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JUL 17 2014

Special Counsel Carolyn N. Lerner
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Washington, D.C. 20036-4505

RE: Whistleblower Investigation – Carl R. Darnall
Army Medical Center, Occupational Health Clinic, Fort Hood, Texas (Office of Special Counsel File Number DI-13-4218) OJSC HQ DC '14JUL2

Dear Ms. Lerner:

In accordance with Title 5, United States Code (U.S.C.), Section 1213(c) and (d), the enclosed report is submitted in response to your referral of information by letter dated October 29, 2013, in which you requested 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 his authority to me, to review, sign, and submit to you the report required by Title 5, U.S.C., Section 1213(c) and (d). [TAB A].

The Department of the Army (DA) has enclosed two versions of its Report. The first version of the Report contains the names and duty titles of military service members and civilian employees of the DA. This first version is for your official use only, as specified in Title 5, U.S.C., Section 1213(e); we understand that, as required by that law, you will provide a copy of this first version of the Report to the whistleblower, the President of the United States, and the Senate and House Armed Services Committees for their review. Other releases of the first version of the Report may result in violations of the Privacy Act¹ and breaches of personal privacy interests.

The second version of the Report has been constructed to eliminate references to privacy-protected information and is suitable for release to all others as well as the regulations that require protection as noted above. We request that only the second version of the Report be made available on your web-site, 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, U.S.C., Section 552a.

INFORMATION INITIATING THE INVESTIGATION

By letter dated October 29, 2013, the Office of Special Counsel (OSC) referred to the Secretary of the Army (SA) specific allegations made by an anonymous whistleblower against Carl R. Darnall Army Medical Center (CRDAMC), Occupational Health Clinic², Fort Hood, Texas, that form the basis of this investigation and report. Generally, the Whistleblower alleged the following:

OSC Referred Allegation 1: CRDAMC Occupational Health Clinic (OHC) nurses regularly recorded or “charted” patient immunizations prior to administering the immunizations.

OSC Referred Allegation 2: Patients frequently left the OHC prior to receiving immunizations, resulting in incorrect charts and placing patients at risk for later complications.

OSC Referred Allegation 3: OHC physician assistants regularly sign charts for patients whom they do not see, all in violation of agency policies and creating a substantial and specific danger to the patients’ health and safety.

The OSC found that there was a substantial likelihood that these allegations constitute violations of law, rule or regulation and pose a substantial and specific danger to public health and safety under 5 U.S.C. § 1213(a)(1).

It should be noted that the OSC Referral Letter also indicated that the above incidents specifically were in violation of 42 U.S.C. § 300aa-25(a) in that a health care provider who administers a vaccine shall record the name and address, and if appropriate, the title of the provider administering the vaccine. Similarly, Army Regulation (AR) 40-562, *Immunizations and Chemoprophylaxis for the Prevention of Infectious Disease*; and AR 40-66, *Medical Record Administration and Healthcare Documentation* require identification of the person administering the vaccine, and AR 40-66 further requires that medical record entries must be made by the provider who observes, treats, or cares for the patient at the time of observation, treatment, or care.

CONDUCT OF THE INVESTIGATION

The SA forwarded the OSC referral to the Commander, U.S. Army Medical Command (MEDCOM) by letter received by MEDCOM on November 4, 2013, and directed the Commander, MEDCOM, to conduct an investigation into the allegations referred to the SA by the OSC. 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 under AR 40-1, *Composition, Mission, and Functions of the Army Medical Department*. [TAB B]. In addition to the investigation, the SA directed that the Commander ensure that appropriate corrective action is initiated.

The Commander, MEDCOM, referred the responsibility for the investigation to the Commander, Southern Regional Medical Command (SRMC), and on November 8, 2013, Major General (MG) Jimmie O. Keenan, Commander, SRMC, appointed [Investigating Officer], Staff Surgeon, Reynolds Army Community Hospital, Fort Sill, Oklahoma, as an Investigating Officer

² Hereinafter, the Occupational Health Clinic may also be referred to as the “Clinic” or the “OHC”.

(IO) under the provisions of AR 15-6, *Procedures for Investigating Officers and Board of Officers*,³ with a mandate to investigate the allegations forwarded by the OSC. [TAB C].

Parameters of the Investigation

MG Keenan directed The IO to investigate the three OSC referred allegations and to determine whether there were any violations of law, rule or regulation, and whether a substantial and specific danger to public health or safety existed. The directives in the Appointment Memorandum related to the specific issues referred to the SA by the OSC.

With respect to OSC Referred Allegation 1, the OSC Referral Letter stated that several OHC registered nurses (RNs) regularly record or “chart” patient immunizations prior to administering the immunizations, in violation of agency policy. The OSC referral letter detailed the following information in support of this Allegation:

“[t]he charting includes the site of immunization, dose, lot number, and type of medication dispensed. The whistleblower explained that although the RNs chart this information, they do not dispense the immunizations themselves, nor do they escort the patients to the proper room to see the immunizations nurse. Rather, the RNs complete the chart and then direct the patient to the immunization room. The whistleblower alleged that patients frequently fail to move on to the immunization room, resulting in a chart that incorrectly reflects that the immunization has been administered. The whistleblower noted that usual practice is to walk the patient to the immunization room without notating the immunization on the chart and to allow the immunization nurse to chart the administration of the immunization. The whistleblower also explained that this was previously the process at the Clinic, but that the responsibility for charting was taken away from the Clinic immunization nurse several years ago because staff believed it took too much time for her to complete the charts. The whistleblower noted that concerns about the current process at the Clinic have been reported to management, including the former Deputy Chief of Nursing, and the Medical Center Chief of Quality Management, but no action has been taken.”

To address the above specific assertions, MG Keenan’s appointment order specifically required The IO to determine the following relating to OSC Referred Allegation 1:

- Whether clinic nurses assigned to the CRDAMC OHC regularly record or chart patient immunizations prior to administration of the immunizations in violation of agency policy?
- What is the applicable federal law, DOD policy or regulation, U.S. Army regulation, U.S. Army Medical Command (MEDCOM) regulation, and published CRDAMC

³ AR 15-6 promulgates guidelines for Army administrative investigations. Army commands and organizations frequently appoint investigating officers under the provisions of AR 15-6 to investigate all manner of allegations and concerns. [TAB D].

regulation on administering and charting immunizations and does CRDAMC's OHC comply with it?

- If CRDAMC OHC does not follow the current law, regulations, or guidance on administering and charting immunizations, have there been recent changes in the law or regulations that account for the CRDAMC OHC not having incorporated those changes into their policies, and thus, are in violation of the current law, regulations, or guidance?
- If CRDAMC OHC does violate the law, regulations, or guidance on administering and charting immunizations, how long has the clinic been in violation; and who initiated the change in the policy or practice?
- If CRDAMC OHC does violate the law, regulations, or guidance on administering and charting immunizations, what is the Clinic's justification/rationale for being in violation of that requirement?
- If CRDAMC OHC does violate the law, regulations, and guidance on administering and charting immunizations; who in the clinic or hospital chain of command has knowledge of the law and regulatory policies; when were they notified of the violations; and what corrective actions, if any, did they take?
- By name, which clinic nurses are allegedly violating the policy or practice on administering and charting immunizations?
- At any time were the clinic nurses, who allegedly violated the policy or practice, notified of the violations? If so, by whom? Did any of those clinic nurses who were put on notice of the violation take any action based on that notice; and if so, what action did they take?
- Has any violation posed a situation which has or may pose a danger to the health of both the patient and the public because of the possibility of infection in the patient who is incorrectly recorded as having received immunizations?

With respect to OSC Referred Allegation 2, the OSC Referral Letter stated that patients frequently leave the Clinic prior to receiving immunizations, resulting in incorrect charts and placing patients at risk for later complications. Therefore, the OSC letter noted "[t]he whistleblower alleged that this process poses a danger to the health of both patients and the public because of the possibility of infection in patients who are incorrectly recorded as having received immunizations."

To address the above specific assertions, MG Keenan's appointment order specifically required The IO to determine the following relating to OSC Referred Allegation 2:

- Whether patients frequently leave the OHC prior to receiving immunizations, resulting in incorrect charts and placing patients at risk for later complications as a result of not receiving the immunization.
- Does the nurse who administers the immunization confirm that a patient was screened and the immunization was properly recorded? If so, how does the nurse verify the immunization was properly charted?
- Have there been any patient reports or complaints that they did not receive immunizations after the immunization was recorded as being administered?
- Have any patients become ill or injured as the result of these alleged violations in procedures?
- Have there been *any* negative outcomes as a result of patients not receiving immunizations that their records indicate they received?

With respect to OSC Referred Allegation 3, the OSC Referral Letter stated that Clinic physician assistants regularly sign charts for patients whom they do not see, in violations of agency policy. The OSC Letter noted the following:

“the physician assistants generally see only one or two patients a day and that around 98 percent of patients are instead seen by nurses. The whistleblower explained that patient charts, which are recorded electronically in a system known as the Armed Forces Health Longitudinal Technology Application (AHLTA), have three required signatories: the assigned, or face-to-face, provider, the secondary provider (e.g., the immunization nurse), and the supervisory provider. According to the whistleblower, records for patients who are seen by nurses are transferred to the physician assistants to sign as the assigned provider, despite the fact that the physician assistants never see the patients. In addition, the physician assistants sign as the secondary and supervisory providers. Nurses are not permitted to sign records for the patients they see. The whistleblower noted that in addition to being improper and incorrect, this practice indicates in the patient records that there is no supervisory physician overseeing the physician assistants. The whistleblower stated that physician assistants are generally required, as a condition of licensure, to practice in collaboration with or under the supervision of an appointed physician.”

Thus, to address the above specific assertions, MG Keenan’s appointment order specifically required The IO to determine the following relating to OSC Referred Allegation 3:

- Whether clinic physician assistants regularly sign charts for patients whom they do not treat in violation of agency policy.

- What is the applicable federal law, DOD policy or regulation, US Army regulation, US Army Medical Command (MEDCOM) regulation, and published CRDAMC regulation on providers entering treatment information in patient medical records and does CRDAMC's OHC comply with it?
- If CRDAMC OHC does not follow the current law, regulations, or guidance on providers entering treatment information in patient medical records have there been recent changes in the law or regulations that account for the CRDAMC OHC not having incorporated those changes into their policies, and thus, are in violation of the current law, regulations, or guidance?
- If CRDAMC OHC does violate the law, regulations, or guidance on providers entering treatment information in patient medical records, how long has the clinic been in violation and who initiated the change in the policy or practice?
- If CRDAMC OHC does violate the law, regulations, or guidance on providers entering treatment information in patient medical records, what is the Clinic's justification/rationale for being in violation of that requirement?
- If CRDAMC OHC does violate the law, regulations, or guidance on providers entering treatment information in patient medical records; who in the clinic or hospital chain of command has knowledge of the law and regulatory policies; when were they notified of the violations; and what corrective actions, if any, did they take?
- By name, which clinic Physician Assistants are allegedly violating the policy on providers entering treatment information in patient medical records?
- At any time were the Physician Assistants, who allegedly violated the policy, notified of the violations? If so by whom? Did any of those clinic nurses who were put on notice of the violation take any action based on that notice; and if so, what action did they take?

In addition to requiring the investigation of the three OSC Referred Allegations, MG Keenan also specifically required The IO to determine whether any of the procedures at CRDAMC OHC constitute a substantial and specific danger to public health or safety.

Launching of the AR 15-6 Investigation

The IO, reported to CRDAMC on November 18, 2013, to begin interviewing witnesses. She was informed at approximately 1000 hours that the Chief, Occupational Health Clinic (OHC), Chief, OHC, allegedly coached witnesses during a meeting in the clinic on Friday, November 15, 2013. A "cure document" with additional questions was developed to address the coaching allegation. [See Exhibit 1]. Subsequent interviewees that day and the following days were presented a cure document as part of their interviews.

On the afternoon of November 20, 2013, at the request of the Army Office of the General Counsel (OGC), the IO was ordered to suspend the investigation and any further interviewing of witnesses by the IO in order to allow further review of the alleged coaching incident by MEDCOM and OGC attorneys. However, the IO requested and obtained permission from OGC to continue the investigation by not interviewing *any OHC personnel* until the alleged coaching issue had been resolved but to proceed and only interview the *non-OHC personnel* until further notice. Henceforth, on December 2, 2013, the IO received permission from OGC to resume the investigation with a new cure document (cure document #2), consisting of a letter and assurance by the Commander, CRDAMC. The IO presented the new cure document to each OHC employee. [Exhibit 2]. This cure document #2 was provided to all previously interviewed OHC employees as well as subsequently interviewed employees. All interviewees acknowledged receipt of cure document #2. No testimonies were changed as a result of any employees' review of the contents of cure document #2.

The IO received notification from Department of Army at the end of December 2013 that she would deploy to Afghanistan, and she began preparations for her deployment on January 17, 2014, and departed for Afghanistan on or about February 1, 2014. At the time of her deployment, the IO had completed the bulk of the AR 15-6 investigation but she recommended to her SRMC legal advisor (who had been appointed to advise her during the AR 15-6 investigation) that a follow-on medical record and coding review should be conducted to confirm the results of her inquiry. This follow-on medical record and coding review was completed by members of SRMC and the U.S. Army Patient Administration Systems and Biostatistics Activity (PASBA). (<http://www.pasba.amedd.army.mil/>), the Army's experts in medical records and coding, on April 1, 2014. While deployed, the IO reviewed those results and incorporated them into her IO report which she finalized and approved on April 8, 2014. The IO redeployed (returned from Afghanistan) in mid-June 2014.

BACKGROUND INFORMATION

To facilitate a better understanding of the facts and circumstances associated with the whistleblower's allegations to the OSC and to permit a more knowledgeable assessment of the testimonial and documentary evidence collected from all of the witnesses, it is important to understand MEDCOM's mission and functional relationships with supporting organizations.

U.S. Army Medical Command (MEDCOM) Mission

The Surgeon General (TSG) of the U. S. Army serves in 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 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 E].

In her role as Commander, MEDCOM, TSG exercises oversight and control of all medical 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 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 E]. Carl R. Darnall Army Medical Center at Fort Hood is funded by and receives operational oversight and guidance from MEDCOM through the SRMC.

Carl R. Darnall Army Medical Center

An Army Medical Center (MEDCEN) is a Military Treatment Facility (MTF) staffed and equipped to provide comprehensive medical care to eligible personnel. A MEDCEN also performs non-therapeutic activities related to the health of the personnel served including physical examinations, immunizations, medical administration, and Preventive Medicine services. It normally has general radiology, laboratory, and pharmacy capabilities and may offer specialty care in one or more of the subspecialties of medicine. Services provided depend on the availability of space and facilities and the capability of the assigned professional staff. MEDCOM Regulation 10-1, *U.S. Army Medical Command (MEDCOM), Organization and Functions*, dated June 12, 2013.

The Darnall Army Community Hospital opened in 1965, replacing the World War II era Fort Hood Hospital. On May 1, 2006, the hospital was officially re-designated as Carl R. Darnall Army Medical Center (CRDAMC). See <http://www.crdamc.amedd.army.mil/visitors/history.aspx>. It has resources for 128 staffed surgical beds and bassinets with a staff of 2,453. It services over 345,000 beneficiaries. See <http://www.crdamc.amedd.army.mil/pao/facts.aspx>. CRDAMC supports the 1st Cavalry Division and the 3d Cavalry Regiment. Its variety of clinics and three community based medical homes, support more than 45,000 active duty personnel and more than 145,000 family members and retirees within a 40-mile radius. On an average day, the staff at CRDAMC delivers eight new babies, handle 4,258 outpatient visits, 19 surgeries, 28 admissions, 226 Emergency Room visits and fills 4,160 prescriptions. Reference <http://www.crdamc.amedd.army.mil/Default.aspx>.

Since early 2003, more than 2,200 wounded and ill Soldiers evacuated from Iraq and Afghanistan have passed through Darnall, the highest total nationally for an Army hospital and third highest facility in the country behind Walter Reed and Eisenhower Medical Centers.

CRDAMC Preventive Medicine Department

One of the departments in the CRDAMC is the Preventive Medicine Department. Preventive Medicine is the specialty of medical practice that focuses on the health of individuals, communities, and defined populations. Its goal is to protect, promote, and maintain health and well-being and to prevent disease, disability, and death. Preventive medicine specialists have core competencies in biostatistics, epidemiology, environmental and occupational medicine, planning and evaluation of health services, management of health care organizations, research into causes of disease and injury in population groups, and the practice of prevention in clinical medicine. They apply knowledge and skills gained from the medical, social, economic, and behavioral sciences. Preventive medicine has three specialty areas with common core knowledge, skills, and competencies that emphasize different populations, environments, or practice settings: aerospace medicine, occupational medicine, and public health and general preventive medicine. <http://www.crdamc.amedd.army.mil/prev-med/Default.aspx>. The clinic that is the subject of this whistleblower complaint, the OHC, falls under the authority of the CRDAMC Preventive Medicine Department. [Exhibits 3, 4, and 5].

CRDAMC Occupational Health Clinic

The CRDAMC OHC serves over 600 soldiers assigned to CRDAMC as well as approximately 6,000 civilian and contract employees both at CRDAMC and the Fort Hood military installation. [Exhibit 3 and Exhibit 4]. It should be noted that these Soldiers receive the majority of their Occupational Health and healthcare related immunizations thru the OHC. However, specific deployment related immunizations (e.g. plague, smallpox, typhoid, etc.) are given thru the Soldier Readiness Processing (SRP) site and not through the OHC.⁴ The OHC performs many functions, including medical surveillance and intervention, pre-employment physicals, health hazard education, immunizations and prophylaxis, epidemiological investigations, and worksite evaluations. [Exhibit 6 and Exhibit 7]. These functions include pre-placement and annual health assessments for Department of the Army and Non-Appropriated Fund Civilian employees; job injury reporting for civilian employees assigned to Medical, Dental and VETCOM (veterinary) activities at Fort Hood; assisting with Worker's Compensation Claims for Department of the Army civilian employees; Pregnancy Surveillance for all pregnant soldiers, Department of the Army Civilians and Non-Appropriated Fund employees to ensure a safe work environment during their pregnancy; Respirator Clearance under which all Department of the Army Civilians and Non-Appropriated Fund employees and Medical Activity active duty personnel receive medical evaluations prior to respirator fit testing; monitoring of Sharps/Splash Injuries under which Fort Hood Active Duty, Department of the Army Civilians and Non-Appropriated Fund employees receive counseling and are followed at 6 weeks, 3 months, and 6 months after a contaminated sharp or splash injury; and Worksite/Ergonomic Evaluations. Services provided by the OHC that are germane to the whistleblower complaint involve data acquisition and health maintenance, under which employees receive evaluations and immunizations for their duties. See <http://www.crdamc.amedd.army.mil/prev-med/oh-ft Hood.aspx>.

