

FOUO

OSC File Number DI-11-4168

Madigan Army Medical Center

Joint Base-Lewis McCord, Washington

Army Report and Documents

January 9, 2013

(Redacted)

FOUO



DEPARTMENT OF THE ARMY
OFFICE OF THE ASSISTANT SECRETARY
MANPOWER AND RESERVE AFFAIRS
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U.S. OFFICE OF
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2013 JAN -9 PM 2:12

JAN 9 2013

Special Counsel Carolyn N. Lerner
U.S. Office of Special Counsel
1730 M Street, N.W., Suite 218
Washington, D.C. 20036-4505

RE: Whistleblower Investigation--Department of the
Army, Madigan Army Medical Center, Allergy and
Immunology Clinic, Joint Base Lewis-McChord,
Washington (Office of Special Counsel File Number
DI-11-4168)

Dear Ms. Lerner:

In accordance with Title 5, United States Code (USC), Section 1213(c) and (d), the enclosed report is submitted in response to your referral of information requesting an investigation of allegations and a report of findings in the above referenced case.

The Secretary of the Army (SA), as agency head, has delegated to me his authority to review, sign, and submit to you the report required by Title 5, USC, Section 1213(c) and (d). [TAB A].

The Department of the Army (DA) encloses two versions of its report. The first version contains the names and duty titles of military service members and civilian employees of the DA associated with the investigation of the allegations in this matter. This version is for your official use only, as specified in Title 5, USC, Section 1213(e); we understand that, as required by that law, you will provide a copy of this first version of the report to Whistleblower, the whistleblower in this case, as well as to the President of the United States and the Senate and House Armed Services Committees. Other releases of the first version of the DA report may result in violations of the Privacy Act¹ and breaches of personal privacy interests.

The second version of the report has been crafted to eliminate references to privacy-protected information. We request that only the second version of the report be made available on your website, in your public library or in any other forum in which it will be accessible to persons not expressly entitled by law to a copy of the report.

¹ The Privacy Act of 1974, Title 5, USC, Section 552a.

INFORMATION INITIATING THE INVESTIGATION

By letter dated December 21, 2011, the Office of Special Counsel (OSC) referred to the SA allegations made by the whistleblower, Whistleblower against Madigan Army Medical Center (MAMC), Allergy and Immunology (A/I) Clinic, Joint Base Lewis-McChord. Whistleblower was employed as a Licensed Practical Nurse (LPN) at the MAMC A/I Clinic from January 15, 2011 until August 15, 2011. Generally, Whistleblower made the following three allegations:

OSC-Referred Allegation 1. Chief, A/I Clinic, Chief, A/I Clinic. MAMC, slept during patient care hours (7:30 a.m. to 4:00 p.m.), and specifically did so on at least four occasions during the seven months Whistleblower was employed at MAMC. Whistleblower observed Chief, A/I Clinic asleep in her office, on either May 2, or 3, 2011, on May 16, 2011, and again in early July 2011. Whistleblower alleged that on each occasion, she saw Chief, A/I Clinic lying on her office couch, covered with a blanket and with her head on the pillow; Chief, A/I Clinic's office door was either completely shut or slightly ajar and her office lights were off.

OSC-Referred Allegation 2. As to the early July 2011 incident, Whistleblower approached and knocked loudly on the Chief, A/I Clinic's door to report that an HIV positive patient had returned to the clinic because he was experiencing an anaphylactic shock reaction to a Hepatitis B vaccine he had received earlier that day. When she received no response to her knock, Whistleblower entered the office and found Chief, A/I Clinic asleep on her couch. Whistleblower alleges that once awakened, Chief, A/I Clinic drowsily instructed her to give the patient Zyrtec. Upon returning to the patient, Whistleblower learned that he had taken a dose of Zyrtec that morning to address his seasonal allergies. Whistleblower returned to Chief, A/I Clinic's office to report this new development and found that rather than rising and reporting to the treatment room to supervise the care of the patient, Chief, A/I Clinic had gone back to sleep. Whistleblower was forced to rouse Chief, A/I Clinic again and estimates that approximately 15 minutes passed between the times that she initially attempted to awaken Chief, A/I Clinic and when Chief, A/I Clinic actually saw the patient.

OSC-Referred Allegation 3. Chief, A/I Clinic was frequently tardy in reporting for work in the mornings. MAMC Standard Operating Procedures (SOPs) specifically require that an allergist or designated surrogate allergist be present in the Clinic or immediately available when immunotherapy injections are given. Notwithstanding this requirement, A/I Clinic personnel proceeded with the administration of allergy shots and immunizations in Chief, A/I Clinic's absence. Whistleblower alleged that she and other nurses were directed by the Clinic's Head Nurse to proceed with the administration of allergy shots and immunizations prior to the Chief, A/I Clinic's arrival at work. Whistleblower stated that on at least 20 occasions during her tenure in the clinic, allergy shots and vaccines were administered prior to Chief, A/I Clinic's arrival at work and without the designation of a surrogate allergist, all in violation of MAMC SOPs.²

² OSC provided a copy of a MAMC SOP, entitled Standard Operating Procedures, Allergy/Immunology Service, Madigan Army Medical Center, dated June 1, 2007, addressing surrogate allergist procedures with its transmittal of Whistleblower's allegations to the Secretary of the Army. DA determined that SOP referred by OSC had been superseded [TABs G-a and G-b], and that an SOP by the same title, dated February 16, 2011, had been in effect at all times relevant to Mr. Ruiz's allegations [TAB F, Exhibit F-2f]. With its referral to the SA, OSC also provided another MAMC SOP for

OSC found that there was a substantial likelihood that the information provided to OSC by Whistleblower disclosed possible violations of law, rule, or regulation, gross mismanagement, abuse of authority, and a substantial and specific danger to public health and safety under Title 5, USC, Section 1213.

CONDUCT OF THE INVESTIGATION

On January 11, 2012, the SA forwarded the OSC referral to the Commander, U.S. Army Medical Command (MEDCOM), and directed her to conduct an investigation into Whistleblower's allegations and, as appropriate, to initiate any corrective action deemed necessary.

This referral was appropriate because MEDCOM provides healthcare oversight and control of all medical centers and medical treatment facilities and activities in the Army, with the exception of field units, as provided for in Army Regulation (AR) 40-1, *Composition, Mission, and Functions of the Army Medical Department*. [TAB B].

In addition, on January 11, 2012, the DA Office of General Counsel (OGC) forwarded the SA's directive to the MEDCOM Office of the Staff Judge Advocate³ to permit the Staff Judge Advocate to assist the MEDCOM commander in taking appropriate action to initiate the required investigation. The MEDCOM Commander subsequently forwarded the action to her subordinate commander, Major General (MG) Philip Volpe, Commander, Western Regional Medical Command (WRMC), who exercised regional responsibility for oversight of MAMC.

On January 13, 2012, MG Volpe appointed First Investigating Officer (IO-1), the Chief of Preventive Medicine, WRMC, as an Investigating Officer (IO), under the provisions of Department of Army Regulation (AR) 15-6, *Procedures for Investigating Officers and Board of Officers*,⁴ with a mandate to investigate the allegations forwarded by OSC to the SA. Specifically, MG Volpe directed the AT 15-6 IO to investigate and determine:

- Whether and to what extent the MAMC A/I Clinic Chief was tardy for work and whether her tardiness affected patient care;
- Whether and to what extent the Clinic Chief was sleeping during patient care hours;
- Whether and to what extent allergy shots and immunizations were administered at the Clinic without the required physician supervision; and

the Management of Anaphylaxis [TAB F, Exhibit F-2e].

³ A Staff Judge Advocate is the senior attorney for a command.

⁴ AR 15-6 promulgates guidelines for Army administrative investigations. Army commands and organizations frequently appoint investigating officers under provisions of AR 15-6 to investigate all manner of allegations and concerns. [TAB C].

- Whether allergy shots and vaccines were administered prior to the Clinic Chief's arrival at the start of the duty day and without designation of a surrogate allergist in violation of MAMC SOPs.

On or about January 17, 2012, the IO, IO-1, commenced his investigation. IO-1 arranged to interview the whistleblower, Whistleblower, on January 28, 2012. However, on January 24, 2012, before Whistleblower met with IO-1, OSC advised OGC by email that Whistleblower had contacted OSC to voice her concern about IO-1's "impartiality and objectivity in this matter given that he works for the same command as Chief, A/I Clinic, the subject of the investigation." The OSC email emphasized that every effort should be made to "allay Whistleblower's concerns and to ensure that the investigation was conducted in an objective manner." OGC responded to the OSC email as follows:

"... By way of background as to why Army Medical Command (MEDCOM) selected IO-1 to be the IO in said investigation, the following rationale is provided by the HQs MEDCOM and Western Regional Medical Command (WRMC) Staff Judge Advocate Offices (SJA):

Both Chief, A/I Clinic and IO-1 (the IO) work for the 'same command' in the sense that those who work for and within the WRMC necessarily work for the Commanding General (CG), WRMC. More specifically, however, IO-1 is on the CG's staff, and is the head of WRMC's Preventive Medicine Section. He works for the Chief, Clinical Operations, WRMC, who works for MG Volpe, the WRMC CG. With his background, IO-1 was a logical pick to be the IO.

Chief, A/I Clinic is the Chief of Immunology at MAMC, which is one echelon below WRMC HQ. She works for the hospital commander, Commander, MAMC. IO-1 does not work for anyone at MAMC or for Commander, MAMC.

MAMC is housed in a separate facility across post from WRMC HQ.

IO-1 is responsible for overseeing preventive medicine efforts across the WRMC, which extends to nine Medical Treatment Facilities (MTFs) (including MAMC). IO-1 has been an [AR 15-6] IO previously and he knows the importance of objectivity.

... IO-1 is familiar with occupational health and preventive medicine issues and ... familiarity with the sort of issues that are being raised thus far in the investigation (e.g., whether Chief, A/I Clinic had obtained appropriate approval from her supervisors to accommodate some physical conditions). I believe this expertise gives IO-1 the insight to ask the pertinent questions and hold the physicians involved to the appropriate standard.

... this investigation would be a natural oversight function for the Regional Medical Command over a subordinate organization."

IO-1 proceeded with his interview of Whistleblower on January 28, 2012. Shortly after the interview, OSC again contacted OGC to advise that Whistleblower had again expressed concern about IO-1. Through OSC, Whistleblower requested that DA relieve IO-1 of his duties as the IO in this matter because she perceived he was biased against her.

Given Whistleblower's allegations of bias on the part of IO-1, and to preclude even the appearance of unfairness or impropriety, OGC advised the CG, WRMC that it would be in the best interests of both the Army and Whistleblower that a new IO be designated to investigate the whistleblower allegations initially forwarded by OSC to the SA on December 21, 2011. MG Volpe concurred in the OGC recommendations and excused IO-1 from his duties as IO in this case.⁵

MG Volpe directed that an officer from outside the Headquarters, WRMC, and with no previous connection to MAMC, be identified as the new IO. The Commander, Evans Army Community Hospital, Fort Carson, Colorado, was asked to provide an officer, and he nominated Investigating Officer, who was subsequently appointed as the new IO by MG Volpe on February 17, 2012.

BACKGROUND

To facilitate a better understanding of the facts and circumstances associated with Whistleblower's allegations to the OSC and to permit a more informed assessment of the testimonial and documentary evidence collected in this matter, it is important to understand MEDCOM's mission and functions and MEDCOM's relationships with supporting organizations.

U.S. Army Medical Command (MEDCOM) Mission

The Surgeon General (TSG) of the U. S. Army serves a dual role as both the U.S. Army Surgeon General and MEDCOM Commander. MEDCOM provides medical, dental, and veterinary capabilities to the Army and designated Department of Defense (DoD) activities. TSG is responsible for the development, policy direction, organization, and overall management of an integrated Army-wide health services system. [See Army Regulation (AR) 40-1, *Composition, Mission, and Functions of the Army Medical Department*, dated July 1, 1983, paragraph 1-6, [TAB B]]. Among many other functions, MEDCOM provides medical and dental care worldwide; coordinates Army health services for Army, civilian, and Federal health care resources in a given health service area; and conducts health care education, training and studies. The Commander, MEDCOM, directs all active duty Army health services activities involved in providing direct health care support within the prescribed geographical limits of responsibility; designates missions and levels of care to be provided by subordinate military treatment facilities; and determines manpower staffing standards and levels of staffing. [AR 10-87, *Army Commands, Army Service Component Commands, and Direct Reporting Units*, dated September 4, 2007, paragraphs 15-2d and 15-3d [TAB D]].

In her role as Commander, MEDCOM, TSG exercises oversight and control of all medical

⁵ The evidence gathered by the first IO, IO-1 prior to his removal was sequestered and was not provided to the second IO, Investigating Officer.

centers and medical treatment facilities and activities in the U.S Army, with the exception of field units. Regional Medical Commands (RMCs) are major subordinate commands (MSCs) of MEDCOM and are multi-state command and control headquarters that allocate resources, oversee day-to-day management, and promote readiness among military treatment facilities in their geographic areas. [See AR 10-87, Chapter 15, TAB D]. MAMC is funded by and receives operational oversight and guidance from MEDCOM through the WRMC. Located at Joint Base Lewis-McChord, Washington, WRMC supervises the operations of 11 MTFs and approximately 13,000 military personnel and civilian employees in the western United States.

Madigan Army Medical Center

An Army Medical Center (MEDCEN) is a Military Treatment Facility (MTF) staffed and equipped to provide healthcare for authorized beneficiaries. Such care includes a wide range of specialized and consultative support for all medical facilities within the assigned geographic area. A MEDCEN also conducts professional training programs and post graduate education in health professions, when designated. MEDCENS also serve as a referral hospital for the Health Service Area (HSA). MEDCENS provide administrative and logistical support, as required, to other satellite TDA and TOE units on the installation. MEDCOM Regulation 10-1, *Organization and Functions Policy* [TAB E].

MAMC is a 243-bed teaching hospital with multiple satellite clinics that provide primary care, specialty, and emergency care to a military population that consists of active duty service members, their families, a large retiree population and their family members. The MEDCEN, fully accredited by the Joint Commission on Accreditation of Healthcare Organizations, is located at Joint Base Lewis-McChord, Washington.

The facility is dedicated to the memory of Colonel (COL) Patrick S. Madigan. Known as "the Father of Army Neuropsychiatry," COL Madigan was Assistant to the Surgeon General of the United States Army from 1940 to 1943. Madigan General Hospital was named in his honor after his death in 1944.⁶

Joint Base Lewis-McChord (JBLM) (formerly known as the two separate organizations of U.S. Army Fort Lewis and McChord Air Force Base) is located on Washington State's South Puget Sound in the Pacific Northwest. It has known almost a century of military service, established as Camp Lewis in 1917, it became Fort Lewis in 1927. McChord Air Force Base started as McChord Army Air Field in 1938 and became McChord Air Force base when the Air Force became a separate military service in 1947. The installation's primary units are the U.S. Army's I Corps U.S. Air Force's 62nd Airlift Wing. Also resident are more than 30 units from the Army (to include several Stryker brigades), Air Force, Navy, Marine Corps, Reserve and National Guard, and Department of

⁶ COL Madigan was born February 14, 1887 in Washington, D.C. COL Madigan received his Bachelor of Arts degree and his Doctor of Medicine degree from Georgetown University. He served as an instructor at Georgetown University from 1913 to 1917. During this period, he received a Master of Arts degree from Gonzaga College, Washington, D.C. In August of 1917 he accepted a commission in the Regular Army and served in France with the 7th Division, 64th Infantry during World War I. After the First World War he remained in the Army, serving as a neuropsychiatrist at Hampton Roads, Virginia and Walter Reed General Hospital until 1926. He then became Chief of Neuropsychiatry at Sternberg General Hospital, Philippines, and in 1929, Chief of Neuropsychiatry at Walter Reed General Hospital. Eventually becoming known as "the Father of Army Neuropsychiatry," COL Madigan was Assistant to the Surgeon General of the United States Army from 1940 to 1943. Madigan General Hospital was named in his honor after his death in 1944.

Defense agencies. In 2005, the Base Realignment and Closure Commission designated Fort Lewis and McChord Air Force Base as a joint base, one of 12 joint bases in the DoD. JBLM is the largest military installation on the west coast of the United States with more than 415,000 acres, including Yakima Training Center in central Washington. The installation supports an on-base population and in neighboring communities of more than 100,000 people including military personnel, families, civilian and contract employees, and retirees and their families.

The Allergy and Immunology Clinic (A/I Clinic)⁷ is one of approximately 14 clinics under the supervision of the Department of Medicine, MAMC. [See Organization Chart, TAB F, Exhibits F-5 and F-6]. The A/I Clinic has 9 staff: 2 physicians, 5 nurses, and 2 support staff. [See A/I Clinic Organization Charts, TAB F, Exhibit F-5].

The mission of the A/I Clinic is to evaluate, diagnose, and treat patients with allergic and immunodeficient diseases. In addition, the service evaluates patients for multiple routine and travel vaccinations and administers them based on the latest recommendations. Research studies initiated by the clinic are done with the approval of Department of Clinical Investigation. The A/I Clinic serves all active duty military, dependents, retired military, and their dependents and unmarried eligible dependents over the age of 21 with appropriate coverage.

There are several nursing specialties that are utilized as part of the staff at the A/I Clinic. They include:

Licensed Practical (or Vocational) Nurse (LPN/LVN): LPNs provide direct patient care in hospitals, doctors' offices, nursing homes, long-term care facilities, and outpatient home health care under the supervision of an RN or physician. An LPN's tasks include taking blood pressure, pulse and temperature. LPNs administer immunizations, change dressings, clean and bandage wounds, administer medication and monitor patient condition. The training program for LPNs is for one year, usually at a community college or vocational/technical college. After successful completion of their training, LPN students receive either a diploma or certificate. In order to be licensed as an LPN, students must then pass the NCLEX-PN national licensing examination. Whistleblower qualified and was hired as an LPN at MAMC.

Registered Nurse (RN): RNs provide direct patient care but are less likely to carry out tasks of a LPN, such as taking temperatures and giving immunizations. RN responsibilities are broader, such as developing and enacting a patient care plan, as well as managing and assigning tasks to LPNs and Nurse Assistants. RNs also have greater opportunities for professional growth in a wide range of specialties. RN students train for at least two years to earn an associate's degree or four years to earn a Bachelor of Science degree. The RN program is usually offered at a community college or a traditional four year college of arts and sciences. RN student training is rigorous, both in a classroom and clinical setting, to prepare students for leadership roles in the nursing profession. Upon graduation, students must pass the NCLEX-RN national licensing examination to be licensed as an RN.

⁷ Witness statements refer alternatively to the Allergy and Immunology Clinic as the Allergy/Immunology Clinic or as the A/I Clinic. Additionally, other witnesses, such as Chief, DOM, refer to the "Allergy/Immunology Service" within the Department of Medicine, and to the "Madigan Allergy/Immunology Clinic." For purposes of this report, all references mentioned above refer to the same organizational element referred herein as A/I Clinic.

SUMMARY OF THE EVIDENCE OBTAINED FROM THE INVESTIGATION

The AR 15-6 IO conducted an exhaustive investigation of the three allegations referred by OSC to the Army. All of the witnesses germane to the allegations were interviewed by the IO. Each witness interviewed in the context of the AR 15-6 investigation was asked to respond to a set of questions developed by the IO to solicit specific information relevant to Whistleblower's allegations. When required for completeness or clarity, some of the witnesses were interviewed several times. A summary of each witness's testimony relevant to the three OSC-referred allegations and a discussion of each of the three OSC-referred allegations in light of relevant testimonial and documentary evidence follow.

Whistleblower, the Whistleblower

The IO afforded Whistleblower ample opportunity to provide both testimonial and documentary evidence in support of her allegations, including permitting her to submit additional evidence through June 11, 2012.⁸ The IO included all of the evidence provided by Whistleblower in the investigative record.

Whistleblower made a sworn statement on February 24, 2012, wherein she described numerous concerns with personnel in the A/I Clinic, with particular focus on the Clinic Chief, Chief, A/I Clinic. Whistleblower testified that Chief, A/I Clinic was frequently tardy--more than three times per week. Whistleblower further stated that she found the Chief, A/I Clinic asleep in her office at least five times during patient care hours.

Whistleblower asserted that on one occasion an A/I Clinic patient asked Whistleblower why Chief, A/I Clinic was asleep during clinic hours.⁹ Whistleblower further asserted that immunizations were given without the requisite supervision, and questioned whether the Internal Medicine Clinic doctors who provided support to the A/I Clinic were always notified that they were to serve as surrogate oversight physicians. She stated that she was "unsure" whether the Internal Medicine Clinic Doctors Physician #1, IMC and Physician #2, IMC were always notified of their surrogate duties, notwithstanding that "the LPNs in the A/I Clinic were always told when these doctors were covering the A/I Clinic."

Whistleblower further complained that that the orientation to the clinic was "not adequate" and that there were discrepancies between the posted procedures and what actually occurred.

Whistleblower described an occasion on which a patient from the Infectious Disease Clinic arrived at the A/I Clinic with a consult for a Hepatitis B vaccine. Whistleblower administered a double vaccine dose as he had been non-reactive with his original single dose. The patient later called the Clinic, apparently complaining of a reaction and was instructed to return to the Clinic.

⁸ Whistleblower made two sworn statements: one on February 24, 2011 and one on March 28, 2012. Additionally, Whistleblower provided the IO with several documents in support of her complaints against the A/I Clinic.

⁹ The IO commented in his Report of Investigation that he was unsuccessful in his attempts to locate this patient to interview him/her as a witness in this case.

Whistleblower stated that “[d]ue to his HIV status”, Whistleblower went to get Chief, A/I Clinic to assist her in the treatment room. When she got to Chief, A/I Clinic’s office, she found Chief, A/I Clinic asleep on her couch. Whistleblower awakened her and informed her of the patient’s symptoms. Chief, A/I Clinic directed Whistleblower to administer Zyrtec to the patient. Whistleblower returned to the patient who told her that he had taken a dose of Zyrtec earlier in the day. Whistleblower reported she was not comfortable giving the patient further doses of medication. Whistleblower noted that neither Chief, A/I Clinic nor another nurse was present in treatment room. Whistleblower returned to Chief, A/I Clinic’s office, found her again asleep, and woke her up. Whistleblower then returned to the treatment room but this time accompanied by Chief, A/I Clinic.

Whistleblower stated she reported these issues to MAMC Department of Medicine leadership and to the local union representative, but nothing was done. Whistleblower stated that she went to see the MAMC Acting Executive Officer, (Formerly) Acting XO, to express her concerns about the A/I Clinic on or about July 26, 2011. Whistleblower asserted that she followed that meeting with a letter to (Formerly) Acting XO in which she detailed several of her concerns in writing, including her concern that Chief, A/I Clinic was sleeping during patient care hours.

Further, Whistleblower contended that she went out of her way to care for patients, to include seeing patients during non-patient care hours to accommodate their schedules.

Chief, A/I Clinic, A/I Clinic Director

Over the course of the investigation, Chief, A/I Clinic provided the IO with several statements as well as documentary evidence. Chief, A/I Clinic made an initial statement to the IO on February 23, 2012. She conceded that she had been occasionally tardy for work, primarily due to traffic and family issues. She noted that traffic on Interstate 5, the main commuting route for personnel who travel from Olympia, Washington, north to Joint Base Lewis McChord was frequently congested. She contended that she always called the clinic to let the nurses know her status and to provide an estimate of how long it would take her to get to work. Chief, A/I Clinic denied sleeping during patient care hours. She reported that she suffered from migraines, and during the time that Whistleblower worked in the clinic, Chief, A/I Clinic was “overtired” as she was training for a half marathon, taking care of her husband who was finishing a Masters in Business Administration degree, as well as caring for her three children, and had been suffering from viral illnesses. She stated she had been taking Relpax, a non-sedating, non-performance impairing drug for migraines. Chief, A/I Clinic stated that she had lain down during lunch “on a few days” after seeing patients, but that she always available to A/I Clinic staff and patients.

In response to a request from the IO for additional information, Chief, A/I Clinic executed two additional statements on March 15, 2012.

The IO inquired further into Whistleblower’s concerns that Chief, A/I Clinic was resting or sleeping during patient care hours. Chief, A/I Clinic denied having ever slept during patient care hours, but conceded that she would rest in her office over the lunch hour only after all patients had been served in the A/I Clinic. Further, Chief, A/I Clinic provided a detailed explanation of her conduct during the specific incident in July 2011 on which Whistleblower appears to have based her allegation that Chief, A/I Clinic was sleeping when an HIV patient reported to the A/I Clinic for care:

"I saw and evaluated a patient on 12 July for a possible hepatitis B vaccine reaction. On that day I also saw a full schedule of patients from 0800-1200 and 1330-1630. I had been laying down intermittently that day after I had seen all my patients because I was feeling poorly from an illness and headache. I saw all patients that needed care and remained immediately available for all patient care needs. The patient in question had been referred by Infectious Disease for a hepatitis B vaccine due to previous non-response. A review of record [indicated] the patient received his vaccine sometime between 1000 and 1030. He was observed for 15 minutes and released. He returned to the clinic around 1130, complaining of itching but no dyspnea¹⁰ or wheezing. The nurse informed me of this while I was in my office finishing notes. I instructed her to give him Zyrtec and I also saw him. On evaluation he had normal vital signs. He appeared anxious but looked well and had a normal physical exam other than some redness of the skin where he had been scratching and mild folliculitis. There were no hives and his lungs were clear. I instructed the nurses to give him Zyrtec to see if it would help with the pruritus.¹¹ After no improvement I then instructed the nurses to give him a dose of epinephrine just in case he was having an allergic reaction. He had no response to the epinephrine which would support that his reaction was not anaphylaxis.¹² However, after about an hour and some additional rest and reassurance the patient felt better and I released him to his work area (he worked in the hospital).

... The next day he [the patient] was contacted by the nurse and all symptoms had resolved ... [the patient] was treated promptly and appropriately and was released in improved condition. I spent nearly an hour with the patient over the course of his care that day and believe standard of care was met. Whistleblower never voiced concerns regarding the care of this patient to me or her nurse supervisor. She likely thought I was asleep because I had been lying down with my door closed over the lunch hour. She had knocked on the door to let me know how the patient was doing as he had been resting in stable condition in the treatment room over the lunch hour."

Chief, A/I Clinic denied that her lying down during the duty day ever affected patient care. Chief, A/I Clinic testified:

"I concede I should have informed my staff and my supervisor that I was taking medically acceptable and medically indicated rest breaks during the day. There was never any harm or danger to patient care ... I was always available for my staff.

I always saw all of the patients scheduled to see me each day, answered any questions brought to me, finished my work, and remained immediately available. During this time I had even increased the number of patients I saw weekly in order to keep access up despite the loss of a provider that year. In addition to direct patient care and supervision of the A/I service, I remained involved in the Risk Management

¹⁰ Dyspnea is difficult or labored breathing.

¹¹ Pruritus is a severe or extreme form of itching or irritation of the skin.

¹² Anaphylaxis is an extreme, often life-threatening, allergic reaction to an antigen (e.g., a bee sting) to which the body has become hypersensitive.

committee for the hospital, medical director to QSD, active in GME training of residents and students, processing of [Reserve Officers' Training Corps] ROTC cadets, successfully accomplished TJC preparation and inspection, and tackled any other administrative tasks. Patient satisfaction continued to remain high."¹³

When asked why, as a military service member, she had not sought a medical "profile"¹⁴ for her migraines as well as a formal medical accommodation that might have permitted her to rest during the duty day in response to her migraines, Chief, A/I Clinic responded:

"I felt that my migraines would get better with time, as had been the usual pattern in the past. I also felt they were not preventing me from doing my job. I did not cut back on my hours, work load, or schedule during this time and was still able to function at a high level and accomplish all of my duties to include [physical training] PT. I therefore did not feel compelled to seek a profile. Since then I have seen Neurology and started new therapy for my migraines, which are now well controlled."

In follow-up testimony of June 22, 2012, Chief, A/I Clinic was asked more about whether she had ever sought a profile for her migraine headaches. Chief, A/I Clinic testified that she had never had a profile for her migraine headaches because she has always been able to continue working and to accomplish all of her military duties notwithstanding the migraines. She stated that, over the last 10 years she believed she had called in sick on only one day because of a migraine. She had not missed any duty days due to a migraine for at least the past 2 years. Chief, A/I Clinic indicated she has sought follow-up care through her Primary Care Manager (PCM) at various times when she needed renewals of her migraine medication. However, she acknowledged that, in retrospect, she should have advised her supervisor, Chief, DOM of her condition, even though she felt she was 'doing OK' managing it on her own. She further testified:

"I've had periods in the past when my migraines get worse for a few weeks, but usually they get better on their own and so I was just trying to ride it out. I saw Neurology last summer and started on a daily prophylactic that worked very well. Since I have discovered some foods that trigger my migraines and have taken those out of my diet, I have found I no longer need a prophylactic medication. Per AR 40-501, I meet retention standards and per my neurologist I don't need a profile. The last time my migraines flared as bad was when I deployed. I think it was the time changes. However, I was still able to successfully complete my job and mission and was subsequently given an outstanding top block [Officer Evaluation Report] OER and ARCOM [Army Commendation Medal]. So, when the headaches started back up

¹³ The following information relates with the acronyms used in this quote: "QSD" is the Quality Services Division at MAMC. It oversees peer reviews, privileging, etc. at MAHC; "GME" is Graduate Medical Education. GME is part of MAMC's mission as a teaching hospital; "TJC" is The Joint Commission, the civilian hospital accreditation body at MAMC.

¹⁴ Army Regulation 40-501, *Standards of Medical Fitness*, December 14, 2007, chapter 7 [TAB F, Exhibit F-7], prescribes a system for classifying individuals according to functional abilities. The physical profile serial system is based primarily upon the function of body systems and their relation to military duties. A profile, which is recorded on DA Army Form 3349, is the means by which a physician communicates to a Soldier's commander or supervisor the impact of physical issues (such as injuries or illnesses) a Soldier may be experiencing on a Soldier's ability to perform his/her military duties.

again I felt I could again continue to work through it. I did successfully meet all goals for the clinic in 2011. I was short a full time active duty allergist for the clinic but despite that was able to see as many patients and keep productivity and patient satisfaction as high as it was in 2010 when we had an additional allergist provider.”

Chief, A/I Clinic provided a portion of her medical records to the IO, where there was an entry made by her health care provider to the effect that they had discussed Chief, A/I Clinic's migraines on February 13, 2009, and that Chief, A/I Clinic was "released without limits" on the types of duties she was capable of performing, her migraines notwithstanding.

The IO also questioned Chief, A/I Clinic regarding Whistleblower's allegation that allergy shots were administered at the Clinic without the requisite physician supervision. Chief, A/I Clinic responded, stating:

“Our policy for physician coverage is reviewed during each nurse's initial orientation. In addition, the information is available in SOPs posted on the clinic Sharepoint site and contained in a notebook in the clinic. We started clinic huddle daily at 1145-1200 in April 2011 and have continued clinic meetings on Fridays from 1100-1200. During these times any patient related concerns or questions can be discussed. During one of these meetings when Whistleblower was present I distinctly remember providing a copy of and reviewing our SOP on anaphylaxis, which discusses the covering physician policy.”

and

“There were a few occasions that I was late to work due to traffic problems, but when that happened I always called the nursing staff on duty that day to notify them where I was and when I expected to be in. I would typically call Head Nurse, A/I Clinic but if she was not available I would speak with LPN #1, A/I Clinic or LPN #3, A/I Clinic. The surrogate allergist was then notified to cover if there were patients in the clinic being treated with allergy shots and I was not yet in the building.

If for any reason I was away from the clinic, the surrogate physician coverage was there in support, present in the vicinity of the clinic. The staffs of both the A/I Clinic and the Internal Medicine Clinic knew that surrogate physician coverage was always available. It was so ingrained in everyone that the A/I Staff knew that if I were away that they were to go to internal medicine and the internal medicine physicians knew they could be called upon for coverage at any time. It all worked seamlessly.”

Chief, A/I Clinic further elaborated on the A/I Clinic policy known as “surrogate coverage” when the IO asked her the question “Did you or Head Nurse, A/I Clinic [the A/I Clinic Head Nurse] ever discuss with Whistleblower the policy that Internal Medicine physicians would provide surrogate coverage when the A/I allergists were not present in the clinic during the time of allergy injections/immunizations?” Chief, A/I Clinic responded:

“The SOP for anaphylaxis was handed out on 21 Jan [2011] to all staff. On several

occasions I personally reviewed the covering physician policy with Whistleblower and the other staff when I had to arrange for someone to cover because I was leaving for a meeting. I often will walk through the clinic and tell all the staff as a reminder where I am and who is covering. On days when Head Nurse, A/I Clinic helped to arrange coverage she would inform others. Working in a large medical center, there are always physicians nearby to our clinic and so it is very easy to arrange for a covering physician. Usually we ask Physician #2, IMC, or Physician #1; IMC [sic] in Internal Medicine. However there are a number of other physicians in IMC and GI clinic next door who are more than willing to be available. If there was a day that Whistleblower was not aware of the covering physician she merely had to ask her nurse colleagues. In addition, I am always available by pager and cell phone even when not in the clinic and she had those numbers.”

Finally, Chief, A/I Clinic noted, “running a clinic and treating patients is a team effort. I have seen this at every facility I have ever practiced in. It takes a team of professionals to learn the organization and know how it works and watch out for each other to identify potential issues and catch them before there is a possible danger to patient safety. This requires teamwork, constant communication and cooperation.”

Former A/I Clinic MSA, formerly employed as a Medical Support Assistant, A/I Clinic

Former A/I Clinic MSA made a sworn statement to the IO on February 24, 2012. She stated that when she had been employed with the A/I Clinic, she had served as a Medical Support Assistant, GS-0649-04. Former A/I Clinic MSA testified that she came “highly recommended” by Chief, A/I Clinic’s husband with whom she had worked previously. She stated that her impression of the A/I Clinic was that it was “chaotic, disorganized, favoritism”, subject to HIPAA violations, “discriminatory” with . . . poor communication, and poor teamwork. She complained that there was “much drama in the clinic”.

Former A/I Clinic MSA asserted that Chief, A/I Clinic was “late almost every day” for work, and that Internal Medicine doctors would “cover” for the A/I Clinic in her absence. In addition to lateness, Former A/I Clinic MSA noted that Chief, A/I Clinic had been asleep in her office during patient care hours on at least two occasions. However, she asserted that Chief, A/I Clinic’s sleeping did not affect patient care as it usually occurred on days when allergy shots were being given and not when patients were scheduled to be seen by physicians. Former A/I Clinic MSA noted that in the absence of a physician, Head Nurse, A/I Clinic, the clinic head nurse, or LPN #3, A/I Clinic, the acting head nurse, would look to an Internal Medicine doctor to assist with coverage. Although shots were given before the arrival of Chief, A/I Clinic at the clinic, Former A/I Clinic MSA was not aware of allergy shots or immunizations being given without requisite physician supervision.

Former A/I Clinic MSA also provided the IO with a letter, dated November 5, 2011, which she had addressed to a “ ”¹⁵ In this letter, Former A/I Clinic MSA raised her concerns about Chief, A/I Clinic sleeping, lack of physician oversight of the clinic, and the lack of patient care.

Chief Nurse, DOM, Chief Nurse, Department of Medicine, MAMC

¹⁵ appears to be an attorney in OSC.

Chief Nurse, DOM made a sworn statement to the IO on February 24, 2012. Chief Nurse, DOM stated that she was not aware that Chief, A/I Clinic had ever slept in her office.

Union Representative, Supply System Analyst, Department of Pharmacy, MAMC and President, AFGE Local 1502

Union Representative made a sworn statement to the IO on February 22, 2012. Union Representative stated that the A/I Clinic had a reputation for “protecting the chief,” and that employees were “unwilling to sign a union grievance.” He stated that Whistleblower seemed motivated to do a good job in the clinic but was upset . . . that Chief, A/I Clinic would come and go on her own time. Union Representative related that Whistleblower went to (Formerly) Acting XO, the Acting Executive Officer, to complain and provide documentation of these issues, but Union Representative did not know what actions may have been taken in response. He stated that Whistleblower reported to him in early August 2011 that she had “gotten into it” with Chief, A/I Clinic and the A/I Clinic head nurse, that Whistleblower was visibly upset, and that she attempted to see the Chief, Department of Medicine, but was told to go back to the A/I Clinic and “work it out.”

Chief, DOM, Chief, Department of Medicine, MAMC

Over the period relevant to the OSC-referred allegations, Chief, DOM was Chief, A/I Clinic’s immediate superior. He made a sworn statement on February 24, 2012. He recounted that Chief, A/I Clinic was tardy to work on several occasions, but that to his knowledge her tardiness did not affect patient care. He acknowledged that it had been reported that Chief, A/I Clinic was sleeping on the couch in her office. He stated that her neurologist had recommended sleeping for “management of migraines.” Although Chief, A/I Clinic was tardy on several occasions, Chief, DOM stated that allergy shots were given in her absence because two physicians in the Internal Medicine clinic, Physician #1, IMC and Physician #2, IMC, were “the designated surrogate providers for any medical problems that occurred during the administration of allergy shots in the A/I Clinic in the absence of Chief, A/I Clinic,” and that their offices are very close to the A/I Clinic. Chief, DOM testified that this plan had been presented by him at a meeting of the MAMC Credentials Committee¹⁶ and that the Committee determined it to be “an acceptable practice.”

Further, Chief, DOM stated that, on August 3, 2011, Whistleblower came to see him to discuss problems in the A/I Clinic, which included assertions that she had found Chief, A/I Clinic asleep on the couch in her office. She also gave him a letter, which he provided to the AR 15-6 IO. This letter was a copy of the July 26, 2011 document Whistleblower sent to (Formerly) Acting XO, the MAMC Acting Executive Officer.

Chief, DOM executed a second statement on May 25, 2012. He provided several organizational charts and diagrams to assist the AR 15-6 IO in understanding the structure of the MAMC Department of Medicine and the proximity of the A/I Clinic to the Internal Medicine Clinic. He described the two surrogate physicians as being only four hallways away from the A/I Clinic. He voiced his confidence that utilizing surrogate physician coverage did not place patients at risk. He also explained why he established the surrogate physician program:

¹⁶ The MAMC Credentials Committee is one of several committees that govern MAMC hospital operations.

“Several of the subspecialty clinics in the Department of Medicine are staffed with only two [Active Duty] physicians. With the deployment of one of these physicians, the subspecialty clinic would be left with only one active duty physician for patient care. When this solo provider went on TDY or Leave, a plan needed to be in place for clinic coverage of patient issues, thus the designation of a surrogate provider. In order for the Madigan Allergy/Immunology Clinic to continue to give allergy immunotherapy, the designated surrogate provider needed to be in the hospital and close to the allergy immunotherapy section in the Allergy/Immunology Clinic in case a patient developed an adverse reaction from immunotherapy requiring attention by the surrogate physician. Physician #2, IMC and Physician #1, IMC are board certified internal medicine physicians who are the designated surrogates whenever Chief, A/I Clinic was TDY or on Leave. The office that they share is four hallways away from the allergy immunology section of the Allergy/Immunology Clinic.”

Chief, DOM added that for the last 5-10 years, the MAMC A/I Clinic has had Dr. Physician #1, IMC and Physician #2, IMC serve as surrogate providers. He also stated that after discussion with both doctors, neither of them felt that the use of surrogate A/I providers had presented any threat to A/I patient safety. Chief, DOM also stated that according to his discussions with Physician #1, IMC, Physician #1, IMC advised him that in his 13 years at Madigan, he has only been called to the A/I Clinic once for a problem and that problem did not require the patient to go to the Madigan emergency department for medical care or to be admitted to the hospital.

Chief, DOM also elaborated on Chief, A/I Clinic’s performance as A/I Clinic Chief, describing her as “in need of military bearing” but as an “EXCELLENT physician” who had dramatically improved the efficiency of the A/I Clinic by more than 50% over the MEDCOM RVU target.¹⁷ He attributed the clinic’s efficiency to the leadership of both Chief, A/I Clinic and her Head Nurse, Head Nurse, A/I Clinic “and [to] her group of dedicated LPNs who are totally devoted to providing the beneficiaries of the DoD healthcare system [with] quality care.”

With respect to A/I Clinic operating hours, Chief, DOM noted that clinic hours at MAMC are 0800-1200 and 1300-1630. He noted that the A/I Clinic would stop signing in patients at 1100 or 1130 so they could be seen before the lunch hour began and still complete the 30 minute period of observation required after receiving an allergy shot.

Chief, DOM rendered another statement on June 22, 2012. Chief, DOM indicated that he was aware of only one instance on which LTC Brown had been tardy for work—in fact, she had missed a day of work in February 2011 due to inclement weather. Chief, DOM stated that he found her explanation for her absence . . .

. . . “unacceptable (traffic was backed up on the free way thus backing up the traffic on

¹⁷ Relative value unit (RVU) is a comparable service measure used by hospitals to permit comparison of the amounts of resources required to perform various services within a single department or between departments. It is determined by assigning weight to such factors as personnel time, level of skill, and sophistication of equipment required to render patient services. TAB F, Exhibit F-1 reflects the RVU for the A/I Clinic.

the roads that led to the freeway). She made the decision to turn around and return home. She checked in with her clinic nurse around noon that day and since clinic operations was minimal she opted to remain at home for the day). I reiterated to her that she is the Service Chief and being Active Duty, she is considered Essential Personnel which means she is to come to work despite inclement weather conditions. Her tardiness on this specific day did not constitute a threat to patient care since outpatient clinic visits were cancelled on that day” due to the weather.¹⁸

He further stated that he first heard allegations that Chief, A/I Clinic was sleeping during the duty day in late July 2011 after Whistleblower advised him of this matter. Upon learning of the issue, he discussed it with Chief, A/I Clinic and learned that she suffered from infrequent migraine headaches. He also learned she had been instructed by her healthcare provider to take her migraine headache medication and to lie down with the lights out to sleep for a short period of time until the migraine had resolved to the point where she could continue with her clinical duties. Chief, DOM indicated that this was confirmed by her neurological provider. Chief, DOM did not require Chief, A/I Clinic to obtain a medical profile as it was the first time he had been made aware that the medical problem made her unable to perform her duty for a short time period.

Subspecialty AO, Subspecialty Administrative Officer, Department of Medicine, MAMC

Subspecialty AO made sworn statements to the IO on February 23, 2012 and June 22, 2012. He stated that he knew Chief, A/I Clinic was tardy for work, usually due to traffic on Interstate 5. Occasionally, Chief, A/I Clinic would call the A/I Clinic and state she would not be to work on time. He was unsure whether she would come in later. He was not aware that Chief, A/I Clinic slept during patient care hours. He reported having heard that she would occasionally lie down in her office because of her migraines. He noted there was always an alternative physician designated during times of decreased coverage in the A/I Clinic. He believed there is a possibility that shots were administered before Chief, A/I Clinic arrived for work in the morning, but he assumed coverage from the Internal Medicine clinic had been arranged.

Mr. Subspecialty AO noted that he had conversations with Chief, DOM and Chief, A/I Clinic approximately one and a half years prior about productivity in the A/I Clinic and that there had been a subsequent increase the productivity of the clinic.

LPN #2, A/I Clinic, LPN, A/I Clinic

LPN #2, A/I Clinic made a sworn statement on February 23, 2012. He reported that he had noticed Chief, A/I Clinic being late for work once or twice due to traffic conditions. In his estimation, this did not affect patient care. While he was not aware of her sleeping during patient hours, he noted that all allergy shots and immunizations are given with physician supervision, even when given prior to Chief, A/I Clinic’s arrival at the clinic. In such cases doctors from Internal

¹⁸ Chief, DOM issued Chief, A/I Clinic a Counseling Statement dated March 7, 2011, wherein he documented that she “failed to report to work” on Thursday, February 24, 2011, a day that had been designated by the Commander as a ‘Delay[ed] Arrival Day’, due to inclement weather and resultant poor traveling conditions.” Chief, A/I Clinic was considered to be “Essential Personnel” and was thus “expected to make every attempt to report to work regardless of severe weather.” Chief, DOM’s Counseling Statement closed by stating, “[a]ny future behavior of this type will result in adverse actions” taken against you [Chief, A/I Clinic].

Medicine would fill in for the A/I Clinic allergists.

Head Nurse, A/I Clinic, Head Nurse, A/I Clinic

Head Nurse, A/I Clinic made a sworn statement on February 23, 2012. She reported she had worked at the Clinic since July 1999. She is a former Army Nurse who retired from active duty in 1997 as a LTC in the Army Nurse Corps. She described the A/I Clinic as a busy clinic. She stated that she elected to personally mentor Whistleblower after she started working at the clinic. During Whistleblower's time at the clinic, Head Nurse, A/I Clinic took leave for approximately three weeks to visit the Philippine Islands. During that time, LPN #3, A/I Clinic served as the Head Nurse.

Head Nurse, A/I Clinic asserted she wanted Whistleblower to succeed. They had a positive relationship at first but then it deteriorated.

Head Nurse, A/I Clinic reported that during the time period at issue, MAMC had temporarily detailed one of the A/I Clinic LPNs to another section and that this led to a "punishing environment involving the A/I Clinic." The joke in the clinic was that "Dr. Head Nurse, A/I Clinic" was there to provide physician coverage but, in reality, it was the Internal Medicine surrogate allergists who were available to cover the A/I Clinic.

Head Nurse, A/I Clinic noted that Chief, A/I Clinic was late for work at times, due to traffic and family care issues but that her tardiness was always communicated ahead of time and coverage for allergy shots was always secured. Head Nurse, A/I Clinic also confirmed that Chief, A/I Clinic slept in her office, though more in the past, due to her migraine headaches.

Physician #2, IMC, Physician, Internal Medicine Clinic

Physician #2, IMC made a sworn statement on February 28, 2012. He stated that he assisted as a surrogate allergist for the A/I Clinic. He stated that he was always aware ahead of time when he was on stand-by for assisting in the A/I Clinic. He further stated there was no set schedule for being the surrogate allergist, and that he would usually be asked around 0730 or lunch time to provide coverage for the A/I Clinic. He reported there were never any surprise requests from the A/I Clinic nursing staff for assistance in the A/I Clinic.

Physician #1, IMC, Physician, Internal Medicine Clinic

Physician #1, IMC made a sworn statement on March 1, 2012. Physician #1, IMC stated that he assisted as a surrogate allergist for the A/I Clinic. He asserted that he was always aware ahead of time if he was to serve as surrogate allergist for the A/I Clinic. His being named a surrogate was never a surprise. He noted that the A/I Clinic nurses would approach him personally to ask him to cover the clinic. He reported this occurred one to two times per month. He stated he was occasionally asked to cover the A/I Clinic for an hour if Chief, A/I Clinic was late for work or to cover for another allergist at the A/I Clinic, Physician Staff Allergist. Coverage would be requested by A/I nurses around 0800-0900. Physician #1, IMC stated there was no set schedule for being the surrogate allergist. He did not believe that such an "ad hoc" coverage posed any sort of problem for the A/I Clinic or that it posed a danger to patient care.

RN, IMC, Registered Nurse, Internal Medicine Clinic

RN, IMC made a sworn statement on February 22, 2012. She stated she had once served as an RN in the A/I Clinic. She stated she was asked to create an orientation for LPNs to help them adjust to the military health care system and that she had been asked to mentor Whistleblower because Whistleblower's initial mentor was leaving and moving to a different clinic.

Concerning the clinic's operation, RN, IMC felt that it is a "stringently" run organization but that there was "process" issue with the giving of allergy shots. RN, IMC stated she was unaware of a "good old boy" network in the clinic. She stated she felt there were good working dynamics in the clinic.

RN, IMC rendered a second sworn statement on February 23, 2012. RN, IMC stated she was unaware that Chief, A/I Clinic was tardy for work, that she may have slept during the day, or that patients were given shots without the requisite surrogate coverage. RN, IMC asserted she was unaware of any violations or other problems in the clinic.

LPN #4, A/I Clinic, LPN, A/I Clinic

LPN #4, A/I Clinic rendered a sworn statement on February 22, 2012. LPN #4, A/I Clinic stated that she was unaware that Chief, A/I Clinic had ever been tardy for work. She stated she either knows Chief, A/I Clinic's location or has access to her through her cell phone and her pager. LPN #4, A/I Clinic noted that she had seen Chief, A/I Clinic rest during lunch, but that Chief, A/I Clinic was never indisposed during patient visiting hours. While LPN #4, A/I Clinic noted she was directed to knock on Chief, A/I Clinic's door [if it was closed], Chief, A/I Clinic was always available. LPN #4, A/I Clinic reported that allergy shots are not administered without physician coverage, and that she never gave shots without supervision.

LPN #4, A/I Clinic noted that she began working at the clinic toward the end of Whistleblower's tenure there. LPN #4, A/I Clinic noted that Whistleblower had told her that she had seen Chief, A/I Clinic sleeping.

LPN #4, A/I Clinic stated that staffing is short in the A/I Clinic and that the head nurse [a Registered Nurse] was performing LPN duties.

LPN #3, A/I Clinic, LPN, A/I Clinic

LPN #3, A/I Clinic rendered a sworn statement on February 27, 2012. She stated she had worked in the A/I Clinic for approximately ten years.

LPN #3, A/I Clinic reported that Chief, A/I Clinic was never tardy, that she did not sleep during the workday, and that no allergy shots or immunizations were given without the requisite supervision. She also noted that Chief, A/I Clinic would call if she were going to be tardy, and that the Internal Medicine Clinic physicians were always notified if they were to be covering as surrogates.

Former A/I Clinic LPN, formerly employed as an LPN, A/I Clinic

Former A/I Clinic LPN rendered a sworn statement on February 29, 2012.

Former A/I Clinic LPN rendered a second sworn statement on March 1, 2012.

Former A/I Clinic LPN noted that LPN #3, A/I Clinic was acting head nurse at this time. Former A/I Clinic LPN stated she was not happy at the clinic. There was "too much drama." She stated that the clinic could have done more patient care, but "the clinic work load was either feast or famine." Spring and after school were the busiest times in the clinic. Former A/I Clinic LPN reported she left she clinic because she was hired for a GS-6 position closer to her home.

Former A/I Clinic LPN stated that, while she never saw Chief, A/I Clinic sleeping at work, she noticed that Chief, A/I Clinic came into work late one to two times per week. She reported that Chief, A/I Clinic did not always call in when she was going to be late. There was, however, always physician coverage of the A/I Clinic through the allergy/immunology providers or through the Internal Medicine clinic. The first question each morning, she stated, was whether there was a physician "in the house." If not, the nurses were instructed to wait before giving allergy shots. Former A/I Clinic LPN worked for approximately two years at the A/I Clinic. Former A/I Clinic LPN felt the care at the allergy clinic was good.

LPN #1, A/I Clinic, LPN, A/I Clinic

LPN #1, A/I Clinic rendered a sworn statement on February 23, 2012. He reported that Chief, A/I Clinic has been tardy for work, typically about 15-20 minutes late. He stated she would always call ahead to alert the clinic staff. The reasons for her tardiness were various personal reasons, usually family related. Chief, A/I Clinic's tardiness did not affect patient care and surrogate allergists from the Internal Medicine Clinic were always available. He further reported there was always coverage when shots were administered.

He also stated he was not aware of Chief, A/I Clinic sleeping during patient care hours. He stated that he felt Whistleblower got along well with the staff.

AGENCY DISCUSSION

Summarized Army Findings

After review and analysis of all available evidence pertinent to the three OSC-referred allegations, the Army determined as follows:

Summarized Army Findings as to OSC-Referred Allegations 1 and 2. The Army determined that on occasion Chief, A/I Clinic would rest by lying down on the couch in her darkened office during the duty day, but found that she did so in order to relieve temporarily the effects of the migraine headaches from which she suffered. The evidence does not support a conclusion that Chief, A/I Clinic was sleeping, only that she was resting. And, although Chief, A/I Clinic sometimes rested

during the duty day, she did not rest during A/I Clinic patient care hours; she was available to her staff and patients at all times and her periods of rest in no way interfered with her performance of duty or adversely affected or endangered the quality of patient care, even in the context of the specific incident detailed in OSC-Referred Allegation 2. In fact, all evidence supports a finding that under Chief, A/I Clinic's leadership, the A/I Clinic provided outstanding patient care to an increased number of patients. However, that Chief, A/I Clinic neglected to obtain a medical profile documenting her medical condition and did not make supervisor aware of her medical condition, was not in keeping with the spirit of Army regulations. Had Chief, A/I Clinic obtained a profile documenting her condition and shared information about her medical condition with her supervisor, it would have been reasonable for her supervisor to accommodate her condition by permitting her to lie down on the couch in her darkened office to rest during the duty day. Such accommodations reflect a well-accepted medical approach to the management of migraine headaches.

