. In conducting such a risk assessment, surgeons should review the most recent assessments and risk maps produced by the National Center for Medical Intelligence (NCMI). This information can be accessed on an unclassified website <https://www.intelink.gov/ncmi/index.php> Products are also accessible on the SIPRNET website <http://www.afmic.dia.smil.mil> Based on NCMI risk assessments and in consultation with the USCENCOM Surgeon, recommendation for modified chemoprophylaxis policy will be provided to Commanders using the following guidelines (Reference DoDI 6420.01):

a. Areas where the projected attack rates are 1-10 percent per month or greater: chemoprophylaxis is required.

b. Areas where the projected attack rates is “a small number of cases (less than 1 per 100 per month)”: chemoprophylaxis is generally indicated for field operations and rural exposures.

c. Areas where NCMI assess the projected attack rate to be “rare cases (less than 1 per 1,000 per month)”: chemoprophylaxis is not always indicated. Personal protective measures may provide sufficient protection. The decision to use chemoprophylaxis should be based on specific mission parameters.

d. Maneuver forces with intermittent and unpredictable exposures to risk areas should employ chemoprophylaxis based on the highest risk areas. Units and individuals with very short term exposure (i.e. aircrew not stationed in the risk area) should have risk and chemoprophylaxis use determined IAW service policy.

e. The Component with BOS-I for medical management / JTF policies will be sent to the USCENCOM Surgeon’s office at CCSG-PMO@CENTCOM.SMIL.MIL and stored on the Command Surgeon home page.

3. Malaria Chemoprophylaxis Utilization.

a. All therapeutic/chemoprophylaxis medications, including antimalarial and medical CBRN defense material (MCDM) will be prescribed IAW FDA guidelines.

b. Doxycycline or atovaquone/proguanil (Malarone®) is acceptable as the primary malaria chemoprophylactic agent. Units may selected based on unit uniformity, side effect profile, pharmacokinetics, individual tolerance, or desire for side benefits such as the antibacterial activity of doxycycline, as well as cost (Malarone ® is significantly more expensive than doxycycline). Individual with contraindication to doxycycline and atovaquone/proguanil may be prescribed mefloquine once screened for any contraindications and should be considered the drug of last resort. Mefloquine should be used with caution in persons with a history of traumatic brain injury (TBI), post-traumatic stress disorder (PTSD), and contraindicated in personnel with psychiatric diagnosis, specifically depression, schizophrenia and anxiety disorders. Each mefloquine prescription will be issued with a wallet card and current FDA safety information indicating the possibility that the neurologic side effects may persist or become permanent IAW Reference ASD(HA) memo 12AUG13. Other FDA approved agent may be used to meet specific situational requirements.

c. Personnel should deploy with their malaria chemoprophylaxis following one of two options:

(1) They may deploy with their entire primary prophylaxis course in hand (excluding terminal primaquine), or

(2) With enough medication to cover half of the deployment with plans to receive the remainder of their medication in theater based on unit preference.

d. Units will distribute terminal prophylaxis (primaquine) upon redeployment. A complete course of primary prophylaxis includes: the entire in theater at-risk period; the pre-exposure period (begins 2-days prior to entering the risk area doxycycline and Malarone ®, 2-weeks for mefloquine); and the post exposure prophylaxis period after leaving the at risk area (4-weeks of doxycycline or mefloquine, or 1-week of Malarone ®). Terminal prophylaxis is required for all personnel except those with G6DP deficiency and consist of taking primaquine for 2-weeks after leaving the risk area.

e. Terminal prophylaxis with primaquine is indicated for all countries in the USCENTCOM Theater where P.Vivax and P.Ovale malaria are transmitted and where primary chemoprophylaxis was administered (unless specifically stated by local Component/JTF Surgeon guidance. Individuals who are noted to be G6PD deficient will not be prescribed primaquine. Individuals should remain on malaria chemoprophylaxis until such time that they can begin primaquine and then continue both for the prescribed duration. Providers should be aware that primaquine dosing recommendations often refer to the base ingredient (primaquine phosphate 26.3mg tablets contain 15mg of primaquine base). While the CDC recommended dose for terminal prophylaxis is not FDA approved, dosing decisions are up to the prescribing provider's discretion in consultation with the member on risks and benefits of separate dosing regimens.

f. Inform personnel that missing one dose of medication or not using the DoD insect repellent system will place them at increased risk for malaria.

g. Commanders and supervisors at all levels will ensure that all individuals they are responsible for have terminal prophylaxis issued to them immediately upon redeployment from the at risk malaria area(s).