⁴ Although there is a risk to military service members and unit protection/operational readiness if immunizations are not received, as part of the deployment process, all military are processed through a SRP site which includes a medical processing portion to ensure that they receive all required immunizations for that deployment.

The OHC has enjoyed generally favorable Interactive Customer Evaluation (ICE) comments (customer reviews) from customers and clients as well as marked improvement in Official Inspection Program inspections and Joint Commission survey visits (overall finding was that all immunization clinics supported by CRDAMC were managed similarly).

Within the past five to six years, Fort Hood has undergone changes related to the re-stationing of units and anticipated growth of mission responsibilities for the Fort Hood military community which led leadership at CRDAMC to believe more personnel would be required to meet the population's healthcare needs. Additional personnel positions (RN and technician) were created in the OHC to meet the anticipated demand. [Exhibit 8]. However, the actual change in the population supported by the OHC actually changed very little, and in fact due to fiscal constraints related to sequestration and furloughs in 2013, the workload has been less than in times past.

GOVERNING STATUTORY AND REGULATORY AUTHORITIES

Licensure and the Federal Practice of Medicine

There are three levels of providers in the OHC, consisting of credentialed providers (doctors and Physician Assistants (PA)); Registered Nurses (RN); and Licensed Practical Nurses and Licensed Vocational Nurses (LPN/LVN).

The credentialed providers are responsible for the overall medical practice and patient care, provide oversight and directions to the nursing staff, and are permitted to (or "privileged" to) order tests, medications and treatments for patients. The doctors and PAs may practice independently, exercise judgment in determining an appropriate diagnosis for the patient and in determining what treatment is appropriate, and they either personally provide medical care to the patient or direct the nursing staff to do so. [See Exhibit 9g].

The RNs are responsible to follow the orders of the privileged providers in providing patient care, administer treatments and medications within their skill level, keep the physician and PAs informed of the patient's status, and they may also exercise supervisory authority over the LPNs and LVNs. [See Exhibits 9a, 9c, 9d, 9e, and 9f].

On the other hand, the LPNs and LVNs work under the authority and supervision of the privileged providers and/or the RNs, and provide much of the direct treatments such as immunizations to the patients. These providers have a more limited skill set and training, and follow the orders of the higher level providers in providing patient care. [See Exhibits 9a and 9b].

In summary, a typical example of how these health care providers interact with each other would include the doctor delegating to the RN the authority to order an immunization under the doctor's credentials, and the RN may then either administer the immunization personally or have the LVN do it. All of these providers are responsible for accurately recording their involvement in the care of any patient by making appropriate entries in the

medical record.

General Statutory and Regulatory Authorities

Title 10 United States Code (U.S.C.) Section 1094, requires independently practicing health care professionals in the Military Health System (MHS) to possess an unrestricted license, unless the requirement is waived due to unusual circumstances. 10 U.S.C. 1094 provides:

"A person under the jurisdiction of the Secretary of a Military Department may not provide healthcare independently as a healthcare professional . . . unless the person has a current license to provide such care. In the case of a physician, the physician may not provide healthcare as a physician under this chapter unless the current license is an unrestricted license that is not subject to limitation on the scope of practice ordinarily granted to other physicians for a similar specialty by a jurisdiction that granted the license."

A *state* may not enforce licensing requirements against an individual performing duties for the *federal* government where those licensing requirements would give the *state* licensing board "virtual power of review" over a *federal* determination of the individual's competency. If a *federal* agency hires employees or contractors pursuant to a *federal* regulation instructing the agency to determine competency by various criteria, a *state* licensing law imposing an additional or separate criteria is in conflict with the *federal* regulatory scheme, and is therefore preempted under the Supremacy Clause of the U.S. Constitution.

The governing Department of Defense regulatory framework for regulating DoD health care professionals is Department of Defense (DoD) 6025.13-R, *Military Health System (MHS) Clinical Quality Assurance (CQA) Program Regulation*, dated June 11, 2004.⁵ The following relevant provisions provide working definitions for some of the key terms used in this Army report.

***DL1.1.7. Credentials.** The documents that constitute evidence of appropriate education, training, licensure, experience, and expertise of a healthcare practitioner.

***DL1.1.6. Clinical Privileging.** The granting of permission and responsibility of a healthcare provider to provide specified or delineated healthcare within the scope of his or her license, certification, or registration. Clinical privileges define the scope and limits of practice for individual providers and are based on the capability of the specific healthcare facility site where the health care provider will provide their services as well as the individual provider's licensure, relevant training and experience, current competence, health status, judgment, and peer and department head recommendations.

⁵ The DoD Regulation 6025.13-R was superseded on October 29, 2013 with DoD Manual 6025.13. However, it should be noted that there were no changes in the entries contained in the definition section contained in the two issuances. Further, please note hereinafter for ease of use, the following is a hyperlink to the Department of Defense issuances (Directives and Instructions, respectively) that will allow for easy retrieval of such issuances including those relevant issuances discussed in this Report: <http://www.dtic.mil/whs/directives/corres/dir.html> and <http://www.dtic.mil/whs/directives/corres/insl.html>.

***DL1.1.16. Healthcare Practitioner.** Synonymous with "healthcare professional." Any physician, dentist, or healthcare practitioner of one of the professions whose members are required to possess a professional license or other similar authorization. These include DoD healthcare personnel who are physicians, dentists, registered nurses, practical nurses, physical therapists, podiatrists, optometrists, clinical dietitians, social workers, clinical pharmacists, clinical psychologists, occupational therapists, audiologists, speech pathologists, physician assistants, or any other person providing direct patient care as may be designated by the Assistant Secretary of Defense for Health Affairs (ASD (HA)).

***DL1.1.17. Healthcare Provider.** Military (Active or Reserve component) and civilian personnel (Civil Service and providers working under contractual or similar arrangement) granted privileges to diagnose, initiate, alter, or terminate healthcare treatment regimens within the scope of his or her license, certification, or registration. This category includes physicians, dentists, nurse practitioners, nurse anesthetists, nurse midwives, physical therapists, podiatrists, optometrists, clinical dietitians, social workers, clinical pharmacists, clinical psychologists, occupational therapists, audiologists, speech pathologists, physician assistants, or any other person providing direct patient care as may be designated by the ASD (HA).

***DL1.1.23. License.** A grant of permission by an official agency of a State, the District of Columbia, a Commonwealth, territory, or possession of the United States to provide healthcare within the scope of practice for a discipline. The stages of license are as follows:

***DL1.1.23.1. Current.** Active, not revoked, suspended, or lapsed in registration.

***DL1.1.23.2. Valid.** The issuing authority accepts, investigates, and acts upon quality assurance information, such as practitioner professional performance, conduct, and ethics of practice, regardless of the practitioner's military status or residency.

***DL1.1.23.3. Unrestricted.** Not subject to limitations on the scope of practice ordinarily granted all other applicants for similar specialty in the granting jurisdiction. An unrestricted license must allow the provider unabridged permission to practice in any civilian community in the jurisdiction of licensure without having to take any additional action on her/his license.

***DL1.1.24. Licensed Independent Practitioner.** Any individual permitted by law and by the organization to provide care, treatment and services, without direction or supervision, within the scope of the individual's license and consistent with individually granted clinical privileges. This term is equivalent to Healthcare Provider. (See DL1.1.17.)

With respect to the interplay between *federal* and *state* licensing requirements, DoD 6025.13-R, paragraph C4.2.1.1, states, "As directed by 10 U.S.C. 1094(d) ... notwithstanding any *State* law regarding the licensure of healthcare professionals, a licensed healthcare professional who is a member of the Armed Forces may practice the member's profession in any *State*, regardless of whether the practice occurs in a healthcare facility of the Department of

Defense, healthcare facility of the Veterans Administration, a civilian facility affiliated with the Department of Defense, or any other authorized location as long as *the individual is practicing within the scope of federal duties.*” (Emphasis supplied) These licensure requirements also apply to *federal* civilian employees and contractors not just to active duty healthcare professionals. [AR 40-68, *Clinical Care Management*, dated February 26, 2004, paragraph 4-3a].⁶

Other relevant regulatory provisions are derived from Army regulations and the Office of Personnel Management (OPM). The relevant Army regulation, AR 40-68, *Clinical Quality Management*, provides that RNs must have a current, valid, *unrestricted* license from a *State*. [AR 40-68, Chapter 4, especially paragraphs 4-2, 4-4, and 4-5]. Additionally, OPM has established standards for civilian positions. [AR 40-68, paragraph 4-4a]. *State* level requirements may change, but requirements related to licensure of Army Medical Department (AMEDD) health care personnel (military/civilian) will at all times comply with current OASD (HA) guidance. [AR 40-68, paragraph 4-4a]. Health care personnel (military/civilian) employed by the Federal Government will abide by the practice requirements imposed by their *State* of licensure to the fullest extent possible. [AR 40-68, paragraph 4-4a(2)]. However, compliance with *State* requirements shall not interfere with the individual's performance of assigned duties/responsibilities in the specified discipline within the Federal sector. [AR 40-68, paragraph 4-4a(2)].

Army Privileging and Delegation Process Under AR 40-68

Clinical privileging is defined by Army Regulation as “[t]he process whereby a health care provider is granted, based on peer and department head recommendations, the permission and responsibility to provide specified or delineated health care within the scope of his or her license, certification, or registration. Clinical Privileges define the scope and limits of practice for individual providers and are based on the capability of the health care facility, the provider’s licensure, relevant training and experience, current competence, health status and judgment.” [AR 40-68, Glossary, Section II – Terms]. AR 40-68, Chapter 7 provides the general information and specific professional requirements related to each category of privileged provider (military and civilian). It details the list of privileged providers, to include (but not limited to) physicians, Physician Assistants, as well as the nursing providers who have advanced training: Advanced Practice Registered Nurse (ARPN), Certified Nurse Midwife (CNM), Certified Registered Nurse Anesthetist (CRNA), Clinical Nurse Specialist (CNS), and Nurse Practitioner (NP). [AR 40-68, paragraph 7-1a].

AR 40-68, Chapter 9 provides guidance distinguishing between health care providers that require privileging and health care personnel that may function without clinical privileges. Specifically, “Health care practitioners who function independently to initiate, alter, or

⁶ Please note hereinafter for ease of use, the following is a hyperlink to the Department of the Army issuances (Army Regulations) that will allow for easy retrieval of such issuances, including those relevant issuances discussed in this Report which are in the “40” series, Medical Services:
<http://www.apd.army.mil/AdminPubs/BrowseRegulations.asp> and
http://www.apd.army.mil/AdminPubs/series_range_regs.asp?search=40.

terminate a regimen of medical care must be privileged.”[AR 40-68, paragraph 9-2a]. However, “Members of the healthcare staff who function under a standard job description in the performance of their duties – *utilizing practice guidelines or standard policies and/or procedures* – do not require clinical privileges. Department/service chiefs are responsible for the ongoing assessment of the competence of personnel to safely perform assigned duties.” [AR 40-68, paragraph 9-2b].

AR 40-68, Chapter 5 provides guidance regarding the competency assessment, delegation and supervision of healthcare personnel within the Army MTFs. Chapter 5 begins with a general overview of the requirement for competency of all staff members within an MTF. Specifically, it provides, “Competence is the ability of a staff member to apply decision-making, psychomotor, and interpersonal skills at the level of knowledge expected of his/her current duty position. Highly competent performance by members of the organization is predicated on a variety of factors to include: a carefully structured new employee orientation, ongoing education and training opportunities, and formalized evaluation processes.” [AR 40-68, paragraph 5-1a]. Competency assessment is required of all health care personnel involved in providing health care. Health care personnel, both privileged and non-privileged, are required to maintain the requisite competencies associated with the duty position that they are assigned. [AR 40-68, paragraph 5-1b(2)].

AR 40-68, Chapter 5 also provides for the delegation of privileged task, function or process to a competent *non-privileged* professional. Specifically,

“Delegation transfers to a competent individual the authority to perform a selected patient care task in a given situation. Typically, delegation involves the licensed or privileged professional allowing a specified patient care activity, which is within his or her own scope of practice, to be performed by the unlicensed assistive personnel (UAPs), an RN/LPN, or other non-nursing personnel. The authority to perform the task is passed to another but the professional responsibility and accountability for the overall care provided, and for associated patient outcomes, remains with the delegating individual.” [AR 40-68, paragraph 5-2a].

The regulatory guidance provides that it is the responsibility of local leadership to ensure that all healthcare providers to whom patient care tasks and procedures have been delegated are assessed as to individual competency; that competency-based orientation is provided; and that individual duties are based on demonstrated knowledge, skill and technical proficiency. [AR 40-68, paragraph 5-2e].

Additionally, all health care personnel are provided *supervision* of their clinical performance to ensure the competence and skill of those providing health care and services. [AR 40-68, paragraph 5-3]. Generally, AR 40-68 addresses the various forms of supervision, and the related procedure referred to as “countersigning” which is conducted by individuals who have medical supervisory responsibility over certain health care providers. AR 40-68 defines “supervision” in the following manner:

“Supervision-The process of reviewing, monitoring, observing, and accepting responsibility for assigned personnel. The three types of supervision are-

- a. Indirect. The supervisor performs retrospective review of selected records. Criteria used for review relate to quality of care, quality of documentation, and the authorized scope of privileges/practice of the individual in question. Reviews may also include *countersignature or authentication of medical entries, reports, or orders prescribed by another.* (Emphasis added).
- b. Direct. The supervisor is involved in the decision-making process. This may be further subdivided as follows: (1) Verbal-the supervisor is contacted by telephone or informal consultation before implementing or changing a regimen of care; and (2) Physically present-the supervisor is present physically through all or a portion of care.
- c. Enhanced supervision. Supervision afforded a provider with regular privileges for whom the need to assess competence and performance has been identified. This may be appropriate following a PCS move or a provider's return to patient care responsibility from an administrative/nonclinical assignment, during a period of temporary duty, or when privileges for a new procedure are granted. This is not an adverse privileging/practice action.” [AR 40-68, Glossary, Section II].

Thus, as stated above, supervision *may be direct or indirect*. [AR 40-68, paragraph 5-3b]. *Direct supervision* requires that the supervisor be involved in the decision-making process either verbally or by being physically present through all or a portion of care. [AR 40-68, paragraph 5-3b(1)(b)]. On the other hand, *indirect supervision* involves retrospective review by the supervisor of selected records and/or observation of the results of the care provided. Criteria for indirect supervisory review relates to quality of care, quality of documentation, and the staff member's scope of practice. [AR 40-68, paragraph 5-3b(1)(a)]. Supervisors of non-privileged health care personnel must complete periodic clinical performance evaluations that address the individual's demonstrated abilities and competency to perform the duties, responsibilities, expectations and components of his/her position. The individual's improvement or lack of improvement related to documented performance limitations/inadequacies are assessed and addressed in each written evaluation. [AR 40-68, paragraph 5-3c(3)(b)].

Privileged and Credentialed Providers

Physicians. Physicians are primary or specialty health care providers who examine, diagnose, and treat or prescribe courses of treatment for beneficiaries suffering from diseases, injuries, or disorders of any or all of the body's systems. As either primary or specialty care providers, physicians are an integral member of the health care team and participate in most clinical pathways in the health care system. They are skilled in the management of acute and chronic conditions that affect their patients and are primary sources of consultation for other health care professionals. [AR 40-68, paragraph 7-15a]. Physicians must have completed an accredited medical degree program acceptable to the Department of the Army, and must maintain a current, active, valid, and unrestricted medical (MD) or osteopathic (DO) medical

license from a U.S. State, District of Columbia, Commonwealth, territory, or jurisdiction acceptable to DA.

The physician's scope of practice is based upon the *privileges* granted by the hospital. These privileges are determined by the physician's credentials. Physician privileges may include examining, diagnosing, and treating or prescribing courses of treatment within the scope of their training and experience for eligible beneficiaries suffering from diseases, injuries, or disorders; serving as consultants for other health care professionals in the Military Health System; or promoting prevention and wellness, health and safety education and training activities, disease screenings, and positive health behaviors [AR 40-68, paragraph 7-15c]. Physicians are licensed independent practitioners and have no requirement for direct supervision. They act independently in areas of medical and surgical care when they have demonstrated competency within their delineated privileges [AR 40-68; paragraph 7-15d].

Physician Assistants. Physician Assistants (PAs) are health care providers who deliver primary or specialty medical care under the supervision of a physician. Within that physician-PA relationship, PAs exercise significant professional autonomy in medical decision making and provide a broad range of diagnostic and therapeutic services to all DOD beneficiaries. The clinical role of the PA includes but is not limited to primary care, family practice, and specialty areas such as aviation medicine, cardiovascular perfusion, emergency medicine, occupational medicine, and orthopedics. PA practice is centered on the management of illness and injury, disease prevention, and health promotion and may include—in addition to patient care responsibilities—didactic instruction in a formal setting, patient education, research, and administrative activities [AR 40-68, paragraph 7-16a].

PAs provide medical care for Soldiers and eligible beneficiaries in all age groups, including children under the age of 2, according to the clinical privileges awarded by the MTF commander. PAs are awarded privileges like physicians, but must practice under the supervision of a physician. Additionally, the PAs ability to practice independently is more limited than the physician based on training. PAs may diagnose, prescribe for, and treat diseases, disorders, and injuries, and they may even perform minor surgery and wound management. In an outpatient setting, a PA's entries in the medical record do not require a physician's countersignature, but countersignature will be within 24 hours in an inpatient setting. [AR 40-68, paragraph 7-16c].

In the Occupational Health area of medical practice, a PA who receives a graduate level degree in occupational health/public health may be designated as an occupational health PA (OHPA). The OHPA assists the occupational medicine physician by conducting job-related, fitness-for-duty, and health-maintenance examinations for military and civilian personnel; conducting occupational and non-occupational disease and injury prevention and treatment of military and civilian personnel; conducting illness and injury monitoring and investigations; supervising chronic disease surveillance to include tuberculosis and sexually transmitted diseases; and providing occupational and environmental health education to Soldiers and DOD civilian employees [AR 40-68, paragraph 7-16c].

The Nursing Profession

The information that follows provides both an overview of the nursing profession and

the governing statutory, regulatory, and policy authorities that govern the practicing nursing health care provider at a federal medical/health facility.

Nursing is the protection, promotion, and optimization of health and abilities; prevention of illness and injury; alleviation of suffering through the diagnosis and treatment of human responses; and advocacy in health care for individuals, families, communities, and populations. (The American Nurses Association (ANA)).

The ANA states there are six essential features of professional nursing:

1. Provision of a caring relationship that facilitates health and healing,
2. Attention to the range of human experiences and responses to health and illness within the physical and social environments,
3. Integration of objective data with knowledge gained from an appreciation of the patient or group's subjective experience,
4. Application of scientific knowledge to the processes of diagnosis and treatment through the use of judgment and critical thinking,
5. Advancement of professional nursing knowledge through scholarly inquiry, and
6. Influence on social and public policy to promote social justice.