Summarized Army Findings as to OSC-Referred Allegation 3. The Army determined that due to personal reasons such as family care concerns and traffic congestion, Chief, A/I Clinic was occasionally tardy in reporting for duty at the A/I Clinic in the mornings. Nevertheless, allergy shots and immunizations were consistently administered under requisite physician oversight in accordance with MAMC and A/I Clinic SOPs. The allergist surrogate program, whereby physicians from the neighboring Internal Medicine Clinic provided coverage for the A/I Clinic, was very effective in ensuring physician oversight of the A/I Clinic, even in Chief, A/I Clinic's absence. Both the staff of the A/I Clinic and the physicians who provided surrogate coverage for the clinic were well versed in the tenets of the surrogate program and implemented the program as necessary.

Army Analysis of Evidence Pertaining to the OSC-Referred Allegations

OSC-Referred Allegations 1 and 2:

References:

AR 40-501, *Medical Services, Standards of Medical Fitness*, Chapter 7 [TAB F, Exhibit F-7], states that a Soldier with a medical condition must have that condition documented and, if necessary, a "profile" should be issued to ensure the Soldier's duties do not aggravate the medical condition. A "profile," which is recorded on DA Army Form 3349, is the means by which a physician communicates to a Soldier's commander or supervisor the impact of physical issues (such as injuries or illnesses) a Soldier may be experiencing on a Soldier's ability to perform his/her military duties. When necessary, the condition's effects on the Soldiers' ability to meet retention standards also must be assessed (in more colloquial terms, an assessment must be made as to whether the medical condition renders a Soldier unfit to serve). While the Army does not have a formal "reasonable accommodation" system for uniformed service members similar to that applicable to the civilian work force, Army policy favors the accommodation of medical conditions that may affect a Soldier's performance of duties but that do not render the Soldier unfit for continued military service. AR 40-501, paragraph 7-3e(1) states that it is the commander's decision as to the determination of individual assignment or duties [in light of the Soldier's medical condition].

AR 600-20, *Command Policy*, paragraph 3-8e [TAB F, Exhibit 8], provides that promoting the well-being of one's subordinates is an overarching responsibility of Army leadership. Paragraph

3-8e also states that “Commanders and other leaders at all levels will provide an environment that contributes positively to the physical, material, mental, and spiritual dimensions of the lives of their subordinates.” Additionally, paragraph 3-3b(1) states that “[t]he physical state centers on one’s health and sense of wellness . . .” Command accommodation of a medical condition that exerts a temporary debilitating effect on a Soldier’s ability to perform his or her duties is consistent with this concept.

Army Findings:

Although the investigation revealed substantial evidence that Chief, A/I Clinic was observed lying down on her couch in her darkened office at various points during the duty day, the evidence is insufficient to determine that Chief, A/I Clinic was *sleeping*. Chief, A/I Clinic herself denied ever sleeping during the duty day, but admitted to *resting* as a means of securing temporary relief from her migraine headaches. The Army believes Chief, A/I Clinic to be the most credible source of evidence on the question of whether she was sleeping or resting; to outward observers of her behavior, Chief, A/I Clinic would have appeared the same whether she was sleeping or resting. The majority of witnesses who were employed in the A/I Clinic (affording them the opportunity to observe Chief, A/I Clinic’s conduct directly) and interviewed in the context of the AR 15-6 investigation testified that they were not aware of Chief, A/I Clinic sleeping during duty hours.¹⁹ Nonetheless, several witnesses testified that they had observed Chief, A/I Clinic lying down on the couch in her darkened office.²⁰ It is reasonable to conclude that having observed Chief, A/I Clinic in this position, these witnesses presumed her to be sleeping. However, given the integrity and transparency Chief, A/I Clinic evidenced in her testimony and conduct throughout the investigation, her assertion that she was *resting*, not *sleeping*, carries great weight. And, there remains some question as to whether it is possible to sleep while beset by a migraine headache. Accordingly, the Army believes that a preponderance of the evidence supports a finding that Chief, A/I Clinic was *resting*, NOT *sleeping*.

Further, the evidence supports the Army’s finding that although Chief, A/I Clinic rested *during the duty day*, she did not rest during A/I Clinic *patient care hours*. None of the witnesses who testified to having observed Chief, A/I Clinic resting during the duty day provided specific details as to the timing of these rest periods. Although Chief, A/I Clinic admits to having rested during the duty day, she denies resting during patient care hours and asserts that she would take a period of rest only during the lunch hour or other periods that were not allocated to patient care. The one exception to her certainty that she rested only during periods not allocated to patient care is Chief, A/I Clinic’s admission that she rested intermittently throughout the day on which the events that form the basis for OSC-referred allegation 2 are alleged to have taken place; even in that single case, the evidence does not support an assertion that her period of rest infringed on her patient care obligations. The substantial weight of evidence supports a finding that Chief, A/I Clinic was available to her staff and patients at all times and her periods of rest in no way interfered with her performance of duty or adversely affected or endangered the quality of patient care.

¹⁹ Chief Nurse, DOM, LPN #4, A/I Clinic, Former A/I Clinic LPN, Subspecialty AO, LPN #2, A/I Clinic, RN, IMC, LPN #3, A/I Clinic, and LPN #1, A/I Clinic.

²⁰ Whistleblower and Former A/I Clinic MSA testified that Chief, A/I Clinic slept during duty hours. Head Nurse, A/I Clinic made a general statement that Chief, A/I Clinic was “sleeping more in the past due to her migraines” but provided no specifics.

All available evidence supports a finding that Chief, A/I Clinic suffered from migraine headaches and that resting during the duty day provided her some temporary relief from the effects of these headaches. At the time relevant to Whistleblower's allegations, Chief, A/I Clinic's migraines were being exacerbated by numerous personal issues related to her family. That Chief, A/I Clinic suffered from migraines was documented in her medical records dating back to February 13, 2009, at which time her health care provider released her "without limits" on her duties or activities. Nonetheless, there is no indication that Chief, A/I Clinic's condition was ever documented on a medical profile, DA Form 3349, or that Chief, A/I Clinic ever informed her MAMC supervisory chain, including Chief, DOM, about her condition. Chief, A/I Clinic's supervisors did not become aware of Chief, A/I Clinic's condition until July 2011, when Whistleblower made certain complaints to the MAMC chain of command.

Rather, the evidence reflects that Chief, A/I Clinic felt her migraines would get better with time, as had been their usual pattern in the past. Chief, A/I Clinic was adamant that her migraines "were not preventing me from doing my job. I did not cut back on my hours, work load, or schedule during this time and was still able to function at a high level and accomplish all of my duties to include PT" and thus, she was not compelled to seek a medical profile or to notify her supervisors about her condition. On August 1, 2011, Chief, DOM counseled Chief, A/I Clinic in writing, stating, "if there is a medical problem that necessitates sleeping during duty hours, it is essential to be seen by your Primary Care Manager (PCM) for evaluation and treatment." Chief, A/I Clinic subsequently consulted with a neurologist and since that time, her use of prescribed drugs and diet modification appear to have worked well to control her migraine symptoms.

All available evidence indicates that had Chief, A/I Clinic sought a medical profile and/or alerted her supervisory chain about her condition when her migraines flared, she would have been accommodated with a formal acknowledgment of her need to rest in a darkened room during the duty day, when required for temporary relief of her migraine symptoms; such forms of respite are well-accepted by medical practitioners as helpful in alleviating the effects of migraine headaches. Specifically, the evidence shows that Chief, A/I Clinic's supervisor, the Chief, MAMC Department of Medicine, was satisfied that her taking periods of rest during duty hours was medically appropriate.

However, in neglecting to seek a medical profile and inform her supervisory chain about her medical condition, Chief, A/I Clinic facilitated appearances that gave rise to the perception—albeit an inaccurate perception—among some of her subordinates, that she was sleeping during duty hours and shirking her duty to care for patients. Thus, although AR 40-501 is neither punitive in nature, nor imposes mandates on individual conduct, Chief, A/I Clinic's failure to comport strictly with its terms contravened the spirit of the regulation and set the stage for the misperceptions that led to the present investigation.

As to the specific incident alleged by Whistleblower to have occurred in July 2011, to the extent Chief, A/I Clinic's recollection of this event differs from that of Whistleblower, Chief, A/I Clinic's testimony should be accorded greater weight. The level of detail provided by Chief, A/I Clinic in her testimony on this specific incident is substantial, logical, internally consistent, and persuasive. Chief, A/I Clinic describes in exacting terms the times of day at which she became informed of the patient's situation and interacted with him, the activities in which she was engaged in her office at the time, her specific observations of the patient and his symptoms, the treatment she

ordered, and the patient's response to that treatment, to include that the patient reported the resolution of all symptoms when contacted by A/I Clinic nurses the next day. Further, Chief, A/I Clinic has evidenced great integrity and transparency in all aspects of this investigation, extending to admissions of conduct that reflected less than favorably on her. In almost every aspect, Chief, A/I Clinic's testimony on other matters raised by this investigation is corroborated by documentary evidence or by the testimony of other witnesses. Accordingly, the Army believes that Chief, A/I Clinic's testimony as to the July 2011 incident is supported by at least the preponderance of the evidence.

Finally, all of the available evidence supports a conclusion that Chief, A/I Clinic's practice of resting during the duty day to relieve temporarily the symptoms of her migraine headaches in no way interfered with her performance of duty or adversely affected or endangered the quality of patient care, even in the context of the specific incident detailed in OSC-Referred Allegation 2. She was available to her staff and patients at all times, including during her periods of rest. In fact, all evidence supports a finding that under Chief, A/I Clinic's leadership, the A/I Clinic provided outstanding patient care to an increased number of patients.

OSC-Referred Allegation 3:

References: The A/I Clinic SOP states, "[w]hen allergists are not available, Internal Medicine Clinic staff on call will cover the A/I Clinic during acute anaphylaxis. SOPs on anaphylaxis will be used as reference, to include the MAMC Immunotherapy SOP." [TAB F, Exhibit F-2b]. Further, the MAMC Immunotherapy Administration SOP states "[t]he allergist or designated surrogate allergist must be in the clinic area or immediately available whenever allergy shots are being administered so they can respond immediately to a suspected systemic reaction." [TAB F, Exhibit F-2d, A/I Clinic Allergy SOP, especially pages 1 and 2].

Army Findings:

All available evidence, to include Chief, A/I Clinic's own testimony supports a finding that she was occasionally tardy in reporting for duty at the A/I Clinic. Nevertheless, even in Chief, A/I Clinic's absence, allergy shots and immunizations were consistently administered under requisite physician oversight in accordance with MAMC and A/I Clinic SOPs. Both the staff of the A/I Clinic and the physicians who provided surrogate coverage for the clinic were well versed in the tenets of the surrogate program and implemented the program as necessary.

A/I Clinic SOPs provided that Internal Medicine Clinic staff would respond to A/I Clinic patients experiencing acute anaphylaxis. In addition, the MAMC Immunotherapy SOP requires the presence of an allergist or designated surrogate allergist in the A/I Clinic area, or that an allergist or designated surrogate be immediately available, whenever allergy shots are being administered to facilitate their immediate response to any suspected systemic reaction. The allergist surrogate program, whereby physicians from the neighboring Internal Medicine Clinic provided coverage for the A/I Clinic, was very effective in ensuring physician oversight of the A/I Clinic, even in Chief, A/I Clinic's absence. Chief, DOM testified that the MAMC Internal Medicine Clinic is in such close proximity to the A/I Clinic in MAMC that it was an obvious source of physician support for the A/I Clinic during the administration of allergy shots and immunizations. The tenets of the physician surrogate program were well-engrained in both the A/I Clinic staff and in the Internal Medicine

Clinic physicians who routinely served as surrogates. The testimony of almost all A/I Clinic staff members verifies that it was standard practice for the A/I Clinic head nurse to notify the Internal Medicine Clinic surrogates, Physician #2, IMC and Physician #1, IMC, between 0730 and 0800 in the morning if there was a need for surrogate coverage that day. Physician #2, IMC and Physician #1, IMC verified that they routinely received such notifications from the A/I Clinic and once notified, were aware of the need to be available to cover the A/I Clinic. All concurred that the surrogate program and process worked well. None of the available evidence revealed a lack of surrogate physician coverage for the A/I Clinic during period when the A/I Clinic physicians, including Chief, A/I Clinic, were absent.

Chief, DOM, the MAMC Director of Medicine, who was responsible for the operations of both the A/I and Internal Medicine Clinics, was satisfied that the Internal Medicine Clinic physicians understand their role and its importance. Chief, DOM testified that he presented a briefing on the allergist surrogate program to the MAMC Credentials Committee and that the Committee concurred that this the allergist surrogate program was an acceptable means of providing requisite physician oversight of the A/I Clinic's administration of allergy shots and immunizations in the absence of an allergist.

VIOLATIONS OR APPARENT VIOLATIONS OF LAW, RULE, OR REGULATION

The investigation of the allegations referred by OSC revealed no evidence of the violation of any established standard. However, in neglecting to seek a medical profile and inform her supervisory chain about her medical condition, Chief, A/I Clinic facilitated appearances that gave rise to the perception—albeit an inaccurate perception—among some of her subordinates, that she was sleeping during duty hours and shirking her duty to care for patients. Thus, although AR 40-501 is neither punitive in nature, nor imposes mandates on individual conduct, Chief, A/I Clinic's failure to comport strictly with its terms contravened the spirit of the regulation and set the stage for the misperceptions that led to the present investigation.

CORRECTIVE ACTIONS UNDERTAKEN RELEVANT TO THE OSC-REFERRED ALLEGATIONS

On or about August 1, 2011, Chief, DOM, the Chief, MAMC Department of Medicine, and Chief, A/I Clinic's supervisor, met with Chief, A/I Clinic and counseled her formally about the need to obtain proper medical care if she had a condition that necessitated resting during the duty day. Chief, A/I Clinic subsequently consulted with a neurologist and since that time, her use of prescribed drugs and diet modification appear to have worked well to control her migraine symptoms.

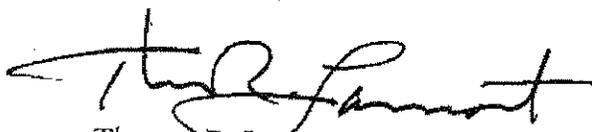
CONCLUSION

The DA takes very seriously its responsibility to address, in a timely and thorough fashion, matters referred by OSC. In this case, the Army conducted a thorough and comprehensive investigation in response to the OSC's referral of allegations submitted by the whistleblower, Whistleblower. Although the Army's investigation revealed certain components of Whistleblower's allegations to be substantiated (*i.e.*, that Chief, A/I Clinic rested in her office during duty hours and that Chief, A/I Clinic was occasionally tardy in reporting for duty at the All Clinic), the investigation established that Chief, A/I Clinic's actions in no way interfered with her performance of duty and in no way adversely affected or endangered the quality of patient care. In fact, all evidence supports a finding that under Chief, A/I Clinic's leadership, the A/I Clinic provided outstanding patient care to an increased number of patients.

I am satisfied that this is the correct outcome in this matter. Accordingly, the Army has made no referral of the alleged criminal violation to the Attorney General pursuant to Title 5, U.S.C. § 1213(d)(5)(d).

This letter, with enclosures, is submitted in satisfaction of my responsibilities under Title 5, USC, Sections 1213(c) and (d). Please direct any further questions you may have concerning this matter to [REDACTED], at 703-614-3500.

Sincerely,



Thomas R. Lamont
Assistant Secretary of the Army
(Manpower and Reserve Affairs)

Army Report Documents
Madigan Army Medical Center
Joint Base Lewis-McChord, Washington
OSC File Number DI-11-4168

<u>Tab/Exhibit</u>	<u>Description</u>
TAB A	Secretary of the Army (SA) delegation to the Assistant Secretary of the Army (Manpower & Reserve Affairs) his authority, as agency head, to review, sign, and submit to Office of Special Counsel the report required by Title 5, USC, Sections 1213(b), (c), and (d), dated March 18, 2011
TAB B	Army Regulation (AR) 40-1, <i>Composition, Mission, and Functions of the Army Medical Department</i> , dated July 1, 1983
TAB C	AR 15-6, <i>Procedures for Investigating Officers and Boards of Officers</i> , dated October 2, 2006
TAB D	AR 10-87, <i>Army Commands, Army Service Component Commands, and Direct Reporting Units</i> , dated September 4, 2007 (extract)
TAB E	MEDCOM Regulation 10-1, <i>Organization and Functions Policy</i> , dated May 6, 2009 (extract)
TAB F	Exhibits from <u>Investigating Officer</u> Report of Investigation, dated 20 June 2012 <ol style="list-style-type: none">1. FY09-12 YTD (14 Feb 12) Provider Aggregate Total RVUs by Provider in Allergy (BAB)2. Standard Operating Procedures:<ol style="list-style-type: none">a. Memorandum concerning Annual Review of the Standard Operating Procedure Manual, Allergy and Immunology Clinic, dated March 1, 2011b. Standard Operating Procedure, Allergy/Immunology Service, Scope of Practice, dated March 3, 2011c. Standard Operating Procedure, Allergy/Immunology Service, ASAP Appointments, dated February 22, 2011d. Madigan Healthcare System, Allergy Immunology Service Allergen Immunotherapy Administration SOP, dated August 4, 2008, updated June 23, 2011

- e. Standard Operating Procedure, Allergy/Immunology Service, Management of Anaphylaxis, dated March 12, 2010
- f. Standard Operating Procedure, Allergy/Immunology Service, Guideline for the Administration of Immunotherapy and SQ Epinephrine in the Absence of an Allergist, dated February 16, 2011
- 3. Memorandum, Subject: Commander's Policy #56, Madigan Code of Conduct, dated March 10, 2011
- 4. American Nursing Association, Nursing Code of Ethics (extract)
- 5. Email, from **Chief, A/I Clinic**, dated June 13, 2012; Allergy/Immunology Organizational Charts
- 6. Charts, provided by **Chief, DOM**: Madigan Army Medical Center and Department of Medicine geographical diagrams and organizational charts
- 7. AR 40-501, *Standards of Medical Fitness*, dated December 14, 2007 (Rapid Action Revision dated August 4, 2011) (extract)
- 8. AR 600-20, *Army Command Policy*, dated March 18, 2008 (Rapid Action Revision dated August 4, 2011) (extract)

TAB G

OSC documents in initial referral submission to Secretary of the Army dated December 21, 2011

- a. Standard Operating Procedure, Allergy/Immunology Service, Madigan Army Medical Center, Management of Anaphylaxis, dated March 12, 2010
- b. Standard Operating Procedure, Allergy/Immunology Service, Madigan Army Medical Center, Surrogate Allergist: Administration of Immunotherapy and Management of Reactions in the Absence of An Allergist, dated June 1, 2007

TAB H

Witness Listing for Army Report – DI-11-4168 (*copy only in unredacted Army Report version*)



SECRETARY OF THE ARMY
WASHINGTON

MAR 18 2011

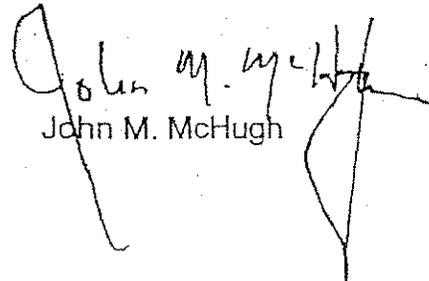
MEMORANDUM FOR ASSISTANT SECRETARY OF THE ARMY
(MANPOWER AND RESERVE AFFAIRS)

SUBJECT: Delegation of Certain Authority Under Title 5, United States Code,
Section 1213

In accordance with Title 10, United States Code, Section 3013(f), I hereby delegate to you certain authority conferred upon me as the head of the Department of the Army by Title 5, United States Code, Section 1213. Specifically, you are authorized to review, sign and submit written reports setting forth the findings of investigations into information and any related matters transmitted to me by The Special Counsel in accordance with Title 5, United States Code, Sections 1213. This authority may not be further delegated.

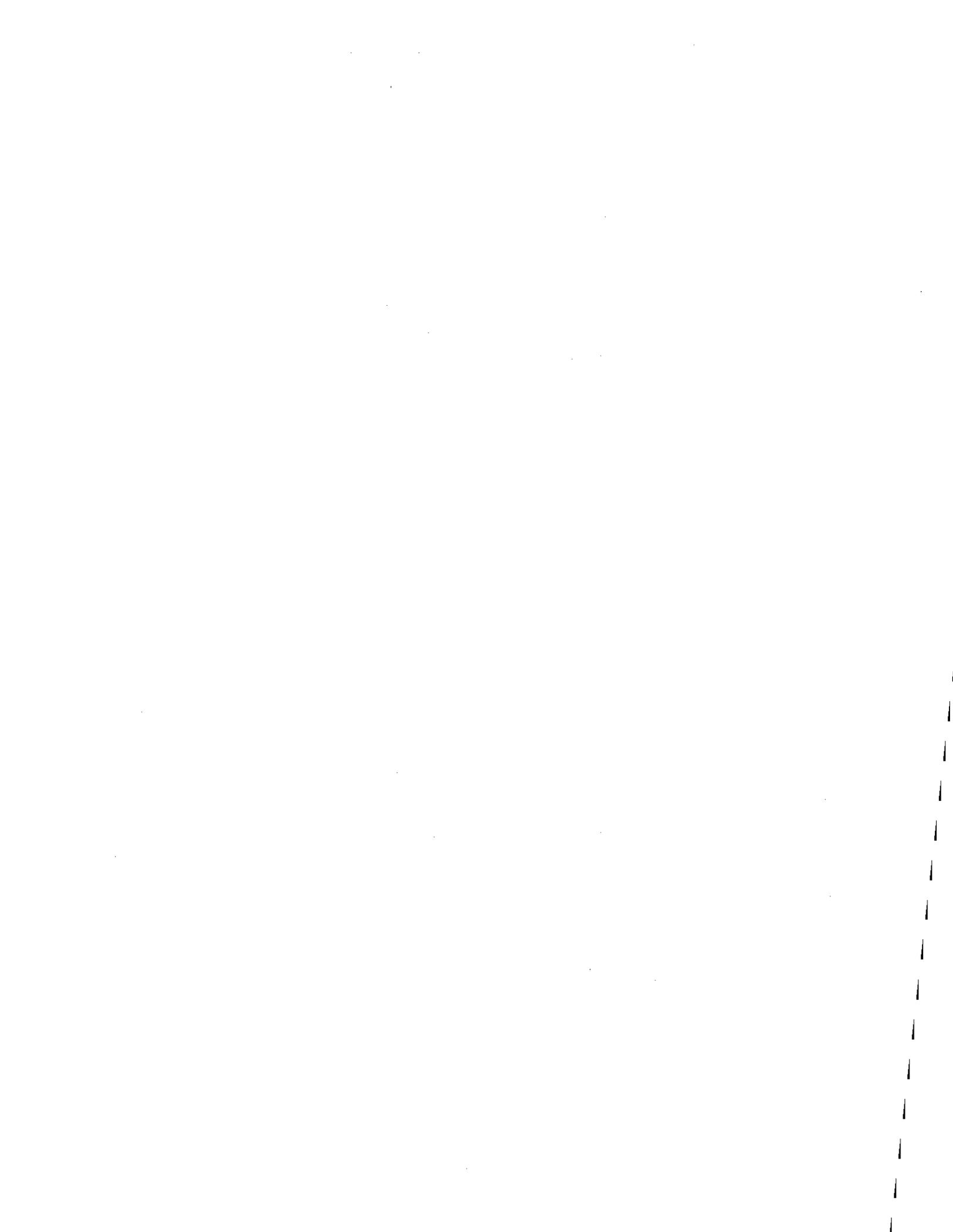
Although not a limitation on your authority to act in my behalf, in those cases in which your proposed decisions or actions represent a change in precedent or policy; are of significant White House, Congressional, Department or public interest; or have been, or should be, of interest or concern to me, for any reason, you will brief me prior to decision or action, unless precluded by the exigencies of the situation.

This delegation shall remain in effect for three years from the date of its execution, unless earlier rescinded in writing by me.


John M. McHugh

CF:
Office of the Army General Counsel





Army Regulation 40-1

MEDICAL SERVICES

**COMPOSITION,
MISSION, AND
FUNCTIONS OF
THE ARMY
MEDICAL
DEPARTMENT**

Headquarters
Department of the Army
Washington, DC
1 July 1983

Unclassified

TAB B

TAB B

SUMMARY of CHANGE

AR 40-1

COMPOSITION, MISSION, AND FUNCTIONS OF THE ARMY MEDICAL DEPARTMENT

Effective 1 August 1983

MEDICAL SERVICES

COMPOSITION, MISSION, AND FUNCTIONS OF THE ARMY MEDICAL DEPARTMENT

By Order of the Secretary of the Army:

JOHN A. WICKHAM, JR.
General, United States Army
Chief of Staff

Official:

ROBERT M. JOYCE
Major General, United States Army
The Adjutant General

History. This revision provides for the designation of The Assistant Surgeon General for Veterinary Services as Executive Agent for all DOD Veterinary Services; sets the policy pertaining to contract surgeons, to include justification for employment, duties, qualifications, full-time or part-time status, compensation and leave, contract negotiations, and contracts; sets the policy pertaining to off-duty employment of Army Medical Department (AMEDD) officers;

makes changes in processing procedures for applications for employment as social workers and psychologists; updates the composition of, and duties of, officers in all AMEDD Corps; makes changes in AMEDD warrant officer descriptions, to reflect Food Inspection Technicians (military occupational specialty 051A); and adds an appendix of required reference publications.

Summary. Not applicable.

Applicability. This regulation applies to—
a. The Active Army and Army National Guard (ARNG).

b. The US Army Reserve (USAR) when called to active duty.

Proponent and exception authority. Not applicable

Impact on New Manning System. This regulation does not contain information that affects the New Manning System.

Army management control process. Not applicable.

Supplementation. Supplementation of the

is regulation is prohibited unless prior approval is obtained from HQDA (DASG-HCD), WASH DC 20310.

Interim changes. Interim changes to this regulation are not official unless they are authenticated by The Adjutant General. Users will destroy interim changes on their expiration dates unless sooner superseded or rescinded.

Suggested Improvements. The proponent agency of this regulation is the Office of The Surgeon General. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) directly to HQDA (DASG-HCD), WASH DC 20310.

Distribution. Active Army, ARNG, USAR: To be distributed in accordance with DA Form 12-9A requirements for AR Medical Services-A. (Applicable to All Army Elements)

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*This regulation supersedes AR 40-1, 5 May 1976.

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Glossary

Chapter 1 INTRODUCTION

1-1. Purpose

This regulation—

- a. Prescribes the composition, mission, and functions of the Army Medical Department (AMEDD).
- b. Provides general information regarding the AMEDD, each AMEDD Corp, and civilian personnel employed by the department.

1-2. Applicability.

This regulation applies to—

- a. The Active Army and Army National Guard (ARNG).
- b. The US Army Reserve (USAR) when called to active duty.

1-3. References.

Required publications are listed in appendix A.

1-4. Explanation of abbreviations.

Abbreviations used in this regulation are explained in the glossary.

1-5. Concept.

a. The AMEDD encompasses those Army special branches that are under the supervision and management of The Surgeon General. Specifically, these special branches are the Medical Corps (MC), Dental Corps (DC), Veterinary Corps (VC), Medical Service Corps (MSC), Army Nurse Corps (ANC), and Army Medical Specialist Corps (AMSC).

b. The mission of the AMEDD is to—

- (1) Maintain the health of members of the Army.
- (2) Conserve the Army's fighting strength.
- (3) Prepare for health support to members of the Army in time of war, international conflict, or natural disaster.
- (4) Provide health care for eligible personnel in peacetime, concurrently with (3) above.

c. Accomplishment of this mission requires the following:

- (1) Development and execution of coordinated plans and programs to provide the best possible health service in war and peace to eligible personnel, within available resources.
- (2) Establishment of health standards.
- (3) Selection of medically fit personnel; disposition of the medically unfit.
- (4) Application of effective means of preventative and curative health services.
- (5) Execution of the approved medical research, development, test, and evaluation (RDTE) program.
- (6) Application of effective means of health education and management.

d. The AMEDD will provide health services for members of the Army and other agencies and organizations under AR 10-5. Each AMEDD component contributes to accomplishing the mission and functions of the AMEDD in its particular sphere of responsibility.

1-6. Responsibilities.

Responsibilities within the AMEDD are outlined below.

a. *The Surgeon General (TSG).* TSG is a general officer of the MC who has—

- (1) Overall responsibilities for development, policy direction, organization, and management of an integrated Army-wide health services system.
- (2) Direct access to the Secretary of the Army and the Chief of Staff, US Army (CSA) on all health and medical matters; these matters include the utilization of AMEDD professional personnel. (See AR 10-5.)

b. *Deputy Surgeon General.* The Deputy Surgeon General is a general officer of the MC who will—

- (1) Perform duties prescribed by TSG.
- (2) Serve as acting TSG in TSG's absence.

c. *Assistant Surgeon General for Dental Services.* The Assistant Surgeon General for Dental Services, a general officer of the DC, will make recommendations to TSG and through TSG to CSA on all

matters concerning dentistry and the dental health of members of the Army. All dental functions of the Army are under the direction of the Assistant Surgeon General for Dental Services.

d. *Assistant Surgeon General for Veterinary Services.* The Assistant Surgeon General for veterinary services, a general officer of the VC, will—

(1) Serve as the Executive Agent for all veterinary services within the Department of Defense (DOD).

(2) Advise, represent, and act for, as directed, TSG on all aspects of DOD veterinary functions.

e. *Officers commissioned in the MC, DC, VC, MSC, ANC, and AMSC.* Officers commissioned in these special branches of the AMEDD will carry out the duties outlined in chapter 2.

f. *Warrant officers of the AMEDD.* Warrant officers assigned to AMEDD specialties will carry out the duties outlined in chapter 3.

g. *Enlisted personnel assigned to the AMEDD.* Enlisted personnel assigned to AMEDD specialties will perform medically related technical and administrative functions prescribed in AR 611-201.

h. *Civilian personnel.* Civilian personnel assigned to the AMEDD will perform the duties shown in chapter 4. These civilian personnel include the following: Physicians, dentists, veterinarians, nurses, specialists in science allied to the practice of medicine, medical support and service personnel, contract surgeons, and professional consultants.

i. *Fee-basis physicians.* Fee-base physicians will perform duties set forth in AR 601-270.

1-7. Policy.

a. An AMEDD member may not be assigned to perform professional duties unless qualified to perform those duties. Assignments that involve professional expertise as recognized in the civilian sector must be filled by members of the AMEDD with equal, or similar, qualifications; however, emergency situations could cause exceptions. Qualifications may be met by education, training, or experience in a particular profession.

b. AMEDD members (including contract surgeons and other civilian employees) while on duty will not recommend to anyone authorized to receive health service in a Uniformed Services medical treatment facility (MTF) or at Army expense that this person receive health services from the member when off duty; this prohibition will include civilians associated in practice with the member. An exception would be that such health service would be provided without cost to the patient, the Government, or any other person or firm.

(1) Active members of the Army will not accept payment or other compensation for providing health services at any time or place to anyone authorized to receive health services in a Uniformed Services MTF, under AR 40-121 and AR 40-3 or at Army expense. Payment or other compensation will exclude military pay and allowances, and whether received directly or indirectly. Health services will include examination or consultation.

(2) AMEDD personnel who are active duty members or civilian employees are prohibited by Federal law from receiving additional US Government compensation of any nature, whether received directly or indirectly, for health services rendered to any person. Active duty members or civilian employees are defined in section 2105, title 5 United States Code; the Federal law cited above is section 5536, title 5, United States Code. Compensation of any nature also cited above will be other than ordinary pay and allowances.

c. The furnishing of testimony or production of records in civil courts by members of the AMEDD will be governed by AR 27-40 and guidance published in related technical bulletins.

(1) Testimony before civilian tribunals can involve State, Federal, or foreign courts, and many different situations. A member of the AMEDD in a nonduty status can appear in court on personal business not connected with the member's profession or official duties; usually, no official clearance will be required for this situation and appearance normally will be in civilian clothing. In cases where litigation is of interest to the United States, appearances and other

matters related to the litigation will be reported to The Judge Advocate General of the Army. A member of the AMEDD receiving an informal request or formal subpoena to give evidence or produce documents immediately will consult with the judge advocate or legal adviser of the member's command or agency.

(2) A member of the AMEDD whose official duties lead to appearance in court as a witness, or to furnishing testimony by deposition in litigation to which the Government is not a party, will not accept payment or compensation other than pay and allowance. Travel and subsistence expenses may be collected if the testimony is limited to matters observed in the performance of official duties. If the member's appearance in court is unrelated to his/her performance of official duties, and if he/she testifies as an expert on behalf of a State or the District of Columbia, or for a private individual, corporation, or agency (for example, other than the US Government) on matters outside the scope of his duties, he/she may accept pay as an expert witness. Further guidance may be obtained from the local Judge Advocate. However, all appearances by military personnel and civilian employees as expert witnesses require prior approval of TJAG under AR 27-40.

(3) No member of the AMEDD is authorized to give testimony against the Government except in the performance of official duty or under AR 27-40.

(4) If a member needs to take time off during normal duty hours because of something connected with his/her off-duty employment, duty or leave status is covered by AR 27-40.

d. No active duty member or civilian employee of the AMEDD, including contract surgeons, will accept appointments as, or act in the capacity of, a State or local official if contrary to Federal law or if included within the restrictions of AR 600-20. Before accepting appointment as, or acting in the capacity of, a State or local official, the advice of the local Judge Advocate will be sought. (See AR 600-50 for restrictions on other outside employment.)

1-8. Remunerative professional civilian employment.

a. A commissioned or warrant officer of the AMEDD on active duty will not engage in civilian employment without command approval. This will include the furnishing of testimony for remuneration. Active duty officers are in a 24-hour, 7-day duty status; their military duties at all times will take precedence on their time, talents, and attention. Subject to the limitations set forth in this regulation, members will not be restrained from employment during their normal off-duty hours. Permission for remunerative civilian professional employment will be withdrawn at any time by the commander when such employment is inconsistent with this regulation. In a case where such permission is withdrawn, the affected officer may submit to the commander a written statement containing views or information pertinent to the situation.

b. Before authorizing engagement in remunerative civilian professional employment, commanders will consider the following conditions of each case regarding the civilian community and the officer involved:

(1) The officer's primary military duty will not be impaired by civilian employment. Requests for civilian employment that exceed 16 hours a week usually will be denied. Commanders can grant exceptions if circumstances clearly show that the additional hours will not adversely affect military duties. Because of potential conflict with military obligations, AMEDD officers will not assume primary responsibility for the care of critically ill or injured persons on a continuing basis nor engage in private (solo) practice. Officer trainees (in graduate training programs) are prohibited from remunerative professional employment.

(2) The officer will not request, or be granted administrative absence for the primary purpose of engaging in civilian employment. However, ordinary leave may be granted to provide testimony in connection with authorized off-duty employment (para 1-7c), providing such absence does not adversely affect military duties.

(3) Civilian employment will not involve expense to the Federal Government nor involve use of military medical equipment or supplies.

(4) Individuals will advise employers that they will be subject to respond to alerts or emergencies that—

(a) May arise during non-duty hours.

(b) Could possibly delay the individual in reporting for civilian employment.

(c) Could require the individual to leave his or her civilian employment without warning.

(5) Civilian employment will be conducted entirely during non-duty hours and outside the Army MTF. Military personnel may not be employed by AMEDD officers in civilian employment.

(6) Except as indicated in (7) below, a demonstrated need must exist because of the relative lack of civilian physicians, veterinarians, nurses, or other professional personnel to serve the local community. A letter from the local professional society (or other responsible community agency) expressing no objection to such employment will be a required attachment to the request. This letter also must certify to the need and to the fact that such service is not available from any reasonable civilian source.

(7) AMEDD officers may engage in charitable civilian employment when voluntarily performed for, or for the benefit of, institutionalized persons and recognized nonprofit, charitable organizations; examples are the Boy Scouts and community clinics. (A letter to the benefiting institution or nonprofit organization should clearly state that the officer is performing charitable work as a private citizen and that the Government assumes no responsibility for the officer's actions.)

(8) Medical, nursing, dental, or veterinary officers prescribing drugs in civilian employment are subject to all the requirements of the Federal narcotic law. This will include Drug Enforcement Agency (DEA) registration and payment of taxes that are imposed upon other physicians, nurses, dentists, or veterinarians conducting private practice.

c. The responsibility for meeting local licensing requirements is a personal matter for officers who wish to engage in civilian employment. Similarly, malpractice insurance is a personal responsibility of the individual requesting permission to engage in civilian employment. The Army will not be responsible for officers' acts while they are engaged in off-duty employment.

d. Officers will submit written requests when they wish to engage in off-duty employment. The request will describe the position to be filled and the terms of employment; it will state that requester fully understands the provisions of this paragraph concerning off-duty employment; see appendix F. Commanders will approve or disapprove the request in writing and return a copy to the requester within 10 days. Approved requests will be reviewed at least annually by the commanders concerned.

e. Provided the provisions cited in b through d above are met (and authorized absence during normal duty hours does not adversely affect military duties) AMEDD officers—

(1) May, in isolated cases, provide remunerative advice or services to civilian practitioners in the diagnosis or treatment of patients not entitled to medical, dental, or veterinary care under AR 40-3. Employment must be authorized by their commanders; officers must be certified by an American Specialty Board or recognized by TSG as having achieved an equivalent level of professional ability.

(2) Will perform procedures necessary to save life or prevent undue suffering at any time in an emergency.

(3) May engage in teaching, lecturing, and writing as provided in AR 600-50.

1-9. Command positions.

a. The provisions of AR 600-20 apply in the designation or assumption of command; exceptions are shown in the modifications outlined below.

(1) *Health clinics.* Administrative directions of small outpatient health clinics may be vested in any qualified health care professional officer; this will be done without regard to the officer's basic health care profession. These clinics will be integral parts of the US Army Medical Center (MEDCEN) or medical department activity (MEDDAC) organization. In implementing this policy, due consideration will be given to the availability of qualified officers and the

size and mission of these outpatient facilities. In certain Army health clinics, the senior position is designated as commander. These commanders will provide for disciplinary control over personnel assigned to these clinics. The clinic will remain as an organizational element of the MEDCEN or MEDDAC to which assigned; the parent organization will be responsible for administrative control over personnel and financial resources. Professional direction of health clinics will come from the MEDCEN or MEDDAC commander, or an MC officer designated for this purpose.

(2) *Dental clinic.* Professional direction of dental clinics will come from the Director of Dental Services (DDS) or dental activity (DENTAC) commander.

b. MEDCENS, MEDDACs, community hospitals, and specific Army health clinics designated by HQDA(DASG-ZA) will be commanded by an MC officer qualified to assume command under AR 600-20. The MC officer will command, even though an officer of another branch may be the senior regularly assigned officer present.

c. DENTACs and dental units and detachments will be commanded by a DC officer qualified to assume command under AR 600-20. The DC officer will command, even though an officer of another branch may be the senior regularly assigned officer present.

d. When tables of organization and equipment (TOE) units normally commanded by MC, DC, or VC officers are in a training status, they will be commanded by the senior AMEDD officer qualified to assume command under AR 600-200, unless otherwise directed by HQDA.

1-10. Utilization of AMEDD officers.

a. AMEDD officers' duty time will be devoted, to the maximum extent possible, to actions and procedures for which they are specifically trained. They normally will be utilized in their primary occupational specialties.

b. Commanders of AMEDD units will establish local utilization policies for assigned members of their commands. These policies will include performance of additional duties. Policies will be based on—

- (1) Workload.
- (2) Assigned level of personnel.
- (3) General situation of the command.

(4) Utilization guidance provided in subsequent chapters in this regulation for each AMEDD Corps and for AMEDD warrant officers.

Chapter 2 CORPS OF THE ARMY MEDICAL DEPARTMENT

Section 1 MEDICAL CORPS

2-1. Composition.

The Medical Corps (MC) consists exclusively of commissioned officers who are qualified doctors of medicine or doctors of osteopathy.

2-2. Duties of MC officers.

a. *Professional.* Professional duties are those directly related to—

(1) Evaluation of medical fitness for duty of members and potential members of the Armed Forces.

(2) Analysis of the medical and physical condition of patients.

(3) Practice of preventive and therapeutic medicine.

(4) Development and adoption of medical principles required for the—

(a) Prevention of disease and disability.

(b) Treatment of patients.

(5) Solution, through research and development (R&D), of medical professional problems in the—

(a) Prevention of disease and injury.

(b) Treatment and reconditioning of patients.

b. *Staff.*

(1) The senior MC officer present for duty with a headquarters (other than medical) will be officially titled—

(a) The "surgeon" of the field command.

(b) The "chief surgeon" of the oversea major Army command (MACOM).

(c) The "director of health services (DHS)" at the installation level.

These titles indicate the medical officer's staff position rather than qualifications.

(2) Duties of these individuals are advisory or technical: advisory as staff officers; technical in the supervision of all medical units of the command. These individuals—

(a) Advise the commander and members of the staff on all medical matters pertaining to the command.

(b) Take part in all planning activities dealing with military operations.

(c) Exercise complete technical control within a command over medical units in the maintenance of health, and in the care of the sick and wounded. This care will include those means of evacuation that are organic to the AMEDD.

(3) Except for direct coordination of professional and technical matters, coordination with staff counterparts at higher and subordinate headquarters is through command channels.

(4) When medical and nonmedical TOE units are stationed at installations where a DHS is authorized and assigned, the designated DHS, if other than the MEDDAC or MEDCEN commander, may retain the position, on approval of the installation commander (see AR 10-43), even though a senior MC officer is on duty with the TOE units.

(5) By mutual agreement between commanders, the appropriate medical staff officer may, as an additional duty, serve as the staff surgeon to other commands which do not have medical staff officers assigned.

(6) Specific duties of a medical staff officer are explained in AR 10-6 and AR 611-101.

2-3. Utilization of MC officers.

a. MC officers' duty time will be devoted, to the maximum extent possible, to actions and procedures for which they are specially trained. A minimum of time will be given to those duties that can be adequately performed under their direction by other AMEDD personnel.

b. Except when regulations provide otherwise, such officers will not be—

(1) Detailed as members of—

(a) Courts-martial.

(b) Nonprofessional boards or committees.

(2) Assigned to other duties in which medical training is not essential.

To preclude requiring the personal appearance of MC officers as witnesses to present testimony, every effort consistent with due process of law will be made to use reports, depositions, or affidavits submitted by MC officers in connection with courts-martial and boards or committees.

2-4. Applicability of Federal and State licensing laws.

When duties are performed by MC officers under valid orders issued by lawful Federal authority, such officers are—

a. "Exempt officials," as explained by the DEA.

b. Not required to register and pay the Federal narcotics tax.

Section II DENTAL CORPS

2-5. Composition.

The Dental Corps (DC) consists exclusively of commissioned officers who are qualified doctors of dental surgery or dental medicine.

2-6. Duties of DC officers.

a. *Professional.* Professional duties will be those directly related to the science of dentistry as practiced by the dental profession.

These will include dental examinations, preservation and promotion of dental health, and execution of approved dental RDTE programs.

b. Staff.

(1) The primary duty of the senior DC officer present for duty with a non-DENTAC headquarters will be that of dental staff officer, except where designated as deputy commander. The title of a dental staff officer will be "dental surgeon."

(2) Individuals exercise complete technical control within the command over dental activities in the—

(a) Prevention of oral disease.

(b) Care of dental patients.

(3) Coordination with staff counterparts at high and subordinate headquarters is through command channels; an exception will be for direct coordination of professional and technical matters.

(4) By mutual agreement between commanders, the appropriate dental staff officers may, as an additional duty, serve as the staff dental surgeon to other commands that do not have a dental staff officer assigned.

(5) Specific duties of a dental staff officer are explained in AR 10-6 and AR 611-101.

2-7. Utilization of DC officers.

This applicable portions of paragraph 2-3 govern in the utilization of dental officers.

2-8. Dental organizations.

a. Dental personnel required by commands will be organized into DENTACs, as well as US Army Area Dental Laboratories (ADLs), and TOE units, as required. The DENTAC is part of the MEDCEN or MEDDAC table of distribution and allowance (TDA); however, the DENTAC is supported by, not commanded by, the MEDCEN or MEDDAC. The DENTAC receives complete administrative and logistical support from the MEDCEN or MEDDAC.

b. The dental care program is managed separately by the appropriate AMEDD command headquarters (for example, Headquarters US Army Health Services Command (HQ, HSC); Medial Command (TOE 8-111H2)) as a discrete, functionally managed program. On matters pertaining to the dental health of the command, the installation commander will communicate directly with the DDS, under AR 5-3.

2-9. Application of narcotic and licensing laws to DC officers.

Paragraph 2-4 applies.

Section III

VETERINARY CORPS

2-10. Composition.

The Veterinary Corps (VC) consists exclusively of commissioned officers who are qualified doctors of veterinary medicine.

2-11. Duties of VC officers.

a. The Assistant Surgeon General for Veterinary Services—

(1) Serves as executive agent for veterinary services for the DOD; see DODD 6015.5.

(2) Provides veterinary support to the DA, Department of the Navy and the US Marine Corps, the Air Force, all DOD agencies, and the US Coast Guard.

b. Professional duties of VC officers are discussed below.

(1) Provide consultative services to personnel performing food hygiene, safety, and quality assurance inspections. This will include advising the appropriate authority on the acceptability of food as follows:

(a) Food processing inspections incident to and following the procurement of foods of animal origin or other foods, when requested by proper authority.

(b) Sanitation inspection of establishments in which foods are produced, processed, prepared, manufactured, stored, or otherwise handled; excluded are food service facilities, such as dining facilities and snack bars.

(c) Inspections on receipt at destination for identity and condition of all foods of animal and non-animal origin.

(d) Perform professional functions in medical laboratories, such as chemical, bacteriological, and radiological analyses of foods.

(e) Inspections to determine fitness for human consumption of all foods which may have been contaminated by chemical, bacteriological, or radioactive materials.

(2) Assist the senior medical staff officer or the MEDCEN or MEDDAC commander at all levels of command in discharging responsibilities for conducting a comprehensive preventive medicine program. This will include the prevention and control of diseases common to man and animals in areas of responsibility specified by the—

(a) Senior medical staff officer.

(b) MEDCEN or MEDDAC commander.

(3) Provide a comprehensive program for prevention and control of diseases or conditions that may—

(a) Be transmissible to humans or animals.

(b) Constitute a military community health problem.

(4) Provide veterinary service support—

(a) In AMEDD training programs.

(b) To medical and subsistence R&D programs and activities.

(5) Provide complete veterinary services for US Government public-owned animals. Morale support activities—owned animals will be provided veterinary services as time and resources permit.

(6) Collect and maintain data on—

(a) Food supplies and animal diseases that may affect the health of members to the Army.

(b) Animal diseases that may affect the health of public animals.

In this respect, they will advise and make recommendations to the appropriate authority of existing or anticipated conditions that may be of military or civilian significance. Under applicable circumstances, these would include local, State, Federal, and comparable agencies.

(7) Provide technical consultation to the senior medical staff officer or the MEDCEN or MEDDAC commander. In this capacity the VC officer will—

(a) Identify unsanitary conditions associated with subsistence and animals.

(b) Make recommendations for correction of these unsanitary conditions.

(8) Assist, on request and when authorized, civilian authorities or other Federal departments in emergency animal disease control programs.

c. Specific duties of a veterinary staff officer are defined in AR 10-6 and AR 611-101.

2-12. Utilization of VC officers.

a. Applicable portions of paragraph 2-3 govern the utilization of VC officers.

b. At installations and activities where no VC officer is assigned, required military veterinary service may be provided on an attending basis; this must be authorized by the Commanding General, US Army Health Services Command (CG, HSC) and the oversea MACOM commander for their areas of responsibility.

2-13. Title of VC officers.

a. The general officer in the VC may, when so designated by TSG, be called—

(1) The Assistant Surgeon General for Veterinary Services.

(2) Chief, Veterinary Services.

(3) Chief, VC.

b. The title of the senior VC officer assigned to a command, agency, or activity is "Veterinarian."

Section IV

MEDICAL SERVICE CORPS

2-14. Composition.

The Medical Service Corps (MSC) is authorized one officer in the grade of Brigadier General who serves as Chief of the MSC. The

MSC by law (section 3068, title 10, United States Code) is organized into four sections: Pharmacy, Supply, and Administration Section; Medical Allied Sciences Section; Sanitary Engineering Section; and Optometry Section. An officer is selected and certified by TSG and the Chief of the MSC to be Chief of each Section; each officer concurrently is designated an Assistant Chief of the MSC. These MSC sections are subdivided as follows:

a. Pharmacy, Supply and Administration Section.

- (1) Health care administration.
- (2) Field medical assistant.
- (3) Health services comptroller.
- (4) Biomedical information systems.
- (5) Patient administration.
- (6) Health services personnel management.
- (7) Health services manpower control.
- (8) Health services plans, operations, intelligence, and training.
- (9) Aeromedical evaluation.
- (10) Health services materiel.
- (11) Health facilities planning.
- (12) Pharmacy.

b. Medical Allied Sciences Section.

- (1) Microbiology.
- (2) Biochemistry.
- (3) Parasitology.
- (4) Immunology.
- (5) Clinical laboratory.
- (6) Physiology.
- (7) Podiatry.
- (8) Audiology.
- (9) Social work.
- (10) Clinical psychology.
- (11) Research psychology.

c. Sanitary Engineering Section.

- (1) Nuclear medical science.
- (2) Entomology.
- (3) Environmental science.
- (4) Sanitary engineering.

d. Optometry Section.

2-15. Duties of MSC officers.

a. Officers of the branch perform a wide variety of administrative, technical, scientific, and clinical duties within the AMEDD. These duties will be consistent with the officer's education, training, and experience. MSC officers will perform duty in branch immaterial assignments only when authorized by HQDA (DASG-PTZ).

b. See AR 10-6 and AR 611-101 for a more definitive explanation of duties of MSC officers.

2-16. Utilization of MSC officers.

a. MSC officers normally will be utilized in their primary professional specialty.

b. Applicable portions of paragraph 2-3 govern the utilization of those MSC officers who, in the performance of their assigned duties, provide patient care through either of the following:

- (1) Direct professional services on an appointment basis.
- (2) Preventative medicine functions.

c. Exceptions to *b* above are duties involving courts, boards, administrative officer of the day (AOD), or staff duty officer (SDO).

d. Provisions of paragraph 1-9d and the annually published HQDA Letter (MEDO Letter) govern MSC officers exercising command.

Section V ARMY NURSE CORPS

2-17. Composition.

The Army Nurse Corps (ANC) consists exclusively of the Chief, Assistant Chief, and other commissioned officers who are qualified, registered, professional nurses.

2-18. Duties of ANC officers.

a. Professional. Duties of ANC officers are those related to the theory and practice of nursing.

(1) The focus of the practice of nursing is on the assessment of individual, family, or group health care needs to—

- (a) Promote health.
- (b) Prevent illness.

(c) Provide assistance in coping with physical and psychological aspects of illness. This goal is accomplished by a variety of modalities, such as teaching, counseling, case-finding, and skilled supportive care.

(2) Nursing is based on recognized professional standards of practice. It has certain functions for which its practitioners accept responsibility. These include both independent nursing functions and delegated medical functions that may be either—

(a) Performed autonomously in coordination with other health team members.

(b) Delegated by the professional nurse to other persons.

(3) In US Army MEDCENs and MEDDACs the Department of Nursing is the administrative unit that provides the organization framework for nursing activities to accomplish the following:

(a) Define, design, and implement nursing care systems.

(b) Establish specific nursing care technologies, processes, and standards; develop mechanisms to insure that these standards are maintained.

(c) Collect and evaluate data concerning categories of patients and nursing resources.

(d) Assess and evaluate results of nursing actions on a continuous basis.

(e) Forecast and plan for requirements in money, materials, and personnel resources.

(f) Coordinate nursing actions with other health care providers.

(g) Establish a climate for and promote nursing research.

(h) Provide opportunities for continuing education for nursing personnel.

(i) Provide flexibility and modification of practice in response to technological advances and social changes.

b. Staff and other duties. Detailed duties, responsibilities, and titles of ANC officers are outlined in AR 40-6, AR 10-6, and AR 611-101.