Licensed Practical (or Vocational) Nurse (LPN/LVN).⁷ LPN/LVNs 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, LPN students receive either a diploma or certificate. In order to be licensed as an LPN, students must then pass the National Council Licensure Examination for Practical/Vocational Nurses (NCLEX-PN Examination) national licensing examination.

Registered Nurse (RN). RNs provide direct patient care but are less likely to carry out tasks of a Licensed Practical Nurse (LPN), such as taking temperatures and giving immunizations. RNs 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 nursing 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 LPN and LVN are equivalent names for “[a]n individual who is specifically prepared in the techniques of nursing, who is a graduate of an accredited school of practical/vocational nursing and whose qualifications have been examined by a State board of nursing, and who has been legally authorized to practice as an LPN/LVN.” See AR 40-68. Texas and California use the title “LVN”, while the remaining 48 states use “LPN”.
<http://allnurses.com/lpn-lvn-corner/what-difference-between-788064.html>.

The CRDAMC OHC employs both RNs and LVNs. The first LVN, LVN1, was hired in 2008 to provide more consistent coverage for the immunization clinic. [Exhibit 9a]. The second LVN to be hired, LVN2, was hired in the summer of 2012 as an Occupational Health Technician, a different job series than an LVN and at a higher grade due to more specialized training in the occupational health area of medical care. However, in the OHC, the LVN and Occupational Health Technician performed largely the same duties. [Exhibit 9b]. LVN1, at the lower grade LVN position description, was doing much of the same work that LVN2 was hired to do, as well as also ensuring that the Immunization Room was manned. Hiring continued in September 2012 with an RN, and again in February 2013 with another RN. [Exhibit 9c]. A Medical Support Assistant (MSA) was also added to the clinic for administrative support purposes.

Statutory and Regulatory Authorities Relating to Immunizations and Charting

Vaccines are addressed in Subchapter XIX of Chapter 6A: Public Health Services, in Title 42 of the United States Code to include the National Vaccine Program and the National Vaccine Injury Compensation Program. 42 U.S.C. § 300aa-25(a), states, "each health care provider who administers a vaccine set forth in the Vaccine Injury Table to any person shall record, or ensure that there is recorded, in such person's permanent medical record (or in a permanent office log or file to which a legal representative shall have access upon request) with respect to each such vaccine—(1) the date of administration of the vaccine, (2) the vaccine manufacturer and lot number of the vaccine, (3) the name and address and, if appropriate, the title of the health care provider administering the vaccine, and (4) any other identifying information on the vaccine required pursuant to regulations promulgated by the Secretary." 42 U.S.C. § 300aa-33 defines "health care provider" as "any licensed health care professional, organization, or institution, whether public or private (including Federal, State, and local departments, agencies, and instrumentalities) under whose authority a vaccine set forth in the Vaccine Injury Table is administered." Therefore, the documentation requirements of 42 U.S.C. § 300aa-25(a) would be triggered only if the particular vaccine was actually administered and was of a type listed on the Table. It follows that if a vaccine were never actually administered or were of a type not listed in the Table, then the 42 U.S.C. § 300aa-25(a) requirements would not apply. *See 42 U.S.C. Section 300aa-25(a)*. [Exhibits 10 and 11].

The Department of Defense has set-out broad guidance in DoD Directive 6205.02E, *Policy and Program for Immunizations to Protect the Health of Service Members and Military Beneficiaries*, dated September 19, 2006, which cites Center for Disease Control (CDC) and Advisory Committee on Immunization Practices (ACIP) as references. This Directive gives broad guidance for the individual Service Medical Departments to implement. [DoD Directive 6205.02E, *Policy and Program for Immunizations to Protect the Health of Service Members and Military Beneficiaries*, dated September 19, 2006]. Paragraph 4.6 of that Directive states, "Immunizations shall be recorded in individual health records and in a centralized electronic database in a manner suitable for standardized tracking and surveillance of force health protection practices."

AR 40-562, *Immunization and Chemoprophylaxis*, dated September 29, 2006, addresses vaccine documentation in paragraph 2-7(d) indicating in part that the National Childhood

Vaccine Injury Act of 1986 (which is codified at 42 U.S.C. §§ 300aa-1 to 300aa-34) requirements applied to those vaccines enumerated in regulation paragraph 2-7(d). Although 42 U.S.C. § 300aa-25 was not expressly referenced per se in paragraph 2-7(d), that paragraph did incorporate the same documentation criteria as contained in the statute. Army Regulation 40-562 was amended on October 7, 2013 and was renamed *Immunizations and Chemoprophylaxis for the Prevention of Infectious Diseases*. Paragraph 1-4(c)(5) therein currently provides that medical commanders, commanding officers, and command surgeons will monitor the immunization status of personnel and ensure compliance with policies and procedures for creating and maintaining immunization records in accordance with 42 U.S.C. § 300aa-25. The Army's electronic immunization tracking system (ITS) also is to comply with 42 U.S.C. § 300aa-25 per Army Regulation 40-562 paragraph 2-7(a)(2)(a).

AR 40-66, *Medical Record Administration and Healthcare Documentation*, dated January 4, 2010, paragraphs 3-4a, 6-7b, and chapter 7, provides guidance relating to documenting the medical record, including broad details about immunization documentation and the Occupational Health Program Civilian Employee Medical Record (CEMR). [http://www.apd.army.mil/AdminPubs/series_range_regs.asp?search=40]. Paragraph 5-19(e)(2) states that "remarks and recommendations concerning immunization and sensitivity tests may be added by MTF personnel. The reasons for waiving any immunization will be recorded in enough detail for later medical evaluation." Paragraph 6-7(b) states that "the reasons for waiving any immunization will be recorded in the AHLTA immunization module. Additional information should be added as necessary to the encounter note to allow for future medical evaluation." Note that the definition of "medical record" on page 199 states that "paramedical documents, such as immunization registers and dosimetry⁸ records, are not considered medical records although they are kept in the same file with other medical records." [AR 40-66].

CRDAMC MEDCEN Regulation 40-6, *Required Immunizations and Post-Exposure Prophylaxis Against Communicable Disease*, dated December 17, 2012, applicable to all staff working at CRDAMC, does not specifically address the procedure for administration and documentation of immunizations, but rather focuses on immunization requirements specifically for health care workers (HCW) assigned to the medical center and dental activity. [CRDAMC MEDCEN Regulation 40-6, Exhibit 13].

CRDAMC MEDCEN Regulation 40-23, *Scope of Practice For Registered Nurses, Licensed Vocational Nurses/68WMS and Nursing Assistants/68W*, dated August 3, 2011, applicable to all staff working at the CRDAMC medical facility, defines the scopes of practice for nursing personnel at CRDAMC. [CRDAMC MEDCEN Regulation 40-23, Exhibit 14].

CRDAMC OHC *Standard Operating Procedure #7, Subject: Booking and AHLTA/Medical Record Documentation of Immunization /PPD Administration or to the health department if they are a contract employee*, dated May 6, 2013, is a standard operating procedure (SOP) used in the CRDAMC OHC which states specifically that the Immunization

⁸ "Dosimetry" or "radiation dosimetry" is the calculation and assessment of the ionizing radiation dose received by the human body due to both external irradiation and the ingestion or inhalation of radioactive materials.

Nurse (an LVN specifically assigned to the immunization room) will document administration of the immunization, and reflects most directly the Army standard for documentation and administration of immunizations. [SOP #7, Exhibit 12].

The Joint Commission (TJC) is an independent, not-for-profit organization that accredits and certifies more than 20,000 health care organizations and programs in the United States. TJC accreditation and certification is recognized nationwide as a symbol of quality that reflects an organization's commitment to meeting certain performance standards. *See* <http://www.jointcommission.org/>. TJC is the nation's oldest and largest standards-setting and accrediting body in healthcare, and its mission is to continuously improve health care for the public, in collaboration with other stakeholders, by evaluating health care organizations and inspiring them to excel in providing safe and effective care of the highest quality and value. TJC establishes standards which accredited bodies must comply.⁹ Some of the standards applicable to medical records and immunization practice include:

*TJC Standard RC.01.01.01 generally requires that the hospital maintain complete and accurate medical records for each individual patient. Elements of Performance (EP)6 requires the medical record to contain the information needed to justify the patient's care, treatment, and services. EP7 requires the medical record to contain information that documents the course and result of the patient's care, treatment, and services.

*TJC Standard RC.01.03.01 requires that documentation in the medical record be entered in a timely manner. EP 3 requires that the hospital implement its policy requiring timely entry of information into the patient's medical record. [See also PC.01.02.03, EP 2].¹⁰ This requirement means that documentation occurs after care treatment or services are provided.

*TJC Standard PC.01.02.03 requires that the hospital assess and reassess the patient and his or her condition according to defined time frames. EP2 states that the hospital must perform initial patient assessments within its defined time frame. [See also RC.01.03.01, EP 3].¹¹ EP3 states that each patient is reassessed as necessary based on his or her plan for care or changes in his or her condition. Note that reassessments may also be based on the patient's diagnosis; desire for care, treatment, and services; response to previous care, treatment, and services; and/or his or her setting requirements.

The Texas Nursing Practice Act was cited by some witnesses as being applicable to the nursing practice for those in Army medical facilities, specifically with regard to integrity. To that point, three of the witnesses (RN3, LVN2 and RN1) specifically referred to the Texas Nursing Practice Act in their statements. However, it was the opinion of two of those witnesses, (LVN2 and RN1), that based on their discussion directly with the Texas Board of Nursing, the practices of the OHC did violate the Act. However, it is arguable whether these standards actually apply on a military installation due to *federal preemption*. CDRAMC MEDCEN Regulation 40-23 states that "none of the policies and procedures of CRDAMC can supersede the Registered Nurse's state Nurse Practice Act."¹² [CDRAMC MEDCEN Regulation 40-23,

⁹ TJC standards are proprietary and are only available on a paid subscription basis.

¹⁰ "PC" is the TJC standard for the provision of care, treatment, and services.

¹¹ "RC" is the TJC standard for record of care, treatment, and services.

¹² It should be noted that this provision in CRDAMC MEDCEN regulation 40-23 is contrary to Army Regulation

Exhibit 14]. On the other hand, the Army position is that *federal preemption* applies in situations where there is conflict between Army (federal) requirements and state requirements. To this point, AR 40-68, paragraph 4-4a(2), states, "Health care personnel (military/civilian) employed by the Federal Government will abide by the practice requirements imposed by their State of licensure/certification/registration to the fullest extent possible. Note: Compliance with State requirements shall not interfere with the individual's performance of assigned duties/responsibilities in the specified discipline within the Federal sector." [AR 40-68]. Therefore, accordingly, there is no violation based on the federal preemption principle.

SUMMARY OF THE EVIDENCE OBTAINED FROM THE INVESTIGATION AND AGENCY DISCUSSION

Overview

The evidence gathered during the subject investigation indicated that nurses in the OHC at CRDAMC do regularly record or "chart" patient immunizations prior to administering the immunizations in violation of the Army Regulation and OHC Standard Operating Procedure, substantiating OSC Referred Allegation 1.

The evidence also supported the conclusion that some OHC patients may leave the OHC prior to administration of their immunization, resulting in erroneous information in their medical record relating to immunizations and tests they should have received, and the potential that they remain unprotected from the disease or bacteria for which the immunization was intended to protect. This vulnerability could lead to additional illness if the employee who was not immunized passes the infection to other employees, soldiers or patients, resulting in a cascade effect. However, there was *no* evidence of a specific case in which this potential outcome occurred, leaving OSC Referred Allegation 2 unsubstantiated.

OSC Referred Allegation 3 was also unsubstantiated, in that the evidence supported the conclusion that OHC physician assistants and the OHC physician do sign charts for patients that they did not treat, but not in violation of law or regulation because they do so in a supervisory capacity. Finally, the evidence did not reveal any incident which constituted a substantial and specific danger to public health or safety. The testimonial and documentary evidence gathered by the IO during the AR 15-6 investigation supports these conclusions by a preponderance of the evidence, the legal standard required of an AR 15-6 Investigation.

Previous Investigations

The OHC clinic has experienced three investigations in the six to eight months prior to the AR 15-6 investigation which was initiated to address the three OSC Referred Allegations. Most witnesses cited the below referenced employee complaints and resulting investigations as contributing to a very "toxic" workplace. There has been significant employee turnover in the OHC as a result.

40-68 and will be changed.

The first investigation involved allegations by three OHC employees (RN3, LVN2, and RN1) of Health Insurance Portability and Accountability Act (HIPAA) violations by several other OHC personnel (RN2, Former MSA, MSA2, RN4, Admin Officer, DPM, Chief, OHC and MSA1). These allegations were reported in April 2013 and the investigations into the allegations were completed on October 28, 2013. The investigations were conducted by the hospital's HIPAA Security/Privacy Officer and approved by the hospital commander, MEDCEN Commander. The allegations were founded against three of the seven OHC employees against whom allegations were made, the complainants were all notified of which violations were substantiated, and the Clinic/Department Chain of Command has implemented the Commander's corrective actions.¹³ These complaints, with the resulting investigations and findings, resulted in a lack of trust among employees in the OHC.

A second investigation, a Commander's Inquiry (CI)¹⁴, was appointed by the CRDAMC Commander and completed by the appointed Investigating Officer prior to any knowledge of the anonymous whistleblower complaint to OSC. This Commander's Inquiry investigated many of the same issues as those investigated as part of the AR 15-6 investigation initiated in response to the OSC referral and provided very detailed witness statements and information that were invaluable to the investigation relating to the OSC referral, and were incorporated into the AR 15-6 report of investigation. The Commander's Inquiry related to an employee removal action during the employee's probationary period, and considered other allegations of clinic wrongdoing, including the allegation relating to nurses charting before immunizations were given, and, the allegation that the doctor and PAs signed patient charts for patients they did not treat. The Commander's Inquiry was initiated on September 20, 2013, was completed at the end of October 2013, and its final recommendations and actions were approved by the Commander, CRDAMC in mid-November 2013, all prior to the CRDAMC command's knowledge of the OSC complaint and investigation. Implementation of corrective actions did not occur, however, at the time due to concern for unduly influencing the OSC investigation which had just gotten underway¹⁵. With respect to the AR 15-6 investigation initiated as a result of the OSC referred allegations, the main allegations of wrongdoing which were being investigated by The IO had been previously investigated as part of the September 20, 2013 Commander's Inquiry, including the issue regarding nursing staff signing off charts instead of credentialed providers (PAs and physician), the allegation involving the flow of patients through the immunization clinic, and "pre-documentation."

A third investigation addressed a union complaint by an OHC employee (LVN2) in 2013. However, the issues in that complaint were not relevant to the OSC investigation. This union complaint with its investigation added to the employees' perception of a toxic workplace and fears of additional complaints.

¹³ The complaints were investigated and some of the allegations were substantiated for each complainant. Complaints were substantiated against three OHC employees for the following reasons: improper access of demographic information to retrieve birth date information for the OHC's Birthday Calendar, to obtain contact information for a hiring interview, and access of a co-worker's medical record (who was taken from the OHC to the Emergency Room) by an employee not providing treatment but who was concerned with that co-worker's wellbeing.

¹⁴ Hereinafter, this inquiry will be referred to as either the Commander's Inquiry or CI.

¹⁵ Again, by point of referral, the OSC referral to the SA occurred on October 29, 2013 and the AR 15-6 investigation was initiated on November 8, 2013 with the appointment of the IO.

CRDAMC OHC Climate

There is evidence of significant mistrust in the OHC, including instances of surreptitious recording of meetings and conversations by some in the nursing staff, and lack of respect for peers and supervisors (loud and contentious discussions regarding clinic practices and policy with the OHC leadership, exclusionary behavior such as closing their office doors while they worked. The September 20, 2013 Commander's Inquiry considered some of these issues, especially as they related to or involved RN1, the nurse who was removed during her probationary period, and RN3, who many employees stated was an instigator of problems in the OHC.

Chief, OHC' supervisory skills were called into question in the September 20, 2013 Commander's inquiry and those deficiencies were confirmed in the AR 15-6 investigation as well.¹⁶ Several employees complained about Chief, OHC and his lack of oversight. For example, the supervisory controls imposed by Chief, OHC to place nurses under the direct supervision of physician assistants ran contradictory to CPAC guidance and Union requirements, and had to be reversed. Also, Chief, OHC did not provide required performance counseling to his employees, indicating a lack of knowledge of the process of civilian personnel management. Further, Chief, OHC generally tried to lead by consensus and felt that the clinic staff was "like a family" and was reluctant to enforce the appropriate rules as were reflected in the Standard Operating Procedures (SOPs) and relevant regulations. His leadership style may have worked well before several new employees arrived (RN3, LVN2 and RN1 who entered duty between June 2012 and February 2013) wherein all of them performed their duties and "got the job done", but when some of the new employees raised enough questions about processes and application of the various Occupational Health guidance sources, he was not able to address their questions with confidence, deferring to his more OHC "tenured" nurses, the PAs, and to his supervisor, the former Chief, DPM, to "fix" the problems. The bottom line is that his leadership style was ineffective with the changed employee mix.

Most employees now work behind closed doors, even when not providing client care. During interviews several employees stated that they feared retribution and were concerned about keeping their jobs as a result of the continued investigative processes. The two cure statements provided to the employees after Chief, OHC had called the staff together prior to the beginning of the AR 15-6 investigative efforts into the OSC referred allegations seemed not to have alleviated some of the staff's fears of retribution, and several employees, including LVN2 and RN3, were concerned because of their experiences with previous investigations, that this investigation was yet another opportunity for someone to find something that would adversely impact them.

OSC Investigation

All of the witnesses germane to the allegations referred by OSC and set-out by MG Keenan, the Appointing Authority, in the AR 15-6 appointment order were interviewed by the IO. Each of these witnesses were asked to respond to a set of questions that were developed by

¹⁶ PAs do not exercise direct supervisory authority and responsibility over RNs but they can order RNs to perform certain duties.

The IO to solicit specific information to address the questions she was directed to answer by the Appointing Authority. Most of these witnesses had also been interviewed in the previous Commander's Inquiry which had been initiated and completed prior to the referral by OSC, and their testimony from that proceeding was also considered by The IO. The IO began with an interview of the chief of the OHC, Chief, OHC. Similar questions were then addressed to other clinic personnel, including the OHC's two Physician Assistants, as well as the OHC's nursing and administrative staff. The IO also interviewed one former employee who had been terminated in her probationary period, RN1, who provided information relevant to the investigation. Additionally, The IO interviewed several employees at the management level of CRDAMC, including the Chief of Preventative Medicine and the Deputy Commander for Nursing. In addition to these witnesses, The IO obtained informational interviews from subject matter experts in coding and medical records.

Documentary and Testimonial Evidence Gathered During the Investigation Concerning the CRDAMC Occupational Health Clinic

Sworn Statements and Informational Interviews

The IO reported to Fort Hood on November 18, 2013, to obtain interviews and documentary evidence from OHC employees. The IO obtained sworn statements from 21 witnesses associated with the CRDAMC and the OHC, and conducted informational interviews with six other witnesses. A staffing memorandum relating to changes in staff in the OHC was obtained after The IO's deployment, as was a follow-on medical record and chart review conducted by three employees at the CRDAMC higher headquarters – Southern Regional Medical Command. Summaries of the pertinent sworn statements and informational interviews follow:

Sworn Statement of Chief, CRDAMC Occupational Health Clinic

Chief, OHC provided a sworn statement on November 18, 2013. Chief, OHC arrived at Fort Hood as the Chief, OHC on October 4, 2010. He testified that he is familiar with OHC policies and procedures on documenting immunizations. Specifically, that the RN sees the patient first, reviews the immunization requirement, uses an order sheet to record the immunization requirement and then proceeds to walk the patient to the immunization room where an LVN administers the immunization.

Chief, OHC further stated that he believed any variations to the procedures were slight, yet still met standard of care and resulted in no adverse outcome. He admitted that in one instance an immunization nurse provided an intramuscular (IM) injection that should have been subcutaneous¹⁷ but that she was removed from patient care until she was retrained. He stated that the wrong immunization did not result in a threat to public health.

Chief, OHC also stated he never witnessed a patient leaving the clinic before receiving

¹⁷ "Subcutaneous" means an injection applied under the skin.

an immunization. When he witnessed compliance variations he would counsel his subordinates and he also informed senior staff. He named LVN2 as a staffer who did not follow procedures. He has made recommendations to streamline the process. He is aware that of the requirement to have privileged providers provide technical supervision over non-privileged providers.

Chief, OHC acknowledged that he met with his staff prior to the start of the investigation after the hospital's Adjutant informed him of the purpose and scope of the investigation. Chief, OHC swore that the purpose of the meeting was to ensure the clinic was informed of the investigation and to gather the documents requested for the investigation (policies and procedures and employees' names). Chief, OHC stated that he gathered several staff members in the hallway "to brainstorm the requirement." He specifically stated:

"As I discussed the items on the list provided to me by the adjutant, we discovered that confusion was created when the RNs filled in and signed data blocks in the immunization module. It created the appearance that the RN had administered the immunization when in fact the LPN had done this. In working this through we discovered that the immunization nurse can change the name to hers, when indeed she is the administering nurse. I verbally established that a new SOP would be that the RNs would not make annotations in the immunization module if they were not actually administering the vaccine. I also discovered that the RNs were documenting portions of the visit in either the Subjective / Objective (S/O) portion or the Assessment / Plan (A/P) portion of the note.¹⁸ We will be writing the SOP soon to standardize who writes what and where. I also addressed the issue of patients leaving without receiving their immunizations. I was not aware that this was happening, and expected to be notified if it did. I was emphatic in stating that if it happened and no one notified me or did nothing about it that I would write them up. In general I emphasized that if someone is going to make general allegations, they need to bring specifics."

Chief, OHC stated he did not coach anyone on how to answer the investigating officer's questions.

Sworn Statement of PA2, Physician's Assistant (PA), CRDAMC OHC

PA2 provided a sworn statement on November 20, 2013. PA2 stated she was familiar with the immunization policies. She said that during a meeting, months earlier, (March – April time frame) everyone agreed that only LPNs would chart immunizations in AHLTA.

PA2 testified that she knew of no adverse outcomes nor any threat to public health issues at CRDAMC. She did not provide any names of staff members who does not comply with the immunization policy. PA2 attested that she had no concern with the current policy as long as everyone follows it and noted that the order sheet the RN uses to record the immunizations is a

¹⁸ In medical practice, a "SOAP" note is an acronym for subjective (S), objective (O), assessment (A), and plan (P), and constitutes a method of documentation by which health care providers ensure specific areas are captured in their notes in a patient's medical record.

back-up in addition to AHLTA.

PA2 testified that as a Physician Assistant she follows the policy that requires privileged providers to maintain oversight of non-privileged providers' clinical activity.

PA2 stated that she was not present for the November 15, 2013 meeting with Chief, OHC.

When asked if she wished to add anything, PA2 mentioned a coding problem where some encounters were not in the coder's report if the note had been transferred¹⁹ to the provider for signature. She stated the computer changed the record to the provider's code. She also added that it was her understanding that privileged providers co-signed the medical record not for RVUs²⁰ but because the nurses were not privileged providers.

Sworn Statement of PA1, Physician's Assistant, CRDAMC OHC

PA1 provided a sworn statement on December 4, 2013. She stated that she is familiar with the CRDAMC immunization policies. In particular, that the Occupational Health Nurse, a RN, screens and reviews the medical history of the patient, and, then if an immunization is needed, she writes it on a piece of paper and walks the patient into the immunization office. It is the immunization nurse that then gives the immunization and documents it in AHLTA. She said "basically each nurse should only document what she does."

PA1 also admitted that some RNs did it differently and documented the immunization in the immunization module of AHLTA when the immunization nurses were not doing it.

PA1 stated that RN5 and RN2 were two RNs who were not following the policy and informed Chief, OHC. She knows of no adverse outcomes nor any threat to public health issues. She identified LVN2 who benefited from additional training on the policies. She identified LVN1 as a very good immunization nurse.

PA1 testified that she is not aware of any threat to public health and gave the example of when six hospital staffers were exposed to TB and LVN1 properly cared for them.

PA1 informed the IO that she addressed compliance issues with individuals and reported them to Chief, OHC. She stated that RN3 documents in the S/O that the immunization nurse gave the immunization and that RN5 and RN2 document in the immunization module.

¹⁹ The term "transferred" or "transfer" is a term used in the medical profession to denote when a patient is transferred or referred to a medical health provider who is a physician or Physician Assistant. Several witnesses use this term (such as PA2, MSA1, and Chief, OHC-BAMC [Exhibit 16, Statement of Chief, OHC-BAMC]).

²⁰ "RVUs" means Relative value units (RVUs) are a measure of value used in the United States Medicare reimbursement formula for physician services. Medicare uses a physician fee schedule to determine payments for over 7,000 physician services. The fee for each service depends on its RVUs, which rank on a common scale the resources used to provide each service. However, the practice of RVUs as a metric has been adopted by all medical facilities even in non-Medicare settings.

PA1 reported that RN2, RN5, LVN2, and LVN1 were nurses who have not complied with policies and procedures regarding immunizations. She did not know of anyone who left the clinic before ordered immunizations were given because “patients cannot work unless these area done. They tend to make sure they get them.”

PA1 stated that she follows the policy requiring privileged providers’ oversight of non-privileged providers’ actions.

Lastly, PA1 was not present for the November 15, 2013 meeting.

Sworn Statement of LVN1²¹, Licensed Vocational Nurse, CRDAMC OHC

LVN1 provided a sworn statement on November 18, 2013. LVN1 stated that she was familiar with the CRDAMC immunization policy because she wrote it and that she was the first LVN immunization nurse hired at the clinic in 2008. This necessitated that new procedures be developed to account for what role the LVN would play in the OHC which had previously only had RNs on its staff to administer the immunizations, and adjustments had to be made now that she was their first LVN who had to be incorporated into the immunization process. She reported that she subsequently updated the policies in May 2013.

LVN1 testified that she has seen an inconsistency in the policy in the immunization needle size and also the location of the placement of the skin tests. She considers it a medical error (using the wrong size needle) and not an inconsistency in the policy. LVN1 does not know of any adverse outcomes as a result of that medical error.

LVN1 did not know of any threat to public health issues as a result of inconsistencies in compliance with immunization procedures and policies.

LVN1 testified that she has both addressed inconsistency concerns herself (as a preceptor to the trainee) and reported it to the Chief, OHC and Former Chief, DPM. LVN1 reported to the IO that Former Chief, DPM and Chief, OHC advised her to make an IG complaint which she did. LVN1 believes that her complaint is the reason for the investigation.

LVN1, when asked to identify staff who did not comply with the policies, she named LVN2. She has no knowledge of anyone leaving the clinic without receiving an immunization because they are escorted to her office.

LVN1 is aware of the requirement for privileged providers to maintain oversight of non-privileged providers but stated that it does not pertain to her as a LVN. She thinks the policy was enacted for “counting beans.”

LVN1 was not present for the November 15, 2013 meeting but heard some of the discussion upon returning to the clinic. She could recall that the staffers present for the meeting were Chief, OHC, RN3, and LVN2.

²¹ LVN1 is also referred to as immunization nurse, including by her co-workers.

Lastly, LVN1 reported that the clinic has become a hostile work environment but that she doesn't fear reprisal or discrimination.

Sworn Statement of RN2, Registered Nurse, CRDAMC OHC

RN2 provided a sworn statement on November 19, 2013. She is familiar with the immunization policies and states that she does not believe that there is a SOP which addresses which staff member writes in the record.

RN2 has not noticed any variation in compliance with written policies. She is unaware of adverse outcomes and has no knowledge of any threat to public health instances.

RN2 also testified that she has no knowledge of individuals who have not complied with the policies, nor of anyone leaving the clinic without receiving an immunization.

RN2 is aware of the policy whereby privileged providers oversee non-privileged providers and states it's in the SOP and she has no concerns with it.

RN2 testified that she was recently made aware of changes to the policy of which staff may fill in the "administered by" portion of the immunization module. She was informed the change was made because as a RN, if she documents in that portion of the record, the system will automatically insert her name and gives the appearance that she administered the vaccine.

RN2 stated that she always knows which LVN is administering the immunization and if that LVN is not present, the one giving the immunization will sign in the record. RN2 indicated that she accepts the new policy change.

Sworn Statement of RN5, Registered Nurse, CRDAMC OHC

RN5 provided a sworn statement on November 20, 2013. She testified that she is familiar with the immunization policies that RNs document in S/O and A/P section and that the immunization nurses document in the immunization module in AHLTA. She advised that the standing orders from the Physician Assistants or Doctors permit LVNs to order immunizations too. She testified that there is a rotation schedule as to which privileged provider is the ordering provider.

RN5 indicated in her sworn statement that it used to be only RNs in the clinic who gave vaccines but with the arrival of LVNs the policy changed and the LVNs are now administering the immunizations.

RN5 testified that there is one LVN who has not complied with the policies because she cannot document well, and that LVN had to go to class for that matter. However, she is not aware of adverse outcomes nor any threat to public health instances that occurred in the OHC. RN2 stated that she walks her patients into the immunization room and sits them down so that they don't walk away before the immunization is given. She testified that "[t]he process is tight to keep it from happening."

In regards to the policy whereby privileged providers oversee non-privileged providers, RN5 states it has always been the policy and if there are no procedures done, the RN could sign the note. She refers to visits where there is a request for an immunization print out or review of Workman's Comp paperwork.

Regarding the November 15, 2013 meeting, RN5 stated that it involved the immunizations documentation issues about which two or three nurses had complained to the Deputy Commander for Nursing (DCN) and that Former Chief, DPM had a meeting with them earlier in the year about that matter. Regarding the immunization documentation issue raised at the meeting, she could not recall the specifics of it. However, she does recall that Chief, OHC did not tell them how to answer questions but that he had a few questions he needed them to answer at that meeting.

Sworn Statement of RN4, Registered Nurse, CRDAMC OHC

RN4 provided a sworn statement on November 20, 2013. She testified that she is familiar with the policies because she received training on it but had not read the SOPs. She indicated that RNs document in the S/O and in the A/P sections and that there are three places in the record where they can chart.

RN4 also stated a few months ago that there was a meeting in August 2013 because it came up that RNs documenting in the record would then show that the RN administered the immunization. She and the other RNs stopped indicating who ordered the immunization charted other parts of the record "because it showed as if we had given the immunization." Further, she testified that she did not think it was a problem until the AR 15-6 investigation and that "a couple of weeks ago, we identified that the RN name was still coming up. After the RNs orders it, it automatically populates in the S/PO and in A/P. So we left the ordering out and continued with the other parts."

RN4 testified that she corrected LVN2 who was drawing the wrong vaccine. If there were other instances she did not witness it.

RN4 indicated that the processes are tight and she is not aware of any threat to public health that may have resulted from a violation of immunization policies. She is also confident that the clinic has processes to catch if someone tried to leave the clinic before they received the vaccine since most employees cannot work without showing the paperwork that they received the immunization. She testified that "these are showstoppers for employees to start work, and they need to present the paperwork in order to work."

RN4 testified that privileged providers oversee RN notes to make sure they are following proper clinical actions. She also stated that occasionally the PA asked them to add information to the record on depression, anxiety suicidal thought, medications or hypertension. These are all actions that are in the scope of the RN's practice.

RN4 indicated that there were no formal changes to the policies that she is aware of.

She described the November 15, 2013 meeting as informing the staff of the investigation. They also discussed the difference in the immunization practices of the various nurses which was confusing to Chief, OHC. No one was instructed to give inaccurate or misleading testimony.

RN4 added to her testimony that there was low morale at the clinic due to all of the investigations.

Lastly, RN4 averred that regarding the November 15, 2013 meeting, Chief, OHC call them together and said that he “had received a lot of questions that he needed some information about. He was getting confused. There was a difference between how RN3 and RN5 and I were doing documentation for immunizations. RN3 was not ordering it in the immunization module because the immunization nurse was supposed to do it (“[Immunization Nurse] orders it”), according to the SOP. We had had addressed this earlier in the year.”

Sworn Statement of MSA3, MSA, CRDAMC OHC

MSA3 provided a sworn statement on November 20, 2013. She testified that she is not familiar with the immunization policy because she is a MSA who schedules appointments, prepare records, answer the phone, and file records.

MSA3 testified that there has been variations in policy compliance but did not indicate it was with immunizations. She did not know of any adverse outcomes nor of any threats to public health.

MSA3 has not witnessed anyone leaving the clinic without receiving an immunization but states there is “no final out process point, though, so I'm not sure i would know if anyone left before receiving their immunizations.”

MSA3 also is aware of the policy of PA oversight of RN notes. She stated that there was a meeting about it several months ago because new nurses thought it was driven by the need for RVUs, and that “there was a big battle in the clinic about this and there was a meeting about this several months ago.”

MSA3 testified that she is not aware of recent changes to the immunization policies and was not present for the November 15, 2013 meeting.

Sworn Statement of MSA1, MSA, CRDAMC OHC

MSA1 provided a sworn statement on December 9, 2013. She testified that she is not aware of the policy on how the immunization is charted in AHLTA but she is aware that nurses send patients to the immunization room with an order.

MSA1 also provided that during the flu campaign front desk personnel may sign in and send the person directly to the immunization room.

MSA1 has not noticed any variations in policy compliance nor any adverse outcomes or

threats to public health.

Regarding patients leaving without receiving an immunization, MSA1 testified that she has only noticed hospital staff leaving the clinic without getting an influenza shot because of long lines and she doesn't know if it was documented before they left.

Additionally, MSA1 stated that she is aware of the policy to have a privileged provider oversee a RN's notes. She also testified that she heard that the nurses were told to "transfer notes to the provider because it can be a higher code. Nurses work under the provider license. Transfer when something needs to be ordered."

Lastly, MSA1 stated that she is not aware of recent changes to the immunization administration policies nor was she present for the November 15, 2013 meeting.

Sworn Statement of MSA2, Program Manager Assistant, CRDAMC OHC

MSA2 provided a sworn statement on December 4, 2013. She testified that as the program manager assistant she is responsible for formatting the SOPs but is unaware of the content. She also testified that she was aware that new nurses to the clinic raised issues of how nurses are completing documentation.

MSA2 is unaware of any adverse outcomes as a result of compliance variations with immunization policies and procedures. She testified though, that she believes that RN3 and RN1 want to and may still sign their own notes against the department policy. MSA2 has not witnessed patients leaving the clinic before ordered immunizations had been given.

Regarding RN oversight by PAs, MSA2 reiterated that the policy was not enacted to generate RVUs; that there were no recent, formal changes to the SOPs and that she was not present for the November 15, 2013 meeting.

Sworn Statement of RN3, Registered Nurse, CRDAMC OHC

RN3 was interviewed on three separate occasions, November 20, 2013, and December 4 and 19, 2013.

RN3, testified that she is familiar with the immunization policies and described particulars of the SOPs but complained that the clinic SOPs did not reflect CDC guidelines and that the standing orders/protocols require updating. She disagreed with the documentation policies and raised her concerns to the Patient Safety officer at CRDAMC. Specifically, RN3 stated that she raised questions about RN staff and the policy change was that RNs are not credentialed to do them.

RN3 testified that there are adverse outcomes as a result of variations in complying with policies and procedures. She stated:

"There have been patient call backs, at least for the patients I have seen. I see

gaps and I am concerned that there are some who have fallen through. Gaps in process of ordering and documentation with no way to verify if immunization was ever given since RN staff document in the note and the AP that it has been given prior to being seen (if seen) in immunization room. With this process if people walk out with the order paper form nobody knows it was not completed. There was an issue with documenting Hep B series, in April 2013. June 13th 2013 I spoke with Chief, OHC and LVN1 about Td²² being changed to T-dap²³ in paper chart. Also, spoke with them about sending patients away when Hep B booster were ordered and not consulting the nurse requesting immunization be given. All T-dap's charted in paper chart prior to 2006 only can be a Td since T-dap came out in 2006 (it appears to me CRDAMC didn't get doses until mid-2007). Very common in paper chart that T-dap is written above another nurse's documentation of Td which can be compared with a DD Form 2766 to show that the chart was doctored. Have spoken with both [PA] PA2 and [PA] PA1 about [LVN] LVN1 turning people away in the immunization room and not giving them what was ordered."

RN3 testified that she sees a "huge" risk to public health due to the variations in the compliance policies and procedures related to administration of immunizations. Specifically:

"Due to pre-documenting immunizations by staff when not seeing employee/service member/volunteer get the immunization along with altered medical chart (Td changed to T-dap) I see this as a huge risk for patients, service members, employee's, and children in CYS²⁴. Employees that are working with newborns and CYS employees that have altered documentation of T-dap, which is to protect from whooping cough, and they don't have it. Employees were not asked to wait after immunization dose given until investigation started. All places staff, service members, patients, and children are at greater risk due to process."

RN3 testified that she raised her concerns to her chain of command and reported that the following individuals did not comply with the immunization policies and procedures: RN2, RN5, LVN1, RN4. She informed Chief, OHC that LVN1 turned away patients after being sent to immunization yet no action was taken. While patients were then to be walked to the immunization room to ensure the vaccine was given, she states that it seldom happened.

Further, RN3 specifically testified that in reviewing her patients' records she noted that the immunization had been documented but the patients denied receiving it and she had to call back the patient to the clinic.

RN3 also testified that she:

"caught 2 charted T-dap's when patient swears they did not get it at all. Multiple

²² Td is a booster shot only for tetanus and diphtheria.

²³ T-dap is a vaccine that protects against tetanus, diphtheria, and pertussis (also known as the whooping cough).