2-19. Utilization of ANC officers.

a. ANC officers will be assigned to nurse-related professional, administrative, and staff duties that directly contribute to the accomplishment of the AMEDD mission. ANC officers will be considered appropriately assigned when performing duties related to their specialty skills identifier.

b. The applicable portions of paragraph 2-3 govern the utilization of ANC officers may be detailed as members of courts-martial boards of nonprofessional boards or committees when ANC officers or other nursing service personnel are involved in the proceedings.

c. ANC officers will not perform AOD, SDO, or other additional duties in which nursing professional education, training, and experience are not essential. Exceptions include serving—

- (1) In an administrative headquarters (for example, HQ, HSC; HQDA; or Medical Group (TOE 8-122H)).
- (2) As an administrative resident.
- (3) As chief nurse in a TOE unit.

Section VI ARMY MEDICAL SPECIALIST CORPS

2-20. Composition.

a. The Army Medical Specialist Corps (AMSC) is composed of a Dietitian Section, Occupational Therapist Section, and Physical Therapist Section.

b. The AMSC consists exclusively of officers who are—

(1) Registered dietitians, certified occupational therapists, or licensed physical therapists.

(2) Eligible for membership in the American Physical Therapy Association.

(3) Taking part in AMSC professional education programs for the purpose of becoming qualified in one of the specialties cited in (1) or (2) above.

2-21. Duties of AMSC officers.

a. Duties of AMSC officers will be directly related to the specialties of dietetics, physical therapy, or occupational therapy, as practiced by the respective civilian professions. These will include development and adoption of principles and standards to meet the total needs of patients in these specialized fields.

b. See AR 10-6 and AR 611-101 for specific duties of AMSC officers.

2-22. Utilization of AMSC officers.

a. When AMSC officers are assigned to Army MTFs—

(1) The senior dietitian will be Chief of the Food Service Division.

(2) The senior physical therapist and senior occupational therapist will be chiefs of their respective sections.

b. The applicable portions of paragraph 2-3 govern the utilization of AMSC officers. An exception is that AMSC officers may be detailed as members of courts-martial boards or nonprofessional boards or committee when the following are involved in the proceedings:

(1) AMSC officers.

(2) Other food service, physical therapy, or occupational therapy personnel.

c. AMSC officers working regularly established clinic hours may perform AOD and SDO functions. Fair and equitable scheduling of those officers who work shifts or who are on weekend and holiday duty rosters within their sections must be evident.

d. AMSC officers will not be assigned to AOD or SDO or assistant AOD or SDO function when they are taking part in the following:

(1) The Army Dietetic Internship Program.

(2) The Army Occupational Fieldwork Program.

e. AMSC officers will not be assigned special administrative duties. These include, but are not limited to, additional duties; for example, line inventory, drug inventory, hospital inspection, and cash verification. The only exception would be those officers serving—

(1) In an administrative HQ.

(2) As administrative residents.

Chapter 3 ARMY MEDICAL DEPARTMENT WARRANT OFFICERS

3-1. Physician assistant, military.

a. *Composition.* Military physician assistants (PAs) are school-trained warrant officers who are qualified for and who have been awarded military occupational specialty (MOS) 011A.

b. *Duties.* Military PAs have the following duties:

(1) Provide general medical care for the sick and wounded under the supervision of designated physicians. Perform technical and administrative duties as—

(a) Indicated in AR 611-112.

(b) Assigned by supervisors in MTFs.

(2) Provide for preparation and maintenance of necessary records and reports.

(3) Supervise or assist in supervising enlisted specialists and comparable civilian employees in utilization, care, and maintenance of medical supplies and equipment.

(4) Assist in the training of enlisted specialists and comparable civilian employees in technical aspects of patient care and treatment.

c. *Utilization.* The provisions of paragraph 1-10 and AR 40-48 govern the utilization of military PAs.

(1) PAs will be utilized only within their MOS in troop medical

clinics, aviation medicine clinics, emergency rooms, physical examination sections, general outpatient clinics, family practice clinics, other primary care clinics, field medical units, and other medical facilities.

(2) Career management of military PAs is monitored by the MC Career Activities Office, US Army Medical Department Personnel Support Agency, WASH DC 20324; this office comes under the direction of the Directorate of Personnel, Office of The Surgeon General (OTSG), HQDA.

3-2. Biomedical equipment repair technician.

a. *Composition.* Biomedical equipment repair technicians are warrant officers who are qualified for and have been awarded MOS 202A.

b. *Duties.* Biomedical equipment repair technicians perform specialized, equipment-oriented management functions; these include skills, knowledge, and abilities to manage programs for the maintenance of medical equipment. AR 611-112 prescribes the full range of duties performed by biomedical equipment repair technicians. Specific areas of responsibility are shown below.

(1) Planning and scheduling workload.

(2) Supervising and instructing subordinates.

(3) Administering a repair parts program.

(4) Recording maintenance performance and historical equipment data; coordinating with user and support activities.

(5) Developing and operating ancillary support programs.

(6) Advising on the layout of health care facilities as related to equipment and applicable installation requirements.

(7) Advising the commander and staff on maintenance-related matters.

c. *Utilization.* Provisions of paragraph 1-10 and AR 40-48 govern utilization of biomedical equipment repair technicians.

(1) Personnel with this specialty will be utilized only in their MOS; they normally will be assigned to TDA hospitals, MEDCENS, MEDDACs, or equivalent modifications TOE units. Some personnel also will be assigned for the following functions:

(a) Managing depot or combined maintenance operations.

(b) Performing as equipment specialists in varying assignments.

(c) Serving as instructors in service schools.

(d) Commanding TOE medical equipment maintenance detachments.

(2) Other personnel with this specialty also serve in successively higher levels of management with MACOMs and the National Maintenance Point.

(3) Career management of biomedical equipment repair technicians is monitored by the MSC Career Activities Office, US Army Medical Department Personnel Support Agency, WASH DC 20324; this office comes under the direction of the Directorate of Personnel, OTSG, HQDA.

3-3. Food inspection technician.

a. *Composition.* Food inspection technicians are school-trained warrant officers who are qualified for and have been awarded MOS 051A.

b. *Duties.* Food inspection technicians—

(1) Manage and direct personnel, facilities, and equipment required for military hygiene, safety, and quality assurance.

(2) Provide assistance in programs to—

(a) Prevent animal diseases.

(b) Control zoonotic and foodborne illnesses.

(3) Assist in animal control programs.

(4) Prepare reports relative to veterinary activities.

(5) Maintain liaison with Federal, State, and local health agencies.

(6) Assistant in the conduct of training of enlisted personnel and civilian employees.

(7) Other technical and administrative duties are performed as—

(a) Indicated in AR 611-112.

(b) Assigned by the technician's supervisor.

c. *Utilization.* The provisions of paragraph 1-10 govern the utilization of food inspection technicians. They will be utilized only

within their MOS in TOE units, TDA activities, MEDCENs or MEDDACs, and other DOD agencies and activities. Career management of food inspection technicians is monitored by the VC Career Activities Office, US Army Medical Department Personnel Support Agency, WASH DC 20324; this office comes under the direction of the Directorate of Personnel, OTSG, HQDA.

Chapter 4 ARMY MEDICAL DEPARTMENT CIVILIAN PERSONNEL

4-1. Civilian employees.

a. Composition. The civilian complement of the AMEDD consists of US citizens and direct- and indirect-hire local nationals employed under appropriate regulations issued by the US Office of Personnel Management, HQDA, and the AMEDD.

b. Duties. Civilian are employed in a wide range of occupational categories; these include physicians, nurses, those in other medical and allied specialties, and support and service personnel.

c. Utilization. General utilization policy of AMEDD civilian employees is outlined in AR 570-4.

d. Social workers and psychologists. Policy for employment of social workers and psychologists is contained in appendix E.

4-2. Contract surgeons.

a. Authorization. In an emergency, TSG may employ as many contract surgeons as may be necessary within applicable personnel limitations (section 4022, title 10, United States Code). An emergency may exist when utilization of the services of an MC officer or a graded Civil Service physician is not practicable or feasible for providing essential health services. Contract surgeons will not be employed as a means for circumventing general schedule pay scales (Civil Service) established for physicians employed by the US Government.

b. Justification for employment. Justification for employment of private physicians as contract surgeons in peacetime will be forwarded for approval through command channels to HQDA (DASG-PSC), WASH DC 20310, to arrive 60 days before the desired date of employment. When intermediate MACOM commanders do not concur with any part of the justifications, it will be returned to the originator with reasons for nonoccurrence. As a minimum, each justification submitted to HQDA will contain appropriate data with the following information:

(1) Workload data for the most recent 6-month period. This will include, for example, the number of visits (inpatient and outpatient, as appropriate) and the number of medical examinations, as pertains to areas in which a private physician will be employed.

(2) Projected workload data for period of contract. (See (1) above.)

(3) Number, by type of personnel (military, civil service, contract surgeon, or fee-for-service), presently authorized, required, and assigned in the work area where the contract surgeon is required.

(4) Other procurement actions taken to provide necessary services; an example is through the US Office of Personnel Management.

(5) Number of active duty medical officers programmed to fill existing or projected vacancies.

(6) Effective dates of contract.

(7) Activity or installation to be serviced by contractor.

(8) Compensation; hourly, daily, weekly, monthly, or yearly, as applicable.

(9) Hours, days, place of duty, and full-time or part-time; examples of place of duty are clinic or emergency room.

(10) Types of services to be provided; examples are sick call or emergency room.

(11) Types of personnel to be provided medical care; see AR 40-3 for eligibility for medical care. Specify as active duty Army, other active duty, dependents of US Uniformed Services personnel

(active duty and retired), retired US Uniformed Services personnel, or other personnel.

(12) Restrictions imposed or contemplated to be imposed upon the contractor.

(13) Proposed source and address.

(14) Monitoring headquarters; name and telephone (automatic voice network (AUTOVON)) of the individual conducting preliminary negotiations with the private physician.

(15) Statements that—

(a) Employment will be within all applicable personnel limitations and funding availability.

(b) The contractor will possess the applicable qualifications outlined in d below.

c. Duties. Professional and administrative duties of contract surgeons will be comparable to those which MC officers with similar training and experience normally would be called upon to perform. Contract surgeons are not eligible for detail on courts-martial boards, but may be detailed to serve on—

(1) Medical boards convened under AR 40-3.

(2) Administrative boards to which civilian employees may be appointed.

d. Qualifications.

(1) To be eligible as a contract surgeon within the United States, the contractor must be one of the following:

(a) A graduate of a medical school approved by the Council on Medical Education and Hospitals of the American Medical Association.

(b) A graduate of a school of osteopathy approved by the Bureau of Professional Education Committee in Colleges of the American Osteopathic Association.

(c) A holder of a permanent certification by the Educational Council for Foreign Medical Graduates.

(2) The candidate must—

(a) Have a full or unrestricted license to practice medicine in a State, the District of Columbia, the Commonwealth of Puerto Rico, or a territory of the United States.

(b) Be legally authorized to prescribe and administer all drugs and perform all surgical procedures in the area concerned.

(3) Oversea MACOM commanders will prescribe the qualifications for contract surgeons for their respective area of employment.

e. Full-time and part-time status.

(1) A full-time contract surgeon is one who is required to devote full time to the performance of duties under the contract; full time here means not less than 40 hours each calendar week.

(2) A part-time contract surgeon is one who is required each week to devote less than 40 hours to the performance of duties under the contract.

f. Compensation and leave.

(1) Pay and allowances for full-time and part-time contract surgeons will be as prescribed in Misc Publ 13-1.

(2) Pay of part-time contract surgeons may not exceed the monthly base pay of an officer, O3, with over 4, but less than 6, years of service.

(3) Part-time contract surgeons are entitled only to the travel and transportation allowances in the same amount and under the same conditions as allowed for commissioned officers.

(4) Special and incentive pays may not be included in the contract for either part-time or full-time contract surgeons.

(5) Contract surgeons are not entitled to officers' uniform allowances.

(6) Within the limitations prescribed above, oversea MACOM commanders are authorized to determine applicable compensation of part-time contract surgeons within the geographical limits of their commands. These rates will take in account—

(a) Comparable rates paid for similar services in the locality.

(b) Background, experience, and other qualifications of the contractor.

(c) Extent of service required under to contract.

g. Contract negotiation. Section 2304a(4) and 2304a(6), title 10, United States Code and Misc Pub 28-25, paragraph 22-102.1 contain authority for negotiation of contracts with private physicians.

On approval of justification by HQDA (DASC-PSC) (para 4-2b), commanders of installations and activities may enter into contracts for services of contract surgeons.

h. Contracts.

(1) *General.* The following provisions apply to both full-time and part-time contract surgeons:

(a) Contracts will be executed by the local contracting officer under applicable provisions of Misc Pub 28-24 and Misc Pub 28-25 (32 CFR 591 et seq.).

(b) The term of the contract will be for a specific period of time; it will not extend beyond the end of a fiscal year during which the available appropriated funds are authorized to be obligated.

(c) A contract will not be renewed automatically upon expiration. Justifications for re-employment of private physicians as contract surgeons for the ensuing fiscal year will be forwarded under paragraph 4-2b.

(d) One copy of each executed contract will be forwarded to HQDA (DASG-PSC), WASH DC 20310 within 10 working days after the effective date of the contract; the executed contract will be for initial employment or re-employment.

(2) *Contract format.*

(a) Contracts will conform to the format prescribed by Misc Pub 28-24 (para 16-102.2) and by Misc Pub 28-25 (app F 100-26).

(b) Each contract will contain a statement of work substantially as shown in appendixes B, C, or D. Modifications to these statements to meet local requirements are not prohibited; however, changes should be kept to a minimum.

4-3. Professional consultants.

a. General. This paragraph contains information and instructions regarding professional consultants (hereafter referred to as consultants). Those portions of this paragraph that deal with civilian consultants supplement CPR A-9 and FPM chapter 304. Unless otherwise specifically indicated, provisions of this paragraph are applicable to both military and civilian consultants.

b. Duties.

(1) Consultants will—

(a) Assist in the maintenance of high standards of professional practice and research.

(b) Further the educational program for the advancement of AMEDD officers in the medical, dental, nursing, and allied specialties.

(c) Provide close liaison with leaders in related professions.

(2) These consultants will assist TSG, the Commanding General, US Army Medical Research and Development Command (CG, USAMRDC), the CG, HSC, chief surgeons of overseas MACOMs, and commanders of AMEDD activities, particularly treatment and R&D facilities—

(a) On matters pertaining to professional practice by providing advice on professional subjects.

(b) On new developments in prophylaxis, diagnosis, treatment, and technical procedures.

(c) By stimulating interest in professional problems and aiding in their investigation.

(d) By giving advice on RDTE programs.

(e) By encouraging participation in programs such as clinical and pathological conferences, ward rounds, and journal clubs.

(3) Proper performance of these duties involves an appraisal of all factors concerned with the prevention of disease and the professional care of patients. These include—

(a) Organization and program of professional services in medical installations.

(b) Quality, numbers, distribution, and assignment of specialty professional personnel.

(c) Diagnostic facilities and availability and suitability of equipment and supplies for professional needs.

(d) Dental care, nursing care, and dietary provisions.

(e) Physical therapy and occupational therapy.

(f) Reconditioning and recreational facilities.

(g) Other ancillary services which are essential to the welfare and morale of patients.

(4) Execution of these duties involves periodic visits to MTFs and other types of AMEDD units concerned with health service or medical R&D activities.

c. Utilization categories. Utilization of consultants falls into the following categories:

(1) *OTSG.* In addition to AMEDD officers assigned or designated as consultants, other specialty qualified individuals may be utilized to—

(a) Provide TSG with professional advice or assistance, as required.

(b) Perform duties set forth in b above.

(2) *OTSG field operating agencies (FOAs).* OTSG FOAs are activities under the command jurisdiction of TSG.

(a) Consultants may be utilized to perform duties set forth in b above. Their services will be utilized, as required, for professional advice or assistance. (For further information regarding the educational program of the AMEDD in the medical, dental, nursing, and allied specialties, see AR 351-3.)

(b) In activities where intern or residency training programs are conducted, a representative consultant may be appointed to the Hospital Education Committee. This consultant may advise and recommend on all matters pertaining to graduate education. (For further information regarding AMEDD residency or intern training programs see AR 351-3.)

(3) *HSC.*

(a) Consultants may be utilized to perform duties set forth in b above. Their services will be utilized, as required, for professional advice or assistance.

(b) In hospitals conducting residency or intern training, a representative consultant may be appointed to the Hospital Education Committee. This consultant may advise and recommend on all matters pertaining to graduate education.

(4) *Overseas MACOMs.*

(a) Consultants may be utilized to perform duties set forth in b above. Their services will be utilized, as required, for professional advice or assistance.

(b) In hospitals conducting residency or intern training, a representative consultant in surgery, internal medicine, psychiatry and neurology, pathology, and dentistry may be appointed to the Hospital Education Committee. These consultants may advise and recommend on matters pertaining to graduate education.

4-4. Administrative procedures for professional consultants.

Before the initial appointment of consultants in the medical, dental, nursing, and allied specialties, the appropriate command or agency will evaluate the prospective consultant's professional qualifications.

a. Appointment.

(1) *Military consultants.* In addition to AMEDD officers assigned as consultants, other specialty qualified individuals may be utilized to advise TSG, the CG, USAMRDC, the CG, HSC, and overseas MACOM commanders on major subjects and board problems connected with the following:

(a) Policy and practice in the prevention of disease.

(b) Care of patients.

(c) Health and environment activities.

(d) Evaluation and maximum utilization of specialized personnel.

(e) R&D program.

(f) Postgraduate education.

(g) Continuing education programs for AMEDD officers.

(h) Other important professional matters. TSG and MACOM commanders will appoint these designated individuals on appropriate military orders.

(2) *Civilian consultants.* TSG, the CG, HSC, the CG, USAMRDC, and overseas MACOM commanders may approve appointment of civilian consultants within their respective commands or agencies. Normally, civilian consultants will not be utilized for a period or periods exceeding 90 calendar days in 1 fiscal year. Prior approval by the appropriate approval authority must be obtained in

additional days of service are required during any fiscal year. In order to maintain a single pay account and to insure that consultants do not exceed the authorized maximum number of days in any fiscal year, civilian consultants will be carried in an appointive status on the rolls of only one command or agency. Short-term consultant appointments, not to exceed 6 months in total tenure, will be requested when individuals are required for brief periods of time to carry out special assignments; examples would be a trip overseas or giving a series of lectures.

(a) *Security requirements.* The security requirements established in the FPM, chapter 732 and CPR A-9, chapter 732 for assignment OT civilian positions in the competitive service will apply to civilian consultants. Nonsensitive positions require completion of National Agency Check and written inquiries with satisfactory results. These may be conducted as post-appointive actions.

(b) *Reappointment.* Civilian consultants will be reappointed by the employing command or agency at the end of each fiscal year instead of at the end of the service year, as specified in CPR A-9.

(c) *Roster.* To maintain a current roster of all AMEDD civilian consultants to the Army in an appointive status, each appointing command or agency will publish an annual roster no later than 15 July of each year. Addendum's will be published as required. Appointment data on consultants is provided through the DA Civilian Personnel Information System (CIVPERSINS). If needed, rosters may be obtained through CIVPERSINS channels.

b. *Joint utilization.* Consultants appointed by one command or agency may be used by another command or agency through agreements made between the commands or agencies concerned. Payment for services rendered by civilian consultants, plus travel and per diem for military consultants, will be made by the parent command from funds available for this purpose and cited by the using command. Transfer of funds between commands is not authorized.

c. *Civilian spaces incident to employment.* Approving authorities will determine the number of civilian spaces required for the employment of consultants in activities under their respective jurisdiction. Such spaces will be included in their overall manpower programs.

d. *Payment.* The rate of pay for each civilian consultant will be determined by the approving authority. However, consultants will not be paid more than the maximum rate per day stated in AT 40-330, paragraph 6.

(1) Consultants will be paid by the parent command or agency. For joint utilization (see b above), prior coordination will be made. Information concerning the consultant's visit must be forwarded to the appropriate command or agency on completion of the visit; such information will include the purpose, additional costs, funding cite, and services rendered.

(2) Funds available locally will be used for employment of professional consultants.

e. *Special services.* Purchase requests for consultant services will clearly state the specific services to be performed.

(1) When the services of a civilian consultant are desired on a one-time basis, a consultant appointment is not required. Services of these individuals may be obtained by contract under Misc Pub 28-24 and Misc Pub 28-25.

(2) A contract can be negotiated locally by the contracting officer when—

(a) The services required are non-personal.

(b) An end product is involved.

(3) Contracts for consultant services that are purely personal in nature will be submitted through contracting channels for advance approval under Misc Pub 28-25, paragraph 22-205. Determinations and findings will be prepared under Misc Pub 28-24, paragraph 22-205.

Appendix A References

Section I

Required Publications

DODI 6015.5

Joint Use of Military Health and Medical Facilities and Services. Cited in paragraph 2-11a. This publication may be obtained from Commander, US Naval Publications and Forms Center (ATTN: Code 301), 581 Tabor Ave., Philadelphia, PA 19120.)

AR 5-3

Installation Management and Organization. Cited in paragraph 2-8b.

AR 10-5

Department of the Army. Cited in paragraphs 1-5d and 1-6a(2).

AR 10-6

Branches of the Army. Cited in paragraphs 2-2b(6), 2-6b(5), 2-11c, 2-15b, 2-18b, and 2-21b.

AR 10-43

US Army Health Services Command. Cited in paragraph 2-2b(4).

AR 27-40

Litigation. Cited in paragraphs 1-7c and c(2), (3), and (4).

AR 40-3

Medical, Dental, and Veterinary Care. Cited in paragraphs 1-7b(1), 1-8e(1), 4-2b(11), and 4-2c(11).

AR 40-6

Army Nurse Corps. Cited in paragraph 2-18b.

AR 40-48

Health Care Extenders. Cited in paragraph 3-1c and 3-2c.

AR 40-121

Uniformed Services Health Benefits Program. Cited in paragraphs 1-7b(1) and B-5a.

AR 40-330

Rate Codes and General Policies for Army Medical Department Activities. Cited in paragraph 4-4d.

AR 351-3

Professional Training of Army Medical Department Personnel. Cited in paragraphs 4-3c(2)(a) and (b).

AR 570-4

Manpower Management. Cited in paragraph 4-1c.

AR 600-20

Army Command Policy and Procedures. Cited in paragraphs 1-7d and 1-9a, b, c, and d.

AR 600-50

Standards of Conduct for Department of the Army Personnel. Cited in paragraphs 1-7d and 1-8e(3).

AR 601-270

Armed Forces Examining and Entrance Stations. Cited in paragraph 1-6i.

AR 611-101

Commissioned Officer Specialty Classification System. Cited in paragraphs 2-2b(6), 2-6b(5), 2-11c, 2-15b, 2-18b, and 2-21b.

AR 611-112

Manual of Warrant Officer Military Occupational Specialties. Cited in paragraphs 3-1b(1)(a), 3-2b, and 3-3b(7).

AR 611-201

Enlisted Career Management Fields and Military Occupational Specialties. Cited in paragraph 1-6g.

AR 630-5

Leave, Passes, Permissive Temporary Duty, and Public Holidays. Cited in paragraph B-4b.

Misc Pub 13-1

DOD Military Pay and Allowances Entitlements Manual. Cited in paragraphs 4-2f(1) and B-4b.

Misc Pub 28-24

Defense Acquisition Regulation. Cited in paragraphs 4-2h(1)(a) and (2)(a) and 4-4e(1) and (3).

Misc Pub 28-25

Army Defense Acquisition Regulation Supplement (ADARS). Cited in paragraph 4-2g and h(1)(a) and (2)(a) and 4-4e(1) and (3).

FPM, chapter 304

Federal Personnel Manual, US Civil Service Commission. Cited in paragraph 4-3a.

FPM, chapter 732

Federal Personnel Manual, US Civil Service Commission. Cited in paragraph 4-4a(2)(a).

CPR A-9

Employment of Experts and Consultants. Cited in paragraphs 4-3a and 4-4a(2)(a) and (b).

OPM HDBK X-118

Qualification of Standards for Position Under the General Schedule. Cited in paragraph E-2.

HQDA Ltr (Sngl Address to MACOMs) (Current FY)

Staffing Authorization and Utilization of Army Medical Department Personnel in Active Component MTOE Unite of US Army Forces Command (FORSCOM) (Short Title: MEDO Letter). Cited in paragraphs 2-16d.

Section II

Related Publications

This section contains no entries.

Section III

Prescribed Forms

This section contains no entries.

Section IV

Referenced Forms

This section contains no entries.

Appendix B

SUGGESTED STATEMENT OF WORK FOR FULL-TIME CONTRACT SURGEON CONTRACT (DUTIES TO BE PERFORMED AT A GOVERNMENT FACILITY)

B-1. Scope of contract.

a. The contractor agrees, during the term of this contract, to perform for and on behalf of the Government the duties of a contract surgeons, US Army, under—

(1) The laws and regulations in effect on the execution of this contract, and as they may be amended from time to time.

(2) Duty assignments specified by the contracting officer or his or her duly authorized representative. Services rendered to eligible personnel will be at no expense to the individual.

b. The contractor will not, while on duty, advise, recommend, or suggest to persons authorized to receive medical care at Army expense that such persons should receive medical care from—

(1) The contractor when he or she is not on duty.

(2) A civilian associated in practice with the contractor. An exception will be unless such medical care will be furnished without cost to the patient, the Government, or any other person or firm.

c. The contractor is not prohibited, by reason of employment under this contract, from conducting a private medical practice, if the following prevail:

(1) No conflict with the performance of duties under the contract exists.

(2) Practice is not conducted during the regular hours established under this contract, during which the contractor is required to render services to the Government.

(3) The contractor makes no use of any Government facilities or other Government property in connection with this contract.

B-2. Duty hours.

The contractor will be on duty at _____

(name and location of medical facility)

on a full-time basis, 40 hours per week, for performance under this contract, in accordance with duties prescribed by this contract and a schedule mutually agreed upon between the contractor and the contracting officer. This schedule may be changed from time to time by mutual agreement.

B-3. Duties.

a. The contractor agrees to perform the service which a Medical Corps officer with similar training and experience normally would be called on to perform while in a similar duty assignment. The contractor's professional and administrative duties will consist of providing health services as specified in this contract, under the control and general supervision of the contracting officer or designated representative.

b. The contractor further agrees to be on call for emergencies at any time. Duty performed as a result of an emergency situation will be credited against the number of hours specified in the contract, when feasible; however, duty performed as a result of emergency situation, in excess of the number of hours specified in contract will not be the subject of additional compensation.

c. The contractor will maintain proper medical records on all military and dependent personnel to whom treatment is provided. The contractor will prepare such additional records and reports, when requested, as would be required of officers of the Army Medical Department charged with the same professional or administrative responsibilities.

d. Specific duties to be performed will include those shown below.

Note. Duties shown below are suggested for guidance. They may be modified, deleted, or supplemented as appropriate to the specific position.)

(1) Sick call service to military personnel on active duty at _____

(name and location of installation concerned)

(2) Sick call service to eligible dependents of such military personnel. (Only applicable when care is also furnished to military.)

(3) Pre-school and pre-athletic examinations, as required.

(4) Administration of vaccines and immunizing agents furnished by the US Government.

(5) Planning and administration of the Army Occupational or Industrial Health Program.

(6) Direction of special preventive medicine programs such as vision or hearing programs and chest X-ray surveys.

(7) Conducting sanitary inspections; submission of appropriate recommendations to concerned commanders.

(8) Other duties appropriate for performance by a contract surgeon as directed or assigned by the contracting officer or duly authorized representative.

B-4. Compensation.

a. For the satisfactory performance of the services required under this contract, the contractor will be paid the basic pay, basic allowances, and other allowances of a commissioned officer in pay grade O3 with over 4, but not more than 6, years of service, as authorized under section 421(a), title 37, United States Code. The contractor's entitlement to pay continues during periods of authorized leave. Special and incentive pays may not be included in the contracts for part-time or full-time contract surgeons.

b. The laws and regulations as to leave of absence for commissioned officers, as they will exist from time to time, will govern leaves and absences of the contractor. The contractor is not entitled to sick leave as such under AR 630-5. (This paragraph may be omitted if leave is not authorized. See Misc Pub 13-1, part four, chap 6.)

c. Subject to a above, the contracting officer will assure that payments are made monthly during the period at the rate of \$_____ per month on SF Form 1034 (Public Voucher for Purchases and Services Other Than Personal), directed to the finance and accounting officer. This contract must be presented at the time of payment for appropriate notation as to the payment made, together with a statement signed by the contracting officer that services have been satisfactorily rendered under terms of this contract.

B-5. Exclusions.

This contract does not include—

a. Medical and surgical care of dependents of military personnel who are hospitalized, or receiving treatment, under conditions that provide a basis for separate reimbursement in accordance with the dependents' medical care under AR 40-121.

b. Routine medical and surgical care of dependents or military personnel involving house calls, furnishing medication, or other care which is considered to be other than office or sick call service.

c. Provision of medicines or medical supplies other than those—

(1) Normally furnished as part of office or sick call treatment.

(2) For which no additional charge is made, unless otherwise provided for by contract.

Appendix C SUGGESTED STATEMENT OF WORK FOR PART-TIME CONTRACT SURGEON CONTRACT DUTIES TO BE PERFORMED AT A GOVERNMENT FACILITY

C-1. Scope of contract.

See paragraph B-1.

C-2. Duty hours.

The contractor will be on duty for the medical treatment of eligible military personnel and their dependents at _____

from _____

(name and location of medical facility)

hours to _____ hours on _____ (days of week)

C-3. Duties.

a. See paragraph B-3a

b. The contractor further agrees to be on call for emergencies in situations when no other physician employee is available. Duty performed as a result of an emergency situation will be credited against the number of hours specified in the contract, when feasible; however, duty performed as a result of an emergency situation, in excess of the number of hours specified in the contract, will not be the subject of additional compensation.

- c. See paragraph B-3c.
- d. See paragraph B-3d.

C-4. Compensation.

a. The Government will pay the contractor the sum of \$_____ for the satisfactory performance of services described in and required by this contract. (Compensation is limited under AR 40-1, para 4-2f.) Special and incentive pays may not be included in the contracts for part-time and full-time contract surgeons.

b. Same as paragraph B-4c.

C-5. Exclusions.

See paragraph B-5.

**Appendix D
SUGGESTED STATEMENT OF WORK FOR
PART-TIME CONTRACT SURGEON CONTRACT
DUTIES TO BE PERFORMED OUTSIDE
GOVERNMENT FURNISHED FACILITY**

Note. The statement of work will follow the suggested format in app C for a part-time contract surgeon who performs at a Government facility. Exceptions and additions are shown below.

</paratext>

D-1. Duty hours.

Add to the end of paragraph C-2, duty hours, the address at which the contractor will be on duty for the purpose of this contract.

D-2. Duties.

Under paragraph C-3d, Duties, those duties to be performed by the contractor will be specified in detail, since supervision by the Government will not be feasible.

D-3. Additional provisions.

The following additional provisions will be included as a separate subparagraph to paragraph C-3, Duties:

- a. A requirement for furnishing drugs and medications or medical supplies from Government sources. Restrictions as to types and quantities of such items will be clearly set forth and procedures for resupply specified.
- b. Methods established to determine eligibility for care.
- c. Instructions for referral of patients to service medical treatment facilities for further evaluation or hospitalization.

**Appendix E
PROCESSING PROCEDURES FOR APPLICATIONS
FOR EMPLOYMENT AS SOCIAL WORKERS AND
PSYCHOLOGISTS**

E-1. General.

a. To insure uniformity of professional standards and a high degree of professional competency, this appendix provides procedures for the processing of applications of civilian personnel for employment or placement in the position of Social Workers, GS-185, or Psychologists, GS-180. These will include those whose duties will be concerned, all or in part, with research activities.

b. Civil Service personnel employed as social workers and psychologists will be under the direction and responsibility of the commander of the installation or MTF on whose TDA the position is authorized. They will be guided in their utilization by overall policies established by TSG.

E-2. Qualifications.

The qualification standards for the position of Social Worker and

Psychologist as set forth in OPM HDBK X-118, will be observed. These are minimum standards; fullest efforts will be made to locate candidates who, for the position of social worker, hold a master's degree in social work. For the position of psychologist, individuals must hold an acceptable doctoral degree in clinical or counseling psychology with an American Psychological Association (APA)-approved internship in clinical psychology if they are to do clinical work. If they do research work they must hold a doctoral degree in psychology in an appropriate specialty. The degree in clinical, counseling, or other sub-specialties of psychology must be from a school accredited by the APA or otherwise acceptable to TSG or the regional psychology consultant (when specifically designated for that purpose).

E-3. Procedure.

Applications for Civil Service positions in social work and psychology will be screened by the commander of the installation or MTF on whose TDA to position is authorized. After determination of the best qualified applicants, and before employment and placement in positions as social workers and psychologists, an appraisal of professional qualifications and an approval of the appointments will be obtained from HQDA(DASG-PSC), WASH DC 20310. For positions that are on medical TDA within the continental United States (CONUS), Alaska, Hawaii, Panama, 7th Medical Command, and 8th Medical Command (Provisional), approval will be obtained from the medical command social worker or psychology consultant, when specifically authorized by OTSG, together with HQDA(DASG-PSC), WASH DC 20310. Forwarded recommendations will be accompanied by—

- a. Complete SF 171 (Application for Federal Employment).
- b. Official transcript of all graduate work completed by the applicant toward professional training.
- c. Written appraisal of the applicant's professional performance by at least three former supervisors or employers familiar with the applicant's work. Letters should contain relevant and specific information regarding individual's qualifications for the position to be filled.

**Appendix F
SUGGESTED REQUEST FOR OFF-DUTY
REMUNERATIVE PROFESSIONAL CIVILIAN
EMPLOYMENT**

FROM: _____ GRADE: _____
name (last, first, middle)
BRANCH: _____ SERVICE: _____
TO: COMMANDER

(activity)

SUBJECT: Request for Off-Duty Remunerative Professional Civilian Employment

F-1. In accordance with AR 40-1, paragraph 1-8, I request permission to engage in remunerative professional civilian employment apart from my assigned military duties. I have attached a statement from the local medical, dental, or other applicable association indicating no objection to my professional employment in the community.

- a. Type of employment and nature of work: _____
- b. Beginning date: _____
- c. Hours per day: _____ Number of days per week: _____
- TOTAL hours per week: _____
- d. Location of work: _____

(name and address of employer)

Telephone number at place of employment: _____

F-2. I understand the provisions of AR 40-1, paragraph 1-8 concerning off-duty employment and I agree to conduct any off-duty employment activities in accordance with those provisions. Further, I understand that—

a. It is my obligation to inform my commanding officer in writing of any deviation in my off-duty employment from my proposal, as set forth in this letter, before the inception of such change.

b. No outside responsibilities will be assumed that will in any manner compromise the effective discharge of my duties as an officer in the US Army Medical Department, both as to number of hours devoted to outside work and my individual limit and capacity.

c. A copy of this proposal may be forwarded to the Office of The Surgeon General of the US Army, HQDA(DASG-PSZ), WASH DC 20310.

F-3. I recognize that I am prohibited from, and cannot in good conscience assume, the primary responsibility as an individual practicing health care, provide for the care and critically ill or injured patients on a continuing basis as this will inevitably result in the compromise of my responsibility to the patient on the one hand, or the primacy of my military obligation on the other hand.

requester (signature)

date

1st Ind

FROM: Commander

TO: Requester

Subject request is _____ approved

_____ not approved Reasons: _____

signature (commander)

(date)

Glossary

Section I Abbreviations

ADL
Area Dental Laboratory

AMEDD
Army Medical Department

AMSC
Army Medical Specialist Corps

ANC
Army Nurse Corps

AOD
administrative officer of the day

ARNG
Army National Guard

AUTOVON
automatic voice network

CG
Commanding General

CIVPERSINS
Civilian Personnel Information System

CPR
Civilian Personnel Regulation

DC
Dental Corps

DDS
Director of Dental Services

DEA
Drug Enforcement Agency

DENTAC
dental activity

DHS
Director of Health Services

DOD
Department of Defense

FPM
Federal Personnel Manual

HSC
US Army Health Services Command

HQ
Headquarters

HQDA
Headquarters, Department of the Army

MACOM
major Army command

MC
Medical Corps

MEDCEN
US Army medical center

MEDDAC
medical department activity

MOS
military occupational specialty

MSC
Medical Service Corps

MTF
medical treatment facility

NAC
National Agency Check

OTSG
Officer of The Surgeon General

PA
physician assistant

R&D
research and development

RDTE
research, development, test, and evaluation

SDO
staff duty officer

SSI
specialty skills identifier

TDA
table of distribution and allowances

TJAG
The Judge Advocate General

TOE
table of organization and equipment

TSG
The Surgeon General

USAR
US Army Reserve

VC
Veterinary Corps

Section II
Terms
This section contains no entries.

Section III
Special Abbreviations and Terms
This section contains no entries.

Army Regulation 15-6

Boards, Commissions, and Committees

Procedures for Investigating Officers and Boards of Officers

Headquarters
Department of the Army
Washington, DC
2 October 2006

UNCLASSIFIED

TABC

TAB C

SUMMARY of CHANGE

AR 15-6

Procedures for Investigating Officers and Boards of Officers

This rapid action revision, dated 2 October 2006--

- o Clarifies the distinction between levels of appointing authorities for hostile fire death investigations and friendly fire death investigations (para 2-1a(3)).
- o Permits the general court-martial convening authority to delegate appointing authority to the special court-martial convening authority in hostile fire death investigations (para 2-1a(3)).

This regulation, dated 30 September 1996--

- o Is a complete revision of the earlier regulation dated 24 August 1977.
- o Updates policies and procedures concerning the procedures for investigating officers and boards of officers.

Boards, Commissions, and Committees

Procedures for Investigating Officers and Boards of Officers

By Order of the Secretary of the Army:

PETER J. SCHOOMAKER
General, United States Army
Chief of Staff

Official:


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

History. This publication is a rapid action revision. The portions affected by this rapid action revision are listed in the summary of change.

Summary. This regulation establishes procedures for investigations and boards of officers not specifically authorized by any other directive.

Applicability. This regulation applies to the Active Army, the Army National Guard/Army National Guard of the United States, and the U.S. Army Reserve, unless otherwise stated. During mobilization,

chapters and policies contained in this regulation may be modified by the proponent.

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

Army management control process. This regulation does not contain management control provisions.

Supplementation. Supplementation of

this regulation and establishment of command and local forms are prohibited without prior approval from HQDA (DAJA-AL), Washington, DC 20310-2212.

Suggested improvements. The proponent agency of this regulation is the Office of The Judge Advocate General. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) directly to HQDA (DAJA-AL), Washington, DC 20310-2212.

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

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*This regulation supersedes AR 15-6 dated 30 September 1996.

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Chapter 1 Introduction

1-1. Purpose

This regulation establishes procedures for investigations and boards of officers not specifically authorized by any other directive. This regulation or any part of it may be made applicable to investigations or boards that are authorized by another directive, but only by specific provision in that directive or in the memorandum of appointment. In case of a conflict between the provisions of this regulation, when made applicable, and the provisions of the specific directive authorizing the investigation or board, the latter will govern. Even when not specifically made applicable, this regulation may be used as a general guide for investigations or boards authorized by another directive, but in that case its provisions are not mandatory.

1-2. References

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

1-3. Explanation of abbreviations and terms

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

1-4. Responsibilities

Responsibilities are listed in chapter 2.

1-5. Types of investigations and boards

a. General. An administrative fact-finding procedure under this regulation may be designated an investigation or a board of officers. The proceedings may be informal (chap 4) or formal (chap 5). Proceedings that involve a single investigating officer using informal procedures are designated investigations. Proceedings that involve more than one investigating officer using formal or informal procedures or a single investigating officer using formal procedures are designated a board of officers.

b. Selection of procedure.

(1) In determining whether to use informal or formal procedures, the appointing authority will consider these among other factors:

(a) Purpose of the inquiry.

(b) Seriousness of the subject matter.

(c) Complexity of issues involved.

(d) Need for documentation.

(e) Desirability of providing a comprehensive hearing for persons whose conduct or performance of duty is being investigated. (See paras 1-8, 4-3, and 5-4a.)

(2) Regardless of the purpose of the investigation, even if it is to inquire into the conduct or performance of a particular individual, formal procedures are not mandatory unless required by other applicable regulations or directed by higher authority.

(3) Unless formal procedures are expressly required, either by the directive authorizing the board or by the memorandum of appointment, all cases to which this regulation applies will use informal procedures.

(4) In determining which procedures to use, the appointing authority will seek the advice of the servicing judge advocate (JA).

(5) Before opening an investigation involving allegations against general officers or senior executive service civilians, the requirements of Army Regulation (AR) 20-1, subparagraph 8-3i(3) must be met.

c. Preliminary investigations. Even when formal procedures are contemplated, a preliminary informal investigation may be advisable to ascertain the magnitude of the problem, to identify and interview witnesses, and to summarize or record their statements. The formal board may then draw upon the results of the preliminary investigation.

d. Concurrent investigations. An administrative fact finding procedure under this regulation, whether designated as an investigation or a board of officers, may be conducted before, concurrently with, or after an investigation into the same or related matters by another command or agency, consistent with subparagraph *b(5)* above. Appointing authorities, investigating officers, and boards of officers will ensure that procedures under this regulation do not hinder or interfere with a concurrent investigation directed by higher headquarters, a counterintelligence investigation or an investigation being conducted by a criminal investigative. In cases of concurrent or subsequent investigations, coordination, coordination with the other command or agency will be made to avoid duplication of investigative effort, where possible.

1-6. Function of investigations and boards

The primary function of any investigation or board of officers is to ascertain facts and to report them to the appointing authority. It is the duty of the investigating officer or board to ascertain and consider the evidence on all sides of each

issue, thoroughly and impartially, and to make findings and recommendations that are warranted by the facts and that comply with the instructions of the appointing authority.

1-7. Interested persons

Appointing authorities have a right to use investigations and boards to obtain information necessary or useful in carrying out their official responsibilities. The fact that an individual may have an interest in the matter under investigation or that the information may reflect adversely on that individual does not require that the proceedings constitute a hearing for that individual.

1-8. Respondents

In formal investigations the appointing authority may designate one or more persons as respondents in the investigation. Such a designation has significant procedural implications. (See chap 5, sec II, in general, and para 5-4a, in particular.) Respondents may not be designated in informal investigations.

1-9. Use of results of investigations in adverse administrative actions

a. This regulation does not require that an investigation be conducted before adverse administrative action, such as relief for cause, can be taken against an individual. However, if an investigation is conducted using the procedures of this regulation, the information obtained, including findings and recommendations, may be used in any administrative action against an individual, whether or not that individual was designated a respondent, and whether formal or informal procedures were used, subject to the limitations of *b* and *c* below.

b. The Office of Personnel Management and Army Regulations establish rules for adverse actions against Army civilian personnel and establish the procedural safeguards. In every case involving contemplated formal disciplinary action against civilian employees, the servicing civilian personnel office and labor counselor will be consulted before the employee is notified of the contemplated adverse action.

c. Except as provided in *d* below, when adverse administrative action is contemplated against an individual (other than a civilian employee, see *b* above), including an individual designated as a respondent, based upon information obtained as a result of an investigation or board conducted pursuant to this regulation, the appropriate military authority must observe the following minimum safeguards before taking final action against the individual:

(1) Notify the person in writing of the proposed adverse action and provide a copy, if not previously provided, of that part of the findings and recommendations of the investigation or board and the supporting evidence on which the proposed adverse action is based.

(2) Give the person a reasonable opportunity to reply in writing and to submit relevant rebuttal material.

(3) Review and evaluate the person's response.

d. There is no requirement to refer the investigation to the individual if the adverse action contemplated is prescribed in regulations or other directives that provide procedural safeguards, such as notice to the individual and opportunity to respond. For example, there is no requirement to refer an investigation conducted under this regulation to a soldier prior to giving the soldier an adverse evaluation report based upon the investigation because the regulations governing evaluation reports provide the necessary procedural safeguards.

e. When the investigation or board is conducted pursuant to this regulation but the contemplated administrative action is prescribed by a different regulation or directive with more stringent procedural safeguards than those in *c* above, the more stringent safeguards must be observed.

Chapter 2 Responsibilities of the Appointing Authority

2-1. Appointment

a. Authority to appoint. The following people may appoint investigations or boards to inquire into matters within their areas of responsibility.

(1) Except as noted in subparagraph 2-1a(3) below, the following individuals may appoint a formal investigation or board (chap 5) after consultation with the servicing judge advocate (JA) or legal advisor (LA):

(a) Any general court-martial (GCM) or special court-martial convening authority, including those who exercise that authority for administrative purposes only.

(b) Any general officer.

(c) Any commander or principal staff officer in the grade of colonel or above at the installation, activity, or unit level.

(d) Any State adjutant general.

(e) A Department of the Army civilian supervisor permanently assigned to a position graded as a general schedule

(GS)/general management, grade 14 or above and who is assigned as the head of an Army agency or activity or as a division or department chief.

(2) Except as noted in subparagraph 2-1a(3), the following individuals may appoint an informal investigation or board (chap 4):

- (a) Any officer authorized to appoint a formal board.
- (b) A commander at any level.
- (c) A principal staff officer or supervisor in the grade of major or above.

(3) Only a general court-martial convening authority may appoint a formal investigation or board (chap 5) or an informal investigation or board (chap 4) for incidents resulting in property damage of \$1,000,000 or more, the loss or destruction of an Army aircraft or missile, an injury and/or illness resulting in, or likely to result in, permanent total disability, the death of one or more persons, and the death of one or more persons by fratricide/friendly fire.

(a) For investigations of a death or deaths involving a deployed force(s), from what is believed to be hostile fire, the general court-martial convening authority may delegate, in writing, appointing/approval authority to a subordinate commander exercising special court-martial convening authority. This authority may not be further delegated.

(b) If evidence is discovered during a hostile fire investigation that indicates that the death(s) may have been the result of fratricide/friendly fire, the investigating officer will immediately suspend the investigation and inform the appointing authority and legal advisor. At this time the general court-martial convening authority will appoint a new investigation into the fratricide/friendly fire incident. Any evidence from the hostile fire investigation may be provided to the investigating officer or board conducting the fratricide/friendly fire investigation.

(4) Appointing authorities who are general officers may delegate the selection of board members to members of their staffs.

(5) When more than one appointing authority has an interest in the matter requiring investigation, a single investigation or board will be conducted whenever practicable. In case of doubt or disagreement as to who will appoint the investigation or board, the first common superior of all organizations concerned will resolve the issue.

(6) Appointing authorities may request, through channels, that persons from outside their organizations serve on boards or conduct investigations under their jurisdictions.

b. Method of appointment. Informal investigations and boards may be appointed orally or in writing. Formal boards will be appointed in writing but, when necessary, may be appointed orally and later confirmed in writing. Any written appointment will be in the form of a memorandum of appointment. (See figs 2-1 through 2-5.) Whether oral or written, the appointment will specify clearly the purpose and scope of the investigation or board and the nature of the findings and recommendations required. If the appointment is made under a specific directive, that directive will be cited. If the procedures of this regulation are intended to apply, the appointment will cite this regulation and, in the case of a board, specify whether it is to be informal or formal. (Refer to chaps 4 and 5.) Any special instructions (for example, requirement for verbatim record or designation of respondents in formal investigations) will be included.

c. Who may be appointed. Investigating officers and board members shall be those persons who, in the opinion of the appointing authority, are best qualified for the duty by reason of their education, training, experience, length of service and temperament.

(1) Except as provided in paragraph 5-1e, only commissioned officers, warrant officers, or Department of the Army civilian employees permanently assigned to a position graded as a GS-13 or above will be appointed as investigating officers or voting members of boards.

(2) Recorders, legal advisors, and persons with special technical knowledge may be appointed to formal boards in a nonvoting capacity. (See para 5-1.)

(3) An investigating officer or voting member of a board will be senior to any person whose conduct or performance of duty may be investigated, or against whom adverse findings or recommendations that may be made, except when the appointing authority determines that it is impracticable because of military exigencies. Inconvenience in obtaining an investigating officer or the unavailability of senior persons within the appointing authority's organization would not normally be considered military exigencies.

(a) The investigating officer or board president will, subject to the approval of the appointing authority, determine the relative seniority of military and civilian personnel. Actual superior/subordinate relationships, relative duty requirements, and other sources may be used as guidance. Except where a material adverse effect on an individual's substantial rights results, the appointing authority's determination of seniority shall be final (see para 2-3c).

(b) An investigating officer or voting member of a board who, during the proceedings, discovers that the completion thereof requires examining the conduct or performance of duty of, or may result in findings or recommendations adverse to, a person senior to him or her will report this fact to the board president or the appointing authority. The appointing authority will then appoint another person, senior to the person affected, who will either replace the investigating officer or member, or conduct a separate inquiry into the matters pertaining to that person. Where necessary, the new investigating officer or board may be furnished any evidence properly considered by the previous investigating officer or board.

(c) If the appointing authority determines that military exigencies make these alternatives impracticable, the appointing authority may direct the investigating officer or member to continue. In formal proceedings, this direction will be

written and will be an enclosure to the report of proceedings. If the appointing authority does not become aware of the problem until the results of the investigation are presented for review and action, the case will be returned for new or supplemental investigation only where specific prejudice is found to exist.

(4) Specific regulations may require that investigating officers or board members be military officers, be professionally certified, or possess an appropriate security clearance.

(Appropriate letterhead)

OFFICE SYMBOL DATE

MEMORANDUM FOR: *(President)*

SUBJECT: Appointment of Board of Officers

1. A board of officers is hereby appointed pursuant to AR 735-5 and AR 15-6 to investigate the circumstances connected with the loss, damage, or destruction of the property listed on reports of survey referred to the board and to determine responsibility for the loss, damage, or destruction of such property.

2. The following members are appointed to the board:

MAJ Robert A. Jones, HHC, 3d Bn, 1st Inf Bde, 20th Inf Div, Ft Blank, WD 88888 Member (President)

CPT Paul R. Wisniewski, Co A, 2d Bn, 3d Inf Bde, 20th Inf Div, Ft Blank, WD 88888 Member

CPT David B. Braun, Co C, 1st Bn, 3d Inf Bde, 20th Inf Div, Ft Blank, WD 88888 Member

CPT John C. Solomon, HHC, 2d S & T Bn, DISCOM 20th Inf Div, Ft Blank, WD 88888 Alternate member (see AR 15-6, para 5-2c)

1LT Steven T. Jefferson, Co B, 2d Bn, 2d Inf Bde, 20th Inf Div, Ft Blank, WD 88888 Recorder (without vote)

3. The board will meet at the call of the President. It will use the procedures set forth in AR 735-5 and AR 15-6 applicable to formal boards with respondents. Respondents will be referred to the board by separate correspondence.

4. Reports of proceedings will be summarized (the findings and recommendations will be verbatim) and submitted to this headquarters, ATTN: ABCD-AG-PA. Reports will be submitted within 3 working days of the conclusion of each case. The Adjutant General's office will furnish necessary administrative support for the board. Legal advice will be obtained, as needed, from the Staff Judge Advocate's office.

5. The board will serve until further notice.

(Authority Line)

(Signature block)

CF: *(Provide copy to board personnel)*

Figure 2-1. Sample memorandum for appointment of a standing board of officers using formal procedures

(Appropriate letterhead)

OFFICE SYMBOL DATE

MEMORANDUM FOR: (President of standing board)

SUBJECT: Referral of Respondent

1. Reference memorandum, this headquarters, dated (day-month-year), subject: Appointment of Board of Officers.
2. (Enter rank, name, SSN, and unit) is hereby designated a respondent before the board appointed by the referenced memorandum. The board will consider whether (enter name of respondent) should be held pecuniarily liable for the loss, damage, or destruction of the property listed on the attached report of survey. The correspondence and supporting documentation recommending referral to a board of officers are enclosed.
3. (Enter rank, name, branch, and unit) is designated counsel for (enter name of respondent).
4. For the consideration of this case only, (enter rank, name, and unit) is designated a voting member of the board, vice (enter rank, name, and unit).