²⁴ "CYS" is Child and Youth Services.

altered T-daps (too many to keep count). One day I sent a patient down to get a PFT²⁵ and a T-dap. He returned with his PFT results and I told him to work the arm a bit to help it from hurting and he said, "oh yeah I was supposed to get a shot". I sent him back down to get the shot. This person would have been missed if seen by any other RN in the clinic due to the pre-documenting of immunization. A patient on 22Nov2013 showed current T-dap given in 2012. When I told him he was current he said he never got it. His chart now shows a T-dap in 2012 and 2013 since he did get a dose that day (22NOV2013)... Also, T-dap is being written in the paper chart above where a Td has been given. Some T-daps are from 2004 and 2002, when T-dap didn't exist."

RN3 testified that she is familiar with the policies and procedures of PA oversight of RN clinical work and disagrees with it because they receive credit for the RN's work and in her opinion constitutes "fraudulent" billing and documentation.

RN3 is aware of a revision of AR 40-562 but has not seen formal changes to the clinic's SOP.

RN3 testified that she was present at the November 15, 2013 meeting and that she felt that Chief, OHC was trying to get his "story straight" and was implying how to answer questions by the Investigating Officer.

Lastly, RN3 added to her testimony that the clinic is very unresponsive to recommendations for improvement and that "[t]he PAs all received an APLSS²⁶ award but the RNs do 95% of the work." She also added that she felt reprimed against for raising issues and for filing a HIPAA complaint.

Sworn Statement of RN1, RN, CRDAMC OHC

RN1 was interviewed twice, first on November 22, 2013, and again on November 26, 2013.

RN1 testified that she is familiar with the policies and procedures that describe how OHC nurses administer and document immunizations. She produced a copy of AR 40-562, which she had tabbed to indicate where the clinic failed to follow the regulation.

RN1 testified that there are numerous inconsistencies in policies and procedures. She provided as examples that the clinic does not stock epinephrine for anaphylactic reactions in violation of the regulation; titers are not being consistently ordered by all the nurses to document varicella or MMR immunity; and tests results are not being entered into the MEDPROS.

RN1 testified that the main issue was that nurses document immunizations and send the

²⁵ "PFT" stands for Pulmonary Function Tests, a broad range of tests that measure how well the lungs take in and exhale air and how efficiently they transfer oxygen into the blood.

²⁶ "APLSS" stands for Army Provider Level Satisfaction Survey.

patient to LVN1 who then will decide that they don't need an immunization and send them away. She gave a specific example of a CRNA who had been overseas and "truly needed a PPD²⁷ and LVN1 turned him away."

RN1 testified that she has witnessed several adverse outcomes as a result of inconsistencies in applying the policies and procedures. Specifically, that a LVN was alone in the clinic when a clinical test result needed to a review by a RN and the patient left before a RN arrived. The test was positive and it was days before the name of the patient was revealed. Additionally, a positive test result was not reported to the County Public Health Office when the protocol required it to be. Finally, a positive TB test was not treated until after several staff members in the OR were exposed. She stated she had witnessed patients leaving the clinic before the ordered immunization was given. She stated multiple times "especially with Child Youth Service employees." She named the following OHC personnel as not following policies: RN5, RN2, RN4, and LVN1.

RN1 testified that she believes that the PA oversight policy is not intended for quality assurance purposes but to generate a workload report to guard against cutbacks.

Lastly, RN1 stated that her termination from federal employment was reprisal for filing a HIPAA complaint. Her grievance was pending at the time she gave her statement.

Unsworn Statement of LVN2, LVN, CRDAMC OHC

LVN2 provided an unsworn statement on December 27, 2013. She stated that she is familiar with the policies and procedures in SOP #7, guidance on immunizations, but added that the SOP is not adhered to. Specifically she testified that:

"Immunizations are being ordered and charted by the RN and given by the Immunization nurse. You cannot chart what you do not do. These vaccines are being administered without the RN present." And; "I was told upon being hired that sometimes LVN1 forgets to chart it, so they chart it and she gives it. Sometimes the reason that it is NOT charted it by LVN1 is because it is NOT given. However, ALHTA reflects otherwise. Upon chart review, she may or may not give it...I have personally witnessed many instances where LVN1 would tell the patient that it was not warranted and would not administer it."

She further stated the following:

"Hepatitis B is another one that I have observed not being administered. She [LVN1] would see 3 or more in the chart and say that the patient has already had the series and does not need it. She would check the titer results sometimes and state the titer results were okay—again not administering the ordered medication. She makes these decisions independently without consulting the RN to clarify why it was ordered to begin with. Again, because it has already been charted by the RN, AHLTA reflects the immunization has been given."

²⁷ A PPD Immunization is defined as a Purified Protein Derivative skin test for tuberculin sensitivity.

LVN2 also stated that T-dap is mis-charted, stating that Td and T-dap are two different immunizations and follow separate guidelines by the CDC.

LVN2 also reported the incorrect immunization documentation on the following vaccines: MMRs were incorrectly documented based on assumptions of the birth year; staff were told to document Varicella immunity based on information from the patient without supporting paper documentation; titers were drawn by not followed up; TWINRIX²⁸ is counted as a Hepatitis A vaccine when it also requires two Hepatitis B doses.

LVN2 indicated that all of the issues she raised in her statement were brought to the attention of the leadership. Lastly, she stated that the following individuals did not follow established policies and procedures:

Former Chief, DPM
Chief, OHC
PA1
PA2
RN2
RN5
RN4
LVN1

Sworn Statement of Admin Officer, DPM, Administrative Officer, CRDAMC DPM

Admin Officer, DPM provided a sworn statement on November 26, 2013. She testified that she is not specifically familiar with the immunization policies and procedures but is knows the clinic's policy on review of SOPs.

Admin Officer, DPM testified that earlier in the year a new nurse brought the issue PA oversight to the DCN and in response she put together a presentation for the Department Chief to present to Occupational Health employees.

Admin Officer, DPM, due to her administrative position, she did not have any knowledge of adverse outcomes, threats to public health, information pertaining to inconsistencies and compliance by clinical personnel regarding immunizations or patients leaving the clinic without immunizations.

Regarding the oversight policy, Admin Officer, DPM reiterated that PA oversight of RN work is for quality assurance purposes, not to generate RVUs.

²⁸ TWINRIX is a vaccine for immunization against disease caused by hepatitis A virus and infection by all known subtypes of hepatitis B virus. TWINRIX is approved for use in persons 18 years of age or older. It is normally administered in a series of three doses given over a period of six months period.

Sworn Statement of Chief, QM, Chief, Quality Management, CRDAMC

Chief, QM provided a sworn statement on November 26, 2013. She testified that she received a complaint from RN3 regarding the PA oversight issue. Chief, QM confirmed that the policy was in place in response to an OIP of the clinic in 2011 that there was not sufficient oversight of RN clinical practice in the clinic. She indicated that she did not believe that the complaint was made as a “patient safety” issue, rather as an observation of a “process” issue in that the PAs were receiving credit for work they did not perform.

Chief, QM testified that after discussing the issue with RN3 on three occasions, she reviewed the 2011 OIP, the most recent The Joint Commission survey, and she made an inquiry in the Occupational Health Clinic which did not reveal any substantive problems or patient safety issues.

Sworn Statement of DCCS, Deputy Commander for Clinical Services, CRDAMC

DCCS provided a sworn statement on November 20, 2013. He testified that he has familiarity with the immunization policies and procedures of the occupational health clinic. He otherwise, did not have any knowledge of adverse outcomes, threats to public health, information pertaining to inconsistencies and compliance by clinical personnel regarding immunizations or patients leaving the clinic without immunizations. He is aware of the PA oversight policy. He has no knowledge of the November 15, 2013 meeting.

Sworn Statement of DCN, Deputy Commander for Nursing, CRDAMC

DCN provided a sworn statement on November 20, 2013. DCN testified that he has tangential familiarity with the immunization policies and procedures of the occupational health clinic. He also stated that he did not have any knowledge of adverse outcomes, threats to public health, information pertaining to inconsistencies and compliance by clinical personnel regarding immunizations or patients leaving the clinic without immunizations. He is aware of the PA oversight policy. He has no knowledge of the November 15, 2013 meeting.

Sworn Statement of Former DCN, former Deputy Commander for Nursing, CRDAMC

Former DCN provided a sworn statement on November 21, 2013. Former DCN testified that she has no familiarity with the immunization policies and procedures of the occupational health clinic because it falls under the responsibilities of the Deputy Commander for Clinical Services. She also stated that she did not have any knowledge of adverse outcomes, threats to public health, or patients leaving the clinic without immunizations.

Regarding information pertaining to compliance to immunization policies and procedures by clinical personnel, Former DCN testified that because RN3 had reported to her that she had concerns with the documentation policies and procedures, Former DCN called the former Chief of the Department of Preventive Medicine to relay the issues raised by RN3. Former DCN reported that Former Chief, DPM told her he would discuss the issues with Chief, OHC.

Former DCN had no knowledge of the November 15, 2013 meeting.

Sworn Statement of Chief, DPM, Chief, Department of Preventive Medicine, CRDAMC

Chief, DPM provided a sworn statement on November 18, 2013. Chief, DPM testified that she was the department chief for preventative medicine for only 2 months and has no familiarity with the immunization policies and procedures of the occupational health clinic. She also stated that she did not have any knowledge of adverse outcomes, threats to public health, information pertaining to inconsistencies and compliance by clinical personnel regarding immunizations or patients leaving the clinic without immunizations. She is unaware of the PA oversight policy and she has no knowledge of the November 15, 2013 meeting.

Sworn Statement of Former Chief DPM, former Chief, Department of Preventive Medicine, CRDAMC

Former Chief, DPM provided a sworn statement on November 25, 2013. He testified that he knows the basics of the immunization policies and procedures of the occupational health clinic and has had no issues with the process (as Chief of Preventive Medicine or as a patient there).

Former Chief, DPM further testified that he was not aware of any variation in compliance with the policies until the former DCN brought it to his attention in April, 2013. He and the clinics PAs investigated the issues and found that there were misunderstandings and not variances in the implementation of the OHC policies and procedures by the OHC personnel. He also stated that during the clinic's inspections by higher headquarters (2011 and 2013) and The Joint Commission (2012), no adverse findings were reported.

Former Chief, DPM stated that he held a meeting in May 2013 and discussed the complaint and the staff raised vague concerns but no specific cases about documentation problems. He and the staff also discussed the PAs signing RN notes and he reiterated that if the clinical visit involved a procedure, his directive was that the PA would sign the note. He stated that the meeting did not address hirings and firings.

Former Chief, DPM testified that he has no personal knowledge of patients leaving before the ordered immunization had been given. He said that he believed there was good communication between LVN1 and the RNs.

Statement of Patient Appointments, Patient Appointing Services, CRDAMC

Patient Appointments provided a sworn statement on November 25, 2013 in which she discussed patient appointment services.

Statement of Lead Coder, CRDAMC OHC

Lead Coder provided telephonic testimony on November 26, 2013. Lead Coder provided the following information. She is the main coder for the Occupational Health Clinic, OB/GYN, and Behavior Health. OHC is has a variety of privileged and non-privileged providers to perform the health care mission. In the OHC, there are nurses who see patients primarily within the scope of their practice (both RNs and LPNs) in accordance with protocols that include standing orders. These protocols and standing orders are authorized by a privileged provider. Lead Coder stated that her job is to ensure that the providers, privileged and non-privileged, are providing the appropriate documentation to support the code selected.

Lead Coder testified that privileged providers are not supposed to code a visit unless they see the patient. There cannot be more than two coded visits for a patient on a given day. There is a code that allows a privileged provider to review a record and counsel the patient, but it still entails that the provider has a conversation with/sees the patient.

Statement of ACN, Assistant Chief Nurse for Ambulatory Care, CRDAMC

ACN is the Assistant Chief Nurse for Ambulatory Care at CRDAMC and provided a statement on November 22, 2013. ACN testified that he has oversight of the Patient Care Medical Home clinics within CRDAMC. Within the various Primary Care settings are embedded Immunization clinics/services.

ACN further testified that the LVN administers the immunization in accordance with what the provider has ordered or if the patient is a walk-in, the patient is screened in accordance with standing orders and protocols (CDC). The immunization is documented in the Immunization module of AHLTA. Once the LVN administers and documents the immunization, the chart is sent to the provider. Further, he testified that they were looking at changing this process to allow the RN to sign off the records when an immunization is given in order "to allow the providers more time to do what they can do." ACN stated that it will not be coded work, but it will allow the provider in the clinic, who does not even see that patient, to spend more time with the patients they do have to see.

Statement of DCA, Deputy Commander for Administration, CRDAMC

DCA provided a statement on November 19, 2013 for the purpose of providing background information on encounter coding. DCA testified that CRDAMC's position on encounter coding is within 3 days for outpatient visits, within 30 days for inpatient medical records, and within 21 days for Ambulatory procedure visits. These are measurable metrics that are checked by providers and coders. DCA also testified that the coded encounter must reflect the correct system and that the right people/providers are doing the coded encounter. The MTF encourages that the coding reflects the most efficient way to provide care. The MTF recognizes that the higher coded events are ones where the work is done by Level 1 and 2 providers, but does not specifically endorse workflow to maximize this coding opportunity. Lastly, he stated that coding guidelines are provided by the administrative officers of each clinical department/division and that similar information is passed through nursing channels and Performance Improvement venues.

Statement of Chief, OHC-BAMC, Chief, Occupational Health Clinic, Brooke Army Medical Center

On December 16, 2013, Chief, OHC-BAMC, Chief of Occupational Medicine at Brooke Army Medical Center, was interviewed for the purpose of comparing the Brooke Army Medical Center operations with the OHC clinic at CRDAMC. [Exhibit 16, Statement of Chief, OHC-BAMC].

Chief, OHC-BAMC provided the following comparisons: His clinic's staff includes physicians and nurses. The nurses work fairly independently, within the protocols. They are generally senior experienced nurses. He recommends Occupational Health certification, but does not require it because the nurses have to do it on their own time and at their own cost. There are no PAs in his clinic, although they are in the process of hiring one.

Chief, OHC-BAMC further provided that not every client visit to the clinic is referred or transferred to the physicians. Within protocols authorized by the Chief, nurses typically perform "Part I"²⁹ of all pre-employment and employment required health assessments. These are nursing assessments, within the scope of their license. They are allowed to sign off on low risk job series workers, such as day care workers, lifeguards, and food service workers. If they have concerns, they call the physician or set up a separate appointment for a physician to see the patient. According to Chief, OHC-BAMC, it depends on what the paperwork says as to whether a nurse's signature constitutes adequate medical provider assessment. Some of the job series specifically state that a physician must perform the evaluation and sign the paperwork (such as firemen, security guards, anyone who has a physical fitness test requirement).

As for coding by nurses, Chief, OHC-BAMC stated that strictly nursing assessments are generally coded with an administrative V code.

Other information provided by Chief, OHC-BAMC:

The BAMC OHC does not have an embedded immunization clinic.

The clinic chief is responsible for ensuring that at least 5% of the charts are audited for completeness IAW BAMC policy. The chart review criteria are found in the specific job series protocol. Physicians and nurses both participate in this function.

BAMC OHC refers clients with positive PPDs to the Public Health Nurse within the DPM if AD. GS and contractors are given the option to seek further evaluation and care with their PCM, outside of the organization. There is no reporting requirement for +PPDs to the local county health department. (The State of Texas reporting requirements are related to subsequent diagnosis of latency or active disease).

Statement of Director, QM-SRMC, Director, Quality Management and Patient Safety,

²⁹ Part I of the physical or assessment generally includes obtaining labs, required x-rays, a hearing exam, and any other tests prior to seeing the medical provider. The results are discussed with the provider at Part II of the physical.

Southern Regional Medical Command

On March 20, 2014, Director, QM-SRMC, the Director of Quality Management and Patient Safety for the Southern Regional Medical Command, provided information related to medical record charting as it relates to standards promulgated by The Joint Commission (TJC), the predominant hospital accrediting body in the United States.

Director, QM-SRMC provided some background information on TJC, stating that TJC accreditation and certification is recognized nationwide as a symbol of quality that reflects an organization's commitment to meeting certain performance standards. To earn and maintain The Joint Commission's Gold Seal of Approval™, an organization must undergo an on-site survey by a Joint Commission survey team at least every three years.

Director, QM-SRMC stated that TJC has Accreditation Participation Requirements (APR) which set standards for medical facilities in a variety of areas. Specifically relating to medical record documentation, APR.01.02.01 requires that the hospital provide accurate information throughout the accreditation process, and that episodes of pre-documentation such as what occurred in the CRDAMC OHC could be considered breaches of this APR. Specifically, when documentation occurs prior to the event (be it injection or surgical intervention), TJC may consider the event as a situation involving a significant threat to the safety of the patients which could result in a medical facility receiving a preliminary denial of accreditation.

Director, QM-SRMC also stated that other TJC standards relating to medical records and charting require that the hospital have policies that ensure timely entry of information into a patient's medical record, and that documentation occur after care or treatment of services are provided.

Statement of MEDCEN Counsel, Center Counsel, Carl R. Darnall Army Medical Center

On 21 March 2014, MEDCEN Counsel, Center Counsel (Attorney) for CRDAMC, provided a memorandum that detailed staffing changes which had occurred in the CRDAMC OHC since the investigation of the OSC Referred Allegations began.

MEDCEN Counsel stated that as of July 2013 there were 13 personnel assigned to the CRDAMC OHC, consisting of Chief, OHC, the Officer in Charge (OIC); PA1, PA2; PA; RN2; RN5; RN4; RN3; RN1; LVN1; LVN2; MSA1; MSA3; and MSA2, Program Assistant.

MEDCEN Counsel further stated that as of March 19, 2014, there were 10 personnel assigned to the clinic, consisting of Acting Chief, OHC, MD, MPH, OIC; PA1; PA2; RN2; RN5; RN3; LVN2; MSA3; MSA2, Program Assistant; and RN4.

Center Counsel stated the differences in staffing are the result of Chief, OHC'S resignation effective March 5, 2014; RN1's removal during her probationary period in August 2013; LVN1's reassignment to another clinic; and MSA1's reassignment to another clinic. Both of the reassignments were voluntary actions at the request of the employee, and Chief, OHC's

resignation resulted from his removal from the OHC during this investigation, and the loss of his supervisory duties.

Statement of Data Quality-SRMC, Data Quality and Medical Records Administrator, Southern Regional Medical Command

On March 31, 2014, Data Quality-SRMC, the Data Quality and Medical Records Administrator for the Southern Regional Medical Command, provided the results of an audit of medical records from the CRDAMC OHC which had been conducted in order to determine if any of the issues relating to pre-documentation or improper coding were ongoing. Data Quality-SRMC enlisted the assistance of two employees from the U.S. Army Medical Command's Patient Administration Systems and Biostatistics Activity (PASBA) to conduct this audit.