(Authority line)

Encl

(Signature block)

CF: (Provide copy to board personnel, counsel, and respondent)

Figure 2-2. Sample memorandum for referral of a respondent to a standing board

(Appropriate letterhead)

OFFICE SYMBOL DATE

MEMORANDUM FOR: (Officer concerned)

SUBJECT: Appointment as a Board of Officers to Investigate Alleged Corruption and Mismanagement

1. You are hereby appointed a board of officers, pursuant to AR 15-6, to investigate allegations of (enter subject matter to be investigated, such as corruption and mismanagement in the office of the Fort Blank Provost Marshal). The scope of your investigation will include (mention specific matters to be investigated, such as whether military police personnel are properly processing traffic tickets, whether supervisory personnel are receiving money or other personal favors from subordinate personnel in return for tolerating the improper processing of traffic tickets, and so forth). Enclosed herewith is a report of proceedings of an earlier informal investigation into alleged improper processing of traffic tickets that was discontinued when it appeared that supervisory personnel may have been involved.
2. As the board, you will use formal procedures under AR 15-6. (Enter duty positions, ranks, and names) are designated respondents. Additional respondents may be designated based on your recommendations during the course of the investigation. Counsel for each respondent, if requested, will be designated by subsequent correspondence.
3. (Enter rank, name, branch, and unit) will serve as legal advisor to you, the board. (Enter rank, name, duty position, and unit), with the concurrence of (his/her) commander, will serve as an advisory member of the board. The office of the adjutant general, this headquarters, will provide necessary administrative support. The Fort Blank Resident Office, Criminal Investigation Division Command (CIDC), will provide technical support, including preserving physical evidence, if needed.
4. Prepare the report of proceedings on DA Form 1574 and submit it to me within 60 days.

(Signature of appointing authority)

CF: (Provide copy to all parties concerned)

Figure 2-3. Sample memorandum for appointment of a single officer as a board of officers, with legal advisor and advisory member, using formal procedures

(Appropriate letterhead)

OFFICE SYMBOL DATE

MEMORANDUM FOR: (Officer concerned)

SUBJECT: Appointment of Investigating Officer

1. You are hereby appointed an investigating officer pursuant to AR 15-6 and AR 210-7, paragraph 4-3, to conduct an informal investigation into complaints that sales representatives of the Fly-By-Night Sales Company have been conducting door-to-door solicitation in the River Bend family housing area in violation of AR 210-7. Details pertaining to the reported violations are in the enclosed file prepared by the Commercial Solicitation Branch, Office of the Adjutant General, this headquarters (Encl).

2. In your investigation, all witness statements will be sworn. From the evidence, you will make findings whether the Fly-By-Night Sales Company has violated AR 210-7 and recommend whether to initiate a show cause hearing pursuant to AR 210-7, paragraph 4-5, and whether to temporarily suspend the company's or individual agents' solicitation privileges pending completion of the show cause hearing.

3. Submit your findings and recommendations in four copies on DA Form 1574 to this headquarters. ATTN: ABCD-AG, within 7 days.

(Authority line)

Encl

(Signature block)

Figure 2-4. Sample memorandum for appointment of an investigating officer under AR 15-6 and other directives

(Appropriate letterhead)

OFFICE SYMBOL DATE

MEMORANDUM FOR: (Officer concerned)

SUBJECT: Appointment as Investigating Officer

1. You are hereby appointed an investigating officer pursuant to AR 15-6 and AR 380-5, paragraph 10-8, to investigate the circumstances surrounding the discovery of a CONFIDENTIAL document in a trash can in the office of the 3d Battalion S-3 on 31 August 1987. A preliminary inquiry into the incident proved inconclusive (see enclosed report).

2. In your investigation, use informal procedures under AR 15-6. You will make findings as to whether security compromise has occurred, who was responsible for any security violation, and whether existing security procedures are adequate.

3. This incident has no known suspects at this time. If in the course of your investigation you come to suspect that certain people may be responsible for the security violation, you must advise them of their rights under the UCMJ, Article 31, or the Fifth Amendment, as appropriate. In addition, you must provide them a Privacy Act statement before you solicit any (further) personal information. You may obtain assistance with these legal matters from the office of the Staff Judge Advocate.

4. Submit your findings and recommendations on DA Form 1574 to the Brigade S-2 within 10 days.

(Authority line)

(Signature block)

Figure 2-5. Sample memorandum for appointment of an investigating officer in a case with potential Privacy Act implications

2-2. Administrative support

The appointing authority will arrange necessary facilities, clerical assistance, and other administrative support for investigating officers and boards of officers. If not required by another directive, a verbatim transcript of the proceedings may be authorized only by The Judge Advocate General (TJAG) or the GCM convening authority in his or her sole discretion. However, before authorization, the GCM convening authority will consult the staff judge advocate (SJA). A contract reporter may be employed only for a formal board and only if authorized by the specific directive under which the board is appointed. A contract reporter will not be employed if a military or Department of the Army

(DA) civilian employee reporter is reasonably available. The servicing JA will determine the availability of a military or DA civilian employee reporter.

2-3. Action of the appointing authority

a. Basis of decision. Unless otherwise provided by another directive, the appointing authority is neither bound nor limited by the findings or recommendations of an investigation or board. Therefore, the appointing authority may take action less favorable than that recommended with regard to a respondent or other individual, unless the specific directive under which the investigation or board is appointed provides otherwise. The appointing authority may consider any relevant information in making a decision to take adverse action against an individual, even information that was not considered at the investigation or board (see para 1-9c and d). In all investigations involving fratricide/friendly fire incidents (see AR 385-40), the appointing authority, after taking action on the investigation, will forward a copy of the completed investigation to the next higher Army headquarters for review.

b. Legal review. Other directives that authorize investigations or boards may require the appointing authority to refer the report of proceedings to the servicing JA for legal review. The appointing authority will also seek legal review of all cases involving serious or complex matters, such as where the incident being investigated has resulted in death or serious bodily injury, or where the findings and recommendations may result in adverse administrative action (see para 1-9), or will be relied upon in actions by higher headquarters. The JA's review will determine—

- (1) Whether the proceedings comply with legal requirements.
- (2) What effects any errors would have.
- (3) Whether sufficient evidence supports the findings of the investigation or board or those substituted or added by the appointing authority (see para 3-10b).
- (4) Whether the recommendations are consistent with the findings.

c. Effect of errors. Generally, procedural errors or irregularities in an investigation or board do not invalidate the proceeding or any action based on it.

(1) *Harmless errors.* Harmless errors are defects in the procedures or proceedings that do not have a material adverse effect on an individual's substantial rights. If the appointing authority notes a harmless error, he or she may still take final action on the investigation.

(2) *Appointing errors.* Where an investigation is convened or directed by an official without the authority to do so (see para 2-1a), the proceedings are a nullity, unless an official with the authority to appoint such an investigation or board subsequently ratifies the appointment. Where a formal board is convened by an official authorized to convene an informal investigation or board but not authorized to convene formal investigations, any action not requiring a formal investigation may be taken, consistent with paragraph 1-9 and this paragraph.

(3) *Substantial errors.*

(a) Substantial errors are those that have a material adverse effect on an individual's substantial rights. Examples are the failure to meet requirements as to composition of the board or denial of a respondent's right to counsel.

(b) When such errors can be corrected without substantial prejudice to the individual concerned, the appointing authority may return the case to the same investigating officer or board for corrective action. Individuals or respondents who are affected by such a return will be notified of the error, of the proposed correction, and of their rights to comment on both.

(c) If the error cannot be corrected, or cannot be corrected without substantial prejudice to the individual concerned, the appointing authority may not use the affected part of that investigation or board as the basis for adverse action against that person. However, evidence considered by the investigation or board may be used in connection with any action under the Uniform Code of Military Justice (UCMJ), civilian personnel regulations, AR 600-37, or any other directive that contains its own procedural safeguards.

(d) In case of an error that cannot be corrected otherwise, the appointing authority may set aside all findings and recommendations and refer the entire case to a new investigating officer or board composed entirely of new voting members. Alternatively, the appointing authority may take action on findings and recommendations not affected by the error, set aside the affected findings and recommendations, and refer the affected portion of the case to a new investigating officer or board. In either case, the new investigating officer or board may be furnished any evidence properly considered by the previous one. The new investigating officer or board may also consider additional evidence. If the directive under which a board is appointed provides that the appointing authority may not take less favorable action than the board recommends, the appointing authority's action is limited by the original recommendations even though the case subsequently is referred to a new board which recommends less favorable action.

(4) *Failure to object.* No error is substantial within the meaning of this paragraph if there is a failure to object or otherwise bring the error to the attention of the legal advisor or the president of the board at the appropriate point in the proceedings. Accordingly, errors described in (3) above may be treated as harmless if the respondent fails to point them out.

Chapter 3 General Guidance for Investigating Officers and Boards

Section I Conduct of the Investigation

3-1. Preliminary responsibilities

Before beginning an informal investigation, an investigating officer shall review all written materials provided by the appointing authority and consult with the servicing staff or command judge advocate to obtain appropriate legal guidance.

3-2. Oaths

a. Requirement. Unless required by the specific directive under which appointed, investigating officers or board members need not be sworn. Reporters, interpreters, and witnesses appearing before a formal board will be sworn. Witnesses in an informal investigation or board may be sworn at the discretion of the investigating officer or president. The memorandum of appointment may require the swearing of witnesses or board members.

b. Administering oaths. An investigating officer, recorder (or assistant recorder), or board member is authorized to administer oaths in the performance of such duties, under UCMJ, Art. 136 (for military personnel administering oaths) and Section 303, Title 5, United States Code (5 USC 303) (for civilian personnel administering oaths) (see fig 3-1 for the format for oaths).

3-3. Challenges

Neither an investigating officer nor any member of a board is subject to challenge, except in a formal board as provided in paragraph 5-7. However, any person who is aware of facts indicating a lack of impartiality or other qualification on the part of an investigating officer or board member will present the facts to the appointing authority.

3-4. Counsel

Only a respondent is entitled to be represented by counsel (see para 5-6). Other interested parties may obtain counsel, at no expense to the Government, who may attend but not participate in proceedings of the investigation or board which are open to the public. The proceedings will not be unduly interrupted to allow the person to consult with counsel. When a civilian employee is a member of an appropriate bargaining unit, the exclusive representative of the unit has the right to be present whenever the employee is a respondent or witness during the proceedings if requested by the employee and if the employee reasonably believes that the inquiry could lead to disciplinary action against him or her (see para 3-8).

3-5. Decisions

A board composed of more than one member arrives at findings and recommendations as provided in section II of this chapter. A formal board decides challenges by a respondent as provided in paragraph 5-7. The investigating officer or president decides administrative matters, such as time of sessions, uniform, and recess. The legal advisor or, if none, the investigating officer or president decides evidentiary and procedural matters, such as motions, acceptance of evidence, and continuances. The legal advisor's decisions are final. Unless a voting member objects to the president's decision on an evidentiary or procedural matter at the time of the decision, it too is final. If there is such an objection, a vote will be taken in closed session, and the president's decision may be reversed by a majority vote of the voting members present.

3-6. Presence of the public and recording of proceedings

a. The public. Proceedings of an investigation or board are normally open to the public only if there is a respondent. However, if a question arises, the determination will be made based on the circumstances of the case. It may be appropriate to open proceedings to the public, even when there is no respondent, if the subject matter is of substantial public interest. It may be appropriate to exclude the public from at least some of the proceedings even though there is a respondent, if the subject matter is classified, inflammatory, or otherwise exceptionally sensitive. In any case, the appointing authority may specify whether the proceedings will be open or closed. If the appointing authority does not specify, the investigating officer or the president of the board decides. If there is a respondent, the servicing JA or the legal advisor, if any, will be consulted before deciding to exclude the public from any portion of the proceedings. Any proceedings that are open to the public will also be open to representatives of the news media.

b. Recording. Neither the public nor the news media will record, photograph, broadcast, or televise the board proceedings. A respondent may record proceedings only with the prior approval of the appointing authority.

Preliminary Matters

PRES: This hearing will come to order. This board of officers has been called to determine_____

When RESP is without counsel:_____

PRES: _____, you may, if you desire, obtain civilian counsel at no expense to the Government for this hearing. If you do not obtain civilian counsel, you are entitled to be represented by a military counsel designated by the appointing authority. Do you have counsel?

RESP: No (Yes).

If RESP has counsel, the RCDR should identify that counsel at this point for the record. If RESP does not have counsel, the PRES should ask this question:

PRES: Do you desire to have military counsel?

RESP: Yes (No).

If RESP answers "yes," the PRES should adjourn the hearing and ask the appointing authority to appoint counsel for RESP (see para 5-6b). If counsel is supplied, the RCDR should identify that counsel for the record when the board reconvenes.

A reporter and an interpreter, if used, should be sworn.

RCDR: The reporter will be sworn.

RCDR: Do you swear (or affirm) that you will faithfully perform the duties of reporter to this board, (so help you God)?

REPORTER: I do.

RCDR: The interpreter will be sworn.

RCDR: Do you swear (or affirm) that you will faithfully perform the duties of interpreter in the case now in hearing, (so help you God)?

INTERPRETER: I do.

RCDR: The board is appointed by Memorandum of Appointment, Headquarters, _____, dated _____. Have all members of the board read the memorandum of appointment? (If not, the memorandum of appointment is read aloud by RCDR or silently by any member who has not read it.)

When RESP has been designated by a separate memorandum of appointment, the same procedure applies to that memorandum of appointment.

RCDR: May the memorandum of appointment be attached to these proceedings as Enclosure 1?

PRES: The memorandum of appointment will be attached as requested.

RCDR: The following members of the board are present:

The following members are absent:

RCDR should account for all personnel of the board, including RESP and COUNSEL, if any, as present or absent at each session. RCDR should state the reason for any absence, if known, and whether the absence was authorized by the appointing authority.

PRES: _____, you may challenge any member of the board (or the legal advisor) for lack of impartiality. Do you desire to make a challenge?

Figure 3-1. Suggested procedure for board of officers with respondents

RESP (COUNSEL): No. (The respondent challenges _____.)

If RESP challenges for lack of impartiality, the LA, PRES, or next senior member, as appropriate, determines the challenge. See paragraph 5-7. If sustaining a challenge results in less than a quorum, the board should recess until additional members are added. See paragraph 5-2b.

RCDR swears board members, if required. PRES then swears RCDR, if required.

RCDR: The board will be sworn.

All persons in the room stand while RCDR administers the oath. Each voting member raises his or her right hand as RCDR calls his or her name in administering the following oath:

RCDR: Do you, Colonel _____, Lieutenant Colonel _____, Major _____, swear (affirm) that you will faithfully perform your duties as a member of this board; that you will impartially examine and inquire into the matter now before you according to the evidence, your conscience, and the laws and regulations provided; that you will make such findings of fact as are supported by the evidence of record; that, in determining those facts, you will use your professional knowledge, best judgment, and common sense; and that you will make such recommendations as are appropriate and warranted by your findings, according to the best of your understanding of the rules, regulations, policies, and customs of the service, guided by your concept of justice, both to the Government and to individuals concerned, (so help you God)?

MEMBERS: I do.

The board members lower their hands but remain standing while the oath is administered to LA and to RCDR, if required.

PRES: Do you _____, swear (or affirm) that you will faithfully perform the duties of (legal advisor) (recorder) of this board, (so help you God)?

LA/RCDR: I do.

All personnel now resume their seats.

PRES may now give general advice concerning applicable rules for the hearing.

RCDR: The respondent was notified of this hearing on _____ 19_____

RCDR presents a copy of the memorandum of notification with a certification that the original was delivered (or dispatched) to RESP (para 5-5) and requests that it be attached to the proceedings as Enclosure _____

PRES: The copy of the memorandum of notification will be attached as requested.

Presentation of Evidence by the Recorder

RCDR may make an opening statement at this point to clarify the expected presentation of evidence.

RCDR then calls witnesses and presents other evidence relevant to the subject of the proceedings. RCDR should logically present the facts to help the board understand what happened. Except as otherwise directed by PRES, RCDR may determine the order of presentation of facts. The following examples are intended to serve as a guide to the manner of presentation, but not to the sequence.

RCDR: I request that this statement of (witness) be marked Exhibit _____ and received in evidence. This witness will not appear in person because _____

LA (PRES): The statement will (not) be accepted.

RCDR may read the statement to the board if it is accepted.

RCDR: I request that this (documentary or real evidence) be marked as Exhibit _____ and received in evidence.

A foundation for the introduction of such evidence normally is established by a certificate or by testimony of a witness indicating its authenticity. LA (PRES) determines the adequacy of this foundation. If LA (PRES) has a reasonable basis to believe the evidence is what it purports to be, he or she may waive formal proof of authenticity.

Figure 3-1. Suggested procedure for board of officers with respondents—Continued

RCDR: The recorder and respondent have agreed to stipulate_____.

Before LA (PRES) accepts the stipulation, he or she should verify that RESP joins in the stipulation.

LA (PRES): The stipulation is accepted.

If the stipulation is in writing, it will be marked as an exhibit.

RCDR conducts direct examination of each witness called by RCDR or at the request of PRES or members. RESP or COUNSEL may then cross-examine the witness. PRES and members of the board may then question the witness, but PRES may control or limit questions by board members.

RCDR: The board calls_____ as a witness.

A military witness approaches and salutes PRES, then raises his or her right hand while RCDR administers the oath. A civilian witness does the same but without saluting. See MCM, Rules for Court-Martial 807, for further guidance with regard to oaths.

RCDR: Do you swear (or affirm) that the evidence you shall give in the case now in hearing shall be the truth, the whole truth, and nothing but the truth, (so help you God)?

If the witness desires to affirm rather than swear, the words "so help you God" will be omitted.

WITNESS: I do.

The witness then takes the witness chair. RCDR asks every witness the following question no matter who called the witness.

RCDR: What is your full name (grade, branch of service, organization, and station) (and address)?

Whenever it appears appropriate and advisable to do so, the board should explain the rights of a witness under Article 31 of the UCMJ or the Fifth Amendment to the Constitution. See paragraph 3-6c(5).

If the report of proceedings will be filed in a system of records under the witness's name, the board must advise that witness in accordance with the Privacy Act. See paragraph 3-7e. Normally, this requirement applies only to RESP.

RCDR then asks questions to develop the matter under consideration.

RCDR: The recorder has no further questions.

RESP (COUNSEL) may cross-examine the witness. RCDR may then conduct a redirect examination.

RCDR: Does the board have any questions?

Any board member wishing to question the witness should first secure the permission of PRES.

If RCDR and RESP (COUNSEL) wish to ask further questions after the board has examined the witness, they should seek permission from the PRES. PRES should normally grant such requests unless the questions are repetitive or go beyond the scope of questions asked by the board.

When all questioning has ended, PRES announces:

PRES: The witness is excused.

PRES may advise the witness as follows:

PRES: Do not discuss your testimony in this case with anyone other than the recorder, the respondent, or his or her counsel. If anyone else attempts to talk with you about your testimony, you should tell the person who originally called you as a witness.

Verbatim proceedings should indicate that the witness (except RESP) withdrew from the room.

Unless expressly excused from further attendance during the hearing, all witnesses remain subject to recall until the proceedings have ended. When a witness is recalled, the RCDR reminds such witness, after he or she has taken the witness stand:

RCDR: You are still under oath.

The procedure in the case of a witness called by the board is the same as outlined above for a witness called by RCDR.

Figure 3-1. Suggested procedure for board of officers with respondents—Continued

RCDR: I have nothing further to offer relating to the matter under consideration.

Presentation of Respondent's Evidence

RESP (COUNSEL): The respondent has (an) (no) opening statement.

RESP presents his or her stipulations, witnesses, and other evidence in the same manner as did RCDR. RCDR administers oath to all witnesses and asks the first question to identify the witness.

Should the RESP be called to the stand as a witness, the RCDR will administer the oath and ask the following preliminary questions, after which the procedure is the same as for other witnesses:

RCDR: What is your name, (grade, branch of service, organization, and station) (address, position, and place of employment)?

RESP: _____

RCDR: Are you the respondent in this case?

RESP: Yes.

The board may advise RESP of his or her rights under Article 31 of the UCMJ, or the Fifth Amendment of the Constitution. See paragraph 3-6c(5).

If the report of proceedings will be filed in a system of records under RESP's name, the board must advise RESP in accordance with the Privacy Act. See paragraph 3-7e.

When RESP has concluded his or her case, RESP announces:

RESP (COUNSEL): The respondent rests.

RCDR: The recorder has no further evidence to offer in this hearing. Does the board wish to have any witnesses called or recalled?

PRES: It does (not).

Closing Arguments and Deliberations

PRES: You may proceed with closing arguments. RCDR: The recorder (has no) (will make an) opening argument.

RCDR may make the opening argument and, if any argument is made on behalf of RESP, the rebuttal argument. Arguments are not required (see para 5-9). If no argument is made, RESP or RCDR may say:

RESP (COUNSEL)/RCDR: The (respondent) (recorder) submits the case without argument.

PRES: The hearing is adjourned.

Adjourning the hearing does not end the duties of the board. It must arrive at findings based on the evidence and make recommendations supported by those findings. See chapter 3, section II. Findings and recommendations need not be announced to RESP, but in certain proceedings, such as elimination actions, they customarily are. RCDR is responsible for compiling the report of proceedings and submitting properly authenticated copies thereof to the appointing authority. See chapter 3, section III.

Legend

PRES: President of the board of officers.

LA: Legal Advisor

LA(PRES): Legal Advisor, if one has been appointed; otherwise the board President.

RCDR: Recorder (junior member of the board if no recorder has been appointed). (If the board consists of only one member, that member has the responsibilities of both PRES and RCDR.)

RESP: Respondent.

RESP (COUNSEL): Respondent or respondent's counsel, if any.

Figure 3-1. Suggested procedure for board of officers with respondents—Continued

3-7. Rules of evidence and proof of facts

a. General. Proceedings under this regulation are administrative, not judicial. Therefore, an investigating officer or board of officers is not bound by the rules of evidence for trials by courts-martial or for court proceedings generally. Accordingly, subject only to the provisions of *c* below, anything that in the minds of reasonable persons is relevant and material to an issue may be accepted as evidence. For example, medical records, counseling statements, police reports, and other records may be considered regardless of whether the preparer of the record is available to give a statement or testify in person. All evidence will be given such weight as circumstances warrant. (See para 3-5 as to who decides whether to accept evidence.)

b. Official notice. Some facts are of such common knowledge that they need no specific evidence to prove them (for example, general facts and laws of nature, general facts of history, location of major elements of the Army, and organization of the Department of Defense (DOD) and its components), including matters of which judicial notice may be taken. (See Military Rules of Evidence (MRE) 201, sec II, part III, Manual for Courts-Martial, United States (MCM).)

c. Limitations. Administrative proceedings governed by this regulation generally are not subject to exclusionary or other evidentiary rules precluding the use of evidence. The following limitations, however, do apply:

(1) *Privileged communications.* MRE, section V, part III, MCM, concerning privileged communications between lawyer and client (MRE 502), privileged communications with clergy (MRE 503), and husband-wife privilege (MRE 504) apply. Present or former inspector general personnel will not be required to testify or provide evidence regarding information that they obtained while acting as inspectors general. They will not be required to disclose the contents of inspector general reports of investigations, inspections, inspector general action requests, or other memoranda, except as disclosure has been approved by the appropriate directing authority (an official authorized to direct that an inspector general investigation or inspection be conducted) or higher authority. (See AR 20-1, para 3-6.)

(2) *Polygraph tests.* No evidence of the results, taking, or refusal of a polygraph (lie detector) test will be considered without the consent of the person involved in such tests. In a formal board proceeding with a respondent, the agreement of the recorder and of any respondent affected is required before such evidence can be accepted.

(3) *"Off the record" statements.* Findings and recommendations of the investigating officer or board must be supported by evidence contained in the report. Accordingly, witnesses will not make statements "off the record" to board members in formal proceedings. Even in informal proceedings, such statements will not be considered for their substance, but only as help in finding additional evidence.

(4) *Statements regarding disease or injury.* A member of the Armed Forces will not be required to sign a statement relating to the origin, incurrence, or aggravation of a disease or injury that he or she has suffered. Any such statement against his or her interest is invalid (10 USC 1219) and may not be considered on the issue of the origin, incurrence, or aggravation of a disease or injury that the member concerned has suffered. A statement made and signed voluntarily by a soldier is not a statement that the soldier was "required to sign" within the meaning of this paragraph.

(5) *Ordering witnesses to testify.*

(a) No military witnesses or military respondents will be compelled to incriminate themselves, to answer any question the answer to which could incriminate them, or to make a statement or produce evidence that is not material to the issue and that might tend to degrade them (see UCMJ, Art. 31).

(b) No witnesses or respondents not subject to the UCMJ will be required to make a statement or produce evidence that would deprive them of rights against self-incrimination under the Fifth Amendment of the U.S. Constitution.

(c) A person refusing to provide information under (a) or (b) above must state specifically that the refusal is based on the protection afforded by UCMJ, Art. 31, or the Fifth Amendment. The investigating officer or board will, after consultation with the legal advisor or, if none has been appointed, the servicing JA, unless impractical to do so, decide whether the reason for refusal is well taken. If it is not, the witness may be ordered to answer.

(d) Whenever it appears appropriate and advisable, an investigating officer or board will explain their rights to witnesses or respondents. A soldier, for example, who is suspected of an offense under the UCMJ, such as dereliction of duty, will be advised of his or her rights under UCMJ, Art. 31, before being asked any questions concerning the suspected offense. The soldier will be given a reasonable amount of time to consult an attorney, if requested, before answering any such questions. No adverse inference will be drawn against soldiers who invoke that right under UCMJ, Art. 31. It is recommended that the procedure for explaining rights set forth on DA Form 3881 (Rights Warning Procedure/Waiver Certificate) be used.

(e) The right to invoke UCMJ, Art. 31, or the Fifth Amendment is personal. No one may assert the right for another person, and no one may assert it to protect anyone other than himself or herself. An answer tends to incriminate a person if it would make it appear that person is guilty of a crime.

(f) In certain cases the appropriate authority may provide a witness or respondent a grant of testimonial immunity

and require testimony notwithstanding UCMJ, Art. 31, or the Fifth Amendment. Grants of immunity will be made under the provisions of AR 27-10, chapter 2.

(6) *Involuntary admissions.* A confession or admission obtained by unlawful coercion or inducement likely to affect its truthfulness will not be accepted as evidence. The fact that a respondent was not advised of his or her rights under UCMJ, Art. 31, or the Fifth Amendment, or of his or her right to a lawyer does not, of itself, prevent acceptance of a confession or admission as evidence.

(7) *Bad faith unlawful searches.* If members of the Armed Forces acting in their official capacity (such as military police acting in furtherance of their official duties) conduct or direct a search that they know is unlawful under the Fourth Amendment of the U.S. Constitution, as applied to the military community, evidence obtained as a result of that search may not be accepted or considered against any respondent whose personal rights were violated by the search. Such evidence is acceptable only if it can reasonably be determined by the legal advisor or, if none, by the investigating officer or president that the evidence would inevitably have been discovered. In all other cases, evidence obtained as a result of any search or inspection may be accepted, even if it has been or would be ruled inadmissible in a criminal proceeding.

3-8. Witnesses

a. General.

(1) Investigating officers and boards generally do not have authority to subpoena witnesses to appear and testify. An appropriate commander or supervisor may, however, order military personnel and Federal civilian employees to appear and testify. Other civilians who agree to appear may be issued invitational travel orders in certain cases (see Joint Travel Regulations (JTR), vol 2, para C6000.11). The investigating officer or board president normally will inform witnesses of the nature of the investigation or board before taking their statements or testimony. The investigating officer or board president, assisted by the recorder and the legal advisor, if any, will protect every witness from improper questions, unnecessarily harsh or insulting treatment, and unnecessary inquiry into his or her private affairs. (See para 3-2 as to placing witnesses under oath.)

(2) During an investigation under this regulation, the exclusive representative of an appropriate bargaining unit has the right to be present whenever a civilian employee of the unit is a respondent or witness during the proceedings if requested by the employee and if the employee reasonably believes that the inquiry could lead to disciplinary action against him or her. Unless required by the collective bargaining agreement, there is no requirement to advise the employee of this right. If the employee requests the presence of the exclusive representative, a reasonable amount of time will be allowed to obtain him or her. The servicing civilian personnel office and labor counselor will be consulted before denying such a request.

b. *Attendance as spectators.* Witnesses other than respondents normally will not be present at the investigation or board proceedings except when they are testifying. In some cases, however, it is necessary to allow expert witnesses to hear evidence presented by other witnesses in order that they may be sufficiently advised of the facts to give informed testimony as to the technical aspects of the case. In such instances, the report of proceedings will indicate that the expert witnesses were present during the testimony of the other witnesses.

c. Taking testimony or statements.

(1) If a board is formal, or if the appointing authority has directed a verbatim record (see para 2-2), witnesses' statements will be elicited by questions and answers. However, narrative testimony may be used.

(2) In informal proceedings, statements of witnesses may be obtained at informal sessions in which they first relate their knowledge and then summarize those statements in writing. A tape recorder may be used to facilitate later preparation of written statements, but the witness will be informed if one is used. The investigating officer or board will assist the witness in preparing a written statement to avoid inclusion of irrelevant material or the omission of important facts and circumstances. However, care must be taken to ensure that the statement is phrased in the words of the witness. The interviewer must scrupulously avoid coaching the witness or suggesting the existence or nonexistence of material facts. The witness may be asked to read, correct, and sign the final statement.

(3) Whether the witness swears to the statement is within the discretion of the investigating officer or president. If the statement is to be sworn, use of DA Form 2823 (Sworn Statement) is recommended. If the witness is unavailable or refuses to sign, the person who took the statement will note, over his or her own signature, the reasons the witness has not signed and will certify that the statement is an accurate summary of what the witness said.

(4) Whether the proceeding is formal or informal, to save time and resources, witnesses may be asked to confirm written sworn or unsworn statements that have first been made exhibits. The witnesses remain subject to questioning on the substance of such statements.

(5) Although the direct testimony of witnesses is preferable, the investigating officer or board may use any previous statements of a witness as evidence on factual issues, whether or not the following conditions exist:

- (a) Proceedings are formal or informal.
- (b) Witness is determined to be unavailable.
- (c) Witness testifies.
- (d) Prior statements were sworn or unsworn.

(e) Prior statements were oral or written.

(f) Prior statements were taken during the course of the investigation.

d. Discussion of evidence. An investigating officer or board may direct witnesses who are subject to Army authority, and request other witnesses, not to discuss their statements or testimony with other witnesses or with persons who have no official interest in the proceedings until the investigation is complete. This precaution is appropriate to eliminate possible influence on the testimony of witnesses still to be heard. Witnesses may not be precluded from discussing any relevant matter with the recorder, a respondent, or counsel for a respondent.

e. Privacy Act statements.

(1) *When required.* A Privacy Act statement (AR 340-21) will be provided to a witness if the report of proceedings will be filed in a system of records from which it can be retrieved by reference to the name or other personal identifier of that witness. Unless otherwise informed by the appointing authority, an investigating officer or board may presume that the report of proceedings will be retrievable by the name of each person designated as a respondent, but that the report will not be retrievable by the name of any other witness. If any question arises as to the need for a Privacy Act statement, the investigating officer or board will consult the legal advisor, if any, or the servicing JA.

(2) *Method of providing statement.* Appendix B provides guidance for preparing Privacy Act statements. The statement may be written or oral, but it must be provided before taking the witness's testimony or statement. A written statement will be attached to the report of proceedings as an enclosure. An oral statement will be noted in the report either as part of a verbatim transcript or as an enclosure, in the form of a certificate by the officer who provided the Privacy Act statement.

(3) *Copy of the statement.* Anyone to whom this requirement applies is entitled to a copy of the Privacy Act statement in a form suitable for retention. Providing a respondent a copy of the part of the report of proceedings (see para 5-10) that includes the statement satisfies this requirement. Any other witness who is provided a Privacy Act statement will, on request, be furnished a copy of the statement in a form suitable for retention.

3-9. Communications with the appointing authority

If in the course of the investigation or board something happens that could cause the appointing authority to consider enlarging, restricting, or terminating the proceedings, altering the composition of the fact-finding body or otherwise modifying any instruction in the original appointment, the investigating officer or president of the board will report this situation to the appointing authority with recommendations.

Section II

Findings and Recommendations

3-10. Findings

a. General. A finding is a clear and concise statement of a fact that can be readily deduced from evidence in the record. It is directly established by evidence in the record or is a conclusion of fact by the investigating officer or board. Negative findings (for example, that the evidence does not establish a fact) are often appropriate. The number and nature of the findings required depend on the purpose of the investigation or board and on the instructions of the appointing authority. The investigating officer or board will normally not exceed the scope of findings indicated by the appointing authority. (See para 3-9.) The findings will be necessary and sufficient to support each recommendation.

b. Standard of proof. Unless another directive or an instruction of the appointing authority establishes a different standard, the findings of investigations and boards governed by this regulation must be supported by a greater weight of evidence than supports a contrary conclusion, that is, evidence which, after considering all evidence presented, points to a particular conclusion as being more credible and probable than any other conclusion. The weight of the evidence is not determined by the number of witnesses or volume of exhibits, but by considering all the evidence and evaluating such factors as the witness's demeanor, opportunity for knowledge, information possessed, ability to recall and relate events, and other indications of veracity.

c. Form. Findings will be stated to reflect clearly the relevant facts established by the evidence and the conclusions thereon of the investigating officer or board. If findings are required on only one subject, normally they will be stated in chronological order. If findings are required on several distinct subjects, they normally will be stated separately for each subject and chronologically within each one. If the investigation or board is authorized by a directive that establishes specific requirements for findings, those requirements must be satisfied.

3-11. Recommendations

The nature and extent of recommendations required also depend on the purpose of the investigation or board and on the instructions of the appointing authority. Each recommendation, even a negative one (for example, that no further action be taken) must be consistent with the findings. Investigating officers and boards will make their recommendations according to their understanding of the rules, regulations, policies, and customs of the service, guided by their concept of fairness both to the Government and to individuals.

3-12. Deliberation

After all the evidence has been received (and arguments heard, if there is a respondent), the investigating officer or board members will consider it carefully in light of any instructions contained in the original appointment and any supplemental instructions. These deliberations will (and if there is a respondent, must) be in closed session, that is, with only voting members present. Nonvoting members of the board do not participate in the board's deliberations but may be consulted. The respondent and the respondent's counsel, if any, will be afforded the opportunity to be present at such consultation. The board may request the legal advisor, if any, to assist in putting findings and recommendations in proper form after their substance has been adopted by the board. A respondent and counsel are not entitled to be present during such assistance.

3-13. Voting

A board composed of more than one voting member arrives at its findings and recommendations by voting. All voting members present must vote. After thoroughly considering and discussing all the evidence, the board will propose and vote on findings of fact. The board will next propose and vote on recommendations. If additional findings are necessary to support a proposed recommendation, the board will vote on such findings before voting on the related recommendation. Unless another directive or an instruction by the appointing authority establishes a different requirement, a majority vote of the voting members present determines questions before the board. In case of a tie vote, the president's vote is the determination of the board. Any member who does not agree with the findings or recommendations of the board may include a minority report in the report of proceedings, stating explicitly what part of the report he or she disagrees with and why. The minority report may include its own findings and/or recommendations.

Section III

Report of Proceedings

3-14. Format

a. Formal. If a verbatim record of the proceedings was directed, the transcript of those proceedings, with a completed DA Form 1574 (Report of Proceedings by Investigating Officer/Board of Officers) as an enclosure, and other enclosures and exhibits will constitute the report. In other formal boards, a completed DA Form 1574, with enclosures and exhibits, will constitute the report.

b. Informal. In an informal investigation or board, the report will be written unless the appointing authority has authorized an oral report. Written reports of informal investigations will use DA Form 1574; however, its use is not required unless specifically directed by the appointing authority. Every report—oral or written, on DA Form 1574 or not—will include findings and, unless the instructions of the appointing authority indicate otherwise, recommendations.

3-15. Enclosures

In written reports, all significant letters and other papers that relate to administrative aspects of the investigation or board and that are not evidence will be numbered consecutively with roman numerals and made enclosures, including such items as these:

a. The memorandum of appointment or, if the appointment was oral, a summary by the investigating officer or board including date of appointment, identification of the appointing authority and of all persons appointed, purpose of the investigation or board, and any special instructions.

b. Copies of the notice to any respondent (see para 5-5).

c. Copies of other correspondence with any respondent or counsel.

d. Written communications to or from the appointing authority (see para 3-8).

e. Privacy Act statements (see para 3-8e).

f. Explanation by the investigating officer or board of any unusual delays, difficulties, irregularities, or other problems encountered.

3-16. Exhibits

a. General. In written reports, every item of evidence offered to or received by the investigation or board will be marked as a separate exhibit. Unless a verbatim record was directed, statements or transcripts of testimony by witnesses will also be exhibits. Exhibits will be numbered consecutively as offered in evidence (even if not accepted), except that those submitted by each respondent will be lettered consecutively (and further identified by the name of the respondent, if more than one). Exhibits submitted but not admitted in evidence will be marked "Not admitted."

b. Real evidence. Because attaching real evidence (physical objects) to the report is usually impractical, clear and accurate descriptions (such as written statements) or depictions (such as photographs) authenticated by the investigating officer, recorder, or president may be substituted in the report. In any case, the real evidence itself will be preserved, including chain of custody, where appropriate, for use if further proceedings are necessary. The exhibit in the report will tell where the real evidence can be found. After final action has been taken in the case, the evidence will be disposed of as provided in AR 190-22, where applicable.

c. Documentary evidence. When the original of an official record or other document that must be returned is an exhibit, an accurate copy, authenticated by the investigating officer, recorder, or president, may be used in the written report. The exhibit in the report will tell where the original can be found.

d. Official notice. Matters of which the investigating officer or board took official notice (para 3-6b) normally need not be recorded in an exhibit. If, however, official notice is taken of a matter over the objection of a respondent or respondent's counsel, that fact will be noted in the written report of proceedings, and the investigating officer or board will include as an exhibit a statement of the matter of which official notice was taken.

e. Objections. In a formal board, if the respondent or counsel makes an objection during the proceedings, the objection and supporting reasons will be noted in the report of proceedings.

3-17. Authentication

Unless otherwise directed, a written report of proceedings will be authenticated by the signature of the investigating officer or of all voting members of the board and the recorder. Board members submitting a minority report (see para 3-13) may authenticate that report instead. If any voting member of the board or the recorder refuses or is unable to authenticate the report (for example, because of death, disability, or absence), the reason will be stated in the report where that authentication would otherwise appear.

3-18. Safeguarding a written report

a. When the report contains material that requires protection but does not have a security classification, the report will be marked "For Official Use Only" as provided by AR 25-55.

b. No one will disclose, release, or cause to be published any part of the report, except as required in the normal course of forwarding and staffing the report or as otherwise authorized by law or regulation, without the approval of the appointing authority.

3-19. Submission

A written report of proceedings will be submitted, in two complete copies, directly to the appointing authority or designee, unless the appointing authority or another directive provides otherwise. If there are respondents, an additional copy for each respondent will be submitted to the appointing authority.

3-20. Action of the appointing authority

The appointing authority will notify the investigating officer or president of the board if further action, such as taking further evidence or making additional findings or recommendations, is required. Such additional proceedings will be conducted under the provisions of the original appointing memorandum, including any modifications, and will be separately authenticated per paragraph 3-16. If applicable, the appointing authority will ensure that the provisions of paragraph 1-8 have been satisfied. (See para 2-3 for further guidance.)

Chapter 4 Informal Investigations and Boards of Officers

4-1. Composition

Informal procedures may be used by a single investigating officer or by a board of two or more members. (One officer is not designated a board unless procedures are formal.) All members are voting members. Appointment of advisory members or a legal advisor is unnecessary because persons with special expertise may be consulted informally whenever desired. The senior member present acts as president. There is no recorder. The president prescribes the duties of each member. A quorum is required only when voting on findings and recommendations. (See para 3-13.)

4-2. Procedure

An informal investigation or board may use whatever method it finds most efficient and effective for acquiring information. (See chap 3 for general guidance.) A board may divide witnesses, issues, or evidentiary aspects of the inquiry among its members for individual investigation and development, holding no collective meeting until ready to review all the information collected. Although witnesses may be called to present formal testimony, information also may be obtained by personal interview, correspondence, telephone inquiry, or other informal means.

4-3. Interested persons

Informal procedures are not intended to provide a hearing for persons who may have an interest in the subject of the investigation or board. No respondents will be designated and no one is entitled to the rights of a respondent. The

investigating officer or board may still make any relevant findings or recommendations, including those adverse to an individual or individuals.

Chapter 5 Formal Boards of Officers

Section I General

5-1. Members

a. Voting members. All members of a formal board of officers are voting members except as provided elsewhere in this paragraph, in other applicable directives, or in the memorandum of appointment.

b. President. The senior voting member present acts as president. The senior voting member appointed will be at least a major, except where the appointing authority determines that such appointment is impracticable because of military exigencies. The president has the following responsibilities:

- (1) *Administrative.* The president will—
 - (a) Preserve order.
 - (b) Determine time and uniform for sessions of the board.
 - (c) Recess or adjourn the board as necessary.
 - (d) Decide routine administrative matters necessary for efficient conduct of the business of the board.
 - (e) Supervise the recorder to ensure that all business of the board is properly conducted and that the report of proceedings is submitted promptly. If the board consists of only one member, that member has the responsibilities of both the president and the recorder.

(2) *Procedural.*

(a) When a legal advisor has been appointed, the legal advisor rules finally on matters set forth in paragraph *d* below.

(b) When a legal advisor has not been appointed, the president will rule on evidentiary and procedural matters. The ruling on any such matter (other than a challenge) may be reversed by majority vote of the voting members present. (See para 3-5.) If the president determines that he or she needs legal advice when ruling on evidentiary and procedural matters, he or she will contact the legal office that ordinarily provides legal advice to the appointing authority and ask that a JA or a civilian attorney who is a member of the Judge Advocate Legal Service be made available for legal consultation. When a respondent has been designated, the respondent and counsel will be afforded the opportunity to be present when the legal advice is provided.

c. Recorder. The memorandum of appointment may designate a commissioned or warrant officer as recorder. It may also designate assistant recorders, who may perform any duty the recorder may perform. A recorder or assistant recorder so designated is a nonvoting member of the board. If the memorandum of appointment does not designate a recorder, the junior member of the board acts as recorder and is a voting member.

d. Legal advisor.

(1) A legal advisor is a nonvoting member. He or she rules finally on challenges for cause made during the proceedings (except a challenge against the legal advisor (see para 5-7c)) and on all evidentiary and procedural matters (see para 3-5), but may not dismiss any question or issue before the board. In appropriate cases, the legal advisor may advise the board on legal and procedural matters. If a respondent has been designated, the respondent and counsel will be afforded the opportunity to be present when legal advice is provided to the board. If legal advice is not provided in person (for example, by telephone or in writing), the right to be "present" is satisfied by providing the opportunity to listen to or read the advice. The right to be present does not extend to general procedural advice given before the board initially convened, to legal advice provided before the respondent was designated, or to advice provided under paragraph 3-12.

(2) A JA or a civilian attorney who is a member of the Judge Advocate Legal Service may be appointed as legal advisor for a formal board of officers under the following circumstances:

- (a) TJAG authorizes the appointment.
- (b) Another directive applicable to the board requires the appointment.
- (c) The appointing authority is a GCM convening authority.
- (d) The appointing authority is other than a GCM convening authority, and a JA is assigned to his or her organization or a subordinate element thereof under an applicable table of organization and equipment or tables of distribution and allowances; or the appropriate GCM convening authority authorizes appointment of a legal adviser.

(3) Appointment of a legal advisor under this paragraph will occur only after consultation with the SJA of the GCM jurisdiction concerned. The SJA will then be responsible for providing or arranging for the legal advisor.

e. Members with special technical knowledge. Persons with special technical knowledge may be appointed as voting

members or, unless there is a respondent, as advisory members without vote. Such persons need not be commissioned or warrant officers. If appointed as advisory members, they need not participate in the board proceedings except as directed by the president. (See para 3-12 with regard to participation in the board's deliberations.) The report of proceedings will indicate the limited participation of an advisory member.

5-2. Attendance of members

a. General. Attendance at the proceedings of the board is the primary duty of each voting member and takes precedence over all other duties. A voting member must attend scheduled sessions of the board, if physically able, unless excused in advance by the appointing authority. If the appointing authority is a GCM convening authority or a commanding general with a legal advisor on his or her staff, the authority to excuse individual members before the first session of the board may be delegated to the SJA or legal advisor. The board may proceed even though a member is absent, provided the necessary quorum is present (see *d* below). If the recorder is absent, the assistant recorder, if any, or the junior member of the board will assume the duties of recorder. The board may then proceed at the discretion of the president.

b. Quorum. Unless another directive requires a larger number, a majority of the appointed voting members (other than nonparticipating alternate members) of a board constitutes a quorum and must be present at all sessions. If another directive prescribes specific qualifications for any voting member (for example, component, branch, or technical or professional qualifications), that member is essential to the quorum and must be present at all board sessions.

c. Alternate members. An unnecessarily large number of officers will not be appointed to a board of officers with the intention of using only those available at the time of the board's meeting. The memorandum of appointment may, however, designate alternate members to serve on the board, in the sequence listed, if necessary to constitute a quorum in the absence of a regular member. These alternate members may then be added to the board at the direction of the president without further consultation with the appointing authority. A member added thereby becomes a regular member with the same obligation to be present at all further proceedings of the board. (See subpara *a* above.)

d. Member not present at prior sessions. A member who has not been present at a prior session of the board, such as an absent member, an alternate member newly authorized to serve as a member, or a newly appointed member, may participate fully in all subsequent proceedings. The member must, however, become thoroughly familiar with the prior proceedings and the evidence. The report of proceedings will reflect how the member became familiar with the proceedings. Except as directed by the appointing authority, however, a member who was not available (because of having been excused or otherwise) for a substantial portion of the proceedings, as determined by the president, will no longer be considered a member of the board in that particular case, even if that member later becomes available to serve.

5-3. Duties of recorder

a. Before a session. The recorder is responsible for administrative preparation and support for the board and will perform the following duties before a session:

(1) Give timely notice of the time, place, and prescribed uniform for the session to all participants, including board members, witnesses, and, if any, legal advisor, respondent, counsel, reporter, and interpreter. Only the notice to a respondent required by paragraph 5-5 need be in writing. It is usually appropriate also to notify the commander or supervisor of each witness and respondent.

(2) Arrange for the presence of witnesses who are to testify in person, including attendance at Government expense of military personnel and civilian government employees ordered to appear and of other civilians voluntarily appearing pursuant to invitational travel orders. (See para 3-8a.)

(3) Ensure that the site for the session is adequate and in good order.

(4) Arrange for necessary personnel support (clerk, reporter, and interpreter), recording equipment, stationery, and other supplies.

(5) Arrange to have available all necessary Privacy Act statements and, with appropriate authentication, all required records, documents, and real evidence.

(6) Ensure, subject to security requirements, that all appropriate records and documents referred with the case are furnished to any respondent or counsel.

(7) Take whatever other action is necessary to ensure a prompt, full, and orderly presentation of the case.

b. During the session. The recorder will perform the following duties during the session:

(1) Read the memorandum of appointment at the initial session or determine that the participants have read it.

(2) Note for the record at the beginning of each session the presence or absence of the members of the board and, if any, the respondent and counsel.

(3) Administer oaths as necessary.

(4) Execute all orders of the board.

(5) Conduct the presentation of evidence and examination of witnesses to bring out all the facts.

c. After the proceedings. The recorder is responsible for the prompt and accurate preparation of the report of

proceedings, for the authentication of the completed report, and, whenever practicable, the hand-carried delivery of the report, including delivery to the appointing authority or designee.

Section II Respondents

5-4. Designation

a. General. A respondent may be designated when the appointing authority desires to provide a hearing for a person with a direct interest in the proceedings. The mere fact that an adverse finding may be made or adverse action recommended against a person, however, does not mean that he or she will be designated a respondent. The appointing authority decides whether to designate a person as a respondent except where designation of a respondent is—

- (1) Directed by authorities senior to the appointing authority; or
- (2) Required by other regulations or directives or where procedural protections available only to a respondent under this regulation are mandated by other regulations or directives.

b. Before proceedings. When it is decided at the time a formal board is appointed that a person will be designated a respondent, the designation will be made in the memorandum of appointment.

c. During the proceedings.

(1) If, during formal board proceedings, the legal advisor or the president decides that it would be advisable to designate a respondent, a recommendation with supporting information will be presented to the appointing authority.

(2) The appointing authority may designate a respondent at any point in the proceedings. A respondent so designated will be allowed a reasonable time to obtain counsel (see para 5-6) and to prepare for subsequent sessions.

(3) If a respondent is designated during the investigation, the record of proceedings and all evidence received by the board to that point will be made available to the newly designated respondent and counsel. The respondent may request that witnesses who have previously testified be recalled for cross-examination. If circumstances do not permit recalling a witness, a written statement may be obtained. In the absence of compelling justification, the proceedings will not be delayed pending the obtaining of such statement. Any testimony given by a person as a witness may be considered even if that witness is subsequently designated a respondent.

5-5. Notice

The recorder will, at a reasonable time in advance of the first session of the board concerning a respondent (including a respondent designated during the proceedings), provide that respondent a copy of all unclassified documents in the case file and a letter of notification. In the absence of special circumstances or a different period established by the directive authorizing the board, a "reasonable time" is 5 working days. The letter of notification will include the following information:

- a.* The date, hour, and place of the session and the appropriate military uniform, if applicable.
- b.* The matter to be investigated, including specific allegations, in sufficient detail to enable the respondent to prepare.
- c.* The respondent's rights with regard to counsel. (See para 5-6.)
- d.* The name and address of each witness expected to be called.
- e.* The respondent's rights to be present, present evidence, and call witnesses. (See para 5-8a.)
- f.* (Only if the board involves classified matters.) The respondent and counsel may examine relevant classified materials on request and, if necessary, the recorder will assist in arranging clearance or access. (See AR 380-67.)

5-6. Counsel

a. Entitlement. A respondent is entitled to have counsel and, to the extent permitted by security classification, to be present with counsel at all open sessions of the board. Counsel may also be provided for the limited purpose of taking a witness's statement or testimony, if respondent has not yet obtained counsel. An appointed counsel will be furnished only to civilian employees or members of the military.

b. Who may act.

(1) *Civilian counsel.* Any respondent may be represented by civilian counsel not employed by and at no expense to the Government. A Government civilian employee may not act as counsel for compensation or if it would be inconsistent with faithful performance of regular duties. (See 18 USC 205.) In addition, a DA civilian employee may act as counsel only while on leave or outside normal hours of employment, except when acting as the exclusive representative of the bargaining unit pursuant to 5 USC 7114(a)(2)(B). (See para 3-4.)

(2) *Military counsel for military respondents.* A military respondent who does not retain a civilian counsel is entitled to be represented by a military counsel designated by the appointing authority. A respondent who declines the services of a qualified designated counsel is not entitled to have a different counsel designated.

(3) *Military counsel for civilian respondents.* In boards appointed under the authority of this regulation, Federal civilian employees, including those of nonappropriated fund instrumentalities, will be provided a military counsel under

the same conditions and procedures as if they were military respondents, unless they are entitled to be assisted by an exclusive representative of an appropriate bargaining unit.

c. Delay. Whenever practicable, the board proceedings will be held in abeyance pending respondent's reasonable and diligent efforts to obtain civilian counsel. However, the proceedings will not be delayed unduly to permit a respondent to obtain a particular counsel or to accommodate the schedule of such counsel.

d. Qualifications. Counsel will be sufficiently mature and experienced to be of genuine assistance to the respondent. Unless specified by the directive under which the board is appointed, counsel is not required to be a lawyer.

e. Independence. No counsel for a respondent will be censured, reprimanded, admonished, coerced, or rated less favorably as a result of the lawful and ethical performance of duties or the zeal with which he or she represents the respondent. Any question concerning the propriety of a counsel's conduct in the performance of his or her duty will be referred to the servicing JA.

5-7. Challenges for cause

a. Right of respondent. A respondent is entitled to have the matter at issue decided by a board composed of impartial members. A respondent may challenge for cause the legal advisor and any voting member of the board who does not meet that standard. Lack of impartiality is the only basis on which a challenge for cause may be made at the board proceedings. Any other matter affecting the qualification of a board member may be brought to the attention of the appointing authority. (See para 3-3.)

b. Making a challenge. A challenge will be made as soon as the respondent or counsel is aware that grounds exist; failure to do so normally will constitute a waiver. If possible, all challenges and grounds will be communicated to the appointing authority before the board convenes. When the board convenes, the respondent or counsel may question members of the board to determine whether to make a challenge. Such questions must relate directly to the issue of impartiality. Discretion will be used, however, to avoid revealing prejudicial matters to other members of the board; if a challenge is made after the board convenes, only the name of the challenged member will be indicated in open session, not the reason for believing the member is not impartial.

c. Deciding challenges. The appointing authority decides any challenge to a board of officers composed of a single member and may decide other challenges made before the board convenes. Otherwise, a challenge is decided by the legal advisor or, if none or if the legal advisor is challenged, by the president. If there is no legal advisor and the president is challenged, that challenge is decided by the next senior voting member.

d. Procedure. Challenges for lack of impartiality not decided by the appointing authority will be heard and decided at a session of the board attended by the legal advisor, the president or the next senior member who will decide the challenge, the member challenged, the respondent and his or her counsel, and the recorder. The respondent or counsel making the challenge may question the challenged member and present any other evidence to support the challenge. The recorder also may present evidence on the issue. The member who is to decide the challenge may question the challenged member and any other witness and may direct the recorder to present additional evidence. If more than one member is challenged at a time, each challenge will be decided independently, in descending order of the challenged members' ranks.

e. Sustained challenge. If the person deciding a challenge sustains it, he or she will excuse the challenged member from the board at once, and that person will no longer be a member of the board. If this excusal prevents a quorum (see para 5-2b), the board will adjourn to allow the addition of another member; otherwise, proceedings will continue.

5-8. Presentation of evidence

a. Rights of respondent. Except for good cause shown in the report of proceedings, a respondent is entitled to be present, with counsel, at all open sessions of the board that deal with any matter concerning the respondent. The respondent may—

- (1) Examine and object to the introduction of real and documentary evidence, including written statements.
- (2) Object to the testimony of witnesses and cross-examine witnesses other than the respondent's own.
- (3) Call witnesses and otherwise introduce evidence.
- (4) Testify as a witness; however, no adverse inference may be drawn from the exercise of the privilege against self-incrimination. (See para 3-7c(5).)

b. Assistance.

(1) Upon receipt of a timely written request, and except as provided in (4) below, the recorder will assist the respondent in obtaining documentary and real evidence in possession of the Government and in arranging for the presence of witnesses for the respondent.

(2) Except as provided in subparagraph (4) below, the respondent is entitled to compulsory attendance at Government expense of witnesses who are soldiers or Federal civilian employees, to authorized reimbursement of expenses of other civilian witnesses who voluntarily appear in response to invitational travel orders, and to official cooperation in obtaining access to evidence in possession of the Government, to the same extent as is the recorder on behalf of the Government. If the recorder, however, believes any witness's testimony or other evidence requested by the respondent is irrelevant or unnecessarily cumulative or that its significance is disproportionate to the delay, expense, or difficulty

in obtaining it, the recorder will submit the respondent's request to the legal advisor or president (see para 3-5), who will decide whether the recorder will comply with the request. Denial of the request does not preclude the respondent from obtaining the evidence or witness without the recorder's assistance and at no expense to the Government.

(3) Nothing in this paragraph relieves a respondent or counsel from the obligation to exercise due diligence in preparing and presenting his or her own case. The fact that any evidence or witness desired by the respondent is not reasonably available normally is not a basis for terminating or invalidating the proceedings.

(4) Evidence that is privileged within the meaning of paragraph 3-7c(1) will not be provided to a respondent or counsel unless the recorder intends to introduce such evidence to the board and has obtained approval to do so.

5-9. Argument

After all evidence has been received, the recorder and the respondent or counsel may make a final statement or argument. The recorder may make the opening argument and, if argument is made on behalf of a respondent, the closing argument in rebuttal.

5-10. After the hearing

Upon approval or other action on the report of proceedings by the appointing authority, the respondent or counsel will be provided a copy of the report, including all exhibits and enclosures that pertain to the respondent. Portions of the report, exhibits, and enclosures may be withheld from a respondent only as required by security classification or for other good cause determined by the appointing authority and explained to the respondent in writing.

Appendix A References

Section I

Required Publications

Military Rules of Evidence are found in the Manual for Courts-Martial, United States.

AR 20-1

Inspector General Activities and Procedures. (Cited in paras 1-5 and 3-7.)

AR 25-55

The Department of the Army Freedom of Information Act Program. (Cited in para 3-18.)

AR 27-10

Military Justice. (Cited in para 3-7 and app B.)

AR 195-5

Evidence Procedures. (Cited in para 3-16.)

AR 340-21

The Army Privacy Program. (Cited in para 3-8 and app B.)

AR 380-67

The Department of the Army Personnel Security Program. (Cited in para 5-5.)

JTR, vol. 2

(Cited in para 3-7.) (Available at <https://secureapp2.hqda.pentagon.mil/perdiem>.)

MCM 2005

See Military Rules of Evidence contained therein. (Cited in para 3-7.)

MRE 201

Judicial notice of adjudicative facts.

MRE 502

Lawyer-client privilege.

MRE 503

Communications to clergy.

MRE 504

Husband-wife privilege.

UCMJ, Art. 31

Compulsory self-incrimination prohibited

UCMJ, Art. 136

Authority to administer oaths and act as notary. (Cited in paras 1-3, 2-3, 3-2, and 3-7.) (Available from www.army.mil/references/UCMJ.)

UCMJ, Art. 138

Complaints of wrongs

Section II

Related Publications

A related publication is a source of additional information. The user does not have to read it to understand this regulation. United States Code is found at www.gpoaccess.gov/uscode.

AR 210-7

Commercial Solicitation on Army Installations

AR 380-5
Department of the Army Information Security Program

AR 385-40
Accident Reporting and Records

AR 600-8-14
Identification Cards for M

AR 600-37
Unfavorable Information

AR 735-5
Policies and Procedures for Property Accountability

5 USC 303
Oaths to witnesses

5 USC 7114
Representation rights and duties

10 USC 933
Conduct unbecoming an officer and a gentleman

10 USC 1219
Statement of origin of disease or injury: limitations

10 USC 3012
Department of the Army: seal

18 USC 205
Activities of offices and employees in claims against and other matters affecting the Government

U.S. Constitution, amend. 5
No person shall be held to answer for a capital, or otherwise infamous crime, unless on a presentment or indictment of a Grand Jury. . . .

**Section III
Prescribed Forms**

The following forms are available on the APD Web site (www.apd.army.mil) unless otherwise stated.

DA Form 1574
Report of Proceedings by Investigating Officer/Board of Officers. (Cited in para 3-14.)

**Section IV
Referenced Forms**

DA Form 2823
Sworn Statement

DA Form 3881
Rights Warning Procedure/Waiver Certificate

**Appendix B
Guidance for Preparing Privacy Act Statements**

B-1. General

- a. The Privacy Act requires that, whenever personal information is solicited from an individual and the information

will be filed so as to be retrievable by reference to the name or other personal identifier of the individual, he or she must be advised of the following information:

- (1) The authority for soliciting the information.
- (2) The principal purposes for which the information is intended to be used.
- (3) The routine uses that may be made of the information.
- (4) Whether disclosure is mandatory or voluntary.
- (5) The effect on the individual of not providing all or part of the information.

b. Each Privacy Act statement must be tailored to the matter being investigated and to the person being asked to provide information. The servicing JA will be consulted for assistance in preparing Privacy Act statements, as necessary.

B-2. Content

a. *Authority.* If a specific statute or executive order authorizes collection of the information, or authorizes performance of a function that necessitates collection of the information, the Privacy Act statement will cite it as the authority for solicitation. For example, if a commander appoints an investigating officer to inquire into a UCMJ, Art. 138, complaint under the provisions of AR 27-10, the statutory authority for solicitation of the information would be 10 USC 938. Regulations will not be cited as the authority. If no specific statute or executive order can be found, the authority to cite is 10 USC 3012.

b. *Principal purposes.* The statement of principal purposes will consist of a short statement of the reason the investigation is being conducted. The following examples apply to particular types of investigations:

(1) Administrative elimination proceeding under AR 635-200: "The purpose for soliciting this information is to provide the commander a basis for a determination regarding your retention on active duty and, if a determination is made not to retain you on active duty, the type of discharge to award."

(2) Investigation of a UCMJ, Art. 138, complaint: "The purpose for soliciting this information is to obtain facts and make recommendations to assist the commander in determining what action to take with regard to (your) (complainant's) UCMJ, Art 138, complaint."

(3) Investigation of a security violation: "The purpose for soliciting this information is to determine whether the security violation under investigation resulted in a compromise of national defense information, to fix responsibility for the violation, and to determine whether to change existing security procedures."

(4) Flying evaluation board pursuant to AR 600-107: "The purpose for soliciting this information is to provide the commander a basis for a determination regarding your flying status."

c. *Routine uses.* In order to advise an individual of what routine uses may be made of solicited information, it is necessary to identify the system of records in which the report of proceedings will be filed. The routine uses will be summarized from the system notice and from the routine uses of general applicability in AR 340-21. The routine use statement may be introduced as follows: "Any information you provide is disclosable to members of the Department of Defense who have a need for the information in the performance of their duties. In addition, the information may be disclosed to Government agencies outside of the Department of Defense as follows: (list of routine uses external to the Department of Defense)."

d. *Routine uses. Disclosure mandatory or voluntary; the effect of not providing information.*

Providing information is voluntary unless the individual may be ordered to testify. The following statement can be used in most situations:

(1) Respondent or other individual warned of his or her rights under the UCMJ, Art. 31, or the Fifth Amendment: "Providing the information is voluntary. There will be no adverse effect on you for not furnishing the information other than that certain information might not otherwise be available to the commander for his or her decision in this matter."

(2) Individual who may be ordered to testify: "Providing the information is mandatory. Failure to provide information could result in disciplinary or other adverse action against you under (the UCMJ or Army regulations) (civilian personnel regulations)."

2. *UCMJ, Art. 31 rights advisement.* If during the proceeding it is determined to advise an individual of his or her rights under the UCMJ, Art. 31, or the Fifth Amendment, after he or she has been told it is mandatory to provide information, the advising official must be certain that the individual understands that such rights warning supersedes this portion of the Privacy Act statement.

Glossary

Section I Abbreviations

AR

Army regulation

DA

Department of the Army

DOD

Department of Defense

GCM

general court-martial

GS

general schedule

JA

judge advocate

LA

legal advisor

MCM

Manual for Courts-Martial, United States, 2005

MRE

Military Rules of Evidence

SJA

staff judge advocate

TJAG

The Judge Advocate General

UCMJ

Uniform Code of Military Justice

USC

United States Code

Section II

Terms

Adverse administrative action

Adverse action taken by appropriate military authority against an individual other than actions taken pursuant to the UCMJ or MCM.

Military exigency

An emergency situation requiring prompt or immediate action to obtain and record facts.

Section III

Special Abbreviations and Terms

This section contains no entries.

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D

Army Regulation 10-87

Organization and Functions

**Army
Commands,
Army Service
Component
Commands, and
Direct Reporting
Units**

Headquarters
Department of the Army
Washington, DC
4 September 2007

UNCLASSIFIED

TABD

SUMMARY of CHANGE

AR 10-87

Army Commands, Army Service Component Commands, and Direct Reporting Units

This major revision dated 4 September 2007--

- o Shifts the Army organizational focus from major Army commands in the continental United States towards all primary Army organizations (throughout).
- o Removes the term major Army command and the acronym MACOM from the Army lexicon and designates each former major Army command as an Army Command, an Army Service Component Command of a combatant command or subunified command, or a Direct Reporting Unit (throughout).
- o Reorganizes the Department of the Army headquarters to more effectively support a leaner, more agile, modular force (throughout).
- o Recognizes the distinction at the Headquarters, Department of the Army level for Army Commands, Army Service Component Commands, and Direct Reporting Units by defining and aligning the responsibilities of each organization for executing policy and operations (throughout).
- o Recognizes the Armywide role and multidiscipline functions of the three Army Commands (U.S. Army Forces Command, U.S. Army Training and Doctrine Command, U.S. Army Materiel Command) (chaps 2, 3, and 4).
- o Recognizes the Theater Army as an Army Service Component Command, reporting directly to Department of the Army, and serving as the Army's single point of contact for combatant commands (para 1-1d(3) and chap 5 through chap 13).
- o Recognizes that Direct Reporting Units are Army organizations that provide broad general support to the Army in a single, unique discipline and exercise authorities as specified in regulation, policy, delegation, or other issuance (throughout).
- o Recognizes each organization's primary missions, functions, and command and staff relationships (throughout).
- o Recognizes for Headquarters, Department of the Army, and when specified Direct Reporting Units, the Administrative Assistant to the Secretary of the Army exercises the same authorities as commanders of Army Commands and Army Service Component Commands, as prescribed by regulation, policy, delegation, or other issuance (throughout).
- o Sets the conditions to implement business transformation processes to effectively and efficiently manage Army resources by formally establishing functional organizations that provide and manage Army operational support globally (throughout).

Headquarters
Department of the Army
Washington, DC
4 September 2007

*Army Regulation 10-87

Effective 4 October 2007

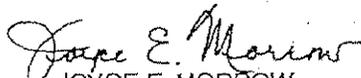
Organization and Functions

Army Commands, Army Service Component Commands, and Direct Reporting Units

By Order of the Secretary of the Army:

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

Official:


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

History. This publication is a major revision.

Summary. This publication reorganizes Army headquarters to more effectively support a leaner, more agile modular force. It distinguishes the differences in scope and responsibility of organizations. It recognizes the Armywide role and multidiscipline functions of the Army Commands; the Theater Army as an Army Service Component Command reporting directly to Department of the Army and serving as the Army's single point of contact for combatant commands; and the Direct Reporting Units as providing broad, general support to the Army in a normally single, unique discipline not otherwise available elsewhere in the Army. It identifies each organization's missions, functions, and command and staff relationships with higher and collateral headquarters and agencies.

Applicability. This regulation applies to the Active Army, the Army National Guard/Army National Guard of the United

States, and the U.S. Army Reserve unless otherwise stated.

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

Army management control process. This regulation contains management control provisions, but does not identify key management controls that must be evaluated.

Supplementation. Supplementation of this regulation and establishment of command and local forms are prohibited without prior approval from Director, Army Staff (DACs-ZD), 2800 Army Pentagon, Washington, DC 20310-0200.

Suggested improvements. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) directly to Director of the

Army Staff (DACs-DMC), 200 Army Pentagon, Washington, DC 20310-0200.

Committee Continuance Approval. The Department of the Army committee management officer concurs in the establishment and/or continuance of the committee(s) outlined herein, in accordance with AR 15-1, Committee Management. The AR 15-1 requires the proponent to justify establishing/continuing its committee(s), coordinate draft publications, and coordinate changes in committee status with the Department of the Army Committee Management Office, ATTN: SAAA-RP, Office of the Administrative Assistant, Resources and Programs Agency, 2511 Jefferson Davis Highway, Taylor Building, 13th Floor, Arlington, VA 22202-3926. Further, if it is determined that an established "group" identified within this regulation later takes on the characteristics of a committee, the proponent will follow all AR 15-1 requirements for establishing and continuing the group as a committee.

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

*This regulation supersedes AR 10-87, dated 30 October 1982.

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Glossary

Chapter 1 Introduction

1-1. Purpose

This regulation prescribes the missions, functions, and command and staff relationships with higher, collateral headquarters, theater-level support commands, and agencies in the Department of the Army (DA) for Army Commands (ACOMs), Army Service Component Commands (ASCCs), and Direct Reporting Units (DRUs). This regulation shall not infringe on the combatant command authority (COCOM) vested, by law, in combatant commanders (CCDRs) or alter the command relationships and authorities specified by the Secretary of Defense (SECDEF). The ASCCs shall address changes in force assignment with their supported combatant command in accordance with (IAW) procedures specified by the SECDEF. This regulation applies to the following Army organizations:

a. Army Commands.

(1) U.S. Army Forces Command (FORSCOM) (the FORSCOM is also an ASCC to the United States Joint Forces Command (USJFCOM)).

(2) U.S. Army Training and Doctrine Command (TRADOC).

(3) U.S. Army Materiel Command (AMC).

b. Army Service Component Commands.

(1) U.S. Army Europe (USAREUR).

(2) U.S. Army Central (USARCENT).

(3) U.S. Army North (USARNORTH).

(4) U.S. Army South (USARSO).

(5) U.S. Army Pacific (USARPAC).

(6) U.S. Army Special Operations Command (USASOC).

(7) Military Surface Deployment and Distribution Command (SDDC).

(8) U.S. Army Space and Missile Defense Command/Army Strategic Command (USASMDC/ARSTRAT).

(9) Eighth Army (EUSA).

c. Direct Reporting Units.

(1) U.S. Army Network Enterprise Technology Command/9th Signal Command (Army) (NETCOM/9th SC(A)).

(2) U.S. Army Medical Command (MEDCOM).

(3) U.S. Army Intelligence and Security Command (INSCOM).

(4) U.S. Army Criminal Investigation Command (USACIDC).

(5) U.S. Army Corps of Engineers (USACE).

(6) U.S. Army Military District of Washington (MDW).

(7) U.S. Army Test and Evaluation Command (ATEC).

(8) United States Military Academy (USMA).

(9) U.S. Army Reserve Command (USARC).

(10) U.S. Army Acquisition Support Center (USAASC).

(11) U.S. Army Installation Management Command (IMCOM).

d. General.

(1) For Headquarters, Department of the Army (HQDA), and when specified DRUs, the Administrative Assistant to the Secretary of the Army exercises the same authorities as commanders of ACOMs and ASCCs, as prescribed by regulation, policy, delegation, or other issuance.

(2) The DRUs shall exercise authorities as specified in regulation, policy, delegation, or other issuance.

(3) The ASCCs exercise command and control under the authority and direction of the combatant commanders to whom they are assigned and IAW the policies and procedures established by the SECDEF. In the event of a discrepancy between this regulation and the policies or procedures established by the SECDEF, the SECDEF policies or procedures takes precedence.

(4) HQDA, ACOMs, ASCCs, and DRUs contribute to the Title 10, United States Code (USC) support of all Army organizations through administrative control (ADCON).

(a) The ADCON relationship conveys the authority necessary to exercise the Secretary of the Army's (SA) Title 10 USC responsibilities as authorized. ADCON is the direction or exercise of authority over subordinate or other organizations in respect to administration and support, including organization of Service forces, control of resources and equipment, personnel management, unit logistics, individual and unit training, readiness, mobilization, demobilization, discipline, and other matters not included in the operational missions.

(b) In some cases, ADCON is shared by more than one Army organization to more efficiently and effectively support Army forces globally using the ACOMs and DRUs.

(c) All operational Army forces are assigned to combatant commands. CCDRs exercise COCOM over these forces. The CCDR normally delegates operational control (OPCON) of Army forces to the ASCC. ASCCs are generally

delegated ADCON by the SA for Army forces assigned to the CCDR; however, select Army units may be ADCON to an ACOM, DRU, or both, as well as the ASCC.

(d) Subject to applicable law, regulation, and policy, the allocation of authorities and responsibilities pertinent to the exercise of shared ADCON should be documented in appropriate agreements/understandings between the commanders of the ACOMs, ASCCs, and DRUs by which ADCON responsibilities are shared.

(5) The USARC performs Title 10 USC support to units with Army Reserve unit identification codes (UICs). Units with Active Army UICs receive Title 10 USC support from their respective Army organization. Units with Army National Guard (ARNG) UICs receive pre-mobilization support from HQDA through the National Guard Bureau (NGB) under Title 32 USC.

(6) The mission sections of this regulation supplement organizational mission statements in their respective DA General Orders.

1-2. References

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

1-3. Explanation of abbreviations and terms

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

Chapter 2

U.S. Army Forces Command

2-1. Mission

FORSCOM trains, mobilizes, deploys, sustains, transforms, and reconstitutes assigned conventional forces, providing relevant and ready land power to combatant commands. FORSCOM is also an operational level Army force designated by the SA as the ASCC to USJFCOM.

2-2. Functions

a. FORSCOM is designated by the SA as both an ACOM under the direction of HQDA and as the assigned ASCC to USJFCOM.

b. In its capacity as an ACOM, FORSCOM commands, controls, trains, sustains, deploys, transforms, and reconstitutes assigned forces. FORSCOM exercises ADCON of assigned forces through designated subordinate commands.

(1) FORSCOM is the Army's manager for Army Force Generation (ARFORGEN) the process by which the Army provides trained and ready conventional forces to combatant commanders.

(2) FORSCOM is the HQDA responsible agent for the continental United States (CONUS), the Commonwealth of Puerto Rico, and the Virgin Islands for mobilization, deployment, redeployment and demobilization planning and execution.

c. As the ASCC to USJFCOM, FORSCOM is the Army force provider for conventional Army forces.

(1) FORSCOM participates in Joint training, integration, concept development and experimentation, and transformation planning with other USJFCOM organizations.

(2) FORSCOM coordinates with applicable ACOMs, ASCCs, DRUs, other agencies, and USJFCOM, as required, to source validated force requirements for operations plans (OPLANs), contingency plans, and contingency operations.

(3) FORSCOM exercises ASCC OPCON responsibilities and authorities subject, by law, to the authority of the Commander, USJFCOM (COMUSJFCOM); FORSCOM exercises ACOM and ASCC ADCON authority and responsibilities on behalf of the SA.

2-3. Command and staff relationships

a. The Commander, FORSCOM, reports to the Chief of Staff, Army (CSA) for ACOM specific responsibilities, directives, authorities, policies, planning and programming guidance.

b. The Commander, FORSCOM is responsible to the SA for execution of assigned responsibilities contained in Section 3013(b), Title 10, United States Code (10 USC 3013(b)), 32 USC 105, and Active Army support for the training and readiness of the RC forces.

c. The Commander, FORSCOM reports to the COMUSJFCOM for operational and Joint training matters, and other matters for which USJFCOM is responsible.

d. The Commander, FORSCOM is authorized to communicate and coordinate directly with other ACOM, ASCC, or DRU commanders; HQDA; other Department of Defense (DOD) headquarters and agencies; and other Government departments, as required, on matters of mutual interest subject to procedures established by COMUSJFCOM pursuant to 10 USC 164(d).

h. NETCOM/9th SC(A) is dependent on other Army organizations and agencies for appropriate support and services per prescribed regulations and policies and maintains the following relationships:

(1) NETCOM/9th SC(A) coordinates requirements, doctrine, design changes, capabilities, modernization, and proposed missions and functions for theater-level signal forces.

(2) NETCOM/9th SC(A) coordinates the management of enterprise-level collaborative intelligence support and predictive analysis to NetOps and its IA component with primary focus on emerging threats.

(3) NETCOM/9th SC(A) collaborates with pertinent commands, the USARC, the materiel developer and responsible program manager for doctrine, fielding, integration, installation, new equipment training team, and sustainment of signal specific systems.

(4) NETCOM/9th SC(A), in conjunction with the USARC and ARNG, develops theater-level signal unit force design updates for TRADOC, influences modernization with HQDA, and coordinates military occupational specialty restructure initiatives with Human Resources Command and TRADOC. Relationships concerning Service responsibilities for RC units are regulated by MOUs.

(5) NETCOM/9th SC(A) advises and assists the USARC and ARNG in developing IDT and AT programs for RC signal units and personnel.

(6) NETCOM/9th SC(A) collaborates with the U.S. Army Corps of Engineers (USACE) on requirements for information and telecommunications in all facilities serviced by outside the CONUS DOIMs.

(7) NETCOM/9th SC(A) coordinates with INSCOM as required for the defense of the LWN.

(8) NETCOM/9th SC(A) for multicomponent SC(T) exercises a shared ADCON relationship with the ASCC and USARC. NETCOM/9th SC(A) exercises ADCON over forward stationed Active Army theater-level signal forces to include the Active Army element of the SC(T) and technical authority over all aspects of the LWN. NETCOM/9th SC(A) exercises C4/IT and NetOps enterprise control over all Army theater signal forces.

Chapter 15

U.S. Army Medical Command

15-1. Mission

MEDCOM provides medical, dental, and veterinary capabilities to the Army and designated DOD activities; operates fixed facilities; conducts medical research, materiel development, testing and evaluation; executes medical materiel acquisition programs as assigned by the Army Acquisition Executive; manages Army medical materiel; educates and trains personnel; and develops medical concepts, doctrine, and systems to support Army health care delivery.

15-2. Functions

a. MEDCOM is designated as a DRU by the SA and reports directly to The Surgeon General (TSG) of the Army.

b. MEDCOM is responsible for the planning and execution of DRU responsibilities by exercising specified ADCON of organic, assigned and attached Army forces.

c. MEDCOM advises supported commanders without adequate organic medical, dental, and veterinary capability for health services and health issues.

d. MEDCOM provides medical and dental care worldwide; coordinates Army health services for Army, civilian, and Federal health care resources in a given health service area; and conducts health care education, training and studies.

e. MEDCOM provides veterinary services for the Army and DOD.

f. MEDCOM manages and conducts activities concerning biomedical research and technology; regulatory compliance and quality; and medical advanced technology. Provides regulatory oversight of all Army research involving human subjects.

g. MEDCOM provides Armywide expertise and services in disease prevention and control; clinical and field preventive medicine, environmental and occupational health, health promotion and wellness, hearing conservation, epidemiology and disease surveillance, toxicology, and related laboratory sciences.

h. MEDCOM provides medical logistics, acquisition services, and materiel research, development, test, and evaluation to Army units and DOD components. Develops logistics policy for management, distribution, and storage of medical materiel and for medical equipment maintenance. Delivers Class VIII support for military health care operations.

i. MEDCOM is the proponent for, and implements, the Medical Professional Filler System.

j. MEDCOM trains the medical force, develops medical doctrine and future concepts; conducts combat developments; develops training devices, simulations, and publications; and manages medical force structure.

k. MEDCOM conducts life cycle management for Army medical information systems.

l. MEDCOM, in coordination with IMCOM, provides base operations support and installation management for MEDCOM and tenant activities at MEDCOM installations. MEDCOM, in coordination with TRICARE Management

Activity and USACE, manages acquisition of Army medical facilities funded by military construction (MILCON), Defense.

15-3. Command and staff relationships

a. TSG is dual hatted as the Commander, MEDCOM and is supervised by the CSA.

b. The Commander, MEDCOM is responsible to the SA for execution of assigned responsibilities contained in 10 USC 3013(b). The Commander, MEDCOM exercises ADCON authority and responsibility on behalf of the SA and in this regard is primarily responsible for the administration and support of Army forces worldwide for certain ADCON functions.

c. The Commander, MEDCOM is authorized to communicate and coordinate directly with ACOM, ASCC, or other DRU commanders; HQDA; other DOD headquarters and agencies; and other Government departments, as required, on matters of mutual interest subject to procedures established by CSA.

d. Commander, MEDCOM directs all Active Army health services activities involved in providing direct health care support within the prescribed geographical limits of responsibility; designates missions and levels of care to be provided by subordinate military treatment facilities; and determines manpower staffing standards and levels of staffing.

e. MEDCOM is dependent on other Army organizations and agencies for appropriate support and services per prescribed regulations and policies and maintains the following relationships:

(1) Coordinates with TRADOC on medical combat development functions and doctrinal concepts and systems for health services support to the Army in the field.

(2) Supervises and evaluates the performance of Army Medical Department RC units when training with MEDCOM activities.

(3) Administers the individual medical training programs for RC personnel performing Advanced Individual Training at MEDCOM activities.

(4) Provides doctrinal support for training and evaluation of both Active Army and RC medical units and individuals throughout the Army.

(5) Coordinates with TRICARE Management Activity to ensure integrated, standardized health care delivery.

(6) Coordinates with Defense Logistics Agency to develop and execute policies and procedures for medical logistics organizations pertaining to Theater Lead Agents for medical materiel.

f. For command relationships—

(1) Command relationships for operational Service forces are established by the SECDEF and applicable CCDRs.

(2) Pursuant to the direction of the SA, certain authorities and responsibilities for ADCON of Army forces assigned to a combatant command are shared by the Commander, MEDCOM; ACOMs; the ASCC of the combatant command; and other DRUs. Subject to applicable law, regulation, and policy, the allocation of authorities and responsibilities pertinent to the exercise of shared ADCON will be documented in appropriate agreements/understandings between the commanders of MEDCOM, ACOMs, the ASCC, and other DRUs as appropriate.

Chapter 16

U.S. Army Intelligence and Security Command

16-1. Mission

a. INSCOM synchronizes the operations of all INSCOM units to produce intelligence in support of the Army, combatant commands, and the National intelligence community. INSCOM responds to taskings from national and departmental authorities for Signal intelligence (SIGINT), human intelligence (HUMINT), counterintelligence (CI), imagery intelligence, measurement and signature intelligence (MASINT), technical intelligence (TI), electronic warfare (EW), and information operations (IO).

b. INSCOM provides Title 50 USC National Intelligence Program support to combatant commands and Army organizations.

16-2. Functions

a. INSCOM is designated by the SA as a DRU and reports directly to the Deputy Chief of Staff, G-2 (DCS, G-2).

b. INSCOM is responsible for the planning and execution of DRU responsibilities by exercising command and control of organic, assigned and attached Army forces.

c. INSCOM serves as the principal Army advisor to the Director, National Security Agency/Chief, Central Security Service for the United States Signals Intelligence Directive System and maintains liaison with national agencies for SIGINT operations. INSCOM supports the National SIGINT Special Activities Office program and DOD and DA SIGINT programs; performs worldwide SIGINT operations; advises and assists other Army organizations on SIGINT

Army Force Generation (ARFORGEN)

A structured progression of increased unit readiness over time, resulting in recurring periods of availability of trained, ready, and cohesive units prepared for operational deployment in support of geographic CCDR requirements.

Army Service Component Command (ASCC)

An Army force, designated by the SA, comprised primarily of operational organizations serving as the Army component of a combatant command or subunified command. If directed by the CCDR, serves as a JFLCC or JTF. Command responsibilities are those assigned to the CCDR and delegated to the ASCC and those established by the SA.

Combatant command

A unified or specified command with a broad continuing mission under a single commander established and so designated by the President, through the SECDEF and with the advice and assistance of the Chairman of the Joint Chiefs of Staff. Combatant commands typically have geographic or functional responsibilities.

Combatant command (command authority) (COCOM)

Nontransferable command authority established by 10 USC 164, exercised only by commanders of unified or specified commands unless otherwise directed by the President or the SECDEF. COCOM cannot be delegated and is the authority of a CCDR to perform those functions of command over assigned forces involving organizing and employing commands and forces, assigning tasks, designating objectives, and giving authoritative direction over all aspects of military operations, Joint training, and logistics necessary to accomplish the missions assigned to the command. COCOM should be exercised through the commanders of subordinate organizations. Normally this authority is exercised through subordinate Joint force commanders and Service and/or functional component commanders. COCOM provides full authority to organize and employ commands and forces, as the CCDR considers necessary to accomplish assigned missions. OPCON is inherent in COCOM.

Command

The authority a commander lawfully exercises over subordinates by virtue of rank or assignment. Command includes the authority and responsibility of effectively using available resources and for planning the employment, organizing, directing, coordinating, and controlling military forces for the accomplishment of assigned missions. It also includes responsibility for health, welfare, morale, and discipline of assigned personnel.

Direct Reporting Unit (DRU)

An Army organization comprised of one or more units with institutional or operational support functions, designated by the SA, normally to provide broad general support to the Army in a single, unique discipline not otherwise available elsewhere in the Army. DRUs report directly to a HQDA principal and/or ACOM and operate under authorities established by the SA.

Institutional Army

Those organizations and activities that generate and sustain trained, ready, and available forces to meet the requirements of the National Military Strategy and support the geographic CCDRs in the performance of the full spectrum of military operations. Administer executive responsibilities IAW public law.

Shared administrative control (shared ADCON)

The internal allocation of 10 USC 3013(b) responsibilities and functions between Army Organizations for the exercise of ADCON responsibilities and authorities of Army personnel and units. Shared ADCON will be as directed by the SA. The allocation of authorities and responsibilities pertinent to the exercise of shared ADCON between ASCCs, ACOMs, and/or DRUs, as appropriate, will be documented in appropriate agreements/understandings. The exercise of shared ADCON responsibilities and authorities with regard to an Army force are subject, by law, to the authority, direction and control of the SECDEF.

Training and readiness oversight (TRO)

The authority CCDRs may exercise over assigned RC forces when not on active duty or when on active duty for training. This authority includes— (1) Providing guidance to Service component commanders on operational requirements and priorities to be addressed in military department training and readiness programs. (2) Commenting on Service component program recommendations and budget requests. (3) Coordinating and approving participation by assigned RC forces in Joint exercises and other Joint training when on active duty for training or performing IDT. (4) Obtaining and reviewing readiness and inspection reports on assigned RC forces. (5) Coordinating and reviewing

DEPARTMENT OF THE ARMY
HEADQUARTERS, UNITED STATES ARMY MEDICAL COMMAND
2050 Worth Road
Fort Sam Houston, Texas 78234-6000

MEDCOM Regulation
No. 10-1

6 May 2009

Organization and Functions
ORGANIZATION AND FUNCTIONS POLICY

Supplementation of this regulation and establishment of forms other than MEDCOM/OTSG forms are prohibited without prior approval from HQ MEDCOM, ATTN: MCRM-M.

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* This regulation supersedes MEDCOM Regulation 10-1, 26 June 1997.

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Chapter 1 General

1-1. History. This issue publishes a major revision of this publication. Because the publication has been extensively revised, the changed portions have not been highlighted.

1-2. Purpose. This regulation provides policy and guidance for the organization and functions of the Army Medical Department (AMEDD) tables of distribution and allowances (TDA) units, activities, and installations assigned to Headquarters (HQ), United States Army (USA) Medical Command (MEDCOM). This regulation prescribes the organization and functions of AMEDD units and activities under the HQ MEDCOM, as required to accomplish the missions prescribed in Army Regulation (AR) 10-87. In areas where functions and/or policies are contained duplication has been omitted from this regulation. HQ MEDCOM staff functions are covered in MEDCOM Memo 10-2/ OTSG Reg 10-32.

1-3. References. References are listed in appendix A.

1-4. Explanation of abbreviations and terms. Abbreviations used in this regulation are explained in the glossary.

1-5. Applicability. This regulation applies to all MEDCOM units, installations, and activities. If the provisions of this policy/regulation conflict with existing negotiated union agreements, the terms of those agreements will be controlling. In any MEDCOM activity where a union has been granted exclusive recognition, no new conditions of employment should be implemented without prior discussion with the servicing civilian personnel officer regarding the obligation to negotiate with recognized unions.

1-6. Supplementation. Publication of supplements to this regulation is prohibited unless specifically approved by the Commander, HQ MEDCOM, ATTN: MCRM-M. Any Organization and Functions publication issued by MEDCOM major subordinate commands (MSCs) must have prior approval as above and shall conform to guidance issued in this regulation.

1-7. General organizational guidance

a. General.

(1) Each MEDCOM organization will structure units and activities to facilitate effective and efficient mission accomplishment; assign specific functional responsibilities to each organizational element oriented to accomplishing missions; group similar functions; eliminate functions and structures that become non-essential;

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consolidate functions and responsibilities where feasible and economical; and eliminate duplicate or fragmented functions that do not support assigned missions.

(2) Military treatment facilities (MTFs) will be documented in a standard manner based on TDA templates approved by HQDA. The prescribed MEDCOM template will be applied at the medical center (MEDCEN), Army community hospital (ACH), and Army health clinic (AHC) levels as appropriate. See chapter 3.

b. Organizational elements. Consult AR 570-4 for general guidance relative to organizational structure and position management. However, since most administrative and technical elements of MEDCOM are small in size, the following guidance applies for MEDCOM subordinate commands and activities (except installations, which should be organized in accordance with Field Manual (FM) 100-22.

(1) All principal elements (such as: logistics, resource management (RM), information management (IM), etc.) will be organized as divisions. Structuring will depend on such factors as size, span of control, and nature of work to be performed. Divisions with fewer than 10 manpower requirements will be unstructured. The establishment of subordinate branches will depend on the size of the division. Branches must have a minimum of four authorized positions. If subdivided, divisions must have at least two branches.

(2) Guidance for organizing medical elements is below; for dental and veterinary elements, see Chapters 4 and 5, respectively. When feasible, the same criteria discussed in paragraph 1-7b (1) above apply for subdividing into services/sections of medical, dental, and veterinary elements. Consider similarity of professional knowledge, graduate medical education, and clinic specialty/subspecialty orientation when designing organizational elements.

c. Structure and position titles.

(1) Normal organizational levels for subdividing clinical/clinical support elements are as follows, in descending order:

- (a) Deputy Commander for Clinical Services (DCCS).
- (b) Department.
- (c) Service.

(2) Normal organizational levels for subdividing administrative support elements are as follows, in descending order:

- (a) Deputy Commander for Administration (DCA).
- (b) Division.
- (c) Service.

(3) Normal organizational levels for subdividing nursing elements are as follows in descending order:

- (a) Deputy Commander for Nursing (DCN).
- (b) Department.
- (c) Section/service.
- (d) Ward/unit/clinic.

(4) The title "office" may be used to designate the immediate office of the head organizational element (for example, Office of the Chief, Department of Medicine; Office of the Chief, Personnel Division).

d. Manpower staffing standards and guides reflect the typical major and subordinate functional or organizational elements. Where conflict exists concerning the organizational placement of elements, the guidance contained in this regulation will apply.

1-8. Establishment, re-designation, or discontinuance of fixed AMEDD facilities or medical services

a. AR 40-4, paragraph 5, applies to all MEDCOM fixed facilities, including those that are outside the continental United States (OCONUS). Submit subject requests to HQ MEDCOM, Assistant Chief of Staff for Facilities Management (ACSFAC) (ATTN: MCFA), for further evaluation as required.

b. The office cited above will process requests for establishment or discontinuance of clinics and veterinary services branches assigned a derivative unit identification code (UIC), and which are located away from the Army MTF.

c. MEDCOM facilities will not be modified for any use outside the original design purpose, without first gaining the approval of HQ MEDCOM, ATTN: MCFA.

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d. Submit proposals to discontinue or significantly reduce professional medical services for any category of beneficiary to HQ MEDCOM, Assistant Chief of Staff for Health Policy and Services (ACSHP&S) (ATTN: MCHO-CL).

1-9. Director of health services (DHS)

a. *Mission.* The DHS is the principal advisor to the installation commander and staff on matters concerning the delivery of healthcare and public health services. The MTF commander for a given health service area (HSA) is the DHS for all active, Army Reserve, state-operated, and inactive installations within that HSA (see MEDCOM Reg 40-21 for listing of HSAs). The DHS will appoint a local deputy or subordinate DHS for Army Reserve and state-operated installations within the HSA. The performance appraisal for the DHS and the deputy/subordinate DHS will be in the medical chain of command.

b. *Responsibilities.* The MTF commander is responsible for semi-active Federal or state-operated installations in their HSA in accordance with MEDCOM Reg 40-21. He or she will appoint on orders, by line and paragraph number or position, and before a mobilization, a deputy/subordinate DHS for each of these semi-active installations. The following priorities will be followed in making this appointment:

(1) Active component (AC) best qualified/branch immaterial AMEDD officer (from command selection list (CSL) or non-CSL AMEDD Command Board).

(2) The Army Reserve best qualified/branch immaterial AMEDD individual mobilization augmentee (IMA) on MTF mobilization tables of distribution and allowances (MOBTDA).

(3) Department of the Army Civilian (DAC) on MTF peacetime and MOBTDA, or best qualified AMEDD DAC at the site's health clinic if statement of work permits.

(4) The Army Reserve augmentation TDA unit's best qualified/branch immaterial AMEDD officer on MTF MOBTDA.

(5) The Army National Guard (ARNG) best qualified/branch immaterial AMEDD officer on appropriate state area command's TDA, such as the state surgeon with approval of the adjutant general (AG).

c. The responsible MTF will provide the appointed deputy/subordinate DHS a letter of instruction for assigned duties at the semi-active Federal or state-operated installation. The commander will incorporate the letter of instruction into the activity mobilization and exercise plans. The appointment of a reserve component (RC) officer as DHS does not transfer overall responsibility for these sites to the RC.

d. The DHS will:

- (1) Serve as the DHS on the installation commander's staff.
- (2) Be responsible and accountable for the total surveillance and evaluation of the scope of practice and quality of healthcare/services provided in all MTFs and battalion aid stations (BAS) in the HSA of the MTF. This includes all MTFs and BASs in the garrison, and those deployed from other installations. BAS is the responsibility of the tactical commander with the technical oversight from the battalion/brigade surgeon.
- (3) Investigate conditions affecting the health of the command.
- (4) Supervise the execution of measures to prevent and control disease.
- (5) Provide assistance in individual and unit medical training. Provide guidance and assistance to the senior tables of organization and equipment (TOE) surgeon who supervises the military occupational specialty (MOS) proficiency training program for medical personnel assigned to TOE units.
- (6) Provide medical assistance for unit training in non-MEDCOM Army medical units (that is, AC, Army Reserve, or ARNG), when requested by parent commands.
- (7) Advise the installation commander on the training of non-medical military personnel in field sanitation, personal hygiene, and emergency medical training.
- (8) Direct the development of the medical portion of the installation plan to support domestic emergencies (that is, civil disturbance, disaster relief, and civil defense) within the local installation's geographic area of responsibility (AOR).
- (9) Serve as a member of the installation planning board in accordance with AR 210-20.
- (10) Coordinate actions pertaining to the radiological advisory medical teams and the emergency medical teams as appropriate and as directed by the commander in accordance with AR 40-13.
- (11) Serve as the installation authority on cross-leveling of AMEDD personnel upon mobilization. The DHS will not be responsible for personnel on mobilization reassignment processing at tenant installations.
- (12) Develop the medical annex to the installation mobilization plan, providing for the execution of healthcare services for mobilizing and deploying units, and including medical examinations, operation of troop medical clinics (TMCs), evacuation of patients

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from training areas and ranges, immunizations, optometry services, medical support to seaports and airports of embarkation, etc. Develop the medical annex to installation emergency plan in accordance with Para 9e (4), MEDCOM Reg 525-4.

(13) Provide the historical alignment (formerly "CAPSTONE") /quick fix early mobilizing/late deploying RC AMEDD units, minus dental, to the installation commander and the RC unit concerned.

(14) Assist the regional dental commands (RDCs), dental activity (DENTAC) and area dental laboratory (ADL) with the functions and services prescribed in subparagraphs (5), (6), (9), (11), and (14) above.

(15) Provide for the centralized management of all activities regarding the coordination of healthcare for eligible beneficiaries through the use of Department of Defense (DOD), Veterans Administration (VA), and civilian healthcare resources.

(16) Be responsible for the privileging and credentialing of RC providers in accordance with AR 40-68 when the providers deliver medical care within the HSA.

(17) Coordinate the delivery of healthcare, preventive medicine (PM)/public health (PH), and community mental health services, as appropriate, for the installation.

(18) Provide staff supervision as directed by the MTF commander of all MEDCOM healthcare services (dental services exempted) located on the installation.

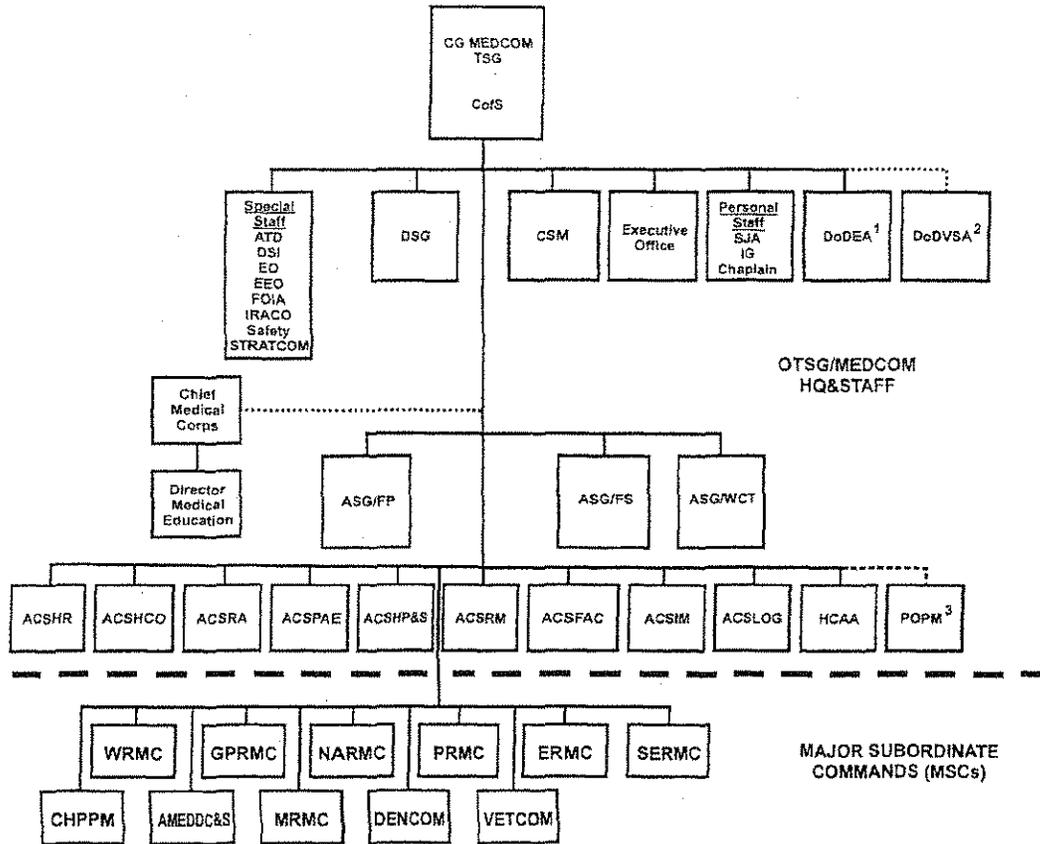
(19) Carry out responsibilities concerning annual training (AT) site medical support in accordance with MEDCOM Reg 40-40 and MEDCOM Pam 40-12.

e. On installations with chemical surety and/or chemical storage site missions, the DHS will be responsible for the coordination of actions pertaining to medical support to storage sites, to include:

- (1) Support to the nuclear, biological, and chemical surety programs.
- (2) Development of medical support plans.
- (3) Support for routine installation chemical/biological operations.
- (4) Support demilitarization of chemical/biological agents and munitions.
- (5) Support for chemical/biological accidents and incidents.

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1-13. **Organizational chart.** The MEDCOM organizational structure, to include the OTSG/HQ MEDCOM Staff and MEDCOM MSCs, is depicted at figure 1-1.



Notes:

1. EA organizations or activities that TSG is responsible for are described in Chapter 14 of the OTSG Reg 10-32/MEDCOM Reg 10-2.
2. Director, DoDVSA works directly for ASG, Veterinary Services/Chief Veterinary Corps
3. POPM works directly for the Functional Proponent for Preventive Medicine (FPPM)

The following positions also exist but are not reflected on the above organization chart: DSG - Mobilization, Readiness and Reserve Affairs; DSG - Army National Guard; ASG - Force Management, Mobilization and Reserve Affairs; ASG - Mobilization, Readiness and National Guard Affairs.

Figure 1-1. OTSG/HQ MEDCOM AND MSCs organizational structure

Chapter 2 Regional Medical Commands (RMCs)

2-1. Purpose. The RMCs are MEDCOM MSCs and operate under the supervision of the RMC commander. The RMC commander provides command and control over the MEDCEN, medical department activity (MEDDAC), and MTF commanders located within his or her respective RMC.

2-2. General. The RMCs are the key operational elements for the delivery of healthcare services for geographical regions within the MEDCOM. The RMC commander will provide intermediate level supervision over, and continuous evaluation of, the delivery and quality of healthcare provided to eligible beneficiaries throughout their respective HSC. Geographic boundaries of the RMCs are identified in MEDCOM Reg 40-21. The RMCs will provide regional support to the RDCs and regional veterinary commands (RVCs) at levels equivalent to the support provided to a dental or medical activity by the co-located MEDCEN, MEDDAC, or health clinic. The responsibilities below are a partial list of functions the RMCs are expected to perform and will vary by RMC. Structural placement of specific responsibilities within the RMC staff may also vary by location (for example, medical readiness functions may be aligned under operations, clinical operations, or elsewhere on the staff). Listed responsibilities will be used as guidelines and are not all inclusive.

2-3. Responsibilities

a. Human resources (HR) will:

- (1) Operate the RMC Personnel Readiness Management System, to support medical readiness and the delivery of quality healthcare.
- (2) Establish and maintain electronic links to the Officer Personnel Management Information System/Enlisted Distribution Assignment System, Army Civilian Personnel Reporting System, Medical Operational Data Systems, and other critical personnel information/management systems with assistance from HQ MEDCOM.
- (3) Advise the commander on current and projected personnel status to support medical readiness and the regional healthcare delivery plan.
- (4) Collect, consolidate, analyze, and report unit strengths.
- (5) Monitor the status of critical skills.
- (6) Manage the RMC personnel strength reporting systems, as outlined in MEDCOM contingency operations guidelines.

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2-4. Organizational chart. The RMC organizational structure is depicted at figure 2-1.

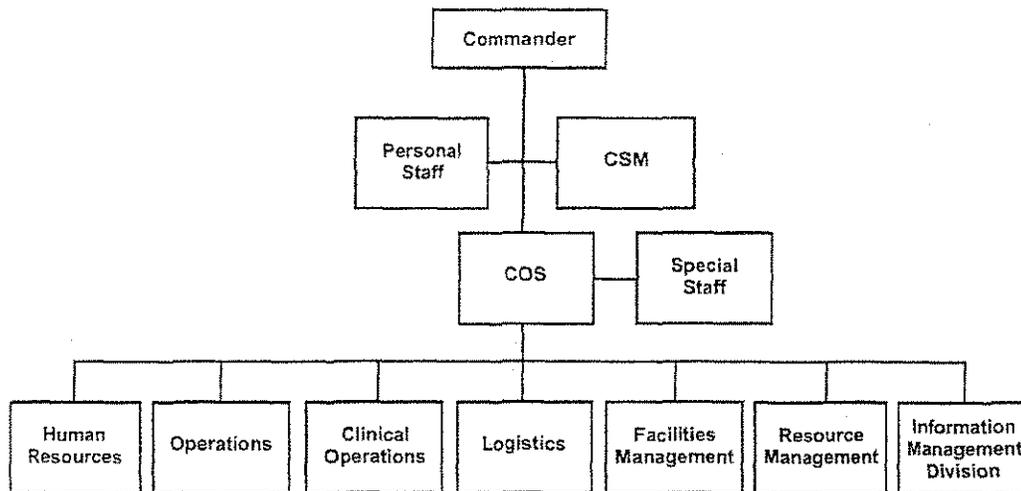


Figure 2-1. RMC organizational structure

Chapter 3 Military Treatment Facilities (MTFs)

3-1. **General.** This chapter prescribes the organization and functions of MTFs which, per AR 40-3, are defined as "civilian or uniformed services MEDCENs, hospitals, clinics or other facilities that are authorized to provide medical, dental, or veterinary care."

a. Each MTF should be categorized as one of the following:

(1) MTF: The umbrella term for uniformed services MEDCENs, ACHs, Army health centers (AHCEs), clinics or other facilities that are authorized to provide medical, dental, or veterinary care.

(2) MEDDAC: An organization that includes ACHs, AHCEs, and those AHCs that are not subordinate to another MTF; and all of which encompass associated activities responsible for providing health services to authorized beneficiaries within an assigned HSA. It normally has command and control over AMEDD facilities, activities, or units (other than TOE units) located within its HSA. The MEDDAC may also be tasked to provide administrative and logistical support to other AMEDD organizations over which it does not exercise command or operational control. These may include Army Medical Laboratories or Army Dental Activities.

(3) MEDCEN is a large hospital staffed and equipped to:

(a) Provide healthcare for authorized beneficiaries. Such care includes a wide range of specialized and consultative support for all medical facilities within the assigned geographic area.

(b) Provide specialized medical care to other patients referred to the MEDCEN by appropriate authority.

(c) Conduct professional training programs and post graduate education in health professions, when designated.

(d) Serve as a referral hospital, to include laboratory, for the MEDDAC within its HSA.

(e) Provide administrative and logistical support, as required, to other satellite TDA and TOE units on the installation. A MEDCEN also performs MEDDAC functions.

(4) ACH: an MTF that provides definitive inpatient care. It is staffed and equipped to provide diagnostic and therapeutic services in the field of primary care, internal medicine, surgery, and PM/PH Services. An ACH may also discharge the functions of an outpatient clinic. When a MEDDAC has a hospital, the ACH is the primary MTF of that MEDDAC and is separately identified in the TDA of the MEDDAC. An ACH may serve as a specialized treatment or teaching facility when specified in its assigned mission.

(5) AHCE: A MTF that is organized, staffed, and equipped to provide preventive, primary, and specialty outpatient services. AHCEs may provide acute care, routine ambulatory care, same day surgery, and observation care. Both same day surgery and observation care are generally for care that will be completed within 24 hours, but may be extended to 48 hours if needed. Observation beds are used for care of patients who cannot be cared for on an outpatient status, but who do not require hospitalization. An AHCE also provides the full range of ambulatory (outpatient) pharmacy services and limited laboratory and radiology services. AHCEs are not subordinate to another MTF.