The audit focused on medical encounters in the CRDAMC OHC occurring after January 1, 2014. Data Quality-SRMC reviewed 50 medical records focusing on medical record documentation, while the two PASBA employees reviewed 25 medical encounters each for coding compliance.

Data Quality-SRMC concluded that vaccines are documented as given, and that patients who had appointments in the same clinic within a few days made no complaints that they did not get their vaccine or that they got the wrong vaccine. Most encounters were co-signed by the physician or PAs on the same day as the appointment or within 10 days after the encounter, which complies with U.S. Army Medical Command guidelines for the closure of encounters.

The PASBA employees concluded that documentation in the medical record meets Military Health System standard (MHS) 5.10 for documentation, including at a minimum information for injections/immunizations the method of administration, unit(s), and substance given. Additionally, all of the encounters were documented by the OHC nurse, and most co-signed by the provider. The record appropriately reflects that the patients are not seen by the provider. The review also noted that some information on the immunization documentation requirement is documented in the immunization module and not in the AHLTA encounter, but the nurse usually enters a note in AHLTA referring the reader to the note to immunization module.

Summary of the Evidence in Response to the OSC Referred Allegations

After a review of all relevant information and evidence, the IO substantiated with respect to OSC-Referred Allegation 1 that clinic nurses were regularly recording or "charting" patient immunizations prior to administering the immunizations; that with respect to OSC-Referred Allegation 2, the potential exists that if patients leave the OHC prior to receiving immunizations, this could result in incorrect charts and place patients at risk for later complications, but no actual occurrence of this was discovered; and that with respect to OSC-Referred Allegation 3, though clinic physician assistants and the physician regularly sign charts for patients whom they do not see, but they do so in their medical supervisory capacity which is appropriate and is not in violation of agency policy.

What follows is a detailed discussion of the testimonial and documentary evidence gathered during the AR 15-6 investigation relative to the three OSC Referred Allegations.

OSC REFERRED ALLEGATION 1 - CLINIC NURSES ASSIGNED TO CRDAMC OHC REGULARLY RECORD OR CHART IMMUNIZATIONS PRIOR TO ADMINISTRATION OF IMMUNIZATIONS IN VIOLATION OF ARMY POLICY

Some nurses assigned to the CRDAMC Occupational Health Clinic, prior to November 18, 2013 (the first day of the AR 15-6 investigation), including RN4, RN5, RN2, and LVN1, regularly charted immunizations prior to the administration of immunizations in violation of Public Law (42 U.S.C. 300aa-25) and Army regulations (AR 40-66 and AR 40-562) and their own CRDAMC OHC SOP #7).

Based on the testimony received from the CRDAMC OHC staff, there were two divergent views in the CRDAMC OHC regarding charting procedures. One group of nurses (both LVNs and RNs) consisting of those with longer tenure in the clinic had a more relaxed approach that included “pre-documentation” of the immunizations to be given. Some OHC nurses (RN4, RN5, RN2, and LVN1) regularly documented immunizations prior to the administration of immunizations. On the other hand, the newer nurses disagreed with that approach, but, correctly believed it was necessary for the nurse administering the immunization(s) to document such at the time of the immunization(s) based on the relevant authorities. Additionally, it should be noted that the previous Commander’s Inquiry also addressed this issue and those witnesses confirmed what they also asserted during the AR 15-6 proceeding. This constituted pre-documentation, which can be characterized as inaccurate documentation, or in the most rigid interpretation of the practice, “fraudulent” documentation.

With respect to the appropriateness of “pre-documentation,” in settings where the process is “reliably repetitive,”³⁰ the practice of documenting prior to the administration of immunizations may be considered expedient and appropriate as long as appropriate screening occurs for safety (i.e. when in-processing new recruits – only one-way in, one-way out, everyone gets immunized unless a mitigating reason presents itself and is addressed on the spot). However, in the instant set of facts, the immunization activity performed in the CRDAMC OHC is not considered to be “reliably repetitive.”

Generally, the practice of pre-documentation is contrary to nursing and medical professional standards of practice, and can result in professional sanctions. The Joint Commission considers episodes of pre-documentation as Type 1 findings which place a health care organization’s certification at risk, according to the Director, Quality Management and Patient Safety, SRMC. Thus, if indeed the care that was pre-documented is not actually

³⁰ Though there is no written standard that defines “reliably repetitive,” it is based only on military practice in very controlled settings such as boot camp, processing new recruits, etc. where there is the utmost control of what occurs. Specifically, the reliably repetitive practice should only be used in group settings where the same lot number of medication is used, the same shot location will be used, the same briefing about the shot is used, and the recipients are literally lined-up and go through the immunization process as a group. If there are any issues, they are addressed on the spot and any record changes made then and there.

provided, and a medical provider is billed for the service not provided, the practice may be called “fraudulent documentation” in its more rigid interpretation. However, a better characterization, at the most, would be a dereliction of duty issue with respect to pre-documentation.

Pre-documentation is a violation of AR 40-66 and could result in a Joint Commission finding. We consulted subject matter experts in the Army’s Medical Department in the Office of The Surgeon General and MEDCOM for Quality Assurance and Patient Administration regarding this matter and its significance. The consensus was that while pre-documentation was more likely done to improve efficiency, standard documentation practice would dictate that you do not pre-populate a note or a medical record prior to the event occurring. If the staff member was just pre-stamping forms with a date in order to make a process more efficient, then it was suggested that it is more a matter of counseling the staff member on proper procedure. It would depend on how far from the standard one has varied. If the practice involved stamping or filling out forms five minutes prior to the immunization, that is still not appropriate, but much less significant than if it was done hours in advance.

Regarding the consequences of pre-documentation, the Quality Assurance subject matter experts stated the “Just Culture Algorithm” would be used.³¹ Army MTFs have been using this algorithm for the last two years. According to the algorithm, when an employee breaches a duty to follow a procedural rule, the issue of pre-documentation appears to fall within the “at-risk behavior” category which would require “coaching”³² the employee and conducting an at-risk behavior investigation. In accordance with the algorithm, only reckless behavior would warrant a punitive action.

Applying the statutory and regulatory guidance in this area, CRDAMC’s OHC did violate 42 U.S.C. 300aa-25 because compliance with this statute is required by AR 40-562. The Army’s standard in AR 40-562 is consistent with and contains the same documentation elements for safe administration of vaccines described in this Statute as its standard.

Additionally, CRDAMC’s OHC actions do not violate DoD Directive 6205.02E, which broadly assigns Service responsibility to administer and track immunizations, but provides no details applicable to individual clinics or specific practices in those clinics. The requirements of DOD Directive 6205.02E are broader and more general than those at issue in this case.

However, CRDAMC’s OHC actions did not comply with AR 40-562 with regard to the documentation and the administration of immunizations when a nurse, other than the one who administers an immunization, documents the encounter as that nurse will not know the location of the immunization and other specific entries required to be entered in the medical record. The immunization module in AHLTA, the Army’s electronic medical record system, is a specific

³¹ “The Just Culture Algorithm” is an analytical process whereby a particular action or event undergoes a three step inquiry: (1) Did an employee put an organizational interest or value in harm’s way?; (2) Did the employee breach a duty to follow a procedural rule in a system designed by the employer?; and (3) Did the employee breach a duty to produce an outcome? The outcome from answering these questions results in a determination as to whether the employee engaged in “at risk behavior,” and if so, the appropriate corrective action to address this conduct.

³² The Just Culture Algorithm defines “coaching” as “supportive discussion with the employee on the need to engage in sage behavioral choices.”

folder in the AHLTA record. It is for individuals who administer the immunization to document specifically what was given, the manufacturer, lot number, where on the body it was given, and by whom. These specific documentation requirements are in accordance with AR 40-562 and 42 U.S.C. 300aa-25. The purpose for the specificity of the documentation is to track any vaccine reactions to not only the manufacturer but to the person who gave it. The process will look at the person who gave the vaccine to determine if they adhered to prescreening and other requirements before administering it. In addition, good nurse practice holds licensed nurses to this standard. When the RNs entered an immunization in the module, but did not actually give it (potential fraudulent documentation), they could be held accountable for any reactions from the immunization/vaccine. Additionally, if the nurse did not give the vaccine personally, they would be unable to enter complete documentation as they would have no idea to what part of the body the immunization was administered.

Further, CRDAMC's OHC actions do not comply with AR 40-66, most specifically with Chapter 3-4a, which states "[e]ntries will be made in all inpatient, outpatient, service treatment, dental, ASAP³³, and occupational health records by the healthcare provider who observes, treats, or cares for the patient at the time of observation, treatment, or care." [AR 40-66, Chapter 3-4a]. The practice of pre-documentation fails to comply with this requirement because the entry for the immunization must occur at the time of the treatment, not before, and with specific knowledge of what occurred such as the location where the immunization was administered.

In addition to not complying with AR 40-562 and AR 40-66, CRDAMC's OHC does not comply with its own standard operating procedure, SOP #7, which delineates a proper, acceptable procedure for immunization practice that if followed would result in proper documentation of immunization encounters. [SOP #7, Exhibit 12]. As with AR 40-66 and AR 40-562, the individual administering the immunization must document the medical record after the immunization is provided to ensure accurate information is entered in the medical chart.

While pre-documentation of the date, manufacturer, lot number, name, address, and title of the administering provider is not expressly prohibited by 42 U.S.C. §300aa-25(a), the Code's language implies that such documentation be recorded only if the vaccine is actually given. If a pre-documentation entry is made, but the vaccine is not actually delivered, then the spirit of the Code is not met. Further, pre-documentation risks omitting other useful information, such as injection site. If the injection site is pre-documented but does not match the site later actually used, then the documentation could contain an erroneous entry (if not corrected).

Given the above instances of regulatory noncompliance, some of CRDAMC'S OHC staff action did not uniformly comply with good documentation practices as endorsed by The Joint Commission or Army regulations.

It should be noted that in the past few years, there have not been any statutory or regulatory changes that validate the practice of "pre-documentation," thus, the requirement remains as the responsibility for the individual who *administers* the immunization is the person to record it in the health record. First, though there have been changes in AR 40-562 from a

³³ "ASAP" is the Army's Substance Abuse Program.

recent update to the regulation dated October 7, 2013, but documentation and administration of immunizations, as it relates to the above question, is not a subject area that has been revised in the updated version of AR 40-562. The update specifies data entry into service specific IT data bases and institution of a reminder system.

Second, the last update to applicable MEDCEN regulations, such as MEDCEN CDRAMC 40-6 (last updated on December 17, 2012) and CDRAMC 40-23 (last updated on August 3, 2011), were both based on the 2006 edition of AR 40-562. [AR 40-562]. Further, the most recent update to OHC SOP #7 is May 2013, which clearly states who is responsible for entering vaccine and immunization data. [SOP #7, Exhibit 12]. It appears, however, that this revision came as the result of a Department of Preventive Medicine (DPM) directed review of the OHC process in May 2013. Consequently, there is no apparent reason to support RNs continuing beyond May 2013 to routinely “pre-document” by entering immunization data into the medical record *if* they did not actually administer the immunization. While it is within their scope of practice to enter immunization data when they administer the immunization and the LVNs are not available, there is no evidence that this practice is done on a routine or by exception basis.

Again, by way of illustration, the process currently in operation in the CRDAMC OHC starts with two MSAs (MSA1 and MSA3) who greet/receive clients, prepare the charts, direct clients to the RNs, the Immunization Clinic, PAs, etc. MSA1 also has MEDPROS access and enters flu immunization data into that database. The RNs (RN3, RN2, RN4, RN5, and previously RN1) are responsible for initial and periodic Occupational Health screenings, Part I, for those clients whose jobs require initial and periodic complete physicals. They see patients in accordance with established SOPs approved by the Chief, OHC.

The RNs place orders in the PAs’ or MD’s name for required immunizations and direct clients to where they can get those things done. Some of the RNs (RN5, RN2, and RN3) were also qualified to do Pulmonary Function Testing, and all RNs were qualified/trained to give immunizations if the LVNs were not available. The RNs follow-up on tests and labs, and call clients back per guidance of the PAs and MD and in accordance with established protocols. LVN1, was primarily responsible for administration of immunizations, but was also cross trained to do vision screening. LVN2, OH Technician/LVN, was also qualified/trained to give immunizations and could do so when LVN1 was unavailable, as well as do various other OH testing.

Every provider was expected to document in AHLTA whatever *they* did regarding patient care. The PAs (PA2 and PA1) and the MD (Chief, OHC) reviewed and signed each patient’s medical record for completeness and quality in their capacity as medical supervisors. They also saw clients for Part II physicals.³⁴ There is no check-out procedure to ensure that a client received all of the services that they were supposed to receive on any given day, which would alleviate the concern that a patient did not receive an immunization that had been recorded in their medical record.

³⁴ “Part II” of the physical examination entails an examination by medical provider and discussion of test results from Part I of the physical.

However, it must be acknowledged that there is also considerable overlap in what the LVNs and RNs are permitted to do, and their position descriptions certainly recognize this in the description of their respective duties. [Exhibits 9a-9g].

The ongoing practice has been in place for at least 18 months, and most likely longer. A new employee (Occupational Health Technician – LVN2) was oriented in this practice beginning in June/July 2012. Additionally, the new RNs (RN3 and RN1) were oriented in this practice in September 2012 and February 2013, respectively, suggesting that it has been routine practice for a while, and perhaps the practice possibly started as long ago as 2008, when the first LVN (LVN1) was hired as the Immunization Nurse in the Occupational Health Clinic. LVN1 stated that she actually wrote OHC SOP#7, which states that the Immunization Nurse will document the administration of immunizations. The employee interviews and SOPs lead to the conclusion that Chief, OHC asked individuals, who were in the position to benefit from a clarification of the roles and responsibilities between RNs and LVNs, to assist in refining the immunization process through the issuance of a SOP under his signature. The drafter of the SOP, LVN1, was allowed to sign the document as well, acknowledging her effort and ownership in the process.

The IO's impression from the interviews was that the other employees appreciated LVN1 taking the initiative to complete the task since there was no precedent in the clinic to have an LVN involved in the immunization process prior to her arrival. The original SOP was endorsed by the Chief, OHC, and continued through the most recent Chief, OHC. Prior to this time, RNs performed all aspects of the immunization process. There was no evidence that the practice of pre-documentation of the immunizations had been specifically condoned by leadership in the clinic; however, it seems that it has been acceptable to the Chief, OHC to allow the individual RNs to document as they desire. The practice had been discussed through emails and verbal discussions with the Chief, OHC and peers in the clinic over the past year, but there has been no revision to SOP#7 to reflect that other methods such as pre-documenting the charts are acceptable practices. Further, there is no clinic audit function, such as a monthly five percent chart review that would have picked this issue up as a violation to clinic policy or acceptable documentation practices in accordance with the above cited references.

Nevertheless, the Chief, OHC, had been approached several times about the practice but had not provided definitive guidance until November 15, 2013 when the issue was discussed in anticipation of the AR 15-6 investigation. Consensus from the meeting was that all would abide by SOP #7 and that a reinforcing memorandum/policy would be forthcoming. However, as of the date the AR 15-6 investigation had been concluded, no such reinforcing memorandum or policy has been issued and there is no audit function in place to determine compliance.

Prior to the 2008 timeframe, before the clinic hired its first LVN, the RNs did the immunizations as part of their encounters. The clinic hired an LVN specifically to man the immunizations section and over time also trained her to do other clinic procedure support (e.g. PFTs). The original SOP #7 was written in 2008 and was endorsed by the OIC at the time to reflect this change in personnel and responsibilities. Apparently the veteran OHC nurses continued the practice of annotating in the immunization module when they documented their encounters, not entirely understanding that it gave the appearance of an inaccurately

documented record when they did not follow thru with actually giving the immunization. This then created a problem with the LVN who gave the immunization not then being able to document that she indeed was the responsible person for actually giving the immunization, and adhering to good nurse practice appropriate for her scope of practice. It is a nursing accountability/practice issue which was not recognized as a potential nurse practice violation until the new nurses came on board. The Texas Board of Nursing rules are mentioned because they are cited in CRDAMC MEDCEN Regulation 40-23, which states nothing in CRDAMC policy is supposed to violate a nurse's state licensing board.³⁵ Where there is a difference between the requirements of a CRDAMC policy and a nurse's state licensing requirements, a nurse may be permitted under this MEDCEN Regulation to claim "safe harbor" and refuse to engage in a practice that would violate his or her licensing requirements. However, the Army position is that federal preemption applies in situations where there is conflict between Army (Federal) requirements and state requirements. Again, AR 40-68, paragraph 4-4a(2), states, "Health care personnel (military/civilian) employed by the Federal Government will abide by the practice requirements imposed by their State of licensure/certification/registration to the fullest extent possible. Note: Compliance with State requirements shall not interfere with the individual's performance of assigned duties/responsibilities in the specified discipline within the Federal sector."

There is no question that Chief, OHC was equivocal on enforcing SOP #7 with regard to administration and documentation of immunizations, and basically allowed the nurses to do what they wanted, failing to see why it was an issue as long as documentation got into the medical record. The three new nurses (LVN2, RN3, and RN1) had valid concerns that the documentation practices violated good nursing practice as they were considered pre-documentation.

One relatively new nurse (RN4) and the established/more senior nurses (RN5, RN2, and LVN1) did not have the same concerns, saying that the documentation in the A/P that the LVN had administered the immunization and that practice was acceptable. The nurses who complained about this practice (RN3, LVN2, and RN1) did not engage in the practice that they believed was improper.

After speaking with several witnesses (RN5, RN3, RN1, PA1, and PA2), the IO determined that the immunization nurse (LVN1) frequently would not chart that she had given the immunization. In accordance with the testimony of the new Occupational Health Technician (LVN2), though, it was more likely that the LVN actually did not give the immunization based on her review of what the patient needed, which was within the scope and responsibility of the LVN, but the LVN did not communicate her concern with the RN who had ordered it to begin with. Also, allegedly the LVN did not correct or change the entry in the AHLTA immunization module, or if she did, she did not notify the RN who ordered it, which would have left a note by the RN that the immunization had been given. The concern is that the record would reflect an immunization not provided and would therefore be erroneous.

The OH Technician (LVN2) stated that she was oriented by LVN1 and worked side by

³⁵ See discussion on page 20, footnote 12 indicating that the CRDAMC MEDCEN regulation 40-23 is contrary to the relevant Army regulation and will be changed.

side with her, observing her in this practice. One RN (RN1) who did not pre-document in the immunization module of AHLTA reported that she identified several of her clients who she had referred to the immunization nurse (LVN1) for either an immunization or a PPD (Purified Protein Derivative skin test for tuberculin sensitivity) that were turned away without receiving the immunization or PPD. She testified that she discussed the issue with LVN1.

Similarly, RN3 mentioned this issue in her statement, and spoke with LVN1 as well as the PAs about it. She testified that she had reported it up to Chief, OHC in September 2012, and was advised that she could do whatever she wanted to do with regard to her documentation.