(6) Clinic: MTFs which are staffed and equipped to provide ambulatory services. They also perform non-therapeutic activities related to the health of the personnel served including physical examinations, immunizations, medical administration, and PM services. Army clinics fall into five categories described below.

(a) AHC: A MTF designed, equipped, and staffed to provide ambulatory health services to eligible personnel. It normally has general radiology, laboratory, and pharmacy capabilities and offers specialty care in one or more of the subspecialties of

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medicine. Services provided depend on the availability of space and facilities and the capability of the assigned professional staff. An AHC may be a stand-alone facility or subordinate to a MEDCEN or MEDDAC and may provide medical administrative and logistical functions when authorized.

(b) Occupational health clinic (OHC): A medical treatment activity which coordinates and implements the occupational health program for military and civilian employees of the Federal government. OHCs are equipped and staffed to evaluate on-the-job illness or injury and dental conditions, to perform pre-placement and work-related medical examinations, and to refer employees to private physicians and dentists. They perform preventive activities related to health and industrial hygiene programs. Where possible, functions of these clinics will be combined with a MEDCEN, MEDDAC (ACH), AHC, AHCE or TMC.

(c) Primary care clinic: A medical treatment activity that performs health screening, diagnosis and treatment of illness or injury, and referral of patients to specialty clinics within the MTF or admission of the patient to the MEDCEN or ACH. It may include family care clinics and aviation medicine clinics.

(d) Specialty clinic. A medical treatment activity established as part of an AHC or of a special department or service of a MEDCEN or MEDDAC.

(7) Occupational health nursing office (OHNO): Similar to an OHC, OHNO healthcare services are provided by a qualified nurse rather than a physician. An OHNO is generally under the command and control of a designated MEDCEN, ACH, or AHCE.

b. DENTAC may be co-located with the MTF. Dental treatment, which is provided by DENTAC personnel in the operating room and other areas under command of the MTF commander, falls under the purview of the MTF commander. Note: DENTAC/ADL commanders are responsible for quality of health care services rendered within their command. See Chapter 4 for additional details.

c. Appropriate Joint Commission standards apply to all MTFs which provide medical care.

3-2. Office of the commander

a. *Mission.* The office of the MTF commander is responsible for responding to all formal requests or taskers received from/through the RMCs for data or information. The complexity, size, and actual composition of the clinical and administrative elements will vary based on the prescribed mission of the MTF.

b. Responsibilities. The MTF commander is responsible for the total healthcare delivery mission. The MTF commander will:

- (1) Command the MTF.
- (2) Provide installation PH services to all eligible beneficiaries.
- (3) Develop and execute the operating program and budget.
- (4) Serve as, or appoint, the DHS.
- (5) Be responsible for continually improving organizational performance in accordance with AR 40-68 and appropriate standards of the Joint Commission.
- (6) Be responsible for implementation of the AMEDD PROFIS, excluding DENCOM assets.
- (7) Be responsible for implementation and support of the active reenlistment program and support to other attached medical, dental, or veterinary activities.
- (8) Be responsible for the implementation of medical. .
- (9) Be responsible for providing training guidance to historical alignment units and approving the METL of each unit.
- (10) Be responsible for the planning, coordination, and execution of AT site medical support, total surveillance, evaluation of scope of practice, and quality of health services at all MTFs within the HSA of the MTF (in accordance with AR 40-68, MEDCOM Reg 40-40, and MEDCOM PAM 40-12).
- (11) Provide base operations (BASOPS) requirements (housekeeping, contracts, GSA vehicles, communications, and IM/IT maintenance), administration and logistics services to the RVC/DVC, RDC, DENTAC, and dental clinic command (DCC) at the same levels of support as provided for in the MTF's installation support agreement with the host garrison (or other MOUs/MOAs with supporting activities as applicable). Changes in MTF support to these organizations may occur but should be commensurate to changes for others in the command. Note: MTFs are funded and staffed to provide the above support to co-located dental/veterinary activities for economies of scale and to avoid duplication of effort.
- (12) Through the business planning process, MTF commanders will forecast a health care delivery plan for their beneficiary population which optimizes resources to provide healthy outcomes.

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(13) Ensure a comprehensive and effective safety health and environmental programs are established and maintained. Fully integrate relevant safety and occupational health and environmental program criteria, regulations, and standards into all operations within the organization.

(14) Be responsible for ensuring facilities with authorized blood banks and blood donor centers operate in support of the Army Blood Program and assist the installation commander in the establishment and promotion of an installation blood program in accordance with AR 40-3.

(15) Be responsible for establishing a command supply discipline program in accordance with AR 40-61, para 1-21c; AR 710-2, para 1-10f; and AR 735-5, para 11-4f.

(16) Ensure establishment of the DQ MCP. The program is designed to monitor financial and clinical workload DQ, as measured with metrics established by TMA. This includes appointing a DQ manager and a DQ assurance team. The commander will approve and sign monthly DQ MCP commander's statement.

(17) Designate the functional responsibilities for the DCCS, DCA, and DCN.

(18) Serve as the senior multi-market manager where applicable.

(19) Ensure, as the management control assessable unit manager, management controls are in place and operating effectively.

(20) As applicable for MEDCEN commanders:

(a) Be responsible for establishing a method for evaluating the quality of healthcare and services provided within the MEDCEN's regional responsibility, through assistance and support provided by the MEDCEN to the MTF.

(b) Serve as the approving authority for clinical privileges requested by MTF commanders and DCCSs within the MEDCEN's regional AOR in accordance with AR 40-68.

c. The DCCS (unless otherwise designated by the MTF commander) will:

(1) Provide MTF force management for all military, civilian, and contract employee resources.

(2) Supervise and control the activities of the medical departments and separate services.

- (3) Serve as chairman of the Credentials Committee.
- (4) Serve as director of medical education in accordance with AR 351-3.
- (5) Perform medical evaluation board and entrance physical standards board functions in accordance with AR 40-400.
- (6) Supervise clinical matters concerning research, clinical investigation, medical training, and the use of consultants.
- (7) Coordinate clinical aspects of the Joint Commission Accreditation Program.
- (8) Supervise the medical management of military inpatients ensuring that unnecessary hospitalization is avoided because of delays in medical and administrative processing requirements.
- (9) Serve as chairman of the clinical investigation and human use committees in hospitals with a clinical investigation service. The DENTAC commander will designate a dental officer who will serve as a member of the committee.
- (10) Coordinate training activities for medical RC personnel. Training for dental RC personnel and units will be coordinated with the DENTAC commander.
- (11) Monitor the medical aspects of the MEDCOM Ambulatory Patient Care Program.
- (12) Serves as the director of the QM program including patient care evaluation, medical management, evidence based practice, risk management, and clinical privileging. Appropriate duties may be delegated to the QM Coordinator. Functions may include, but are not limited to, being the supervisor or senior rater of the QM Coordinator. The QM Coordinator is directly responsible to the DCCS (or other designee) for the operational and managerial aspects of the QM program, as described in AR 40-68 and the current Joint Commission standards.

Note: The DENTAC commander is responsible for the quality assurance program within their geographic AOR. DENTAC and ADL commanders are approving authority for practice privileges within their commands. Individuals, whose duties require delivery of health care services within an organization different from their parent unit, will require the approval of the commands concerned.

- (13) Serves as the chairman of the Utilization Management Committee (when established).

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(14) Supervises the operation of the Patient Appointment System (PAS) when established.

(15) Assist the MTF commander with regional coordination of the quality of care through assistance and support provided by the region to the MTF. Ensure that optimal standard of care is provided. The RDC commander will be the review authority for all dental services within the region.

(16) Supervises the operation of the Substance Abuse Rehabilitation Department (SARD), where established by mission statement.

(17) Coordinates with the RDC and/or DENTAC/ADL deputy commander in establishment of policies and practices. Ensure requested medical support services are provided to the dental care system as needed.

(18) Manages the clinical educational missions published by RMCs and RDCs, to facilitate patient care and access; provide quality care on an economical basis; support mobilization preparedness efforts of the command; and support the regional MEDCEN and its teaching programs. MTFs will forward requests for missions to the RMC/RDC commander.

(19) Provides senior level leadership and guidance to the MTF and ensure clinical staff support is provided to the Managed Care Division.

(20) Collaborates in forecasting and formulating program planning, financial strategies, and evaluation processes.

(21) Coordinate and collaborate with AMEDD corporate leaders to develop operational policy and healthcare initiatives.

(22) Provide HR support for worldwide medical deployments, specified personnel taskings, and joint service initiatives.

d. The DCA/Chief of Staff (COS) will (unless otherwise designated by the MTF commander):

(1) Represent and assist the commander, as required, and assume command when necessary.

(2) Provide MTF force management for all military, civilian, and contract employee resources.

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3-4. Staff offices/Special staff. Organization and responsibilities are as follow:

a. Executive officer will:

- (1) Be responsible for control of staff actions.
- (2) Serve as the protocol officer (at facilities without full-time protocol officers).
- (3) Serve as office manager for the MTF commander and DCA/COS. Includes writing correspondence for the commander and DCA, and handling congressional and special inquiries.
- (4) Manage and supervise after duty hours staffing.
- (5) Serve as the public affairs officer (at facilities without full-time public affairs officers).
- (6) Manage gifts and donations program in accordance with AR 1-100 and MEDCOM Supp 1 to AR 1-100.

b. Staff officers and special staff, excluding the executive officer; also support other MEDCOM subordinate commanders (that is, dental and veterinary) within the MTF AOR. If an intermediate rater has not been designated by the MTF commander, the dental treatment facility (DTF) commander will serve as intermediate rater for those division and branch chiefs that provide 10-1 support to the DTF.

c. Public Affairs Office (PAO).

(1) Mission. The mission of the PAO is to serve as a principal advisor to the commander with overall responsibility to build understanding and awareness of MTF programs by the serviced population. PAO uses external and internal communications media for disseminating information about the command, and operates community relations programs to establish and maintain valuable contacts with local leaders and civic/professional organizations.

(2) Responsibilities. For MEDCENS, PAO duties are handled by full-time civilian specialists. At some MTFs, PAO duties are frequently combined with other functions and necessitate support and coordination with a full-time PAO at the host installation and/or their respective RMC or HQ MEDCOM. PAO functions and policies are described in AR 360-1, as well as MEDCOM supplements. Although emphasis may vary at a given location, PAO will:

- (a) Act as the commander's principal advisor in the area of public affairs.

*MEDCOM Reg 10-1

(f) Submit quarterly narrative statistical reports to the MEDCOM EO program manager office initial operational test report key data points on the individual EO program within the command.

3-5. Clinical and support elements

a. *Mission.* Each major clinical element listed below is to provide diagnoses, care, and treatment of all patients commensurate with the highest standards of quality patient care.

b. *Responsibilities.* The Office of the Chief will head every major clinical element listed below. Functions of the chief are to, but not limited to:

- (1) Provide diagnoses, care, treatment, and proper medical disposition of patients.
- (2) Conduct medical education as assigned.
- (3) Conduct other professional training.
- (4) Evaluate the quality and appropriateness of care.
- (5) Conduct medical research.
- (6) Prepare and complete all medical records in accordance with AR 40-66 and AR 40-400. Ensure an annotation is made in the permanent record when separate records, case management, or working files are maintained. Coordinate any release of medical information with the Chief, Patient Administration Division (PAD).
- (7) Review and analyze work methods and operational procedures within the department.
- (8) Coordinate administrative support services for the element when a clinical support division is established. When a clinical support division is not established, provides administrative support services for the element as specified in paragraph 3-5d below.
- (9) Manage military inpatients to expedite timely disposition with completed medical and administrative processing requirements.

c. Functions for every clinical element listed below are to, but are not limited to:

- (1) Provide diagnoses, care, treatment, and proper medical disposition of patients.

- (2) Provide clinical and consultative services.
- (3) Conduct professional training as directed.
- (4) Conduct medical care evaluations.
- (5) Prepare and submit records and reports.

d. Administrative support is provided when the workload justifies such, or by administrative personnel assigned organically to the office of the chief when the workload does not justify a separate element. The administrative support services for the clinical support elements listed below are to:

- (1) Develop the operating program for the element.
- (2) Provide managerial support in areas of professional meetings and conferences, budget planning, logistical matters, manpower management, and personnel administration.
- (3) Develop and operate appropriate administrative training programs and supporting professional training programs.
- (4) Coordinate activities pertaining to hospital accreditation by the Joint Commission.
- (5) Review and analyze administrative work methods and operational procedures within the element.
- (6) Coordinate in-service education programs.
- (7) Coordinate with PAD to ensure timely preparation and accuracy of outpatient medical statistics and workload data submitted to PAD.
- (8) Provide administrative, stenographic, and typing support services within the element, as required.
- (9) Develop an effective interpersonal relations program regarding concerned patient care.

3-6. Medicine

a. *Mission.* The mission is to provide comprehensive well-and-sick care of adults in both the inpatient and outpatient setting.

*MEDCOM Reg 10-1

b. Organization is as follows:

- (1) Allergy-immunology service.
- (2) Cardiology service.
 - (a) Cardiac catheterization.
 - (b) Cardiac rehab.
 - (c) Data analyst research.
 - (d) Electrocardiogram.
 - (e) Non-invasive cardiology.
 - (f) Echo cardiogram.
- (3) Medical critical care/trauma.
 - (a) Electrophysiology lab.
 - (b) Coumadin clinic.
 - (c) CHF clinic.
 - (d) Lipid clinic.
 - (e) Chest pain unit.
- (4) Dermatology.
- (5) Endocrinology.
 - (a) Endocrinology clinic.
 - (b) Metabolic lab.
- (6) Gastroenterology service.
 - (a) GI clinic.
 - (b) Endoscopy lab.

b. Organization is as follows:

- (1) Emergency room.
- (2) Acute care.
- (3) Ambulance service.
- (4) Emergency communications.
- (5) Reception.
- (6) Triage clinic.

3-14. Nursing

a. Mission. The mission of nursing is to ensure appropriate nursing resources are provided in support of ambulatory, inpatient, administrative and education missions in accordance with the established plan for provision of care.

b. The DCN, assisted by a chief, clinical nursing (and in larger facilities, a chief, administrative nursing), oversees nursing care and practices across the MTF. Functions include the following:

- (1) Oversee the provision of quality, safe, effective, compassionate and efficient nursing care.
- (2) Coordinate, organize and implement required or applicable education and training programs.
- (3) Promote the utilization of nursing research.
- (4) Analyze and evaluate nursing care requirements throughout the organization.
- (5) Collaborate with the deputy commanders, or designee, on assignment of nursing resources.
- (6) Ensure appropriate direction, supervision, evaluation and control of nursing personnel throughout the organization.

*MEDCOM Reg 10-1

(7) Ensure that the establishment and/or maintenance of clinical elements are commensurate with the qualifications and credentials of the nursing staff. These clinical elements include but are not limited to:

(a) Ambulatory clinics.

(b) Inpatient areas: Critical care, Medical-surgical, Pediatrics, Labor and delivery, Mother baby unit, Neonatal intensive care unit, Step-down unit, Psychiatric, Telemetry.

(c) Nursing education and staff development (see hospital education, para 3-19).

(d) Infection control.

(e) QM.

(f) Same day surgery.

(g) Nursing research promotes interdisciplinary research to advance military nursing knowledge and science to improve practice, leadership, policy and education (such as, Evidence-based practice and interventions or Process and practice evaluations.)

3-15. Behavioral health

a. *Mission.* The mission of behavioral health is to provide psychiatric, clinical psychology and social work services to maintain the mental health of active duty military personnel and their Families.

b. Organization is as follows:

(1) Psychiatry.

(a) Adolescent & child psychiatry.

(b) Adolescent psychiatry.

(c) Psychiatric inpatient.

(d) Psychiatric outpatient.

(e) Psychiatric liaison.

(f) Psychiatric adult part-day.

(1) Clinical director – ASAP. Outpatient clinical director will possess, at a minimum, a master's level independent social work license, master's level independent marriage and Family therapy license, or a PhD level psychology license and specialty certification in substance abuse. The clinical director will also have at least one year of management experience.

(2) ASAP day treatment facility. MTF commanders may, on an as needed basis, establish a day treatment or intensive day hospital treatment program that meets the Joint Commission and American Society of Addiction Medicine Standards for medical management of higher risk substance abuse/dependent diagnosed cases.

(3) Residential treatment facility. This mission of the residential treatment facility is currently assigned in CONUS to only TAMC and DDEAMC. Overseas, the mission is assigned to the 121 general hospitals in Korea and Landstuh! Regional Medical Center in Germany.

(4) ASAP intensive outpatient program.

(5) Partial-residential treatment facility. Present partial-residential treatment facilities are at TAMC and DDEAMC.

3-18. Quality management (QM)

a. *Mission.* The mission of QM is to establish policies and procedures for administration of the MTF Performance Improvement Program (PIP). The QM staff coordinates hospital-wide monitoring and evaluation activities to ensure the quality and appropriateness of care for all beneficiaries. QM is an umbrella program that links institutional activity, through functional measurement of performance, with the goal of continuous improvement through prioritized and informed decision making. QM builds upon, integrates, links and refines medical quality assurance, risk management, credentials management, patient safety initiatives, the Joint Commission accreditation, and outcomes management.

b. *Organization is as follows:*

(1) Chief, QM.

(2) Credentialing/privileging.

(3) Patient safety.

(4) Performance improvement.

*MEDCOM Reg 10-1

(5) Risk management.

c. Functions. QM will:

(1) Provide technical support and educational assistance to MTF staff on PIP.

(2) Prepare the annual report evaluating the objectives, scope, organization, and effectiveness of all functions of the PIP.

(3) Monitor the PIP/risk management data collection, analysis, and reporting of trends and patterns for both problem resolution and opportunities to improve patient care.

(4) Maintain oversight of the confidentiality and anonymity of the PIP activities and records.

(5) Coordinate with MTF's SJA on medicolegal aspects relating to PIP and risk management. Identify risk management trends and recommends to the risk manager/committee system-wide preventive measures and/or solution to identified problems.

(6) Maintain liaison with the HQ MEDCOM QM Division on PIP-specific activities, using the appropriate chain of command.

(7) Maintain liaison with state, local, and private agencies.

(8) Maintain practitioner credential files and prepare documents for the clinical privileging process.

(9) Conduct medical management activities.

(10) Provide oversight of safe patient care including fostering a culture of safety to encourage staff to report issues in order that processes needing improvement can be identified. Implement national patient safety goals in accordance with TJC guidance. Implement other patient safety initiatives.

d. The Chief of QM, as applicable, is directly responsible to the DCCS (and other designee) for the functions of the QM office. The Chief of QM may be the supervisor and rater for the credentials coordinator, risk manager, and other assigned QM office personnel. The QM staff performs duties as outlined in AR 40-68, as well as ensuring the Joint Commission standards compliance.

*MEDCOM Reg 10-1

c. Functions are to:

- (1) Exercise command as outlined in AR 600-20.
- (2) Be responsible for administration, supply, billeting, training, housekeeping, military discipline, morale and welfare, planning, programming, and budgeting in support of troop command operations.
- (3) Perform personnel functions.
- (4) Maintain supply and accounting records for individual and organizational clothing, equipment, and other supplies for all personnel assigned/employed in accordance with AR 710-2.

3-38. Human resources (HR)

a. Mission. The mission of HR is to provide prescribed personnel administration services for military and civilian personnel of the command.

b. Functions are to:

- (1) Provide consultative services to all elements of the command on matters pertaining to military personnel management.
- (2) Act as liaison with the supporting CPAC/CPOC on matters of civilian personnel management.
- (3) Provide staff supervision and implementation of the PROFIS Program in accordance with AR 601-142.
- (4) Coordinate with appropriate local organizational staff for the identification, selection, Soldier readiness program, and training of PROFIS personnel, including the maintenance of a current PROFIS roster.
- (5) Exercise staff supervision of the command's reenlistment program.
- (6) Advise and assist the dental company or detachment reenlistment NCO on current policies and changes on all matters pertaining to reenlistment.
- (7) Monitor the officer counseling programs in accordance with AR 600-8-24.
- (8) Provide staff supervision of off-duty employment program.

(9) Provide military personnel administration services in coordination with the host installation personnel offices.

(10) Process awards and officer evaluation reports, NCO evaluation reports, and civilian appraisals.

(11) Implement the Joint Commission HR standards and provide guidance for compliance throughout the command.

(12) Ensure the maintenance of a hospital-wide competency assessment and documentation program for non-privileged health care personnel in accordance with AR 40-68.

(13) Serve as the liaison to the CPACs/CPOCs.

3-39. Resource management

a. Mission. The mission of the RM is to program, budget, execute and account for the assets, funding and manpower that is required to accomplish the healthcare mission. The chief of resource management is the command's chief financial officer (CFO). The resource management ensures the proper assignment of funding; maintains a system of positive funds control; and ensures accurate allocation and accounting of the cost of the healthcare mission. The RM conducts reviews, performs analysis and maintains internal controls to ensure the effective and efficient use of resources.

b. Functions are to:

(1) Serve as the commander's principal staff advisor on RM matters and consult on the overall management of the command.

(2) Ensure the proper general ledger accounting of command assets and cost accounting of resources consumed.

(3) Ensure the effective and efficient use of resources.

(4) Interface with the DFAS in accounting of resources.

(5) Conduct the program and budget process of the command to determine resource requirements.

(6) Ensure the timely and accurate payment of goods and services received.

*MEDCOM Reg 10-1

- (7) Conduct review and analysis of command programs.
- (8) Conduct management studies and cost/economic analyses to determine effective and efficient use of resources and return on investment for proposed courses of action.
- (9) Oversee Defense regional interservice support agreement programs in accordance with DODI 4000-19 (that is, MOUs/MOAs, installation support agreements, training agreements, and interagency agreements).
- (10) Administer the MCP in accordance with AR 11-2 as applicable to RM processes.
- (11) Oversee the competitive sourcing program in accordance with AR 5-20.
- (12) Administer MEPRS functions, if applicable, in accordance with the MEPRS manual (DOD 6010.13-M).
- (13) Ensure compliance with the prescribed organizational structure and functions outlined in this regulation, process exceptions, and prepare an MTF supplement to this regulation as necessary.
- (14) Manage the Army Ideas for Excellence Program in accordance with AR 5-17.
- (15) Perform manpower management functions in accordance with AR 570-4.
- (16) Provide advice to the command on the impact that changes in the organization have on manpower requirements and authorizations.
- (17) Conduct local studies to determine proper manpower utilization.
- (18) Be responsible for MTF management of the Army Authorization Document System.
- (19) Assist in the establishment of policies concerning civilian hires.
- (20) Review/analyze and/or develop and submit the MTF business plan(s).
- (21) Monitor PBAM results; provide expert analysis of MTF performance; and in collaboration with MTF clinical operations, advise the MTF commander on maximizing workload to enhance MTF revenue and produce positive healthcare outcomes.

c. Commanders must organize elements to use resources in the most efficient and effective manner. The following element titles are not intended to mandate a specific structure but common use, easily recognized terminology:

- (1) Program and Budget Branch.
- (2) Management Analysis Branch.
- (3) MEPRS Branch.
- (4) Manpower Branch (as applicable).
- (5) Program Analysis and Evaluation Branch.

3-40. Operations and readiness

a. *Mission.* The mission of operations and readiness is to provide a variety of services pertaining to emergency preparedness and contingency planning, readiness and mobilization expansion, AC and RC training, historical activities and security programs.

b. *Functions are to:*

- (1) Develop, publish, and update the activity mobilization plan in accordance with MEDCOM Reg 500-5.
- (2) Develop, maintain, and test activity medical emergency management plan in accordance with MEDCOM Reg 525-4 and MEDCOM Pam 525-1.
- (3) Complete operations plans and exercises the NDMS for activities assigned as Federal coordinating centers in accordance with MEDCOM_Pam 525-1.
- (4) Conduct contingency planning and negotiate support agreements with the Department of Veterans Affairs in accordance with MEDCOM Reg 500-3.
- (5) Complete historical alignment units planning actions and review unit METL, including publication of the mission guidance document.
- (6) Ensure the Mobilization Planning Committee is organized and functions.
- (7) Coordinate TOE air and ground ambulance support for the MTF, as applicable.

*MEDCOM Reg 10-1

3-46. Organization charts. Examples of MTF organizational structures are depicted at figures 3-1, 3-2, and 3-3.

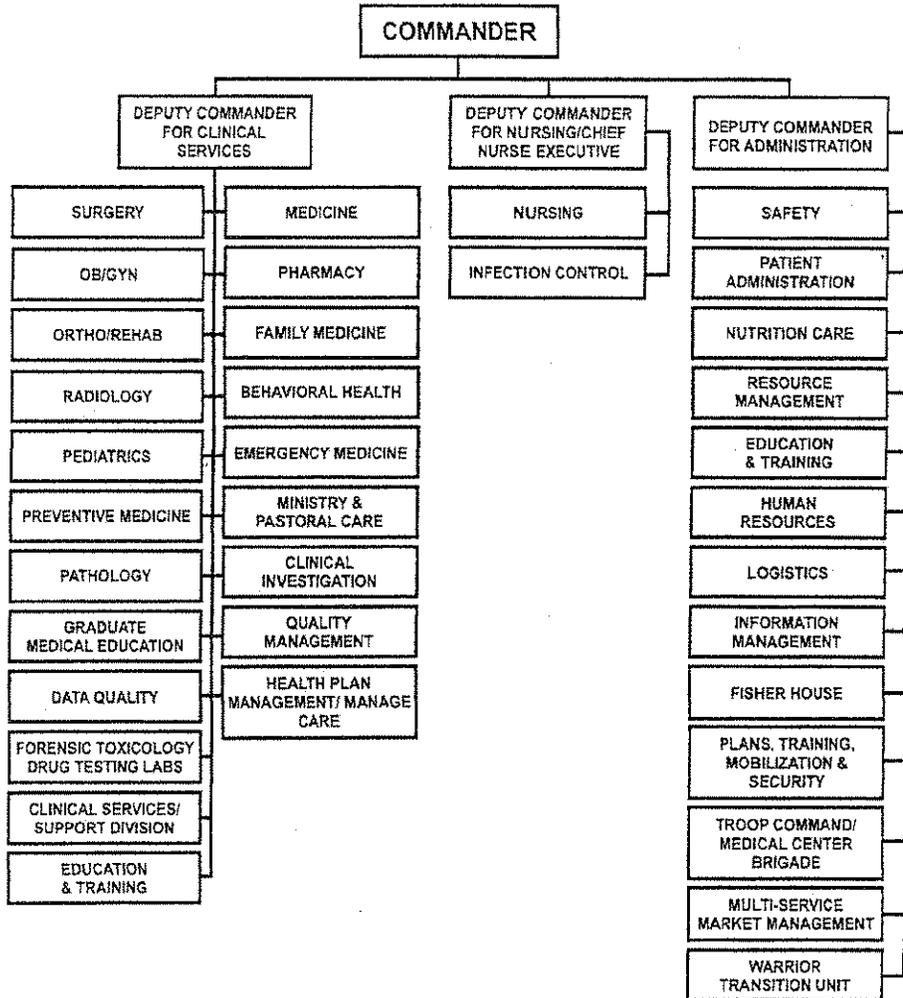


Figure 3-1. MTF organizational structure (Example #1)

TAB F

**FY09-12 YTD (14 Feb 12) Provider Aggregate Total RVUs by
Provider in Allergy (BAB)**

FM

(All)

Sum of Provider Aggregate Total RVU Row Labels	Column Labels				
	2009	2010	2011	2012	Grand Total
LPN #1, A/I Clinic	494.93	17.67	74.51		587.11
	228.83	160.20	617.41	6.82	1,013.26
Head Nurse, A/I Clinic	72.62	26.26	150.39	0.98	250.25
Chief, A/I Clinic	2,378.21	4,527.49	6,057.70	2,812.20	15,775.60
	1,038.43	1,921.53	4.82		2,964.78
LPN #2, A/I Clinic	317.38	805.19	1,067.79		2,190.36
	0.00				0.00
Former A/I Clinic LPN	370.35	749.42	372.89		1,492.66
	387.70				387.70
	3,998.00	2,080.76			6,078.76
			0.40		0.40
	47.01				47.01
LPN #4, A/I Clinic			299.57		299.57
			416.66	3,770.76	4,187.42
	184.70				184.70
Whistleblower			276.11		276.11
	1.00				1.00
Physician Staff Allergist	3,038.14	3,294.27	5,078.46	1,764.52	13,175.39
Grand Total	12,557.30	13,582.79	14,416.71	8,356.28	48,912.08

BAB-F-1



DEPARTMENT OF THE ARMY
MADIGAN HEALTHCARE SYSTEM
9040 JACKSON AVENUE
TACOMA, WA 98431-1100

REPLY TO
ATTENTION OF

MCHJ-CLM-A

01 MARCH 2011

MEMORANDUM FOR Review

As of 1 March 2011 the Annual Review of the Standard Operating Procedure (SOP) manual took place. Information over two years old was updated or reviewed for continued relevancy.

These Policies and Procedures shall remain in effect for all patients seen in the Allergy Immunology Clinic until rescinded.

Chief, A/I Clinic

Chief of Allergy Immunology

JACF-2a

STANDARD OPERATING PROCEDURE
ALLERGY/IMMUNOLOGY SERVICE
MADIGAN HEALTHCARE SYSTEM

SCOPE OF PRACTICE

1. **MISSION:** The mission of the Allergy & Immunology Service is to evaluate, diagnose and treat patients with allergic and immunodeficient diseases. In addition, the service will evaluate patients for multiple routine and travel vaccinations and administer them based on the latest recommendations. In addition, research studies initiated by the clinic will be done with the approval of Department of Clinical Investigation.

2. **ELIGIBILITY:** The Allergy Immunology Clinic serves all active duty military, dependents, retired military and their dependents and unmarried eligible dependents over the age of 21 with TRICARE Prime coverage. TRICARE Plus patients who have already established care can continue to be seen at the Allergy Immunology clinic. Eligibility for care will be determined through DEERS enrollment or verified through PAD.

ELIGIBILITY-IMMUNIZATIONS to be done at the Allergy Immunology Clinic:

- Madigan staff members both TRICARE and non-TRICARE recipients will receive Immunizations pertinent to their employment as ordered by Occupational Health.
- Patients in need of basic travel vaccinations not stocked by their Primary Care Clinic.
An order from a Madigan Primary Care Clinic or a Preventive Medicine Travel Clinic staff member is required.

NON-ELIGIBILITY: TRICARE Plus patients with initial Allergy consultations will be Deferred to Network.

NON-ELIGIBILITY- IMMUNIZATIONS:

- Patients in need of routine vaccinations will go to their Primary Care Clinic.
- TRICARE Prime and TRICARE for Life patients, who are not enrolled at Madigan, will go to their enrolled clinic for routine vaccinations.
- Deployment vaccinations are offered at the SRP site at Waller Hall.

3. **CLINIC ACCESS:** Access to the clinic is on a consult basis for Allergy/ Immunology patients. All consults requiring other than routine priority require telephonic contact by the referring physician. Access Standards for Specialty Care: ASAP-24 hours, ROUTINE-28 days, FUTURE-Providers' discretion. Enhanced Access Standards for Warriors in Transition: ASAP-24 hours, ROUTINE- 7 days, FUTURE -Provider's discretion.

Patient's on the physician's schedule who are more than 15 minutes late will be rescheduled or seen that day at the physician's discretion.

TAB F-2b

Allergen Immunotherapy usually takes place Monday, Wednesday and Thursday 0800-1100, 1300-1600, Tuesday 1300-1600. Allergy shot patients can come in to the clinic on a walk-in basis on Monday, Wednesday and Thursday mornings between 0800 and before 1100 as staffing allows. Allergy shot patients who arrive outside of the allotted schedule times will be directed to schedule for another day. The clinic is closed for Federal Holidays and Training Holidays. The clinic is closed to Allergy shots on the third Tuesday of every month in order to accommodate Madigan staff members for immunization taking place at their Mandatory Annual Training Day.

Immunizations are done during routine hours on a walk-in basis. Priority is given to active duty in uniform and other hospital personnel on duty. Hours may vary based on staffing. Immunizations usually take place M-Th 0800-1100, 1300-1500, Fri 0800-1100.

If the wait is more than 1 hour for immunotherapy or vaccinations, the patient may come back at another time for care.

4. **STRUCTURE:** The Chief of the Allergy Clinic is responsible for the overall policy with the approval of the Chief, Department of Medicine.

Clinical privileges for patient care in the Allergy/Immunology service are delineated by the administration. Privileges for staffing the clinic are restricted to a Chief and Assistant Chief, both of whom are fully trained and board certified or board eligible by a co-joint board of the American Board of Allergy/Immunology and the American Board of Internal Medicine or American Board of Pediatrics, and at times, allergists meeting the same criteria who are TDY. House staff train under the supervision of the Chief, Assistant Chief and staff of the Allergy/Immunology Service.

The Chief, Assistant Chief and staff allergist are directly responsible for evaluations of all patients formally referred to the service. This includes responsibilities for all inpatient and outpatient consultations upon appropriate requests on Standard Form 513 from all clinical services within the hospital and outlying dispensaries or civilian physicians. The allergists are responsible for training students and house staff in the broad general field of Allergy and Immunology. The training will consist of clinical evaluation of patients by informal teaching sessions and periodic formal lectures in Allergy and Immunology. The residents or students present each patient to an allergist for their guidance.

5. **NURSING SUPPORT:** Professional and paraprofessional staff is provided by the Department of Medicine. The Head Nurse is responsible for development of nursing policies, implementation, and supervision of quality ambulatory nursing care with the Chief, Ambulatory Care Nursing Service and the NCOIC of Ambulatory Nursing Service. Nursing staff will insure efficient assessment of patients undergoing diagnosis or treatment procedures and will report any changes in patients' condition to the physician and initiate emergency treatment when necessary. Each member of the nursing staff will function within their scope of practice as outlined for this clinic IAW hospital policy.

6. **CLERICAL SUPPORT:** Staff will be provided by the Department of Medicine to insure efficient processing of records, patient check in, make appointments, and assist with prescription renewals. Administrative staff provides administrative support and performs clerical functions for the Chief of the Allergy Immunology Service, Head Nurse, and clinic staff. Guidance and Supervision will be provided by the Chief.

7. STAFFING FOR NURSING PERSONNEL:

Head Nurse 1 YH
Administration1
LPN 5
Receptionist..... 1
Allergists..... 1.5

8. **MINIMAL STAFFING:** Patient care hours are generally Monday through Friday, 0800 to 1630, and there will be nursing personnel present during that time. However, there will be at least one nursing personnel staffing the clinic from 0730-1630 and at least minimal staffing whenever allergy shot patients are being observed. The minimal staffing will be at least one professional and one paraprofessional during patient care hours, and this requires approval of the Chief of the Clinic. When allergists are not available, Internal medicine clinic staff on call will cover the A/I clinic during acute anaphylaxis. SOP's on anaphylaxis will be used for reference.

Chief, A/I Clinic

Chief Allergy/Immunology Service

(Updated 03Mar2011)

STANDARD OPERATING PROCEDURE
ALLERGY/IMMUNOLOGY SERVICE
MADIGAN HEALTHCARE SYSTEM

ASAP APPOINTMENTS

1. Consults for WTB soldiers, MEB consults, SRP referrals, OIF referrals must be seen within 7 working days from receipt of the consult by command policy. We will attempt to have them scheduled within 3 working days.
 - a. Appointments will be booked by our clinic into open SPEC or SPEC \$ slots. If there are still no SPEC \$ slots within the time frame needed, book in open EST slots. If there are still no available appointment slots within the time frame needed, refer to the on call allergist for a day and time to provide a walk-in appointment.
 - b. If the soldier prefers an appointment outside of the command policy timeframe, the name of the soldier and reason for delay will be forwarded to the DOM AO.
 - c. If the soldier cannot be booked due to inadequate contact information, contact the referring clinic or case manager and provide the name of the soldier and reason for delay in booking to the DOM AO.
2. ASAP consults for other patients not in the above categories should be brought to the attention of the on call allergist to determine appropriate time frame for booking. These appointment must be booked by the clinic.

Chief, A/I Clinic

Chief, Allergy/Immunology Service

ABF-20

MADIGAN HEALTHCARE SYSTEM
Allergy Immunology Service
Allergen Immunotherapy Administration SOP

1. Background

- a. **Allergen Immunotherapy (AIT) efficacy.**
 - i. Up to 85% of patients with allergic rhinitis achieve benefit after they have been on maintenance for one year.
 - ii. AIT is usually considered when medical management fails.
- b. **Dosing:** Some patients need more and some less allergen to have a good response. The therapeutic dose range for each allergen is still under active investigation. The current recommendations are that between 0.5cc to 1.0cc of each extract mixed into the 10cc vial should provide clinical benefit. Cat and dust mite are weaker and so more extract is used. Some allergens, especially grass, have cross-reactive antigens. When the antigens are cross-reactive the total dose of antigen is therefore greater when they are mixed together. For example, 1.0ml of two northern grasses is comparable to giving 2.0ml of only one northern grass.
- c. **Manufacturer variation:** Allergen extracts made from different manufacturers vary widely in potency, especially those in w/v. For example, some of the Greer mold extracts may be up to 100 fold stronger than Hollister Steer. This is the reason for cutbacks with source changes.
- d. **Extract standardization:** Some extracts are standardized (grass, cat, dust mite) to improve consistency in potency. More allergens should become standardized in the future.
- e. **Risk:** The major risk of allergen immunotherapy is anaphylaxis, which in extremely rare cases can be fatal, despite optimal management. The overall rate of systemic reactions is approximately 1/1000 per injection.
 - i. Risk for systemic reactions is highest with:
 1. During advancement of immunotherapy
 2. Highly sensitive individuals on potent extract mixes
 3. Patients with asthma
 - ii. Delay in epinephrine treatment causes increased risk of a bad outcome and death from anaphylaxis. Anaphylaxis can progress unpredictably
 - iii. A handful of people die every year from allergy shots. Those patients usually have a history of severe or poorly controlled asthma. Careful screening and appropriate management is essential.

2. Administering Immunotherapy

- a. Immunotherapy should be administered in a setting that permits prompt recognition and management of adverse and systemic reactions. The staff should be trained in how to give immunotherapy and be trained and able to recognize and treat anaphylaxis.

- b. Patients must remain in the clinic for 30 minutes after each injection. All patients will present to the technician prior to leaving the clinic to have injection site checked for local reactions. Patients experiencing any unusual symptoms, especially itching of the throat or skin, cough or sneezing, rash, or chest tightness or wheezing must immediately report to the technician
- c. The allergist or designated surrogate allergist must be in the clinic area or immediately available whenever allergy shots are being administered so they can immediately respond to a suspected systemic reaction.
- d. Patient should verify name, vial number, and expiration date on immunotherapy vial.
- e. Patient is questioned about reaction to previous shot and any current symptoms. If individual has asthma, s/he is specifically questioned about asthma control in the preceding 24 hours. Some patients may be requested to perform PFTs or peak flow measurements prior to receiving immunotherapy. If significantly decreased from usual values or below minimal requirement as ordered in chart, immunotherapy will be withheld.
- f. Allergy shots are administered subcutaneously in the upper lateral area of the arm near the base of the deltoid. After drawing up the correct amount of antigen into a 1cc tuberculin syringe with a 27-gauge 1/2-inch needle, the skin is cleansed with an alcohol sponge. The patient will be advised and confirm the dose that will be administered. The area is pinched and the needle is inserted at a 60 to 90-degree angle. The plunger is pulled to check for blood return and, if present, the syringe is immediately withdrawn. If no blood return is observed, syringe contents are administered and the syringe is withdrawn. Gentle pressure with the alcohol sponge is maintained over the injection site for a brief time but the site should not be rubbed.
- g. Sites of injections should alternate from one arm to the other at each subsequent visit.
- h. Keep all vials at the same dose as much as possible to reduce chances for error

3. Immunotherapy Schedule for Advancement

- a. Starting dose, advancement schedule, and reduction in dosing for missing doses will be according to each patient's extract order form in the immunotherapy record. These schedules can vary for each patient and should be checked each visit. Patient's who have reached maintenance without any systemic reactions may have their schedule for the maintenance changed from E to D.

4. Local reactions

- a. There is no increased risk of systemic reactions when patients have local reactions (even "C") to their shots. Patients may continue to advance on their schedule despite local reactions. However, if the patient is bothered by the reaction or the local reaction is very large, dosing can be held or cut back on an individual basis.

5. Maintenance

- a. Once patients reach maintenance, they should be encouraged to come in every two weeks during their first year as this will give them a better clinical response. However, they should not be considered late unless it has been more than 4 weeks since their last shot.
- b. Routine maintenance shots should otherwise be every 4 weeks. However, patients may come in more frequently if they have breakthrough allergy symptoms and achieve improved benefit with more frequent shots.

6. Follow-up

- a. All patients must see a staff allergist once a year for a follow-up visit. More frequent follow-up should be needed for patients with asthma, particularly not well controlled, and for patients having trouble advancing on schedule due to local reactions or other reasons.
- b. All patients must also have follow-up with an allergist after systemic reactions

7. Holding or postponing shots

- a. If patients are acutely ill with fever or severe cough or shortness of breath, they should not receive their allergy shot until symptoms have improved. They may receive their shot if they have only mild upper respiratory infection or cold symptoms that are not accompanied by fever, wheeze, shortness of breath or severe cough.
- b. Asthma patients should not receive their allergy shot if they are having a flare in their symptoms, a decrease in their peak flows, or are requiring increased use of their albuterol. If there is concern that their asthma is flaring, spirometry should be performed and compared to their baseline and the allergist notified.
- c. Pregnant patients must be seen by the allergist before continuing immunotherapy. In general they will be permitted to continue immunotherapy if they have reached a dose that they are achieving benefit at and that they understand there is a small risk of adverse effect on the pregnancy or fetus if they were to have a systemic reaction to their allergy shot. Immunotherapy is not advanced during pregnancy.
- d. Any patient on a beta-blocker should not receive their allergy shot since there is an increased risk of more severe systemic reaction on this medication. Patients should be asked regularly if they have started any new medications and verifications made that any new medicine is not a beta-blocker. A sign should also be posted where allergy shots patients can see it that lists the common beta-blocker medicines used.
- e. Other conditions for withholding allergy shots until the allergist can review the patient's history include:
 - i. Myocardial infarction
 - ii. Development of other heart disease or lung disease
 - iii. Other medical conditions that could make treatment or recovery from anaphylaxis more difficult.

8. **Cut-backs or holding during tree and grass season (Feb through July)**
 - a. Consider holding at current level for patient's with history of systemic reaction the previous allergy season, if they have severe asthma, or they are advancing in the maintenance (Red) vial for the first time.
 - b. Cut back by 50% for patients with previous history of repeat systemic reaction
 - c. Patients do not need to cut back if they have been at full maintenance during previous grass seasons without problems.
 - d. Consult with the allergist on these patients if there are questions.

9. **Systemic Reactions Management (see also Management of Anaphylaxis SOP)**
 - a. The allergist or surrogate allergist should be notified immediately for any possible systemic reaction. However, treatment with epinephrine should not be delayed if the patient is having a moderate to severe reaction or a progressing reaction and the MD has not yet arrived.
 - b. See Management of Anaphylaxis SOP
 - c. Patient's with a history of systemic reaction should wait a minimum of 45 minutes after each shot. Exceptions can be made if the patient has history of only mild reaction, they have reached maintenance, and it has been at least a year since their reaction, or at the discretion of the allergist. Patients may be asked to temporarily arrive even earlier depending on the severity and frequency of the reactions.
 - d. Patients with history of systemic reactions may, at the discretion of the allergist, be required to carry an epi-pen with them on shot days.
 - e. Only the allergist will determine adjustments in immunotherapy doses or schedules following a systemic reaction.

10. **Allergy shot record**
 - a. After the first allergy injection, an appropriate note is written on the SF 600, MAMC OP 1116-M and/or AHLTA. This note includes the statement that procedures were explained, consent was obtained, and a copy of the same was given to patient. Also note that the immunotherapy extract was identified, contents were checked with the prescription, and that the prescription was placed in immunotherapy record.
 - b. MAMC 1181-M Record of Immunotherapy Administration: This form identifies the patient, extract contents, prescription number, schedules for the vials, whether patient has asthma, when the next follow-up visit with the allergist is due and maintenance interval. A different MAMC 1181-M is maintained for each extract when patients are receiving more than one shot. Each entry includes date, amount administered, time given and time patient left, reaction observed, and technician initials. If the patient has asthma, it should also note if the patient had increased asthma symptoms in the preceding 24 hours. The vial number, concentration, expiration date and schedule are noted and highlighted using an entire line each time a new vial is started. Hymenoptera venom injections are recorded on MAMC Form 544-M.

- c. Labeling of extract vials and documentation in the record will be in keeping with USACAEL as follows:
 - i. Vials are color coded as silver, blue, green, yellow, red. Red is the strongest vial and is usually consider the maintenance vial. It is labeled with the BAU, AU, or w/v units and is also labeled as 1/1 v/v (volume to volume). Each color before is a 10-fold dilution and labeled as 1/10 v/v for yellow, 1/100 v/v for green, 1/1,000 v/v for blue and 1/10,000 v/v for silver. This labeling system replaces the old number system. The immunotherapy record should use labeling in keeping with the labeling on the vial.
- d. Include a blank SF 600 in chart for writing and documenting verbal or written orders by the allergist regarding changes in immunotherapy schedules or other matters.
- e. AHLTA notes should also be included for each patient with documentation of screening questions. This note is saved in AHLTA and the visit coded, but does not need to be added to the Immunotherapy Record.
- f. Include emergency contact numbers (stick-on label for inside of jacket)

11. Coding

- a. Diagnosis 477.90 Allergic rhinitis; 493.90 Asthma
- b. E&M 99499 for routine visit; 99212 for a visit when additional counseling or care is given and documented
- c. CPT AIT 95115 (single injection); 95117 (2 or more injections)
- d. CPT VIT 95130 (one venom); 95131 (two venoms); 95132 (three venoms); 95133 (four venoms)
- e. CPT PFT 94101

12. Capturing work-load

- a. If a patient is seen by an allergist the same day, the nurse will finish documenting their portion of care and then the visit must be transferred to the allergist who will sign off on and complete any final coding.

Chief, A/I Clinic

Chief, Allergy Immunology Service
Madigan Healthcare System

**STANDARD OPERATING PROCEDURE
ALLERGY/IMMUNOLOGY SERVICE, MADIGAN ARMY MEDICAL CENTER**

MANAGEMENT OF ANAPHYLAXIS

The allergist or surrogate allergist will be notified immediately for any possible systemic reaction. However, treatment with epinephrine should not be delayed if the patient is having a moderate to severe reaction or a progressing reaction and the MD has not yet arrived. The patient will be taken to the treatment room and one nurse will remain with the patient at all times.

Check vital signs (blood pressure, heart rate, respiratory rate, pulse oximetry) immediately

Signs/Symptoms of Anaphylaxis: diffuse itching, hives, flushing, throat tightness, chest tightness, wheeze, cough, shortness of breath, nausea/vomiting, abdominal cramps, lightheadedness. One or more symptoms may be present. Cutaneous symptoms are usually present, but may be absent.

Administer epinephrine immediately for all systemic reactions

Use of epinephrine is recommended for all systemic or anaphylactic reactions. Administration should be given promptly since delay of administration increases risk for progression to more severe reaction and increases risk of mortality. The preferable route of administration of epinephrine is intramuscular, although subcutaneous is acceptable. Antihistamine and systemic corticosteroids may help modify symptoms, but should never replace epinephrine because of their slow onset of action and lack of immediate effect.

Dosing of epinephrine:

Adult dose = 0.3 ml of 1/1,000 IM

Child dose = 0.01ml/kg of 1/1,000 IM

Or 0.3ml if > 65 pounds and 0.10 to 0.15ml if < 65 pounds

Dosing may be repeated every 5 to 15 minutes if symptoms persist

Administer oral antihistamine

Dosing of antihistamines:

Adult dose = Zyrtec 10mg, Allegra 180mg, or loratadine 10mg orally

Child dose = Zyrtec 5mg or loratadine 5mg for children up to age 6

10mg for age 6 and above

Dose may be repeated 12 hours later at the discretion of the allergist.

Administer oral steroids

Dosing of oral steroids: One dose of 0.5mg/kg – 2.0mg/kg of prednisone or prednisolone (up to 80mg). Dose may be repeated 6 hours later at the discretion of the allergist.

Vital Signs: Monitor vital signs every 5-10 minutes and observe the patient a minimum of one hour after the symptoms have resolved.

Spirometry: Check PFT after treatment on patients with a history of asthma or who have symptoms of wheeze or shortness of breath. Compare to previous PFT's.

Severe or unresponsive reactions:

Transfer the patient to the emergency room if symptoms do not resolve after 2 doses of epinephrine or if vital signs or symptoms are unstable.

JABF-2e

Call for immediate code and institute BLS procedures if the patient loses consciousness or stops breathing.

Supplemental oxygen at 2-4 liters may be required if the patient has significant bronchospasm, breathing difficulty, or low pulse oximetry reading.

Discharge to home: The patient may be released from the clinic to home after a minimum of one hour of observation after symptoms have all resolved and vital signs are stable. Observation may be longer depending on the severity of the reaction. The patient may be released only after being cleared by the treating allergist or surrogate allergist. The patient will be provided with an epinephrine autoinjector and educated on how and when to use. The patient will be educated on the possibility of late phase anaphylaxis reaction developing approximately 6-12 hours after initial reaction. If such a reaction occurs the patient should use the epinephrine autoinjector immediately and go to the ER or call 911. Risk of developing late phase reactions increases in cases where symptoms are prolonged (exceed 30 minutes) or are more severe.

Documentation: Documentation of the encounter and QA will be completed by the treating allergist and nurse. Once all documentation is complete all paperwork and the record will be given to the clinic Head Nurse for review.

1. Allergen immunotherapy Reaction Summary Sheet on DA Form 4700
2. QA worksheet
3. QA notebook located in the treatment room.
4. A supplemental note will also be made in AHLTA. Nurse will enter in AHLTA note brief description of patients chief complaint, time of shot given and onset of symptoms, vital signs, pulse oximetry, medications given, and documentation of the allergy shot.
5. Allergy shot hard copy record will have "Systemic reaction" written in red on the line below documentation of the shot. Amount to cut back next dose will also be written.

Coding: The AHLTA visit will be transferred under the treating allergist and the allergist will code the visit

1. Diagnosis anaphylactic shock 999.4 or serum reaction 999.5
2. CPT for emergency office visit: 99058
3. CPT for Epinephrine administration: 96732
4. CPT for PFT 94101 (pre albuterol) or 94060 (post albuterol)
5. CPT for nebulizer treatment 94640
6. CPT for pulse oximetry 94760
7. Prolonged services: first additional hour 99354, each additional 30 minutes 99355
8. Include codes for the allergy shot injection (95115 or 95117) or skin testing (95004), challenge, etc as appropriate
9. Include diagnosis of allergic rhinitis, asthma, or other conditions that are related to the visit.

Chief, A/I Clinic

Chief, Allergy/Immunization Service
Madigan Army Medical Center

STANDARD OPERATING PROCEDURE
ALLERGY/IMMUNOLOGY SERVICE
MADIGAN ARMY MEDICAL CENTER

GUIDELINE FOR THE ADMINISTRATION OF IMMUNOTHERAPY AND SQ
EPINEPHRINE IN THE ABSENCE OF AN ALLERGIST

1. Allergy shots will only be administered when there is an allergist in the clinic area or when there is a surrogate allergist designated by the allergist to cover the clinic. The surrogate allergist does not need to be in the allergy clinic area, but must be within the internal medicine clinic-area or Letterman auditorium. The surrogate allergist will be contacted prior to starting allergy shots and will confirm where they can be reached in case of a question or reaction. Both a telephone number and beeper number are preferred.
2. The surrogate allergist will be contacted for the following:
 - a) If there is any question about whether the patient should receive their immunotherapy on that day. In general, if there is a question they should not get the shots.
 - b) If there is an immunotherapy reaction or suspected reaction.
3. The surrogate allergist will not be contacted for a dose adjustment due to a reaction or to break in immunotherapy longer than allowed on the immunotherapy prescription. The patient will be advised to return when allergist will next be available.
4. In the event of significant wheezing that occurs after an allergy injection, and a physician is not in the clinic up to 0.3 (0.1ml/kg in children) of 1:100 aqueous epinephrine may be injected. 0.15ml may be injected over the injection site with a tourniquet placed lightly above it and the rest to be injected in the opposite arm. The allergist would be immediately contacted. In the event of a delayed systemic reaction and the patient returns to the clinic with no allergist available, the patient should be taken to the Emergency Room immediately or call ER Patient transport (968-1396/7 or 911) depending on the acuity of the patient.

16 FEB 2011

Chief, A/I Clinic

Chief, Allergy/Immunology Service
Madigan Army Medical Center

Addendums to the above for Bangor Branch Clinic:

Paragraph 1, line 3: the surrogate allergist at the clinic must be in the clinic building.

Paragraph 4, line 3: Phone # at BBMC = (596-4444)

JABF-2f



DEPARTMENT OF THE ARMY
MADIGAN HEALTHCARE SYSTEM
9040 JACKSON AVENUE
TACOMA, WA 98431-1100

REPLY TO
ATTENTION OF

MCHJ-CG

10 March 2011

MEMORANDUM FOR All Personnel

SUBJECT: Commander's Policy #56: Madigan Code of Conduct

1. This policy seeks to enhance and support the existing culture of professionalism at Madigan Healthcare System. Its objective is to define disruptive and inappropriate behaviors which adversely impact patient safety, professional dialogue, and retention of critical personnel on the healthcare team. This initiative aligns with my intent to focus on "people first."
2. Disruptive and inappropriate behavior can be defined as "behavior that interferes with work or creates a hostile, fearful, offensive, or disrespectful environment." These behaviors include aggressive, passive/aggressive, and even passive actions which involve verbal communication, non-verbal communication, or written materials. In a healthcare organization, disruptive and inappropriate behaviors can foster medical errors, contribute to poor patient satisfaction and adverse outcomes, increase the cost of care, and cause qualified clinicians, administrators, and managers to seek new positions in more professional environments.
3. Examples of disruptive and inappropriate behaviors as well as appropriate and encouraged behaviors are at Appendix A.
4. Personnel witnessing inappropriate and disruptive behaviors are expected to address such behaviors at the lowest level possible using the Chain of Command unless the behaviors are egregious, criminal or violent in nature, or in direct violation of Equal Opportunity or Sexual Harassment policies. Incidents that are violent or criminal in nature should be immediately reported to the Madigan Provost Marshal Office at 968-1515. Incidents that are discriminatory in nature should be reported to the Equal Opportunity Office at 968-4072. Incidents may be anonymously reported via the Patient Safety Hotline at 968-3322. For observations that do not meet the criteria above, staff should contact a supervisor or utilize their chain of command to report incidents. There are other mechanisms for reporting which could also be utilized to include filing a patient safety incident report or contacting the Inspector General.
5. Addressing disruptive behavior in our organization is a leadership responsibility – from modeling the correct behaviors to expeditiously addressing instances of inappropriate behavior. Supervisors are encouraged to use private, yet on-the-spot

TAF-3

MCHJ-CG

SUBJECT: Commander's Policy #56: Madigan Code of Conduct

corrections or counseling sessions to address individual issues regarding unprofessional behavior. If a pattern of disruptive and inappropriate behavior develops, leaders will consider initiation of disciplinary action in accordance with the Uniformed Code of Military Justice or Fort Lewis Regulation 690-14.

6. Madigan staff will be provided a copy of the Madigan Code of Conduct Card (see Appendix B) at New Employee Orientation (NEO) and annually during Mandatory Annual Training (MAT).

Commander, MAMC

Encls

COL, MC
Commanding

DISTRIBUTION:
Electronic Bulletin Board

MCHJ-CG

SUBJECT: Commander's Policy #56: Madigan Code of Conduct

Appendix A

Table 1 - Examples of disruptive and inappropriate behaviors
Physically threatening language directed at anyone
Physical contact that is threatening or intimidating
Threatening violence
Throwing instruments, charts, or other items
Threatening retaliation, retribution, or litigation
Sexual harassment and discrimination in all its forms
Use of degrading, demeaning, belittling, condescending, berating, or profane language
Name calling and use of disparaging terms
Writing inappropriate comments (not patient care focused) in medical records
Blatantly failing to respond to patient care needs or staff requests
Lack of cooperation without good cause
Failing to return phone calls or pages concerning patient care

Table 2 - Examples of appropriate and encouraged behaviors
Clear and concise communication and clarification of intended messages
Concerns of patient safety expressed audibly and appropriately
Cooperatively approaching problem resolution
Treating others with respect and dignity
Professional and courteous behavior
Conveying feedback and comments in a respectful and professional manner
Expressing dissatisfaction with policies through appropriate procedures

MCHJ-CG

SUBJECT: Commander's Policy #56: Madigan Code of Conduct

Appendix B

Madigan Code of Conduct Card

Be People-Focused
Add Value to the Madigan Team
Exhibit Professional Behavior
Communicate Effectively
Respect Our Patients and Each Other
Show Dedication to Duty and to the Mission/Vision
Maintain Privacy and Confidentiality
Act with Integrity
Embody "Care with Compassion"

People First...Patients Always



*Guide to the
Code of Ethics
for Nurses*

**Interpretation
and Application**

Barbara D.M. Fowler, PhD, MDiv, MS, RN, FAAN

EDITOR

TABF-4

Appendix A ■ Code of Ethics for Nurses with Interpretive Statements

The nurse has a responsibility to implement and maintain standards of professional nursing practice. The nurse should participate in planning, establishing, implementing, and evaluating review mechanisms designed to safeguard patients and nurses, such as peer review processes or committees, credentialing processes, quality improvement initiatives, and ethics committees. Nurse administrators must ensure that nurses have access to and inclusion on institutional ethics committees. *Nurses must bring forward difficult issues related to patient care and/or institutional constraints upon ethical practice for discussion and review.* The nurse acts to promote inclusion of appropriate others in all deliberations related to patient care.

Nurses should also be active participants in the development of policies and review mechanisms designed to promote patient safety, reduce the likelihood of errors, and address both environmental system factors and human factors that present increased risk to patients. In addition, when errors do occur, nurses are expected to follow institutional guidelines in reporting errors committed or observed to the appropriate supervisory personnel and for assuring responsible disclosure of errors to patients. Under no circumstances should the nurse participate in, or condone through silence, either an attempt to hide an error or a punitive response that serves only to fix blame rather than correct the conditions that led to the error.

3.5 Acting on questionable practice

The nurse's primary commitment is to the health, well-being, and safety of the patient across the life span and in all settings in which healthcare needs are addressed. As an advocate for the patient, the nurse must be alert to and take appropriate action regarding any instances of incompetent, unethical, illegal, or impaired practice by any member of the healthcare team or the healthcare system or any action on the part of others that places the rights or best interests of the patient in jeopardy. To function effectively in this role, nurses must be knowledgeable about the Code of Ethics, standards of practice of the profession, relevant federal, state and local laws and regulations, and the employing organization's policies and procedures.

When the nurse is aware of inappropriate or questionable practice in the provision or denial of health care, concern should be expressed to the person carrying out the questionable practice. Attention should be called to the possible detrimental affect upon the patient's well-being or best interests as well as the integrity of nursing practice. When factors in the healthcare delivery system or healthcare organization threaten the welfare of the patient, similar action should be directed

Guide to the Code of Ethics for Nurses: Interpretation and Application

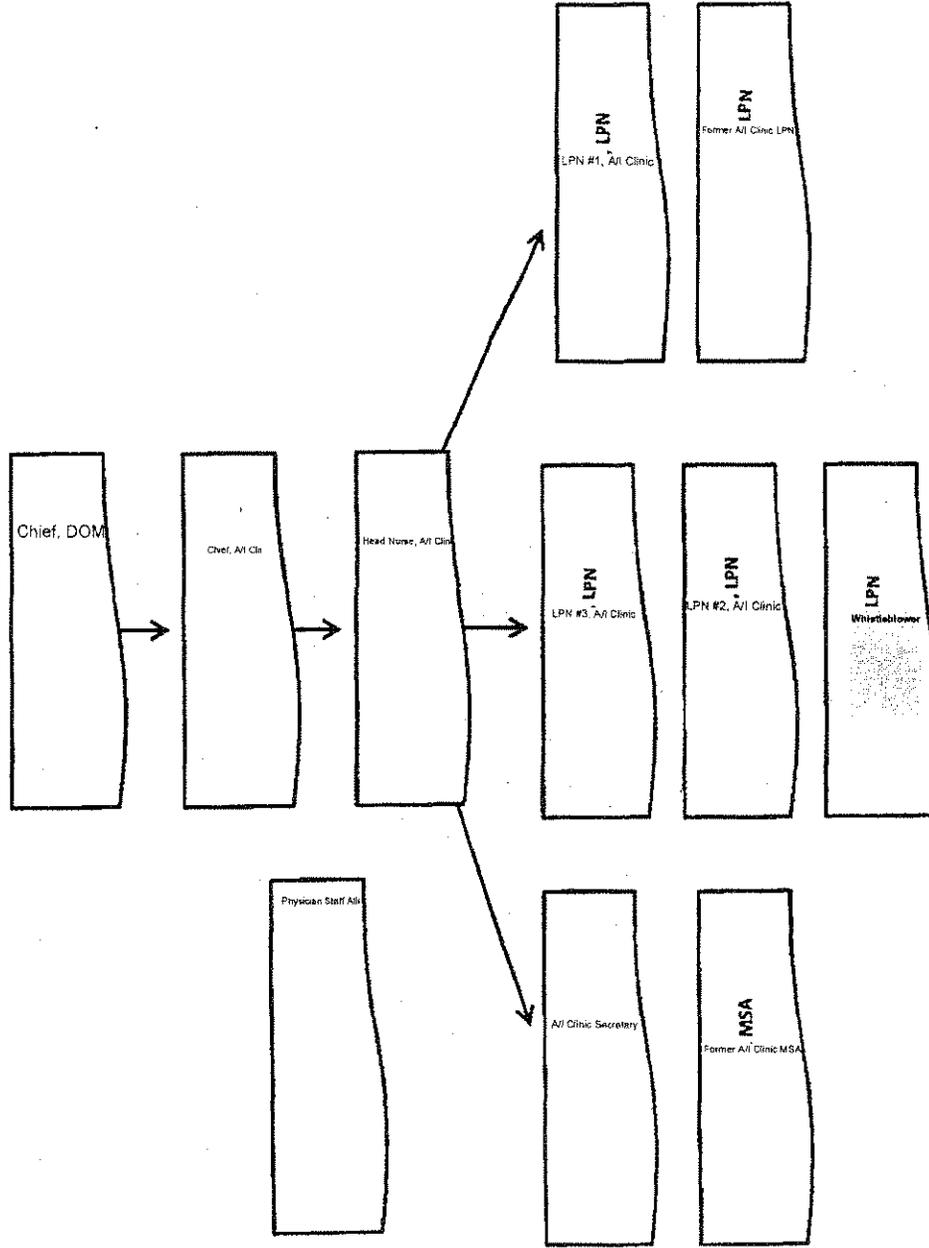
to the responsible administrator. If indicated, the problem should be reported to an appropriate higher authority within the institution or agency, or to an appropriate external authority.

There should be established processes for reporting and handling incompetent, unethical, illegal, or impaired practice within the employment setting so that such reporting can go through official channels, thereby reducing the risk of reprisal against the reporting nurse. All nurses have a responsibility to assist those who identify potentially questionable practice. State nurses associations should be prepared to provide assistance and support in the development and evaluation of such processes and reporting procedures. When incompetent, unethical, illegal, or impaired practice is not corrected within the employment setting and continues to jeopardize patient well-being and safety, the problem should be reported to other appropriate authorities such as practice committees of the pertinent professional organizations, the legally constituted bodies concerned with licensing of specific categories of health workers and professional practitioners, or the regulatory agencies concerned with evaluating standards or practice. Some situations may warrant the concern and involvement of all such groups. Accurate reporting and factual documentation, and not merely opinion, undergird all such responsible actions. When a nurse chooses to engage in the act of responsible reporting about situations that are perceived as unethical, incompetent, illegal, or impaired, the professional organization has a responsibility to provide the nurse with support and assistance and to protect the practice of those nurses who choose to voice their concerns. Reporting unethical, illegal, incompetent, or impaired practices, even when done appropriately, may present substantial risks to the nurse; nevertheless, such risks do not eliminate the obligation to address serious threats to patient safety.

3.6 Addressing impaired practice

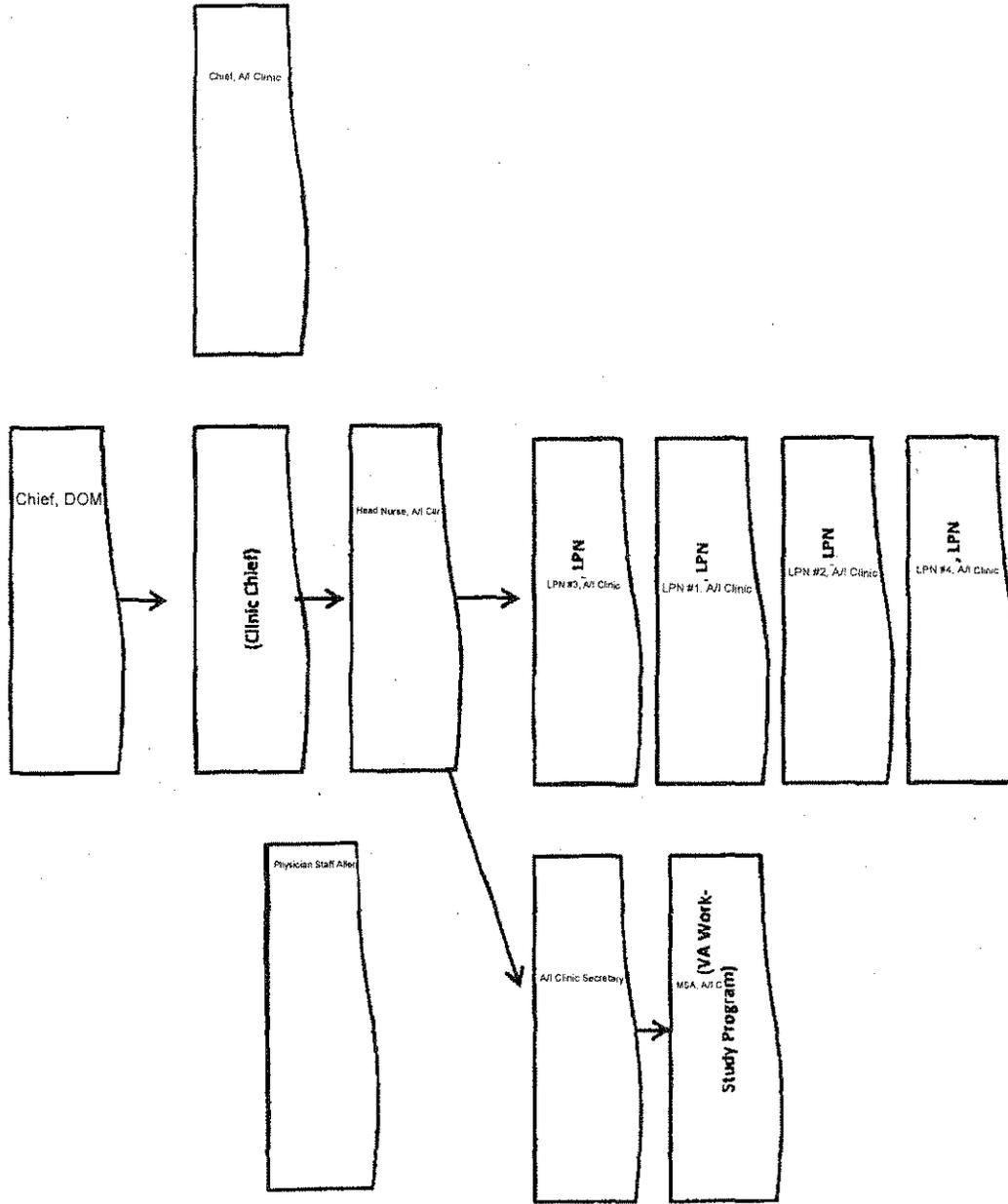
Nurses must be vigilant to protect the patient, the public and the profession from potential harm when a colleague's practice, in any setting, appears to be impaired. The nurse extends compassion and caring to colleagues who are in recovery from illness or when illness interferes with job performance. In a situation where a nurse suspects another's practice may be impaired, the nurse's duty is to take action designed both to protect patients and to assure that the impaired individual receives assistance in regaining optimal function. Such action should usually begin with consulting supervisory personnel and may also include confronting the individual in a supportive manner and with the assistance of others or helping the individual to access appropriate resources. Nurses are encouraged to follow guidelines

ALLERGY/IMMUNOLOGY CLINIC ORGANIZATIONAL CHART AS OF 1 FEBRUARY 2011



UPDATED: 22 AUG 2011

ALLERGY/IMMUNOLOGY CLINIC ORGANIZATIONAL CHART AS OF 1 JUNE 2012



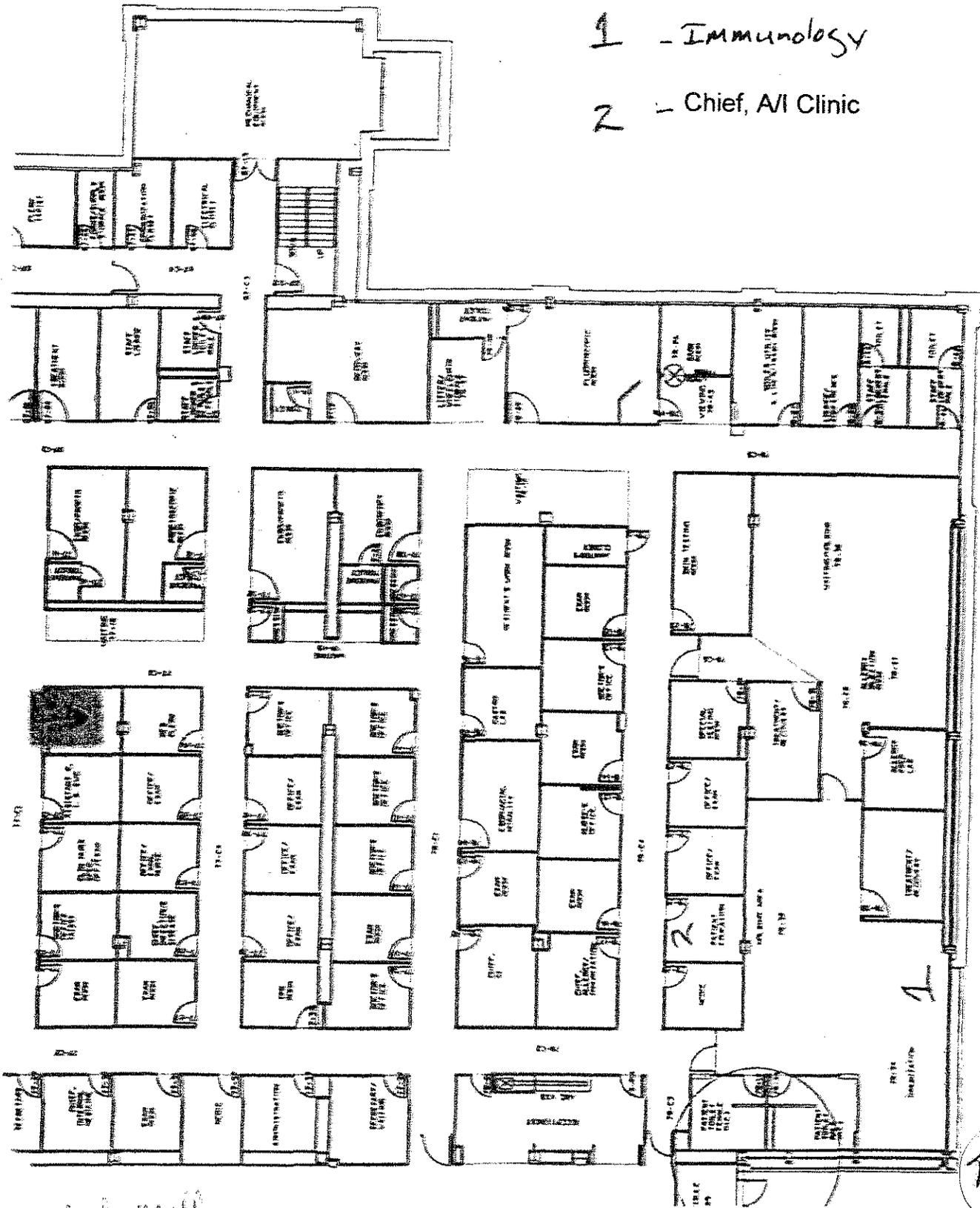
UPDATED: 22 AUG 2011

KEY



Office for
Dr Physician #2, IMC → Physician #1, IMC

- 1 - Immunology
- 2 - Chief, AI Clinic



TAB 6

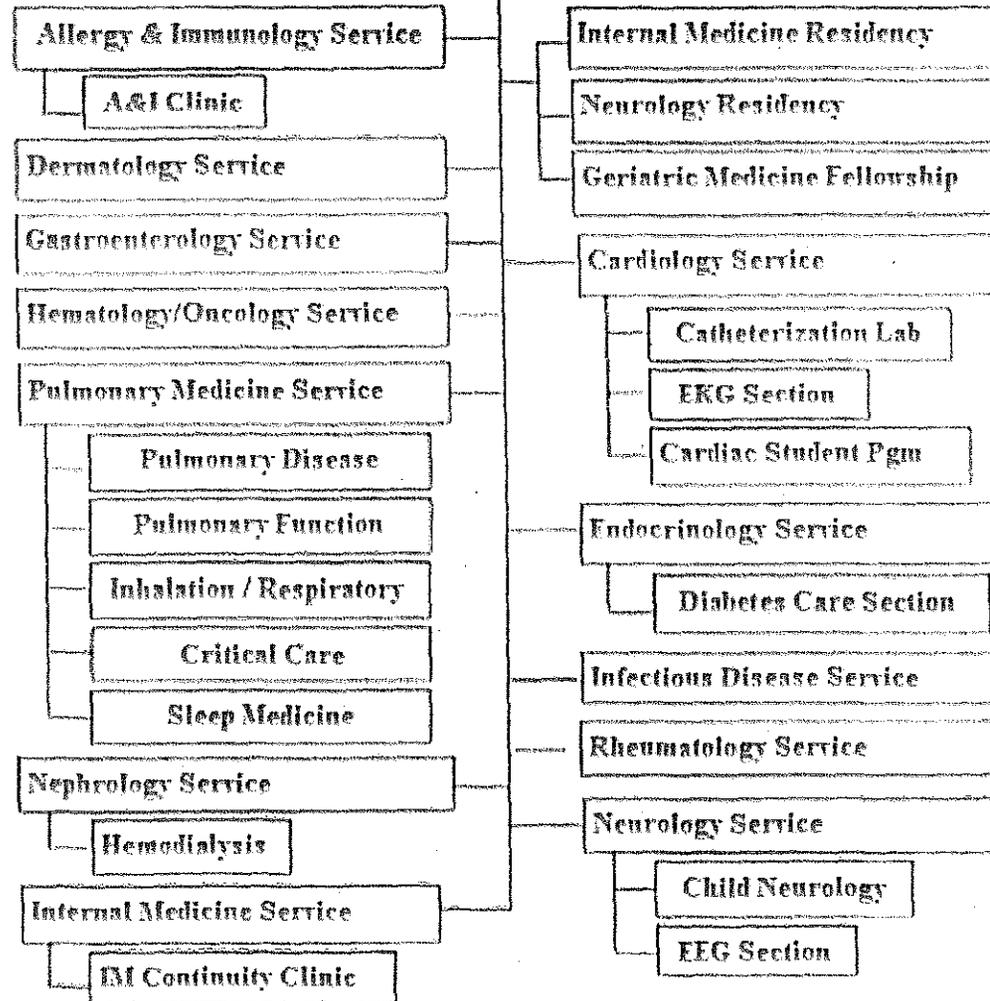
Chief, DOM

ALPHABETIC # A

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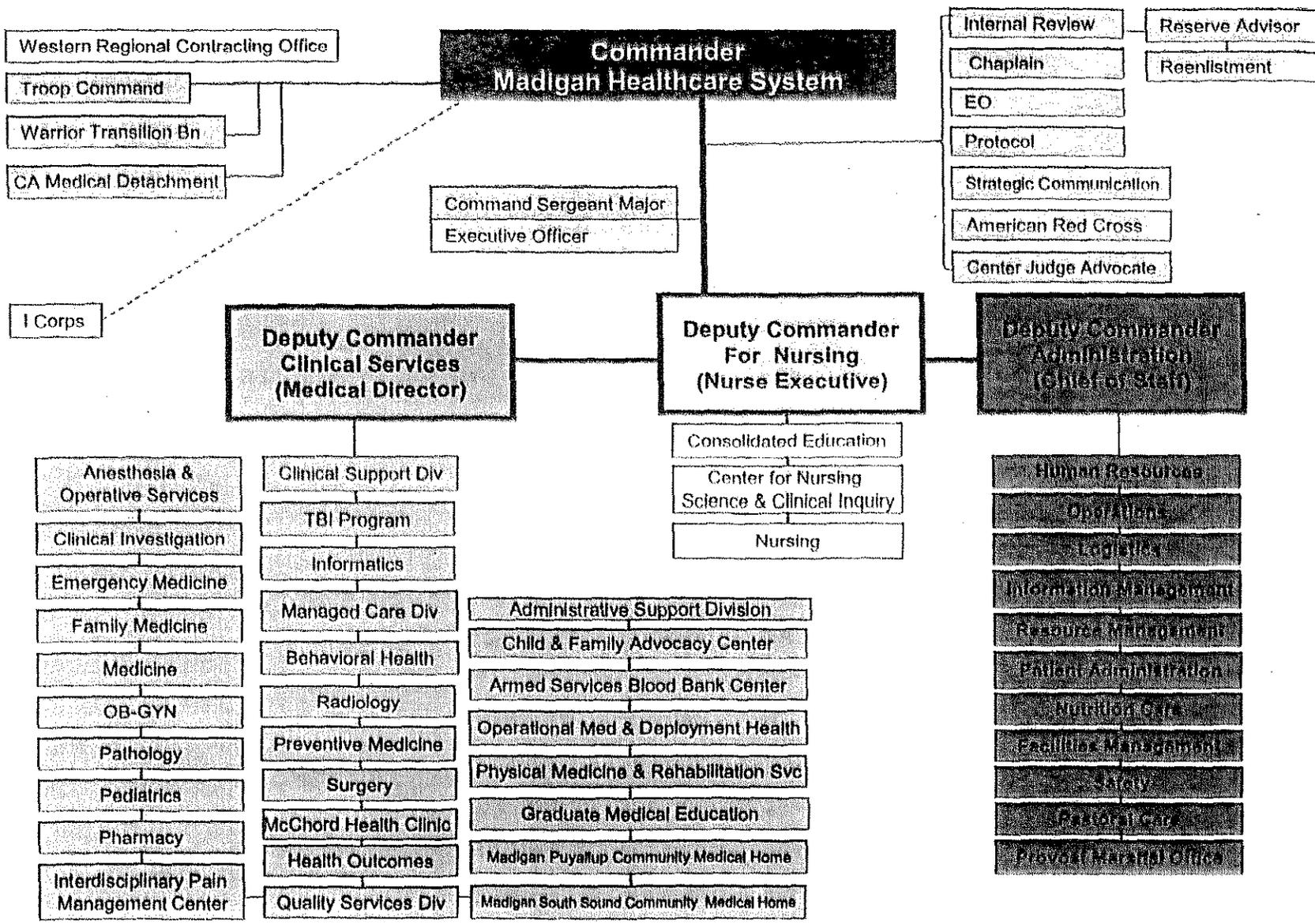
med mail

COL Joseph T. Morris III, MD
Chief, Department of Medicine



Chief, DOM

ATTACHMENT #3
Page # 9



Chief, DOM

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 Page #3

Army Regulation 40-501

Medical Services

Standards of Medical Fitness

Rapid Action Revision (RAR) Issue Date: 4 August 2011

Headquarters
Department of the Army
Washington, DC
14 December 2007

JAB P.7

UNCLASSIFIED

EXH 7

Chapter 7 Physical Profiling

7-1. General

This chapter prescribes a system for classifying individuals according to functional abilities. Also see paragraphs 3-12, 3-13, 3-25, 3-27, 3-30, 3-45, and 3-46 for additional guidance on amputations, coronary artery disease, asthma, seizure disorders, and heat and cold injuries.

7-2. Application

The physical profile system is applicable to the following categories of personnel:

- a. Registrants who undergo an induction or pre-induction medical examination related to Selective Service processing.
- b. All applicants examined for enlistment, appointment, or induction.
- c. Members of any component of the U.S. Army throughout their military Service, whether or not on active duty.

7-3. Physical profile serial system

a. The physical profile serial system is based primarily upon the function of body systems and their relation to military duties. The functions of the various organs, systems, and integral parts of the body are considered. Since the analysis of the individual's medical, physical, and mental status plays an important role in assignment and welfare, not only must the functional grading be executed with great care, but clear and accurate descriptions of medical, physical, and mental deviations from normal are essential.

b. In developing the system, the functions have been considered under six factors designated "P-U-L-H-E-S." Four numerical designations are used to reflect different levels of functional capacity. The basic purpose of the physical profile serial is to provide an index to overall functional capacity. Therefore, the functional capacity of a particular organ or system of the body, RATHER THAN THE DEFECT PER SE, will be evaluated in determining the numerical designation 1, 2, 3, or 4.

c. The factors to be considered are as follows:

(1) *P—Physical capacity or stamina.* This factor, general physical capacity, normally includes conditions of the heart; respiratory system; gastrointestinal system, genitourinary system; nervous system; allergic, endocrine, metabolic and nutritional diseases; diseases of the blood and blood forming tissues; dental conditions; diseases of the breast, and other organic defects and diseases that do not fall under other specific factors of the system.

(2) *U—Upper extremities.* This factor concerns the hands, arms, shoulder girdle, and upper spine (cervical, thoracic, and upper lumbar) in regard to strength, range of motion, and general efficiency.

(3) *L—Lower extremities.* This factor concerns the feet, legs, pelvic girdle, lower back musculature and lower spine (lower lumbar and sacral) in regard to strength, range of motion, and general efficiency.

(4) *H—Hearing and ears.* This factor concerns auditory acuity and disease and defects of the ear.

(5) *E—Eyes.* This factor concerns visual acuity and diseases and defects of the eye.

(6) *S—Psychiatric.* This factor concerns personality, emotional stability, and psychiatric diseases.

d. Four numerical designations are assigned for evaluating the individual's functional capacity in each of the six factors. Guidance for assigning numerical designators is contained in table 7-1. The numerical designator is not an automatic indicator of "deployability" or assignment restrictions, or referral to an MEB. The conditions listed in chapter 3 and the Soldier's functional limitations, rather than the numerical designator of the profile, will be the determining factors for MEB processing.

(1) An individual having a numerical designation of "1" under all factors is considered to possess a high level of medical fitness.

(2) A physical profile designator of "2" under any or all factors indicates that an individual possesses some medical condition or physical defect that may require some activity limitations.

(3) A profile containing one or more numerical designators of "3" signifies that the individual has one or more medical conditions or physical defects that may require significant limitations. The individual should receive assignments commensurate with his or her physical capability for military duty.

(4) A profile serial containing one or more numerical designators of "4" indicates that the individual has one or more medical conditions or physical defects of such severity that performance of military duty must be drastically limited.

e. Anatomical defects or pathological conditions will not of themselves form the sole basis for recommending assignment or duty limitations. While these conditions must be given consideration when accomplishing the profile, the prognosis and the possibility of further aggravation must also be considered. In this respect, profiling officers must consider the effect of their recommendations upon the Soldier's ability to perform duty. Profiles must be realistic. All profiles and assignment limitations must be specific, and written in lay terms. If the commander has questions about a profile or is unable to use the Soldier within the profile limitations, the procedures in paragraph 7-12 will apply.

(1) Determination of individual assignment or duties to be performed is a commander's decision. Limitations such

as "no field duty," or "no overseas duty," are not proper medical recommendations. (However, they are included as administrative guidelines in pregnancy profiles.) Profiling officers will provide enough information regarding the Soldier's physical limitations to enable the nonmedical commander and AHRC to make a determination on individual assignments or duties. The profiling officer is responsible for entering the correct administrative code from table 7-2 into Item 2 of the DA Form 3349.

(2) It is the responsibility of the commander or personnel management officer to determine proper assignment and duty, based upon knowledge of the Soldier's profile, assignment limitations, and the duties of their grade and MOS.

(3) The commander has the final decision on the deployment of Soldiers in his/her unit. When medical providers and commanders disagree on the medical readiness status of a Soldier, the decision will be raised to the first general officer in the Soldier's chain of command, who will review both medical and commander recommendations and make the final decision whether to deploy the Soldier.

(4) Table 7-1 contains the physical profile functional capacity guide.

(5) See TB MED 287 for profiling Soldiers with pseudofolliculitis.

7-4. Temporary vs. permanent profiles

a. Electronic requirements. All temporary profiles greater than 30 days and all permanent profiles must be completed electronically. There are two ways to access the electronic profile; one through AHLTA (Version 3.3.2), and one through MODS.

(1) *AHLTA.* Providers first sign into AHLTA and then select the "Medical Readiness" link in AHLTA. From the Medical Readiness portal, the provider then selects the link for the e-Profile.

(2) *MODS.* Providers can also access the e-Profile application at: <https://apps.mods.army.mil>.

Note. If the electronic systems are unavailable, the provider will issue a temporary profile in paper form for 30 days duration until the profile can be entered into e-Profile.

b. Permanent profiles. A profile is considered permanent unless a modifier of "T" (temporary) is added. A permanent profile may only be awarded or changed by the authority designated in paragraph 7-6, below. All permanent "3" and "4" profiles, for Soldiers on active duty, will be reviewed by an MEB physician or physician approval authority. An MEB physician is an MTF dedicated subject matter expert trained to perform disability evaluations per guidelines established in DODI 1332.38 (see AR 40-400 for MEB process). The MEB physician will assist the MTF commander in educating profiling officers on current physical profiling regulation and policy guidance.

(1) If the profile is permanent, the profiling officer must assess if the Soldier meets the medical retention standards of chapter 3. Those Soldiers on active duty who do not meet the medical retention standards must be referred to an MEB as per chapter 3. (See paras 9-10 and 10-25, respectively, for disposition of USAR and ARNG Soldiers not on active duty who do not meet medical retention standards.)

(2) Soldiers who have one or more condition(s) that do not meet medical retention standards are referred to a MEB / PEB after attaining the Medical Retention Determination Point (MRDP). The MRDP is when the Soldier's progress appears to have medically stabilized; the course of further recovery is relatively predictable; and where it can be reasonably determined that the Soldier is most likely not capable of performing the duties required of his MOS, grade, or rank. This MRDP and referral to a MEB/PEB will be made within 1 year of being diagnosed with a medical condition(s) that does not appear to meet medical retention standards, but the referral may be earlier if the medical provider determines that the Soldier will not be capable of returning to duty within 1 year. The MEB physician or physician approval authority will review all MEB referrals to insure that MRDP has been achieved prior to initiating a medical evaluation board; coordinate inappropriate MEB referrals back through the profiling officer for appropriate disposition; and assist physician approving authorities in reconciling profiling officer's questions and concerns about MRDP timing and MMRB versus MEB referrals. The MEB physician or physician approval authority will review all profiles to confirm that the MRDP has been reached before obtaining the approving authority signature.

(3) Those Soldiers (active duty and USAR/ARNG) who meet retention standards but have at least a 3 or 4 PULHES serial will be referred to a Medical MOS Retention Board (MMRB) in accordance with AR 600-60, unless waived by the MMRB convening authority.

(4) Permanent profiles may be amended (following the correct procedure) at any time if clinically indicated and will automatically be reviewed and verified by the privileged provider at the time of a Soldier's periodic health assessment or other medical examination.

(5) The Soldier's commander may also request a review of a permanent profile, in accordance with paragraph 7-12b.

c. Temporary profiles. Soldiers receiving medical or surgical care or recovering from illness, injury, or surgery, will be managed with temporary physical profiles until they reach the point in their evaluation, recovery, or rehabilitation where the profiling officer determines that MRDP has been achieved but no longer than 12 months. A temporary profile is given if the condition is considered temporary, the correction or treatment of the condition is medically advisable, and correction usually will result in a higher physical capacity. Soldiers on active duty and RC Soldiers not on active duty with a temporary profile will be medically evaluated at least once every 3 months at which time the profile may be extended for a maximum of 6 months from the initial profile start date by the profiling officer.

(1) Temporary profiles exceeding 6 months duration, for the same medical condition, will be referred to a specialist (for that medical condition) for management and consideration for one of the following actions:

(a) Continuation of a temporary profile for a maximum of 12 months from the initial profile start date;

(b) Change the temporary profile to a permanent profile;

(c) Determination of whether the Soldier meets the medical retention standards of chapter 3 and, if not, referral to an MEB.

(2) The profiling officer must review previous profiles before making a decision to extend a temporary profile and refer the Soldier to a medical specialist for management if the temporary profile has been in effect for 6 months. Any extension of a temporary profile must be recorded on DA Form 3349, and if renewed, item 8 on the DA Form 3349 will contain the following statement: "This temporary profile is an extension of a temporary profile first issued on (date)."

(3) Temporary profiles will specify an expiration date. If no date is specified, the profile will automatically expire at the end of 30 days from issuance of the profile. In no case will Soldiers carry a temporary profile that has been extended for more than 12 months. If a profile is needed beyond the 12 months, the temporary profile will be changed to a permanent profile. Exceptions to the 12-month temporary physical profile restriction must be approved by the medical treatment facility (MTF) commander or their designated senior physician approval authority (often the deputy commander for clinical services).

7-5. Representative profile serial and codes

To facilitate the assignment of individuals after they have been given a physical profile serial and for statistical purposes, code designations have been adopted to represent certain combinations of physical limitations or assignment guidance (see table 7-2, below). The alphabetical coding system will be recorded on the DA Form 3349, item 2 and personnel qualifications records. Up to three different codes can be listed in item 2. This coding system will not be used on medical records to identify limitations. The numerical designations under each profile factor, PULHES, are given in table 7-1, below.

7-6. Profiling officer and approving authority

a. Profiling officers. Commanders of Army MTFs are authorized to designate one or more physicians, dentists, optometrists, podiatrists, audiologists, nurse practitioners, nurse midwives, licensed clinical psychologists, and physician assistants as profiling officers. The commander will assure that those designated are thoroughly familiar with the contents of this regulation. Profiling officer limitations are as follows:

(1) *Physicians.* No limitations except for temporary profiles that exceed 6 months that require referral to a specialist (see para 7-4c(1)).

(2) *Dentists, optometrists, physical therapists, chiropractors, and occupational therapists.* No limitation within their specialty for awarding temporary or permanent numerical designators "1" and "2." A temporary numerical designator "3" may be awarded for a period not to exceed 90 days. Any extension beyond 90 days must be signed by a physician. (See para 7-8.)

(3) *Audiologists.* No limitation within their specialty for awarding permanent numerical designators "1," "2," "3," or "4" in cases of sensorineural hearing loss, if retrocochlear lesion has been ruled out. Changing from or to a permanent numerical designator "3" or "4" requires the co-signature of a physician approving authority (see para 7-8).

(4) *Physician assistants, nurse midwives, nurse practitioners, and licensed clinical psychologists.* Limited to awarding temporary numerical designators "2," "3," and "4" for a period not to exceed 90 days. Any extension of a temporary profile beyond 90 days must be signed by a physician, except when the provisions of paragraph 7-9 apply. However, physician assistants with AOC 65DM1 certified in orthopedics have no limitations in awarding temporary orthopedic profiles or permanent profiles with a numerical designator of "1" or "2." Physician assistants, nurse midwives, nurse practitioners, and licensed clinical psychologists may award permanent profiles of "2," "3," or "4" provided the profile is signed by the physician approving authority.

(5) *Podiatrists.* No limitations within their specialty for awarding temporary or permanent profiles with a numerical designator of "1" or "2." Podiatrists may award permanent profiles of "3" or "4" providing the profile is signed by a physician approving authority.

(6) *MEPS physicians, physician assistants, and nurse practitioners.* They will also be designated as profiling officers. (See para 7-7b.)

(7) *Other DOD physicians.* In those instances where a Soldier does not have access to an Army MTF, but is assigned to a location with another Department of Defense medical facility (Navy, Air Force), a physician from another Service can be a profiling officer, if designated by the commander.

(8) *AD TRICARE Prime Remote Soldiers, Selected Reserve (TPU, AGR, IMA) and ARNG Soldiers.* These Soldiers may have profiles completed via the current agencies contracted to provide these medical services.

b. Approving authority. Commanders of Army MTFs are authorized to designate or delegate one or more physicians as approving authorities. The commander will assure that those designated are thoroughly familiar with the contents of

this regulation. The approving authority must be a physician. Permanent "3" or "4" physical profiles require an approving authority signature.

7-7. Recording and reporting of initial physical profile

a. Individuals accepted for initial appointment, enlistment, or induction in peacetime normally will be given a numerical designator "1" or "2" physical profile in accordance with the instructions contained in this regulation. Initial physical profiles will be recorded on DD Form 2808 by the medical profiling officer at the time of the initial appointment, enlistment, or induction medical examination.

b. The initial physical profile serial will be entered on DD Form 2808 and also recorded on DD Forms 1966 (Record of Military Processing—Armed Forces of the United States), in the appropriate spaces. When the modifier "T" is entered on the profile serial, or in those exceptional cases where the numerical designator "3" is used on initial entry, a brief, nontechnical description of the defect will be recorded in the "Summary of Defects" section on the DD Form 2808, in addition to the exact diagnosis. All physical, geographic, or climatic area limitations applicable to the defect will also be entered in that section. If sufficient room for a full explanation is not available in that section, proper reference will be made in that section number and an additional sheet of paper attached. It is not uncommon for the MEPS to assign a profile with the numerical designator of "3" or "0" pending a medical waiver review of a disqualifying condition. This is for their administrative purposes only. If the individual receives a medical waiver, the waiver documentation completed by the waiver authority should indicate the appropriate profile in accordance with table 7-1.

7-8. Profiling reviews and approvals

a. Permanent "3" or "4" profiles require the signatures of 2 profiling officers, one of which is a physician approving authority (unless the provisions of 7-8f apply). (Permanent profiles of "3" or "4" for the Individual Ready Reserve are valid with only one signature if signed by the AHRC Surgeon or his/her designee.) (ANG requires the signatures of 2 profiling officers for all permanent profiles to include permanent "1" or "2." See para 10-12). Temporary or permanent profiles of "1" or "2" require the signature of one profiling officer. See paragraph 7-6 to determine who is authorized to sign profiles.

b. Situations that require a mandatory review of an existing physical profile include—

(1) Return to duty of a Soldier hospitalized. The attending physician will ensure that the patient has the correct physical profile, assignment limitations(s), and medical followup instructions, as appropriate.

(2) When directed by the appointing authority in cases of a problematical or controversial nature requiring temporary revision of profile.

(3) At the time of the periodic health assessment or other medical examination.

(4) Upon request of the unit commander.

(5) On request of a PEB.

(6) When a permanent "3" or "4" profile is changed to a permanent "1" or "2" the change requires the signatures of 2 profiling officers, one of which is a physician approving authority (unless the provisions of 7-8f apply).

c. A temporary revision of profile will be completed when, in the opinion of the profiling officer, the functional capacity of the individual has changed to such an extent that it temporarily alters the individual's ability to perform duty. Temporary profiles written on DA Form 3349 will not exceed 3 months except as provided for in paragraphs 7-8d and 7-9. Temporary profiles written on DD Form 689 (Individual Sick Slip) will not exceed 30 days.

d. Tuberculous patients returned to a duty status who require anti-tuberculous chemotherapy following hospitalization will be given a temporary "2" profile under the P factor of the physical profile for a period of 1 year with recommendation that the Soldier be placed on duty at a fixed installation and will be provided the required medical supervision for a period of 1 year.

e. The physical profile in controversial or equivocal cases may be verified or revised by the hospital commander or command surgeon.

f. Physical profiles for Reserve Soldiers not on active duty and for those Soldiers activated on orders for greater than 30 days in the Ready Reserve (ARNG/AR), Standby Reserve (AR), and Retired Reserve (AR), may be accomplished by the U.S. Army Regional Support Command (RSC) surgeons, division staff surgeons, Active Army medical facility profiling officers (Reserve Soldiers on orders for 30 days or greater only), USAR/ARNG contracted agencies profiling officers, the U.S. Army Reserve (USARC) command surgeon and the AHRC command surgeon or their designees (Ready Reserve only). For ARNG/ARNGUS Soldiers not on active duty, profiles will be accomplished by State ARNG/ARNGUS providers. The respective State surgeons (if physician) or their designated physician alternate can be the approving authority for permanent "3" or "4" profiles. The NGB chief surgeon is also an ARNG approval authority for all ARNG Soldiers. The ARNG division surgeons may be designated as approval authority, but would require delegation by each concerned State or Territory State surgeon. Approval authorities for the Army Reserve are the USARC command surgeon and the Regional Support Command surgeons. The USAR operational and functional command surgeons and division surgeons that function as command surgeons may be delegated profile-approving authority by the USARC command surgeon.

g. Individuals who were found unfit by a PEB but COAD used to be assigned a code "V" on their physical profile code. The code "V" is no longer used for this purpose but rather to identify Soldiers with restrictions on deployment. An "X" is now used to identify individuals who were found unfit by a PEB but COAD or COAR.

h. MEB physicians must ensure that all physical profile and assignment limitations are fully recorded on one DA Form 3349. When the Soldier is referred to a PEB, a copy of the consolidated DA Form 3349 will be forwarded to the PEB with the MEB proceeding, with distribution of the form as indicated in paragraph 7-11b, below. On the consolidated DA Form 3349, the MEB physician may be the profiling officer (1st signature). Cooperation between the MEB physician, PEB liaison officers, and the PEB is essential when additional medical information or profile reconsideration is requested from the MTF by the PEB. The limitations described on the profile form may affect the decision of fitness by the PEB.

i. Table 7-1 will be used when determining the numerical designator of the PULHES factors. (For example, a Soldier will not be given a permanent "3" or "4" solely on the basis of a referral to a PEB.)

7-9. Profiling pregnant Soldiers

a. *Intent.* The intent of these provisions is to protect the fetus while ensuring productive use of the Soldier. Common sense, good judgement, and cooperation must prevail between policy, Soldier, and Soldier's commander to ensure a viable program. This profile has been revised from the previous profile published in the 1995 edition of this regulation. This profile guidance has been revised and includes mandating an occupational health interview to assess risks to the Soldier and fetus and adding additional restrictions to reduce exposure to solvents, lead, and fuels that may be associated with adverse pregnancy outcomes.

b. Responsibilities.

(1) *Soldier.* The Soldier will seek medical confirmation of pregnancy and will comply with the instructions of medical personnel and the individual's unit commander.

(2) *Medical personnel.* A privileged provider (physician, nurse midwife/practitioner or physician assistant) will confirm pregnancy and once confirmed will initiate prenatal care of the Soldier and issue a physical profile. Nurse midwives, nurse practitioners, and physician assistants are authorized to issue routine or standard pregnancy profiles for the duration of the pregnancy. An occupational history will be taken at the first visit to assess potential exposures related to the Soldier's specific MOS. This history is ideally taken by the occupational medicine physician or nurse. However, if this is not feasible, the profiling officer must complete the occupational history. After review of the occupational history, the profiling officer (physician, nurse midwife/practitioner, or physician assistant), in conjunction with the occupational health clinic as needed, will determine whether any additional occupational exposures, other than those indicated in the paragraphs below, should be avoided for the remainder of the pregnancy. Examples include but are not limited to hazardous chemicals, ionizing radiation, and excessive vibration. If the occupational history or industrial hygiene sampling data indicate significant exposure to physical, chemical, or biological hazards, then the profile will be revised to restrict exposure from these workplace hazards.

(3) *Unit commander.* The commander will counsel all female Soldiers as required by AR 600-8-24 or AR 635-200. The unit commander will consult with medical personnel as required. This includes establishing liaison with the occupational health clinic and requesting site visits by the occupational health personnel if necessary to assess any work place hazards.

c. Physical profiles.

(1) Profiles will be issued for the duration of the pregnancy. The MTF will ensure that the unit commander is provided a copy of the profile, and advise the unit commander as required. Upon termination of pregnancy, a new profile will be issued reflecting revised profile information. Physical profiles will be issued as follows:

(2) Under factor "P" of the physical profile, indicate "T-3."

(3) List diagnosis as "pregnancy, estimated delivery date."

d. *Limitations.* Unless superceded by an occupational health assessment, the standard pregnancy profile, DA Form 3349, will indicate the following limitations:

(1) Except under unusual circumstances, the Soldier should not be reassigned to overseas commands until pregnancy is terminated. (See AR 614-30 for waiver provisions and for criteria curtailing OCONUS tours.) She may be assigned within CONUS. Medical clearance must be obtained prior to any reassignment.

(2) The Soldier will not receive an assignment to duties where nausea, easy fatigue, or sudden lightheadedness would be hazardous to the Soldier, or others, to include all aviation duty, Classes 1/2/3. (However, there are specific provisions in para 4-13c that allow the aircrew member to request and be granted permission to remain on flight status. ATC personnel may continue ATC duties with approval of the flight surgeon, obstetrician, and ATC supervisor.)

(3) Restrict exposures to military fuels. Pregnant Soldiers must be restricted from assignments involving frequent or routine exposures to fuel vapors or skin exposure to spilled fuel such as fuel handling or otherwise filling military vehicles with fuels such as mogas, JP8, and JP4.

(4) No weapons training in indoor firing ranges due to airborne lead concentrations and bore gas emissions. Firing of weapons is permitted at outdoor sites. (See (11) below, for other weapons training restrictions.) No exposure to

g. Individuals who were found unfit by a PEB but COAD used to be assigned a code "V" on their physical profile code. The code "V" is no longer used for this purpose but rather to identify Soldiers with restrictions on deployment. An "X" is now used to identify individuals who were found unfit by a PEB but COAD or COAR.

h. MEB physicians must ensure that all physical profile and assignment limitations are fully recorded on one DA Form 3349. When the Soldier is referred to a PEB, a copy of the consolidated DA Form 3349 will be forwarded to the PEB with the MEB proceeding, with distribution of the form as indicated in paragraph 7-11b, below. On the consolidated DA Form 3349, the MEB physician may be the profiling officer (1st signature). Cooperation between the MEB physician, PEB liaison officers, and the PEB is essential when additional medical information or profile reconsideration is requested from the MTF by the PEB. The limitations described on the profile form may affect the decision of fitness by the PEB.

i. Table 7-1 will be used when determining the numerical designator of the PULHES factors. (For example, a Soldier will not be given a permanent "3" or "4" solely on the basis of a referral to a PEB.)

7-9. Profiling pregnant Soldiers

a. *Intent.* The intent of these provisions is to protect the fetus while ensuring productive use of the Soldier. Common sense, good judgement, and cooperation must prevail between policy, Soldier, and Soldier's commander to ensure a viable program. This profile has been revised from the previous profile published in the 1995 edition of this regulation. This profile guidance has been revised and includes mandating an occupational health interview to assess risks to the Soldier and fetus and adding additional restrictions to reduce exposure to solvents, lead, and fuels that may be associated with adverse pregnancy outcomes.

b. Responsibilities.

(1) *Soldier.* The Soldier will seek medical confirmation of pregnancy and will comply with the instructions of medical personnel and the individual's unit commander.

(2) *Medical personnel.* A privileged provider (physician, nurse midwife/practitioner or physician assistant) will confirm pregnancy and once confirmed will initiate prenatal care of the Soldier and issue a physical profile. Nurse midwives, nurse practitioners, and physician assistants are authorized to issue routine or standard pregnancy profiles for the duration of the pregnancy. An occupational history will be taken at the first visit to assess potential exposures related to the Soldier's specific MOS. This history is ideally taken by the occupational medicine physician or nurse. However, if this is not feasible, the profiling officer must complete the occupational history. After review of the occupational history, the profiling officer (physician, nurse midwife/practitioner, or physician assistant), in conjunction with the occupational health clinic as needed, will determine whether any additional occupational exposures, other than those indicated in the paragraphs below, should be avoided for the remainder of the pregnancy. Examples include but are not limited to hazardous chemicals, ionizing radiation, and excessive vibration. If the occupational history or industrial hygiene sampling data indicate significant exposure to physical, chemical, or biological hazards, then the profile will be revised to restrict exposure from these workplace hazards.