Nonetheless, if no one changed the entry in the immunization module of AHLTA to reflect that the immunization had not been given, it would appear that the individual had received it, leaving the individual and co-workers at risk due to not receiving the required immunization and leaving the individual susceptible to the bacteria or viruses for which the immunization was intended to protect, and the co-workers susceptible to infection if the individual became ill.

There is evidence that the practice of pre-documentation was raised several times over the course of a year, beginning in the summer of 2012, by new personnel to the clinic (LVN2 and RN3). It was first discussed peer to peer, and it was then brought to the attention of the Clinic Chief (Chief, OHC) in September 2012 and the DCN (Former DCN) in April 2013. The DCN referred the issue to the former Chief of Preventive Medicine, as the clinic was within his chain of command and area of responsibility, but did not have any specific concerns about scope of nursing practice based on what was presented to her. Former Chief, DPM gave a briefing to the OHC staff on May 2, 2013 which included documentation of immunizations and tasked Chief, OHC and the PAs in the clinic to review the process and make recommended changes. Further, as recently as November 15, 2013, the process had still not been integrated as the standard. SOP #7 (May 2013) clearly states that the immunization nurse (LVN) is to document when the immunization is given, so the policy is in fact in place, but not followed consistently within the clinic. [SOP #7, Exhibit 12]. The meeting that Chief, OHC had on the afternoon of November 15, 2013 verbally re-emphasized to all nurses that only the LVNs were to document in the Immunization module when an immunization was given. The RNs were not to document in the immunization module unless they actually gave the immunization, which could occur if the LVN was not available, as was provided for in SOP #7. [SOP #7, Exhibit 12].

RN2, RN4, and RN5 stated in their statements that as of the meeting on November 15, 2013, they are no longer entering data into the immunization module of AHLTA. However, one witness (RN3) states that in the course of a week in seeing her assigned patients she often sees another RN's name in the immunization module (related to previous visits to the OHC) and asks the patient/client specifically if he/she recalls receiving a documented immunization. The IO believed corrective action had been taken, and the follow-on audit conducted on April 1, 2014 supports that conclusion although a definitive check-out system in the OHC will be beneficial to ensure the process runs correctly, as was advised by Data Quality-SRMC, the Data Quality/Medical Records Administration, SRMC; MRS-2, the Medical Records Administration Specialist, PASBA; and MRS-1, Medical Records Administration Specialist, PASBA, and as detailed below.

A follow-on medical chart review and coding review was completed on April 1, 2014 by members of SRMC and the U.S. Army Medical Command's PASBA. This follow-on review looked at 50 medical charts with visits to the OHC after January 1, 2014. The SRMC employee reviewed the medical charting (50 encounters), and the PASBA employees reviewed the charts for coding compliance (25 encounters each). The review revealed that:

(1) Charting in the OHC is appropriate and within required guidelines for charting in medical records, with minor deviations not attributable to inaccurate documentation or misconduct. Vaccines are documented as given, but there is no indication at what point they are given and it is not entirely clear if the notation "additional provider: *name of LVN*" means that the LVN actually gave the vaccination instead of the individual who signed the record. The chart does make it clear who entered the required vaccine details, and the review also considered other appointments by patients in the same clinic within a few days after their vaccination, none of which revealed that the wrong vaccination had been given.

(2) Coding in the OHC charts is appropriate and within required coding guidelines, with minor deviations. Documentation meets the coding guidelines which state that for injections/immunization administration, documentation must include at a minimum the method of administration, unit(s), and substance. All of the encounters were documented by the OH Nurse, and most co-signed by the provider. Some required information relating to the immunization documentation requirement is documented in the immunization and not in the AHLTA encounter where it is usually documented. Some, but not all, of the encounters noted patient education provided by the provider on medication adverse reactions.

The three newest employees, LVN2, RN3, and RN1 (who is no longer employed in the clinic) have stated that RN4, RN2, and RN5 consistently documented in the immunization module of AHLTA, prior to November 15, 2013. LVN1, the immunization nurse, also stated that these nurses typically documented in the immunization module. However, all three of these nurses acknowledged during their interviews that since the meeting on November 15, 2013, they had been advised that they are to not document in the immunization section of AHLTA unless they were actually the nurse giving the immunization.

In spite of what appears to be clear guidance as to how documentation of immunizations is supposed to properly occur, there had been vacillation on the part of the Clinic Chief, Chief, OHC, to enforce it until the meeting on November 15, 2013. The veteran nurses interpreted Chief, OHC' guidance that they could continue to do as they had in the past with regard to documentation of immunizations, while the newer nurses found issues with past practice, but were allowed to do as they wanted as well. However, as of the time of the AR 15-6 investigation, no disciplinary actions had been taken to enforce the correct procedures vis-à-vis the noncompliant staff.

However, despite the above described noncompliance with the correct documentation requirements, the IO did not find any substantiated situation in which the health of the public or a specific patient was placed at risk due to pre-documentation. Nevertheless there were several witnesses who asserted their concerns with this matter. One specific incident was noted by two

witnesses (LVN2 and RN3) during the course of performing their duties, where they noted that the record of a client indicated that he had received a T-dap (a vaccine that protects against diphtheria, tetanus, and pertussis (whooping cough)) on his previous annual employment physical, but the patient stated he had received no immunizations. Further, the record reflected the name of a nurse who regularly documented in the immunizations section of AHLTA prior to the administration of the immunization. RN3 stated there have been others, but the IO has not validated these. This potentially placed a patient at risk for illness, as well as potentially spreading the illness to others during a prodromal period or during actual illness. Since becoming aware of this case, one RN (RN3) has noticed several of these situations weekly and has changed her interview technique to specifically inquire of the patient whether he/she had received an immunization recorded.

According to several witnesses, including the terminated nurse, some patients did not receive documented immunizations which they asserted was based on patient histories that these nurses had obtained. Once these nurses identified this issue, at least one of them pointedly investigated each patient seen thereafter. Sloppy mis-documentation of T-dap vs Td (a booster shot only for tetanus and diphtheria) as well, basically supported issues raised of mis-documentation. However, there does not appear to be an issue related to double documentation, and it does not appear that records are easily amended once documentation occurs in the immunization module, and more importantly whatever is entered in this module gets transferred into the Medical Protection System (MEDPROS – the database used by the Army Medical Department to track all immunization, medical readiness, and deployability data for Soldiers) (at least 90% of the time if the patients match what is in DEERS).³⁶ This allegation was one of the anonymous complainant's main concerns, especially with regard to the flu vaccine. Regarding this matter, it should be noted that an RN provided the IO with an information page from the CDC regarding this potential danger with pertussis. The potential domino effect of a pertussis infected healthcare worker infecting patients and co-workers is problematic, and an unnecessary risk that can be mitigated by attention to proper documentation and administration of T-dap. CRDAMC MEDCEN Regulation 40-6 supports this position for healthcare workers assigned to the MEDCEN and DENTAC.

A separate but related issue concerns the documentation of immunizations with respect to annotation/overmarking in the hard copy Civilian Employee Medical Record (CEMR) of a T-dap³⁷ having been given when a Td³⁸ was actually given. RN3 and LVN2 noticed this during the course of their duties, reporting that some of the overwrites were made before the T-dap was even available as an immunization for anyone until 2005. However, because this problem was reported to the IO somewhat late in the investigation, the IO did not investigate it but did recommend that a "retrospective review be conducted of all CEMRs for evidence of inappropriate documentation."³⁹ If founded, this would constitute incorrect documentation as

³⁶ Defense Enrollment Eligibility Reporting System (DEERS) is a computerized database of military sponsors, families and others worldwide who are entitled under the law to TRICARE benefits.

³⁷ Td is a booster shot only for tetanus and diphtheria. [Exhibit 16, Statement of Chief, OHC-BAMC].

³⁸ T-dap is a vaccine that protects against diphtheria, tetanus, and pertussis (also known as the whooping cough). [Exhibit 16, Statement of Chief, OHC-BAMC].

³⁹ This matter is one of the corrective actions that MG Keenan approved from the AR 15-6 report on June 19, 2014.

well as creating a risk for individuals and unimmunized contacts. However, it should be noted that the follow-on chart and coding review did not reveal this potential matter to be occurring from January 1, 2014 onward.

The IO believed it to be an overstatement that the practices at the OHC constitute a *public health threat* because the scope of the clinic does *not* encompass the *public at large*. However, the IO concluded that appropriate documentation requirements need to be enforced since one-third of OHC's client population includes CRDAMC and DENTAC health care personnel and the impact of failing to ensure accurate documentation and administration of immunizations could be significant this finite population that delivers health care.

Conclusion. Army Findings as to Allegation 1.

This Allegation is SUBSTANTIATED. In summary, some nurses assigned to the CRDAMC OHC, prior to November 18, 2013, did regularly chart immunizations prior to administration of immunizations in violation of Public Law, Army Regulation and OHC Standard Operating Procedure. This practice allowed for the possibility of patients leaving the area without receiving their immunizations, is considered "pre-documentation," and constituted substandard medical recordkeeping. However, appropriate corrective measures have been implemented.

OSC REFERRED ALLEGATION 2 - PATIENTS FREQUENTLY LEAVE THE OHC PRIOR TO RECEIVING IMMUNIZATIONS, RESULTING IN INCORRECT CHARTING AND PLACING PATIENTS AT RISK FOR LATER COMPLICATIONS AS A RESULT OF NOT RECEIVING THE IMMUNIZATION

Some patients may have left the clinic without receiving ordered immunizations, but the IO was unable to determine the actual frequency or rate, if any. The meeting on November 15, 2013 appears to have corrected the problem with "pre-documentation." Failure to adhere to OHC policies and procedures, lack of leadership holding accountability to adherence to policy, and absence of a meaningful administrative chart audit process within the clinic contributed to incorrect charting and theoretically placing clients at risk. However, there was no evidence of actual patient, unit, or workplace harm as a result of patients/clients leaving the clinic without receiving immunizations.

Several witnesses (RN3, RN1, and LVN2) identified patients that they claim they had to call back because it was not clear whether they had received the immunizations they needed. More specifically, RN3 asserted in her testimony that errors in the immunizations' documentation were reported to be occurring as frequently as several times a week in the course of performing her duties on her assigned clients/patients.

Again, as previously stated, the correct process is that the nurse who administers the immunization, usually an LVN, is charged with the responsibility to review the patient's needs and provide the immunization if needed, in accordance with protocols. Most often, the patient/client presents to the immunization nurse with a pre-printed slip of paper annotating

which vaccines or PPD (purified protein derivative – a skin test used to diagnose silent (latent) tuberculosis (TB) infection). However, the LVN is still responsible for validating both the patient's needs as well as any contraindications.

Regarding the “final say” or validation by the LVN, several witnesses indicated that *if* there is a difference in the interpretation of what immunizations or treatment a patient needs, there should be a dialog between the initial screening nurse and the LVN to ensure the record is correct and the appropriate treatment is given. Credentialed providers (two PAs and one physician) are also available to clarify the patient's needs. Further, according to the SOP #7, the LVN needs to communicate issues to the “ordering” RN (all immunizations are ordered under the name of a credentialed provider IAW protocols endorsed by the C, OHC). [SOP #7, Exhibit 12]. Unfortunately, the evidence reflects that communication within the CRDAMC OHC is poor in this regard, though. There is no difference in the scope of responsibility between RNs and LVNs when it comes to reviewing the patient's immunization needs/contraindications against clinic protocols. Reviewing immunizations and addressing contraindications is a general responsibility applicable to any nurse, and constitutes the application of the “5 Rights” for safe medication administration that all nurses are supposed to adhere to do prior to the administration of medications that are within their scope of practice. The “5 Rights”, as commonly accepted within the nursing community consists of the following elements whereby the nurse ensures that they are (1) Giving the Right Medication; (2) In the Right Dose; (3) At the Right Time; (4) By the Right Route (mouth, subcutaneous injection, intramuscular injection, etc.); and, (5) To the Right Patient. (see, for example, the article discussing the “5 Rights” at <http://www.ihl.org/resources/Pages/ImprovementStories/FiveRightsofMedicationAdministration.aspx>).

Nevertheless, based on all of the testimonial and documentary evidence gathered during the AR 15-6 investigation, there have been no reports or complaints from patients that they did not receive immunizations after the immunization was recorded as being administered. Additionally, there is no evidence that a client/patient has been harmed, became ill, or been injured as a result of these alleged violations in procedures.

Additionally, the record evidence reflects that there were no documented negative outcomes related to a patient not receiving immunizations identified any of the witnesses. However, in the management of positive or indeterminate PPDs, there is a potential risk of a negative outcome due to the way in which the process occurs in the OHC. Two OHC personnel (LVN2 and RN1) testified to this as a concern. Civilian employees or potential employees are given the option to receive further diagnostic procedures and treatment with personal primary care providers (PCP). With the exception of contract employees all others are referred to the CRDAMC Public Health Nurse. There is no follow-up regarding whether these clients actually see their PCP.

Conclusion. Army Findings as to Allegation 2.

This Allegation is UNSUBSTANTIATED. In summary, though some witnesses indicated that there were instances where it was unclear as to whether some patients may have left the OHC without receiving ordered immunizations for a variety of reasons, the IO was unable to either verify those assertions or determine the actual frequency or rate of that

occurrence. Failure to adhere to OHC policies and procedures, no check out mechanism after administering immunizations, lack of leadership holding staff accountability to adherence to policy, and the absence of a meaningful administrative chart audit process within the clinic contributed to incorrect charting, thus, theoretically, potentially placing patients at risk. However, there was no evidence of actual patient, unit, or workplace harm even if any of patients/clients left the clinic without receiving documented immunizations. Appropriate corrective actions have been implemented to address these recognized deficiencies.

**OSC REFERRED ALLEGATION 3 - CLINIC PHYSICIAN ASSISTANTS
REGULARLY SIGN CHARTS FOR PATIENTS WHOM THEY DO NOT TREAT IN
VIOLATION OF AGENCY POLICY**

OHC physicians' assistants (and the physician) regularly sign records for patients for whom they do not see, but this is not in violation of any public law or Army regulation when done as part of their technical supervisory responsibilities as privileged providers. The current practice in the OHC could violate DoD guidelines for coding of encounters, but the follow-on medical record and coding review confirmed that it does not. The follow-on chart and coding review reveals that encounters are being documented and coded correctly, but a definitive check out procedure is required to ensure that patients did receive the appropriate immunizations, do not have a reaction to the immunization, and that the process is running correctly.

The applicable regulations are AR 40-66, Chapter 3-4a; AR 40-68 (Chapter 5 regarding delegation matters); and DoD 6010.13-M, DoD Coding Guidelines. Review of a patient's medical record and any history/exam performed by a non-credentialed provider, review of tests ordered in his/her name, or review of a record to which delegated care has been granted (such as OHC nurses seeing and documenting on patients/clients in accordance with physician authorized protocols) is appropriate, and should bear the privileged provider's signature.

The MTF has the authority based on AR 40-66 to define whether a co-signature is acceptable or if total assumption of the record is required. In Graduate Medical Education (GME), for example, to demonstrate very tight oversight responsibility the record is assumed by the privileged staff. For the record to meet acceptable coding standards, though, the privileged provider must annotate a significant presence in the care of the patient. AR 40-68, paragraph 5-2, addresses the responsibility of privileged providers (Level 1 and 2) over non-privileged providers (Level 3 and 4 – RNs and LVNs) with regard to delegation and oversight. Further, this "oversight" responsibility between the privileged versus non-privileged providers as applied at the OHC was clearly addressed in the recent Commander's Inquiry at CRDAMC, and was found to be correct.

There is evidence that the physician in OHC and the physicians assistants documented on patients/clients that they had not seen or treated on the same day that the patient/client was seen by a RN or LVN. However, this practice is not necessarily in conflict with any AR or MEDCEN Regulations as fully explained below. The IO conducted "a chart pull" from a day in October 2013 to look at nursing documentation as it related to the PAs "countersigning"⁴⁰ the

⁴⁰ According to AR 40-68, Glossary, Section II, the process of reviewing, monitoring, observing and accepting responsibility for assigned personnel by physicians and PAs as captured by their "countersigning" of particular

records pursuant to their medical supervisory role. The IO asked the OHC chief coder, to pull up the codes related to these patients - all were the minimal codes that could have been attributed based on the documentation provided. The record documentation by the providers indicates that they only reviewed the record and did not actually see the patient, indicating that they were acting appropriately in their supervisory capacity. AR 40-68, paragraphs 5-2 and 5-3 as well as CRDAMC policy fully supports the Level 1 and 2 providers (Physician and PAs) providing documentation that reflects oversight or supervision of the nurses.

Additionally, AR 40-66, AR 40-562, and CRDAMC policy fully supports the requirement that coding reflects who sees the patient. The follow-on chart and coding review confirms that the PAs and the physician do appropriately record their actions with respect to their "supervision" responsibilities and duties versus based on their actually having seen the patient, again all well within the procedures provided for by AR 40-68.

As with the process oriented issue relating to pre-documentation, there were two lines of thought among the OHC staff as to the appropriateness of the PAs and the physician "countersigning" charts, the IO stated there based on the witnesses' testimony, one group of nurses felt that this practice was based on "ill intent" (as some of the witnesses testified, such as RN3, LVN2, and RN1), and the other thought being that it was for "supervisory"/responsibility purposes (as was explained in the testimony from Chief, OHC, the PAs PA1 and PA2, and several of the nurses). Additionally, the previous Commander's Inquiry, which considered this issue in detail, concluded the procedure was correct and that the PAs and Chief, OHC should be reviewing and closing out AHLTA encounters. The change in clinical practice and the change in business practice, were not adequately understood by RN1 and RN3 nor appropriately explained to them by their supervisors. Their lack of understanding and their lack of willingness to accept Former Chief, DPM's guidance coupled with Chief, OHC waffling when he received push back from RN1 and RN3 resulted in RN3 taking her complaints to higher levels straight to the DCN. However, the follow-on chart review revealed that the documentation by the physician and PAs was appropriately reflected as "*supervisory*" and not as *direct* patient care.