(3) *Unit commander.* The commander will counsel all female Soldiers as required by AR 600-8-24 or AR 635-200. The unit commander will consult with medical personnel as required. This includes establishing liaison with the occupational health clinic and requesting site visits by the occupational health personnel if necessary to assess any work place hazards.

c. Physical profiles.

(1) Profiles will be issued for the duration of the pregnancy. The MTF will ensure that the unit commander is provided a copy of the profile, and advise the unit commander as required. Upon termination of pregnancy, a new profile will be issued reflecting revised profile information. Physical profiles will be issued as follows:

(2) Under factor "P" of the physical profile, indicate "T-3."

(3) List diagnosis as "pregnancy, estimated delivery date."

d. *Limitations.* Unless superseded by an occupational health assessment, the standard pregnancy profile, DA Form 3349, will indicate the following limitations:

(1) Except under unusual circumstances, the Soldier should not be reassigned to overseas commands until pregnancy is terminated. (See AR 614-30 for waiver provisions and for criteria curtailing OCONUS tours.) She may be assigned within CONUS. Medical clearance must be obtained prior to any reassignment.

(2) The Soldier will not receive an assignment to duties where nausea, easy fatigue, or sudden lightheadedness would be hazardous to the Soldier, or others, to include all aviation duty, Classes 1/2/3. (However, there are specific provisions in para 4-13c that allow the aircrew member to request and be granted permission to remain on flight status. ATC personnel may continue ATC duties with approval of the flight surgeon, obstetrician, and ATC supervisor.)

(3) Restrict exposures to military fuels. Pregnant Soldiers must be restricted from assignments involving frequent or routine exposures to fuel vapors or skin exposure to spilled fuel such as fuel handling or otherwise filling military vehicles with fuels such as mogas, JP8, and JP4.

(4) No weapons training in indoor firing ranges due to airborne lead concentrations and bore gas emissions. Firing of weapons is permitted at outdoor sites. (See (11) below, for other weapons training restrictions.) No exposure to

organic solvent vapors above permissible levels. (For example, work in ARMS room is permitted if solvents are restricted to 1999 MIL-PRF-680, degreasing solvent.)

(5) No work in the motor pool involving painting, welding, soldering, grinding, and sanding on metal, parts washing, or other duties where the Soldier is routinely exposed to carbon monoxide, diesel exhaust, hazardous chemicals, paints, organic solvent vapors, or metal dusts and fumes (for example, motor vehicle mechanics). It does not apply to pregnant Soldiers who perform preventive maintenance checks and services (PMCS) on military vehicles using impermeable gloves and coveralls, nor does it apply to Soldiers who do work in areas adjacent to the motor pool bay (for example, administrative offices) if the work site is adequately ventilated and industrial hygiene sampling shows carbon monoxide, benzene, organic solvent vapors, metal dusts and fumes do not pose a hazard to pregnant Soldiers. (See (11), below, for PMCS restrictions at 20 weeks of pregnancy.)

(6) The Soldier must avoid excessive vibrations. Excessive vibrations occur in larger ground vehicles (greater than 1 1/4 ton) when the vehicle is driven on unpaved surfaces.

(7) Upon the diagnosis of pregnancy, the Soldier is exempt from regular unit physical fitness training and APFT testing/weight standards for the duration of the pregnancy and 180 days past pregnancy termination. After receiving medical clearance from their health care provider to participate in physical training, commanders will enroll Soldiers who are pregnant or postpartum to take part in the Army Pregnancy/Postpartum Physical Training (PPPT) program, an element of the Army Physical Fitness Training Program, in accordance with AR 350-1, Army Training and Education. The PPPT Program is designed to maintain health and fitness levels of pregnant Soldiers, and successfully integrate postpartum Soldiers back into unit physical fitness training programs with emphasis on achieving the APFT standards in accordance with guidance provided in the Army Physical Fitness Training Program, and meeting height/weight standards in accordance with guidance provided in the Army Weight Control Program. Pregnant and postpartum Soldiers must be cleared by their health care provider prior to participating in physical fitness training. Once pregnancy has been confirmed, the Soldier is exempt from wearing load bearing equipment (LBE) to include the web belt, individual body armor (IBA) and/or any other additional equipment. Wearing of individual body armor and/or any other additional equipment is not recommended and must be avoided after 14 weeks gestation.

(8) The Soldier is exempt from all immunizations except influenza and tetanus-diphtheria and from exposure to all fetotoxic chemicals noted on the occupational history form. The Soldier is exempt from exposure to chemical warfare and riot control agents (for example, nuclear, biological, and chemical training) and wearing MOPP gear at any time.

(9) The Soldier may work shifts.

(10) The Soldier must not climb or work on ladders or scaffolding.

(11) At 20 weeks of pregnancy, the Soldier is exempt from standing at parade rest or attention for longer than 15 minutes. The Soldier is exempt from participating in swimming qualifications, drown proofing, field duty, and weapons training. The Soldier must not ride in, perform PMCS on, or drive in vehicles larger than light medium tactical vehicles due to concerns regarding balance and possible hazards from falls.

(12) At 28 weeks of pregnancy, the Soldier must be provided a 15-minute rest period every 2 hours. Her workweek should not exceed 40 hours and the Soldier must not work more than 8 hours in any 1 day. The 8-hour work day does include one hour for physical training (PT) and the hours worked after reporting to work or work call formation, but does not include the PT hygiene time and travel time to and from PT.

e. Performance of duty. A woman who is experiencing a normal pregnancy may continue to perform military duty until delivery. Only those women experiencing unusual and complicated problems (for example, pregnancy-induced hypertension) will be excused from all duty, in which case they may be hospitalized or placed sick in quarters. Medical personnel will assist unit commanders in determining duties.

f. Sick in quarters. A pregnant Soldier will not be placed sick in quarters solely on the basis of her pregnancy unless there are complications present that would preclude any type of duty performance.

7-10. Postpartum profiles

a. Convalescent leave (as prescribed by AR 600-8-10) after delivery will be for a period determined by the attending physician. This will normally be for 42 days following normal pregnancy and delivery.

b. Convalescent leave after a termination of pregnancy (for example, miscarriage) will be determined on an individual basis by the attending physician.

c. Prior to commencing convalescent leave, postpartum Soldiers will be issued a postpartum profile. The temporary profile will be for 45 days. It begins on the day of child birth or termination of pregnancy and will allow PT at the Soldier's own pace. Soldiers are encouraged to use the AT-Home component of the ARMY PPPT Program while on convalescent leave. If a Soldier decides to return early from convalescent leave, the temporary profile remains in effect for the entire 45 days.

d. Soldiers will receive clearance from the profiling officer to return to full duty.

e. Postpartum (any pregnancy that lasts 20 weeks and beyond) Soldiers, in accordance with DODD 1308.1, are exempt from the APFT and from record weigh-in for 180 days following termination of pregnancy. After receiving clearance from their health care provider to resume physical fitness training, postpartum Soldiers will take part in the postpartum physical fitness training element of the Army. Postpartum Soldiers must receive clearance from their health

care provider prior to returning to regular unit physical fitness training if it is before 180 days following pregnancy termination. After receiving clearance from their physician to resume physical training, they are expected to use the time in preparation for the APFT.

f. The above guidance will only be modified if, upon evaluation of a physician, it has been determined the postpartum Soldier requires a more restrictive or longer profile because of complicated or unusual medical problems.

7-11. Preparation, approval, and disposition of DA Form 3349

a. Preparation of DA Form 3349.

(1) The DA Form 3349 will be used to record both permanent profiles and temporary profiles. The DA Form 689 (Individual Sick Slip) may be used in lieu of DA Form 3349 for temporary profiles not to exceed 30 days and will include information on activities the Soldier can perform, as well as the physical limitations. An SF 600 will be used to attach additional information to the DA Form 3349 on the physical activities a Soldier can or cannot perform if there is inadequate space on the DA Form 3349. This additional SF 600 will be clearly labeled as a continuation of the DA Form 3349.

(2) If electronic profiling is available, an electronic DA Form 3349 will be used for all profiles over 30 days duration.

(3) The DA Form 3349 will be prepared as follows:

(a) *Item 1.* Record medical conditions and/or physical defects in common usage, nontechnical language that a layman can understand. For example, "compound comminuted fracture, left tibia" might simply be described as "broken leg." The checkboxes labeled Injury and Illness/Disease are used for tracking purposes. Check the injury box if the Soldier's medical condition is the result of an injury; otherwise, check the box labeled Illness/Disease.

(b) *Item 2.* Code designations (defined in table 7-2) are limited to permanent profiles for administrative use only and are to be completed by the profiling officer. Up to three different codes can be listed. All functional and assignment limitations are recorded in item 8.

(c) *Item 3.* Enter under each permanent and temporary PULHES factors the appropriate profile serial code (1, 2, 3, and 4) as prescribed) for the specific PULHES factor. A Soldier may have a permanent profile for one condition and a temporary profile for another. All permanent profile blocks must be filled in. Only the applicable block under the temporary profile needs to be completed. For example, a Soldier with a sprained ankle who has permanent H3 hearing loss would be coded 111311 in the permanent PULHES space but 3 under the temporary PULHES space.

(d) *Item 4.* Profile type. Check the appropriate block "a" or "b" for the type of profile. If the profile is temporary, enter the expiration date. If the profile is permanent, the profiling officer must assess if the Soldier meets retention standards of chapter 3 (Item 7).

(e) *Item 5.* Answer "Yes" or "No" to items 5a through 5j. These functional activities are the minimum requirements to be considered medically qualified for military duties worldwide and under field conditions. If any answer is "No" then the appropriate profile serial will in most cases be at least a 3 and the Soldier will be referred to a MEB. If the Soldier is able to do all the functional activities listed in 5 and meets the retention standards of chapter 3, the Soldier will be referred to a MMRB in accordance with AR 600-60, unless waived by the MMRB convening authority.

(f) *Item 6.* Physical Fitness Test. Check either "Yes" or "No" to indicate whether the Soldier can perform the activities for the APFT. The "Yes" or "No" blocks on the alternate APFT need only be completed if the Soldier has restrictions for the regular APFT. If the Soldier cannot perform at least an alternate APFT the profile serial will be at least a 3 and referred to an MEB.

(g) *Item 7.* Those Soldiers (active duty and USAR/ARNG) who meet retention standards but have at least a permanent 3 or 4 PULHES (yes for item 7) serial will be referred to a MMRB in accordance with AR 600-60, unless waived by the MMRB convening authority. Those Soldiers on active duty who do not meet retention standards ("No" for item 7), must be referred to an MEB as per chapter 3. (See paras 9-10 and 10-26 for disposition of USAR and ARNG Soldiers not on active duty who do not meet medical retention standards.)

(h) *Item 8.* This space will be used to list any other physical activity restrictions or limitations not listed elsewhere on the form. In accordance with paragraph 7-4b, the profiling officer must review previous profiles before making a decision to extend a temporary profile. If this is an extension of a previous temporary profile, fill in the date of the original temporary profile in Item 8.

(i) *Items 9, 10, and 11.* Name and signature of profiling officer and date profile completed. Print name, grade and title of profiling officer, signature, and date. Permanent "1" or "2" profiles require the signature of one profiling officer. The signature of the profiling officer for "1" or "2" profiles is written in the section: "Typed name, grade, and title of profiling officer." Permanent "3" or "4" profiles require the signatures of two profiling officers, one of whom is the physician approving authority (unless the provisions of 7-8f apply). (See para 7-8 to determine who is qualified to be a profiling officer.) Temporary profiles require only the signature of one profiling officer except for extensions of profiles noted in paragraph 7-6a(2).

(j) *Items 12, 13, and 14.* Name and signature of approving authority and date reviewed. The approving authority will be designated by the MTF commander. (In the case of RC Soldiers not on active duty, see para 7-8f.) The approving

authority for permanent "3" or "4" profiles must be a physician. If the approving authority does not concur with the profiling officer recommendation, the MTF commander will make the final decision.

(k) *Item 15.* How to access electronic profiles on Soldiers. Commanders can access the electronic profiles of Soldiers in their unit by going to <http://www.mods.army.mil/> and clicking on "e-Profile" in MODS in the list of applications. Commanders are required to register and be approved to access the e-Profile module in MODS before they can gain access to the electronic profiles

(l) *Item 16.* Include patient identification: Name (Last, First); Grade/Rank; SSN (last 4 numbers or SSN); and the Soldier's unit.

(m) *Item 17.* Hospital or Medical facility.

(n) *Item 18.* Profiling Officer E-mail.

b. *Disposition of DA Form 3349 (temporary or permanent) by the MTF.* The electronic profile will be routed to the military personnel office (MILPO) and the Soldier's medical record. A paper copy of DA Form 3349 will be given to the Soldier. If the e-Profile is not available, a paper copy will be delivered by means other than the individual on whom the report is made to the following:

- (1) Original to the Soldier's health record.
- (2) One copy to the Soldier's commander.
- (3) One copy to the MILPO.

c. *Medical Protection System.* The profiling officer (or approving authority if applicable) is responsible for ensuring the PULHES and Date of Profile is entered into the Medical Protection System (MEDPROS).

7-12. Responsibility for personnel actions

a. Commanders and personnel officers are responsible for necessary personnel actions, including appropriate entries on personnel management records and the assignment of the individual to military duties commensurate with the individual's physical profile and recorded assignment limitations.

b. If the Soldier's commander believes the Soldier cannot perform within the limits of the permanent profile, the commander will request reconsideration of the profile by the profiling physician. Reconsideration must be accomplished by the profiling officer, who will either amend the profile or revalidate the profile as appropriate. Commanders may also request a review of temporary profiles.

7-13. Physical profile and the Army Weight Control Program

The DA Form 3349 will not be used to excuse Soldiers from the provisions of AR 600-9. The AR 600-9 contains a standard memorandum for completion by a physician if there is an underlying or associated disease process that is the cause of the overweight condition. The inability to perform all APFT events or the use of certain medications is not generally considered sufficient medical rationale to exempt a Soldier from AR 600-9.

Army Regulation 600-20

Personnel-General

Army Command Policy

Rapid Action Revision (RAR) Issue Date: 4 August 2011

Headquarters
Department of the Army
Washington, DC
18 March 2008

UNCLASSIFIED

TACF-8

EXH 8

1. Sergeants and below will be considered for promotion if eligible; and, if promoted, their DOR will be the date of current entry on AD.

2. Staff sergeant and above, if they are in the zone for consideration while in TDRL, Soldiers will be considered for promotion. If selected, their DOR will be the date they would have been promoted had they not been on TDRL. DOR with peers will be granted if a Soldier was previously selected for promotion by a DA Centralized Promotion Selection Board and placed on TDRL before promotions were made through their sequence number.

c. On call or ordered to AD or ADT.

(1) An ARNG or USAR Soldier is ordered to EAD in the AA, to include mobilization, but not including orders to AD under 10 USC 12304 or 12302, a call of the National Guard into Federal Service under Chapter 1211 of Title 10, United States Code (10 USC chapter 1211), or a call of members of the militia into Federal Service under Chapter 15 of Title 10, United States Code (10 USC chapter 15). The DOR is a date preceding the date of entry on EAD by a period spent on active status in the grade in which ordered to EAD subject to the following conditions:

(a) Only service performed after the most recent break in Service is creditable. For the purpose of this paragraph, a period during which the Soldier was not a member of the Armed Forces is a break in Service if such a period is in excess of 90 days (enlisted Soldier) or 180 days (former officers).

(b) Service performed prior to reduction to a pay grade lower than that in which a person enters on EAD is not credited.

(2) An ARNG or USAR Soldier is ordered to (AGR status, full-time national guard duty (FTNGD), AD for special work, temporary tour of active duty (TTAD), AD under Sections 12302 or 12304, Title 10 United States Code (10 USC 12302 or 12304), ADT, a call of the National Guard into Federal Service under 10 USC 12301, 12302, 12303, and 12304, or a call of the militia into Federal Service under 10 USC chapter 15. The DOR of the grade in which ordered to AD or ADT is the date on which the Soldier was advanced or promoted in that grade. If voluntarily reduced to enter on AD or ADT, the DOR will be the date of the rank to which reduced as if the Soldier had never attained a higher grade.

(3) A retired Soldier is called or ordered to AD (includes EAD, TTAD, and mobilization). The DOR of the grade in which ordered to AD will be stated on the AD orders. It is computed by adding, at the time of retirement, the period of time between the date of the retirement and the date of return to AD. In case of additional periods of inactive Service, the DOR is adjusted further.

d. On advancement, promotion, reduction, and grade restoration.

(1) The DOR for advancement and promotion to a higher grade is the date specified in the instrument of promotion or, when no date is specified, is the date of the instrument of promotion.

(2) The DOR for the lateral appointment to a different grade within the same pay grade is date held in the grade from which the appointment was made.

(3) The DOR for the grade held during a period in which lost time occurs will be adjusted to reflect lost time accumulated for any reason. This paragraph is retroactive to include adjustment of DOR held during previous periods of lost time.

(4) The DOR of a grade to which reduced for inefficiency or failure to complete a school course is the same as that previously held in that grade. If reduction is to a higher grade than that previously held, it is the date the Soldier was eligible for promotion under the promotion criteria set forth for that grade.

(5) The DOR on reduction for all other reasons is the effective date of reduction. (See AR 27-10, chap 3, when a Soldier is reduced under UCMJ, ART. 15.)

(6) The DOR on restoration to a grade from which reduced following a successful appeal of the reduction or action by a superior authority to mitigate the punishment, is the date held before the reduction. (See AR 27-10, chap 3, when a Soldier is reduced under the MCM (UCMJ, ART. 15).)

(7) The DOR on restoration to a higher grade held before reduction to comply with requirements to enter initial ADT, or to attend school under an Army program will be the DOR held prior to reduction.

(8) The DOR of an ARNG/USAR Soldier promoted to a higher grade held before acceptance of the reduction of one or more grades, without prejudice, due to lack of position vacancy, unit reorganization, unit inactivation/deactivation, or for entry on FTNGD, AD, or ADT will be a date preceding the promotion by a period equal to the length of time previously served in the grade to which promoted.

Chapter 3 Army Well-Being

3-1. General

This chapter discusses the overarching command responsibility for "taking care of people." Applied at all levels of command, the principles of Army Well-being form the basis upon which commanders and other leaders understand and

support the individual aspirations of their people while focusing on mission accomplishment. Such leadership creates the environment necessary to maximize the human dimension of Army readiness.

3-2. Definition

Army Well-being is the personal—physical, material, mental, and spiritual—state of the Army Family, including Soldiers (active, reserve, and guard), retirees, veterans, DA civilians, and all their Families, that contributes to their preparedness to perform and support the Army's mission. The focus of Army Well-being is to take care of our Army Family before, during, and after deployments.

3-3. Concept

a. An institutional perspective. Well-being is actually a "condition" resulting from the effects of a system of individual programs, policies, and initiatives. The term "Army Well-being" is not synonymous with "quality of life", but rather expands the concept. Army Well-being—

(1) Incorporates an integrated, holistic view of Well-being programs, policies, and initiatives across the Army community.

(2) Establishes strategic oversight of those diverse programs, policies, and initiatives that contribute to Well-being through a Well-being framework.

(3) Provides a mechanism to measure performance against established standards.

(4) Links Well-being programs and initiatives to the four institutional outcomes of attracting, developing, retaining, and supporting.

b. An individual perspective. Well-being is a personal state, experienced by the individual. While there is no formula for prescribing this personal state, individuals must be self-reliant in order for this experience to be positive. Individuals are ultimately responsible for their own Well-being, but commanders are responsible for creating and sustaining a climate that contributes positively to the lives of the Army Family, including Soldiers (active, reserve and guard) retirees, veterans and DA civilians, and all their Families. The state of Well-being includes four basic dimensions of individual life experience:

(1) The physical state centers on one's health and sense of wellness, satisfying physical needs through a healthy lifestyle.

(2) The material state centers on essential needs such as shelter, food, and financial resources.

(3) The mental state centers on basic needs to learn, grow, achieve recognition, and be accepted.

(4) The spiritual state centers on a person's religious/philosophical needs, providing powerful support for values, morals, strength of character, and endurance in difficult and dangerous circumstances.

3-4. The Well-being framework

The four institutional outcomes of attracting, developing, retaining, and supporting are a function of the actions people take in response to their views of the actions of the institution. Therefore, the concept of Well-being principally focuses on the perceptions of the people who make up the Army. A framework or critical tool for organizing the thought process and structure associated with Well-being results from relating individual needs and aspirations with Army functions designed to meet those needs and aspirations. Within this framework not all individual needs or aspirations should, or can, be met by the Army. While oriented on the personal needs of individuals, Well-being acknowledges a basic rule of soldiering in the Army—that personal responsibilities and needs may be subordinated when duty calls. Soldiers and civilians must ensure that personal issues do not influence or impair the ability to deploy and perform the mission. The Army must provide an environment that makes mission accomplishment possible. The Well-being framework is described in terms of four individual aspirations:

a. To serve. The Army exists to fight and win the nation's wars. Individuals choose to join the Army to fulfill the aspiration "to serve" the nation, its people, and the cause of freedom. This sense of service is considered "fundamental" to Army Well-being.

b. To live. This aspiration addresses the basic physical and material needs of shelter, food, and health. Individuals seek to satisfy this need by earning a living, achieving financial security, and providing for their Families. This role as provider is considered "essential" to Army Well-being.

c. To connect. The need "to connect" centers on acceptance, contribution, and social interaction. Individuals want to be accepted and valued, to contribute to a winning team, to perform meaningful work, and to unite around a common purpose and shared beliefs. The unique Army esprit de corps that connects individuals to the Army team serves a "defining" role in Army Well-being.

d. To grow. Personal growth involves mental and spiritual needs, and encompasses the individual's desire to be creative, productive, and to use and expand one's capabilities. Individuals' ability to fulfill their personal aspirations "enhances" both their own lives and their relationship to the Army.

3-5. Well-being strategic goals

Army Well-being is achieved by providing for four strategic goals linked to the Well-being framework of the Army Family, including Soldiers (active, reserve, and guard), retirees, veterans, and DA civilians, and all their Families:

a. *Opportunity for service.* Whether in a combat zone or a garrison environment, we all must embrace the concept that we have an opportunity to serve in support of something larger than ourselves.

b. *Standard of living.* To be able to live at a standard of living that we as an Army can be proud of.

c. *Pride and sense of belonging.* To develop and maintain a sense of pride and belonging with the Army team—Soldiers, DA civilians, retirees, veterans, and their Families.

d. *Personal enrichment.* To take advantage of the numerous opportunities the Army provides for personal and professional growth.

3-6. Well-being end state

a. *A system perspective.* An integrated system of Well-being functions and programs that—

(1) Recognizes that the institutional needs of the Army cannot be adequately addressed without fostering self-reliance and meeting the personal needs and aspirations of its people.

(2) Is designed and resourced to successfully account for the dynamic nature of the Army's operational challenges and America's societal changes.

(3) Maximizes readiness; retention, and recruiting.

(4) Contributes to an institutional strength that enables the Army to accomplish its "full spectrum mission."

b. *A cultural perspective.* An Army culture that balances the commitment expected of our people and the Army's commitment to those people.

3-7. The Army Well-being strategic process

At the Department of Army level, the Well-being process improves and sustains the institutional strength of the Army through a comprehensive strategy that integrates Well-being initiatives, programs, and resources to meet the Well-being needs of the Army. The process integrates all Army Well-being issues, initiatives, and programs to provide senior decision makers with a holistic perspective of Army Well-being. It uses the Army Well-being framework to synchronize the effects of all associated programs to achieve an integrated result. The process can be viewed as "a strategic umbrella" over individual programs and processes that have previously operated independently of one another. The significant components of the Well-being process include:

a. *Deputy Chief of Staff, G-1.* As the executive agent for Army Well-Being, the DCS, G-1 coordinates and integrates the efforts of the DA staff, through the Well-Being Division, in the execution of the Well-being process.

b. *Well-being general officer steering committee.* The Well-being general officer steering committee (GOSC) is responsible to the SA, through the CSA, for providing strategic oversight of the Well-being process from a holistic perspective and identifying required policy changes for Army Staff development and SA approval necessary to achieve the Army's Well-being end state.

c. *Well-being council of colonels.* The Well-being council of colonels is responsible for reviewing Well-being initiatives, issues, and recommendations for submission to the Well-being GOSC.

d. *Well-being management tools.*

(1) The Well-being architecture translates the Well-being philosophy into manageable functional areas. In so doing, the architecture defines the scope of Well-being and ensures that all Well-being tools are properly integrated into the overall process.

(2) The Well-being action plan describes the functional architecture and represents the strategic plan for each of the individual Well-being functions. The Well-being action plan is linked directly to the Well-being status report and the Army campaign plan.

(3) The Well-being status report uses results-oriented performance measures to quantify the current status, progress, perspective and impact of each of the Well-being functions. In so doing, the Well-being status report delineates the standards for measuring components of the individual Well-being functions. The ultimate output of the Well-being status report is a representation of the function's impact on the human dimension of readiness. This critical information is a major component of the Strategic Readiness System.

(4) The Well-Being resource crosswalk captures programming and budgeting information for all forms of Army funding that contribute to Well-being (for example, appropriated, nonappropriated, or DOD). This data, formatted in accordance with the Well-being architecture, provides senior army leaders funding profiles for each Well-being function and a holistic perspective.

(5) The Well-Being strategic communications plan provides a disciplined mechanism to communicate the Army's Well-being message to complex audiences both inside and outside the Army.

(6) The Army Campaign Plan provides the vehicle by which Well-being planning is integrated and synchronized with the overall Army Transformation.

3-8. Responsibilities

a. The SA and CSA together form the senior Army leadership responsible for the readiness of the force. Accordingly, they ensure the effective and timely implementation of policy, program, and budget decisions necessary to enable Army Well-being.

b. The Vice Chief of Staff, Army--

(1) Supervises the Army Staff in their coordinated efforts to develop an integrated and holistic approach to enabling the Well-being of the force.

(2) Chairs the Army Well-Being GOSC.

(3) Advises the SA and CSA on recommendations from the Well-Being GOSC.

c. The DCS, G-1 is the responsible official for Army Well-being and provides strategic oversight of Army Well-being by integrating all Well-being programs, identifying policy changes necessary to achieve the Army's Well-being end-state, and developing a holistic perspective of the human dimension's impact on readiness. Responsibilities include:

(1) Serving as executive agent for the Well-being GOSC.

(2) Ensuring disciplined adherence to the Well-being process.

(3) Coordinating the agenda for and conducting meetings of the Well-being GOSC.

(4) Providing staff and administrative support to the Well-being GOSC.

(5) Maintaining and updating the tools necessary to ensure a holistic approach to integrated strategic planning for Well-being programs.

(6) Representing the holistic perspective of Army Well-being programs in the planning, programming, budgeting, and execution.

d. Heads of other HQDA staff agencies (and field operating agencies as appropriate) are responsible for Armywide policies, plans, and initiatives within their areas of proponentcy. The DCS, G-1 and the Well-being GOSC using the Well-being process will integrate their policies, plans, and initiatives pertaining to Army Well-being into the Army's overall plan to achieve the Army Well-being end-state.

e. Commanders and other leaders at all levels will provide an environment that contributes positively to the physical, material, mental, and spiritual dimensions of the lives of their subordinates and their Families as well as members of the greater, extended Army Family, including veterans, retirees, and DA civilian employees as appropriate. The Well-being definition, concept, framework, strategic goals, and end-state described in paragraphs 3-2 through 3-6 apply Armywide. The Well-being architecture provides commanders at all levels an integrated approach for focusing on and assessing functional outcomes. Commanders should adapt the architecture and other Well-being tools listed in paragraph 3-7 in meeting their responsibilities to manage implementation of Army Well-being within their organizations.

Chapter 4 Military Discipline and Conduct

4-1. Military discipline

a. Military discipline is founded upon self-discipline, respect for properly constituted authority, and the embracing of the professional Army ethic with its supporting individual values. Military discipline will be developed by individual and group training to create a mental attitude resulting in proper conduct and prompt obedience to lawful military authority.

b. While military discipline is the result of effective training, it is affected by every feature of military life. It is manifested in individuals and units by cohesion, bonding, and a spirit of teamwork; by smartness of appearance and action; by cleanliness and maintenance of dress, equipment, and quarters; by deference to seniors and mutual respect between senior and subordinate personnel; by the prompt and willing execution of both the letter and the spirit of the legal orders of their lawful commanders; and by fairness, justice, and equity for all Soldiers, regardless of race, religion, color, gender, and national origin.

c. Commanders and other leaders will maintain discipline according to the policies of this chapter, applicable laws and regulations, and the orders of seniors.

4-2. Obedience to orders

All persons in the military Service are required to strictly obey and promptly execute the legal orders of their lawful seniors.

4-3. Military courtesy

a. Courtesy among members of the Armed Forces is vital to maintain military discipline. Respect to seniors will be extended at all times (see AR 600-25, chap 4).

b. The actions of military personnel will reflect respect to both the national anthem and the national colors. The



**STANDARD OPERATING PROCEDURE
ALLERGY/IMMUNOLOGY SERVICE, MADIGAN ARMY MEDICAL CENTER**

MANAGEMENT OF ANAPHYLAXIS

The allergist or surrogate allergist will be notified immediately for any possible systemic reaction. However, treatment with epinephrine should not be delayed if the patient is having a moderate to severe reaction or a progressing reaction and the MD has not yet arrived. The patient will be taken to the treatment room and one nurse will remain with the patient at all times.

Check vital signs (blood pressure, heart rate, respiratory rate, pulse oximetry) immediately

Signs/Symptoms of Anaphylaxis: diffuse itching, hives, flushing, throat tightness, chest tightness, wheeze, cough, shortness of breath, nausea/vomiting, abdominal cramps, lightheadedness. One or more symptoms may be present. Cutaneous symptoms are usually present, but may be absent.

Administer epinephrine immediately for all systemic reactions

Use of epinephrine is recommended for all systemic or anaphylactic reactions. Administration should be given promptly since delay of administration increases risk for progression to more severe reaction and increases risk of mortality. The preferable route of administration of epinephrine is intramuscular, although subcutaneous is acceptable. Antihistamine and systemic corticosteroids may help modify symptoms, but should never replace epinephrine because of their slow onset of action and lack of immediate effect.

Dosing of epinephrine:

Adult dose = 0.3 ml of 1/1,000 IM
Child dose = 0.01ml/kg of 1/1,000 IM
Or 0.3ml if > 65 pounds and 0.10 to 0.15ml if < 65 pounds
Dosing may be repeated every 5 to 15 minutes if symptoms persist

Administer oral antihistamine

Dosing of antihistamines:

Adult dose = Zyrtec 10mg, Allegra 180mg, or loratadine 10mg orally
Child dose = Zyrtec 5mg or loratadine 5mg for children up to age 6
10mg for age 6 and above
Dose may be repeated 12 hours later at the discretion of the allergist.

Administer oral steroids

Dosing of oral steroids: One dose of 0.5mg/kg – 2.0mg/kg of prednisone or prednisolone (up to 80mg). Dose may be repeated 6 hours later at the discretion of the allergist.

Vital Signs: Monitor vital signs every 5-10 minutes and observe the patient a minimum of one hour after the symptoms have resolved.

Spirometry: Check PFT after treatment on patients with a history of asthma or who have symptoms of wheeze or shortness of breath. Compare to previous PFT's.

Severe or unresponsive reactions:

Transfer the patient to the emergency room if symptoms do not resolve after 2 doses of epinephrine or if vital signs or symptoms are unstable.

TAB G-a

Call for immediate code and institute BLS procedures if the patient loses consciousness or stops breathing.

Supplemental oxygen at 2-4 liters may be required if the patient has significant bronchospasm, breathing difficulty, or low pulse oximetry reading.

Discharge to home: The patient may be released from the clinic to home after a minimum of one hour of observation after symptoms have all resolved and vital signs are stable. Observation may be longer depending on the severity of the reaction. The patient may be released only after being cleared by the treating allergist or surrogate allergist. The patient will be provided with an epinephrine autoinjector and educated on how and when to use. The patient will be educated on the possibility of late phase anaphylaxis reaction developing approximately 6-12 hours after initial reaction. If such a reaction occurs the patient should use the epinephrine autoinjector immediately and go to the ER or call 911. Risk of developing late phase reactions increases in cases where symptoms are prolonged (exceed 30 minutes) or are more severe.

Documentation: Documentation of the encounter and QA will be completed by the treating allergist and nurse. Once all documentation is complete all paperwork and the record will be given to the clinic Head Nurse for review.

1. Allergen immunotherapy Reaction Summary Sheet on DA Form 4700
2. QA worksheet
3. QA notebook located in the treatment room.
4. A supplemental note will also be made in AHLTA. Nurse will enter in AHLTA note brief description of patients chief complaint, time of shot given and onset of symptoms, vital signs, pulse oximetry, medications given, and documentation of the allergy shot.
5. Allergy shot hard copy record will have "Systemic reaction" written in red on the line below documentation of the shot. Amount to cut back next dose will also be written.

Coding: The AHLTA visit will be transferred under the treating allergist and the allergist will code the visit

1. Diagnosis anaphylactic shock 999.4 or serum reaction 999.5
2. CPT for emergency office visit: 99058
3. CPT for Epinephrine administration: 96732
4. CPT for PFT 94101 (pre albuterol) or 94060 (post albuterol)
5. CPT for nebulizer treatment 94640
6. CPT for pulse oximetry 94760
7. Prolonged services: first additional hour 99354, each additional 30 minutes 99355
8. Include codes for the allergy shot injection (95115 or 95117) or skin testing (95004), challenge, etc as appropriate
9. Include diagnosis of allergic rhinitis, asthma, or other conditions that are related to the visit.

██████████ MD
LTC, MC, USA
Chief, Allergy/Immunization Service
Madigan Army Medical Center

**STANDARD OPERATING PROCEDURE
ALLERGY/IMMUNOLOGY SERVICE, MADIGAN ARMY MEDICAL CENTER**

**SURROGATE ALLERGIST: ADMINISTRATION OF IMMUNOTHERAPY AND
MANAGEMENT OF REACTIONS IN THE ABSENCE OF AN ALLERGIST**

1. When an allergist cannot be present when immunotherapy injections are being given, a surrogate allergist will be designated by the A/I service allergist or head nurse to cover the clinic. The designated allergist may be a DoD provider from the GI or IMC clinic or other licensed provider in the immediate area and who is knowledgeable in the management of anaphylaxis. The surrogate allergist does not need to be in the allergy clinic area, but must be within the GI clinic, internal medicine clinic area or in Letterman auditorium. The surrogate allergist will be contacted prior to starting allergy shots and will confirm where they can be reached in case of a question or reaction. Both a telephone number and beeper number are preferred.
2. The surrogate allergist will be contacted for the following:
 - a) If there is any question about whether the patient should receive their immunotherapy on that day. In general, if there is a question the patient should not get their shot.
 - b) If there is an immunotherapy reaction or suspected reaction.
3. The surrogate allergist will not be contacted for a dosage adjustment due to a reaction or to break in immunotherapy longer than allowed on the immunotherapy prescription order. The patient will be advised to return when the allergist will next be available.
4. In the event of a significant reaction that occurs after an allergy injection, the surrogate allergist will be immediately contacted. Treatment should be started immediately per SOP and should not be delayed if the surrogate allergist has not arrived yet. In the event of a delayed systemic reaction and the patient returns to the clinic with no allergist available, the patient should be taken to the Emergency Room immediately or call 911.

██████████, M.D.
Chief, Allergy/Immunology Service
Madigan Army Medical Center

TAB G-b

TAB G - b

MAMC Allergy Immunology Service

Allergen Immunotherapy Administration SOP

1. Background

- a. **Allergen Immunotherapy (AIT) efficacy.**
 - i. Up to 85% of patients with allergic rhinitis achieve benefit after they have been on maintenance for one year.
 - ii. AIT is usually considered when medical management fails.
- b. **Dosing:** Some patients need more and some less allergen to have a good response. The therapeutic dose range for each allergen is still under active investigation. The current recommendations are that between 0.5cc to 1.0cc of each extract mixed into the 10cc vial should provide clinical benefit. Cat and dust mite are weaker and so more extract is used. Some allergens, especially grass, have cross-reactive antigens. When the antigens are cross-reactive the total dose of antigen is therefore greater when they are mixed together. For example, 1.0ml of two northern grasses is comparable to giving 2.0ml of only one northern grass.
- c. **Manufacturer variation:** Allergen extracts made from different manufacturers vary widely in potency, especially those in w/v. For example, some of the Greer mold extracts may be up to 100 fold stronger than Hollister Steer. This is the reason for cutbacks with source changes.
- d. **Extract standardization:** Some extracts are standardized (grass, cat, dust mite) to improve consistency in potency. More allergens should become standardized in the future.
- e. **Risk:** The major risk of allergen immunotherapy is anaphylaxis, which in extremely rare cases can be fatal, despite optimal management. The overall rate of systemic reactions is approximately 1/1000 per injection.
 - i. Risk for systemic reactions is highest with:
 1. During advancement of immunotherapy
 2. Highly sensitive individuals on potent extract mixes
 3. Patients with asthma
 - ii. Delay in epinephrine treatment causes increased risk of a bad outcome and death from anaphylaxis. Anaphylaxis can progress unpredictably
 - iii. A handful of people die every year from allergy shots. Those patients usually have a history of severe or poorly controlled asthma. Careful screening and appropriate management is essential.

2. Administering Immunotherapy

- a. Immunotherapy should be administered in a setting that permits prompt recognition and management of adverse and systemic reactions. The staff should be trained in how to give immunotherapy and be trained and able to recognize and treat anaphylaxis.

- b. Patients must remain in the clinic for 30 minutes after each injection. All patients will present to the technician prior to leaving the clinic to have injection site checked for local reactions. Patients experiencing any unusual symptoms, especially itching of the throat or skin, cough or sneezing, rash, or chest tightness or wheezing must immediately report to the technician
 - c. The allergist or designated surrogate allergist must be in the clinic area or immediately available whenever allergy shots are being administered so they can immediately respond to a suspected systemic reaction.
 - d. Patient should verify name, vial number, and expiration date on immunotherapy vial.
 - e. Patient is questioned about reaction to previous shot and any current symptoms. If individual has asthma, s/he is specifically questioned about asthma control in the preceding 24 hours. Some patients may be requested to perform PFTs or peak flow measurements prior to receiving immunotherapy. If significantly decreased from usual values or below minimal requirement as ordered in chart, immunotherapy will be withheld.
 - f. Allergy shots are administered subcutaneously in the upper lateral area of the arm near the base of the deltoid. After drawing up the correct amount of antigen into a 1cc tuberculin syringe with a 27-gauge 1/2-inch needle, the skin is cleansed with an alcohol sponge. The patient will be advised and confirm the dose that will be administered. The area is pinched and the needle is inserted at a 60 to 90-degree angle. The plunger is pulled to check for blood return and, if present, the syringe is immediately withdrawn. If no blood return is observed, syringe contents are administered and the syringe is withdrawn. Gentle pressure with the alcohol sponge is maintained over the injection site for a brief time but the site should not be rubbed.
 - g. Sites of injections should alternate from one arm to the other at each subsequent visit.
 - h. Keep all vials at the same dose as much as possible to reduce chances for error
3. **Immunotherapy Schedule for Advancement**
- a. Starting dose, advancement schedule, and reduction in dosing for missing doses will be according to each patient's extract order form in the immunotherapy record. These schedules can vary for each patient and should be checked each visit. Patient's who have reached maintenance without any systemic reactions may have their schedule for the maintenance changed from E to D.
4. **Local reactions**
- a. There is no increased risk of systemic reactions when patients have local reactions (even "C") to their shots. Patients may continue to advance on their schedule despite local reactions. However, if the patient is bothered by the reaction or the local reaction is very large, dosing can be held or cut back on an individual basis.
5. **Maintenance**

- a. Once patients reach maintenance, they should be encouraged to come in every two weeks during their first year as this will give them a better clinical response. However, they should not be considered late unless it has been more than 4 weeks since their last shot.
- b. Routine maintenance shots should otherwise be every 4 weeks. However, patients may come in more frequently if they have breakthrough allergy symptoms and achieve improved benefit with more frequent shots.

6. Follow-up

- a. All patients must see a staff allergist once a year for a follow-up visit. More frequent follow-up should be needed for patients with asthma, particularly not well controlled, and for patients having trouble advancing on schedule due to local reactions or other reasons.
- b. All patients must also have follow-up with an allergist after systemic reactions

7. Holding or postponing shots

- a. If patients are acutely ill with fever or severe cough or shortness of breath, they should not receive their allergy shot until symptoms have improved. They may receive their shot if they have only mild upper respiratory infection or cold symptoms that is not accompanied by fever, wheeze, shortness of breath or severe cough.
- b. Asthma patients should not receive their allergy shot if they are having a flare in their symptoms, a decrease in their peak flows, or are requiring increased use of their albuterol. If there is concern that their asthma is flaring, spirometry should be performed and compared to their baseline and the allergist notified.
- c. Pregnant patients must be seen by the allergist before continuing immunotherapy. In general they will be permitted to continue immunotherapy if they have reached a dose that they are achieving benefit at and that they understand there is a small risk of adverse effect on the pregnancy or fetus if they were to have a systemic reaction to their allergy shot. Immunotherapy is not advanced during pregnancy.
- d. Any patient on a beta-blocker should not receive their allergy shot since there is an increased risk of more severe systemic reaction on this medication. Patients should be asked regularly if they have started any new medications and verifications made that any new medicine is not a beta-blocker. A sign should also be posted where allergy shots patients can see it that lists the common beta-blocker medicines used.
- e. Other conditions for withholding allergy shots until the allergist can review the patient's history include:
 - i. Myocardial infarction
 - ii. Development of other heart disease or lung disease
 - iii. Other medical conditions that could make treatment or recovery from anaphylaxis more difficult.

8. Cut-backs or holding during tree and grass season (Feb through July)

- a. Consider holding at current level for patient's with history of systemic reaction the previous allergy season, if they have severe asthma, or they are advancing in the maintenance (Red) vial for the first time.
- b. Cut back by 50% for patients with previous history of repeat systemic reaction
- c. Patients do not need to cut back if they have been at full maintenance during previous grass seasons without problems.
- d. Consult with the allergist on these patients if there are questions.

9. Systemic Reactions Management (see also Management of Anaphylaxis SOP)

- a. The allergist or surrogate allergist should be notified immediately for any possible systemic reaction. However, treatment with epinephrine should not be delayed if the patient is having a moderate to severe reaction or a progressing reaction and the MD has not yet arrived.
- b. See Management of Anaphylaxis SOP
- c. Patient's with a history of systemic reaction should wait a minimum of 45 minutes after each shot. Exceptions can be made if the patient has history of only mild reaction, they have reached maintenance, and it has been at least a year since their reaction, or at the discretion of the allergist. Patients may be asked to temporarily arrive even earlier depending on the severity and frequency of the reactions.
- d. Patients with history of systemic reactions may, at the discretion of the allergist, be required to carry an epi-pen with them on shot days.
- e. Only the allergist will determine adjustments in immunotherapy doses or schedules following a systemic reaction.

10. Allergy shot record

- a. After the first allergy injection, an appropriate note is written on the SF 600, MAMC OP 1116-M and/or AHLTA. This note includes the statement that procedures were explained, consent was obtained, and a copy of the same was given to patient. Also note that the immunotherapy extract was identified, contents were checked with the prescription, and that the prescription was placed in immunotherapy record.
- b. MAMC 1181-M Record of Immunotherapy Administration: This form identifies the patient, extract contents, prescription number, schedules for the vials, whether patient has asthma, when the next follow-up visit with the allergist is due and maintenance interval. A different MAMC 1181-M is maintained for each extract when patients are receiving more than one shot. Each entry includes date, amount administered, time given and time patient left, reaction observed, and technician initials. If the patient has asthma, it should also note if the patient had increased asthma symptoms in the preceding 24 hours. The vial number, concentration, expiration date and schedule are noted and highlighted using an entire line each time a new vial is started. Hymenoptera venom injections are recorded on MAMC Form 544-M.

- c. Labeling of extract vials and documentation in the record will be in keeping with USACAEI as follows:
 - i. Vials are color coded as silver, blue, green, yellow, red. Red is the strongest vial and is usually consider the maintenance vial. It is labeled with the BAU, AU, or w/v units and is also labeled as 1/1 v/v (volume to volume). Each color before is a 10-fold dilution and labeled as 1/10 v/v for yellow, 1/100 v/v for green, 1/1,000 v/v for blue and 1/10,000 v/v for silver. This labeling system replaces the old number system. The immunotherapy record should use labeling in keeping with the labeling on the vial.
- d. Include a blank SF 600 in chart for writing and documenting verbal or written orders by the allergist regarding changes in immunotherapy schedules or other matters.
- e. AHLTA notes should also be included for each patient with documentation of screening questions. This note is saved in AHLTA and the visit coded, but does not need to be added to the Immunotherapy Record.
- f. Include emergency contact numbers (stick-on label for inside of jacket)

11. Coding

- a. Diagnosis 477.90 Allergic rhinitis; 493.90 Asthma
- b. E&M 99499 for routine visit; 99212 for a visit when additional counseling or care is given and documented
- c. CPT AIT 95115 (single injection); 95117 (2 or more injections)
- d. CPT VIT 95130 (one venom); 95131 (two venoms); 95132 (three venoms); 95133 (four venoms)
- e. CPT PFT 94101

12. Capturing work-load

- a. If a patient is seen by an allergist the same day, the nurse will finish documenting their portion of care and then the visit must be transferred to the allergist who will sign off on and complete any final coding.

[REDACTED]
Chief, Allergy/Immunology Service
Madigan Army Medical Center
Tacoma, WA 98431
[REDACTED]

Tab H

Witness Listing for Army Report --DI-11-4168--

Copy only in unredacted Army Report version

MADIGAN ARMY MEDICAL CENTER (MAMC)
Joint Base Lewis-McChord, Washington

Office of Special Counsel Case File Number DI-11-4168

List of Witnesses

Reference @Title in Report

MER Specialist

Management Employee Relations (MER) Specialist
Civilian Personnel Action Center
Joint Base Lewis McChord, WA

MER Specialist

Chief, Human Resources

Chief, Human Resources, MAMC
Joint Base Lewis McChord, WA

Chief, Human Resources

LPN #1, A/I Clinic

Licensed Practical Nurse
Allergy/Immunology Clinic, MAMC
Joint Base Lewis McChord, WA

LPN #1, A/I Clinic

Head Nurse, A/I Clinic

Registered Nurse
Head Nurse, Allergy/Immunology Clinic, MAMC
Joint Base Lewis McChord, WA

Head Nurse, A/I Clinic

Chief, A/I Clinic

Physician (Allergist)
(Formerly) Allergy/Immunology Clinic, MAMC
Joint Base Lewis McChord, WA

Chief, A/I Clinic

Physician, Family Medicine

Physician, Family Medicine, MAMC
Joint Base Lewis McChord, WA

Physician, Family Medicine

Admin Assistant, RMD

Administrative (Admin) Assistant
Resource Management Division, MAMC
Joint Base Lewis McChord, WA

Admin Assistant, RMD

NCOIC

Noncommissioned Officer in Charge (NOIC)
Command Group, MAMC
Joint Base Lewis McChord, WA

NOIC

TAB H

TAB H

DCA
Deputy Commander, Clinical Services, MAMC
Joint Base Lewis McChord, WA

DCA

LPN #2, A/I Clinic
Licensed Practical Nurse
Allergy/Immunology Clinic, MAMC
Joint Base Lewis McChord, WA

LPN #2, A/I Clinic

A/I Clinic Secretary
Secretary
Allergy/Immunology Clinic, MAMC
Joint Base Lewis McChord, WA

A/I Clinic Secretary

Former A/I Clinic LPN
Licensed Practical Nurse
(formerly) Allergy/Immunology Clinic, MAMC
Joint Base Lewis McChord, WA

Former A/I Clinic LPN

Former ADC Admin
(formerly) Acting Deputy Commander for
Administration (ADC Admin), MAMC
Joint Base Lewis McChord, WA

Former ADC Admin

Physician #1, IMC
Physician, Internal Medicine Clinic (IMC), MAMC
Joint Base Lewis McChord, WA

Physician #1, IMC

Chief Nurse, DOM
Chief Nurse, Department of Medicine (DOM), MAMC
Joint Base Lewis McChord, WA

Chief Nurse, DOM

Commander, MAMC
Commander, MAMC
Joint Base Lewis McChord, WA

Commander, MAMC

EEO Advisor
Equal Employment Opportunity (EEO) Advisor
Equal Employment Opportunity Office
Joint Base Lewis McChord, WA

EEO Advisor

MSA, A/I Clinic
Medical Support Assistant (MSA)
Allergy/Immunology Clinic, MAMC
Joint Base Lewis McChord, WA

MSA, A/I Clinic

LPN #3, A/I Clinic
Allergy/Immunology Clinic, MAMC
Joint Base Lewis McChord, WA

LPN #3, A/I Clinic

Physician #2, IMC
Physician, Internal Medicine Clinic, MAMC
Joint Base Lewis McChord, WA

Physician #2, IMC

Investigating Officer
Investigating Officer
Pathologist, Evans Army Community Hospital
Fort Carson, Colorado

Investigating Officer

Physician, Neurology
Physician
Officer in Charge, Neurology Section
Evans Army Community Hospital
Fort Carson, Colorado

Physician, Neurology

Union Representative
Supply System Analyst
Omniceil Pharmacy Administrator
Department of Pharmacy,
President, AFGE Local 1502, MAMC
Joint Base Lewis McChord, WA

Union Representative

Executive Officer, MAMC
Executive Officer, MAMC
Joint Base Lewis McChord, WA

Executive Officer, MAMC

LPN #4, A/I Clinic
Licensed Practical Nurse
Allergy/Immunology Clinic, MAMC
Joint Base Lewis McChord, WA

LPN #4, A/I Clinic

HIPAA Officer
HIPAA Officer
Patient Administration Division, MAMC
Joint Base Lewis McChord, WA

HIPAA Officer

JA, MAMC
Center Judge Advocate (JA), MAMC
Joint Base Lewis McChord, WA

JA, MAMC

Former A/I Clinic MSA
(Formerly) Medical Support Assistant, MAMC
Joint Base Lewis McChord, WA

Former A/I Clinic MSA

Chief, Hospital Education
Physician, Chief, Hospital Education, MAMC
Joint Base Lewis McChord, WA

Chief, Hospital Education

Chief, DOM
Chief, Department of Medicine, MAMC
Joint Base Lewis McChord, WA

Chief, DOM

DC for CS
Deputy Commander for Clinical Services (DC for CS), MAMC
Joint Base Lewis McChord, WA

DC for CS

LER Specialist, CPAC
Labor and Employee Relations (LER) Specialist
Civilian Personnel Action Center (CPAC)
Joint Base Lewis McChord, WA

LER Specialist, CPAC

Secretary, DC for CS
Secretary, Deputy Commander for
Clinical Services, MAMC
Joint Base Lewis McChord, WA

Secretary, DC for CS

Legal Assistant
Legal Assistant/Notary
Office of the Command Judge Advocate
Western Regional Medical Command
Joint Base Lewis-McChord, WA

Legal Assistant

Whistleblower
(Formerly) Licensed Practical Nurse
Allergy/Immunology Clinic, MAMC
Joint Base Lewis McChord, WA

Whistleblower

Chief, Civilian Pay
Chief, Civilian Pay, MAMC
Joint Base Lewis McChord, WA

Chief, Civilian Pay

(Formerly) Acting XO
(Formerly) Acting Executive Officer (XO), MAMC
Joint Base Lewis McChord, WA

(Formerly) Acting XO

Subspecialty AO
Subspecialty Administrative Officer
Department of Medicine, MAMC
Joint Base Lewis McChord, WA

Subspecialty AO

A/I Clinic MSA
Medical Support Assistant
Allergy/Immunology Clinic, MAMC
Joint Base Lewis McChord, WA

A/I Clinic MSA

RN, IMC
Registered Nurse (RN)
Head Nurse, Internal Medicine Clinic
Department of Medicine, MAMC
Joint Base Lewis McChord, WA

RN, IMC

Chief, CS Division
Chief, Clinical Services (CS) Division, MAMC
Joint Base Lewis McChord, WA

Chief, CS Division

First Investigating Officer (IO-1)
Chief, Preventive Medicine
Western Regional Medical Command
Joint Base Lewis, McChord, WA

First Investigating Officer (IO-1)

Physician Staff Allergist
Physician, Staff Allergist
Allergy/Immunology Clinic, MAMC
Joint Base Lewis McChord, WA

Physician Staff Allergist