It should be noted that there is a way in the module to modify/change who actually gives the immunization, but it is unnecessary redundant documentation, more prone to error than to just do it right the first time. However, for clarity purposes, because the LVN has the same scope/responsibility as the RN to ensure the immunization is appropriate for the patient, it was incumbent that any changes made by the LVN to the RN's direction needed to be corrected and coordinated with between the LVN and the RN. Unless the RN and LVN communicated why or why not a pre-documented immunization was indicated, it would stand as having been given based on the initial pre-documented entry. It should be noted that this can be problematic for the Active Duty personnel in that MEDPROS will pull specifically from the immunization module and populate the readiness Individual Medical Readiness (IMR) field in MEDPROS. If

medical procedures is defined as being part of "Indirect supervision" defined as when the "supervisor performs retrospective review of selected records. Criteria used for review relate to quality of care, quality of documentation, and the authorized scope of privileges/practice of the individual in question. Reviews may also include countersignature or authentication of medical entries, reports, or orders prescribed by another." (Emphasis added).

the information is not accurate in AHLTA, it will not be accurate in MEDPROS.⁴¹

A related matter is whether these immunization records are being utilized for billing *and/or* workload credit purposes. The IO found that the MTF codes patient encounters in accordance with DoD policy that requires accurate coding which reflects what patient care actually occurred. The MTF is also responsible for educating providers and enforcing appropriate coding based on documentation in the medical record. To put this in perspective, by way of analogy, under Medicare, “up coding” and/or “down coding” are considered errors in service coding and may be considered fraudulent if it occurs in a billing setting whereby payments are based on specific coding entries made by the health care provider.⁴² However, in the world of the MTFs, the MTF Commander is accountable for inconsistencies as reported on the Data Quality Report. Further, to address these inconsistencies, the Darnall Medical Center Commander has hired certified coders to audit and train providers in the appropriate coding procedures.

Though several witnesses used the term “transferred” in their testimony, some of the witnesses testified that in the OHC, part of the reason a record is “transferred” from a *non-credentialed/ privileged Level 3 or 4 provider* (e.g., an RN or LVN) to a *privileged Level 1 or 2 provider* (Physician or PA in the OHC) is to enhance coding opportunities. The first page (of multiple paged document) of an unsigned document gathered by the IO indicates that there is an entry under the “major performance objectives section” of the Army Senior System Civilian Evaluation Report Support Form, DA Form 7222-1, that states “AHLTA encounters will include procedures ordered/performed and transferred to the PA or MD to collect maximum RVU productivity of the clinic”. However, this performance objective merely addresses the encounter as being captured for workload and productivity purposes even though it *is* an appropriate action recorded by the physician and the PAs as part of their medical supervision responsibilities. This activity is authorized by AR 40-68 and was acknowledged by the follow-on chart and coding review which showed that these encounters are being documented appropriately. More importantly, there is no billing for the services provided for the OHC.

The relative value of a “codable” encounter by a Level 1 or 2 provider is higher than a Level 3 or 4 provider, and the Military Health System Professional Services Coding Guidelines, http://www.tricare.mil/ocfo/bea/ubu/coding_guidelines.cfm, have defined which codes can be applied by the different levels of providers, however the documentation must be present in the record to support a higher complexity encounter code. The organization, in accordance with AR 40-66, can stipulate to whom encounters will be attributed and workflow performed in support of accomplishing efficient and high quality healthcare, without breaking any law or violating any regulation as long as it is done without fraudulent intent.

⁴¹ See footnote 4 on SRP military readiness.

⁴² Under Medicare provisions, “up coding” is a fraudulent practice in which provider services are billed at a higher RVU code than were actually performed resulting in a higher payment by Medicare or third-party payer (insurer). On the other hand, “down coding” is defined as the alteration by an insurer or other third-party payer of service codes for physicians or other health care providers, to those of lesser complexity, resulting in decreased reimbursement.

A review of a sampling of records in the OHC undertaken in the audit review reflected that there is no evidence that the OHC physician and PAs “up code” any encounters that were documented by the Level 3 or 4 providers, and were therefore coding appropriately. Thus, the follow-on chart and coding review confirmed that “up coding” is not an issue in the OHC. Furthermore, I agree with the IO’s conclusion that the Level 1 and 2 providers (two PAs and one physician) were appropriately documenting their roles in the process, be it supervisory or actually seeing the patient.

Based on the above analysis of the evidence, the OHC is not in violation of AR 40-66 or AR 40-68, paragraph 5-2 as it pertains to providing oversight of delegated patient care, since physicians and PAs are required to supervise their subordinate nursing staff and reflect that supervision in the medical record. Hence, the OHC is not in violation of coding guidelines. All three privileged providers (Chief, OHC –the physician, and the PAs-PA1, and PA2) indicated that the reason the records are transferred to them is to document their *technical supervisory role* over the nursing personnel in part because they [the nurses] are ordering things under the *privileged providers’ names*. Further, both PAs have been consulting with the coders regarding the proper documentation required for provider level coding to justify the work they do. In order to determine whether the patient files were compliant with the coding requirements, the IO requested the coder in charge of OHC coding to review selected records to see if indeed the records were coded with an appropriate level code, to be followed by a follow-on chart and coding review to be completed by members of SRMC and PASBA, the Army’s recognized experts in charting and coding compliance. As a result of this review, it was confirmed that the practice in the OHC is occurring in an appropriate manner since January 1, 2014.

It should be noted that this subject was brought to the attention of the Chief of Occupational Medicine as early as September 2012 by one new employee (RN3). This employee then raised the issue to Chief, QM, the Chief, Quality Management; the former DCN; and to the Chief, DPM, over the next 8 months. Another new employee (RN1) questioned the practice beginning in February/March of 2013. As part of the Commander’s Inquiry directed by the CRDAMC Acting Commander in 2013, the issue was reviewed and was found not to be in violation of AR 40-66.

Further, RN3 and RN1 brought this matter to the attention of the PAs at each at about the same time that they started working at the OHC (September 2012 and February/March 2013, respectively). RN1 testified that she spoke directly with the coders and was told that the OHC had been doing it wrong for a long time. Since the start of this investigation, PA2 has been speaking with the coders for OHC to clarify what if anything can be appropriately coded when the patient sees only the nurse on a given visit. The IO spoke with the lead coder for OHC who verified that if the patient is not seen by the PA or physician, there is no enhanced coding associated with the visit. Simply transferring the record to a privileged provider as part of the supervision process does *not* constitute a Level 1 or 2 provider encounter code.

Upon review of the testimonial evidence, it reflects that all of the nurses (LVN1, RN2, RN5, RN4, RN3, RN1 and LVN2) seemed to recall different guidance coming from Chief, OHC, some testified that Chief, OHC told them that they were to transfer all notes, others testified that they were to only sign some notes (i.e., ones not involving immunizations or

procedures), others said to go back to the “old way.” Obviously it appears that there is much confusion among the witnesses as to what Chief, OHC wanted them to do.

Also, very clearly, there is no consensus of what the purpose of transferring the note to the privileged provider is supposed to entail. According to some witnesses (LVN2, RN1 and RN3), there is a nefarious intent in transferring notes in the OHC and it is purely to justify an increased coding opportunity which translates in increased provider workload, even though in reality, the IO appropriately concluded that there is no increased provider workload associated with this medical supervisory review. Clearly, as discussed above, the follow-on chart and coding review revealed that the OHC PAs and physician are documenting appropriately and are not up coding at all, including for additional workload. The bottom line is that the encounters were being captured solely for medical supervisory review.

Conclusion. Army Findings as to Allegation 3.

In summary, this Allegation is UNSUBSTANTIATED. Though OHC PAs and the physician regularly sign records for patients for whom they do not see, this is not in violation of any Public Law or Army Regulation when done as part of their *technical supervisory responsibilities*. A medical record and coding review revealed that the PAs and physician in the CRDAMC OHC are signing the records appropriately in a *supervisory capacity*, and *not* to make it appear as though they actually saw the patient when they did not.

**VIOLATIONS OR APPARENT VIOLATIONS OF
LAW, RULE, OR REGULATION**

The Army investigation revealed violations of Public Law 42 U.S.C. 300aa-25, Army Regulation 40-66 and Army Regulation 40-562, and CDRAMC OHC Standard Operating Procedure #7.

CORRECTIVE ACTIONS UNDERTAKEN

The IO recommended several corrective actions be undertaken to ensure that issues in CRDAMC OHC are resolved, and MG Keenan, Commander, SRMC, directed that the recommendations be implemented and that she be notified of their progress every 45 days until all recommendations were fully implemented.

The required corrective actions include the Commander, CRDAMC, to implement immediately the already approved recommendations of the Commander’s Inquiry completed on November 1, 2013, which included the following seven items:

- RNI's dismissal stands.
- Staff members who violated protected health information (PHI) need to be held accountable. Recommend leniency in fines since these violations were not malicious in nature.
- Recommend retraining of all staff regarding management of PHI.

- The ineffective leadership needs to be addressed. Recommend Chief, OHC be formally counseled regarding his role in this matter; receive meaningful leadership training; be held accountable regarding required documentation; he received appropriate initial, intermediate and final evaluation counseling and; to better understand the roles of each of his employees. Recommend Chief, OHC be guided and mentored by the new Chief of Preventive Medicine.
- Continued questioning of command decisions need to stop.
- Each staff member receives counseling regarding roles, expectations, and accountability.
- Surreptitious recording of conversations needs to stop.

Additionally, MG Keenan approved the following recommendations from the current investigation:

- The new Chief, OHC, with heightened oversight by the Chief, Department of Preventive Medicine, is required to:
 - Take all mandatory and recommended training for Supervisors of Civilian Employees, as well as training on TAPES with stress placed upon adherence to counseling timeframes;
 - Obtain a thorough working knowledge of AR 40-562 and ensure that MEDCEN regulations for which the OHC is the proponent, and OHC SOPs are in line with this regulation;
 - Codify CDC, Military Vaccination Agency (MILVAX), and ACIP guidelines into clinic SOPs and/or standard orders that are readily available to OHC personnel (e.g. on a shared drive or folder);
 - Ensure that all OHC personnel read and acknowledge OHC SOPs on a recurring basis, at least annually;
 - Obtain a thorough working knowledge of the encounter codes applicable to the OHC, AR 40-66 and AR 40-68 in order to design workflow in the clinic that assigns personnel to work at the “top of their license” in order to provide efficient, coordinated, and high quality care to clients;
 - Use subject matter experts within CRDAMC to achieve this result;
 - Develop a credible quarterly administrative chart audit function that addresses key elements of the occupational health program, and involves all members of the healthcare team IAW AR 40-66, chapter 12;
 - Conduct a retrospective review of all CEMRs for evidence of inappropriate documentation of T-dap;
 - Counsel for record those individuals who are identified in violation of this standard of professional ethics;

- Conduct a focused/prospective review of the immunization module of AHLTA encounters to ensure that OHC nurses are adhering to documentation standards in OHC SOP #7;
- Ensure that a check out system is implemented which requires all patients to physically check out of the OHC after receiving any immunization, during which check out the immunization the patient received is confirmed, the immunization site is checked, and the record is annotated to reflect the check-out confirmation.
- The CRDAMC DCCS will review and standardize the administration and documentation of immunizations across all CRDAMC clinical settings that provide immunization services, to include data entry into MEDPROS at the point of service for military service members, IAW AR 40-562.
- The CRDAMC Center Judge Advocate will provide training for OHC personnel on what constitutes fraudulent medical record documentation and the legal implications. Record the training in each employee's CAF.
- The CRDAMC Chief, Department of Preventive Medicine, will review supervisory relationships in the OHC, both technical and administrative, to improve communication, respect for others, and the overall workplace environment (which is currently very toxic).
- The CRDAMC Chief, Quality Management, will provide a training opportunity to the OHC for TJC standards of medical record documentation.

CONCLUSION

The Department of the Army takes very seriously its responsibility to address, in a timely and thorough fashion, the concerns of the OSC. In this case, the Army conducted a comprehensive investigation in response to the OSC's referral.

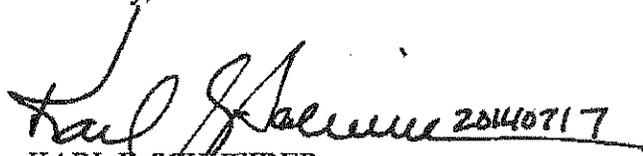
The Army's investigation provided three important findings relating to the OSC Referred Allegations. First, the investigation revealed that the manner in which immunizations were recorded in the medical records of patients in the CRDAMC OHC was not in compliance with good medical record keeping practices. The practice of documenting immunizations prior to their administration did not comply with Army Regulations or the CRDAMC OHC's own SOP, and resulted from the failure of the previous OHC Chief to enforce these standards. The second important finding from the Army's investigation was that the practice of "pre-documentation" may have allowed some patients to leave the OHC without having received their immunizations. This led to the potential that these patients were not protected from the diseases for which the inoculations were intended to provide immunity. However, the investigation did not reveal any specific cases of harm resulting from this potential danger. The third important finding from the Army's investigation was that although the CRDAMC OHC PAs and physician sign the medical records of immunization patients after they are treated by the OHC nurses, the PAs and physicians are signing these records in an appropriate manner in their supervisory health care provider status, and did not change any coding to make it look like they saw any patients that they did not actually see. Lastly, the SRMC Commander directed corrective actions to the immunization and medical recordkeeping practices which are consistent with the findings and recommendations of the investigation, and which will remedy the issues involved in this case.

Finally, my concluding thoughts for this Report are the following: Lax management and supervision based on consensus rather than following the established rules is not always viewed as an acceptable practice for any organization to endorse, let alone a medical facility where public health and safety can be clearly threatened by inattention to details and appropriate protocols.

I am satisfied that this is the correct outcome in this matter. Accordingly, the Army has made no referral 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, U.S.C. § 1213(c) and (d). Please direct any further questions you may have concerning this matter to (b) (6) at (b) (6)

Sincerely,


KARL F. SCHNEIDER
Acting Assistant Secretary of the Army
(Manpower and Reserve Affairs)

Army Report Documents
Carl R. Darnall Army Medical Center
Fort Hood, Texas
OSC File Number DI-13-4218

<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 April 17, 2014
TAB B	Army Regulation 40-1, <i>Composition, Mission, and Functions of the Army Medical Department</i> , dated July 1, 1983
TAB C	Memorandum for [Investigating Officer], Staff Surgeon, Reynolds Army Community Hospital, Fort Sill, Oklahoma, from Major General (MG) Jimmie O. Keenan, Commander, Southern Regional Medical Command, Subject: Whistleblower Investigation – Immunization Practices at Occupational Health Clinic. Carl R. Darnall Army Medical center, Fort Hood, Texas, dated November 8, 2013.
TAB D	Army Regulation (AR) 15-6, <i>Procedures for Investigating Officers and Boards of Officers</i> , dated October 2, 2006
TAB E	Army Regulation 10-87, <i>Army Commands, Army Service Component Commands, and Direct Reporting Units</i> , dated September 4, 2007, Chapter 15
1	Initial Cure Notice, November 18, 2013 regarding Meeting on Friday
2	Commander's Cure Memorandum, December 2, 2013
3	Organizational Chart for Darnall Army Medical Center
4	CRDAMC Medical Center Facts
5	Organizational Chart for Department of Preventive Medicine
6	Organizational Chart for Occupational Health Clinic
7	CRDAMC Occupational Health Clinic Fact Sheet
8	List of OHC employees as of September 4, 2013 and November 18, 2013

- 9 Position descriptions-
- a. Practical Nurse, GS-0620-05 (LVN1)
 - b. Occupational Health Technician, GS-0640-07 (LVN2)
 - c. Clinical Nurse (Comm-Occ Health), GS-0610-10 (RN3)
 - d. Clinical Nurse (Comm-OCC Health), GS-610-10, (RN4)
 - e. Nurse (Clinical/Comm-Occ Health), YH-0610-02 (RN5)
 - f. Nurse (Clinical/Comm-Occ Health), YH-0610-02 (RN2)
 - g. Physician Assistant (Occupational Health), GS-0603-12 (PA2)
- 10 42 U.S.C. Section 300aa-25 (Reporting and recording of information)
- 11 42 U.S.C. 300aa-14 (Vaccine Injury Table)
- 12 CRDAMC OHC *Standard Operating Procedure #7, Subject: Booking and AHLTA/Medical Record Documentation of Immunization /PPD Administration or to the health department if they are a contract employee*, dated May 6, 2013
- 13 CRDAMC MEDCEN Regulation 40-6, *Required Immunizations and Post-Exposure Prophylaxis Against Communicable Disease*, dated December 17, 2012
- 14 CRDAMC MEDCEN Regulation 40-23, Medical Services, Scope of Practice for registered Nurses, Licensed Vocational Nurses/68WM6 and Nursing Assistants/SSW, dated August 3, 2011
- 15 Centers for Disease Control, Vaccine Information Statement-Td or Tdap Vaccine, What You Need to Know (Tetanus and Diphtheria or Tetanus, Diphtheria and Pertussis)
- 16 Statement of Chief, Occupational Health Clinic, Brooke Army Medical Center, dated December 16, 2013
- 17 Witness Listing for Army Report – DI-13-4218 (*copy only in unredacted Army Report version*)



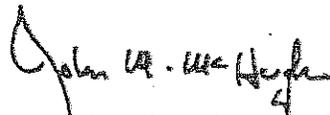
SECRETARY OF THE ARMY
WASHINGTON

17 APR 2014

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

SUBJECT: Delegation of Authority Under Title 5, U.S. Code, Sections 1213(c) and (d)

1. In accordance with Title 10, U.S. Code, section 3013(f), I hereby delegate to you certain authorities conferred on me, as agency head, under Title 5, U.S. Code, section 1213. Specifically, you are authorized to review, sign and submit written reports of investigations of information and related matters transmitted to the Department of the Army by The Special Counsel, in accordance with Title 5, U.S. Code, sections 1213(c) and (d). In addition, you may respond to the Office of Special Counsel (OSC) in other related OSC matters, subject to coordination in each case with the Office of the Army General Counsel.
2. When the position of the Assistant Secretary of the Army (Manpower and Reserve Affairs) (ASA (M&RA)) is vacant, or you are temporarily absent or otherwise not available to take timely action, these authorities may be exercised by the Principal Deputy ASA (M&RA) or by the designated Senior Official performing the duties of the ASA (M&RA). This authority may not be further delegated.
3. This delegation will remain in effect for 3 years from the date of this memorandum unless earlier modified or rescinded, in writing, by me.


John M. McHugh

CF:
Office of the Army General Counsel
Office of the Administrative Assistant to the Secretary of the Army



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



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. KOYCE
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)

Contents (Listed by paragraph and page number),

Chapter 1

INTRODUCTION, page 1

Purpose • 1-1, page 1

Applicability • 1-2, page 1

References • 1-3, page 1

Explanation of abbreviations • 1-4, page 1

Concept • 1-5, page 1

Responsibilities • 1-6, page 1

Policy • 1-7, page 1

Remunerative professional civilian employment • 1-8, page 2

Command positions • 1-9, page 2

Utilization of AMEDD officers • 1-10, page 3

Chapter 2

CORPS OF THE ARMY MEDICAL DEPARTMENT, page 3

Section 1

MEDICAL CORPS, page 3

Composition • 2-1, page 3

Duties of MC officers • 2-2, page 3

Utilization of MC officers • 2-3, page 3

Applicability of Federal and State licensing laws • 2-4, page 3

Section II

DENTAL CORPS, page 3

Composition • 2-5, page 3

Duties of DC officers • 2-6, page 3

Utilization of DC officers • 2-7, page 4

Dental organizations • 2-8, page 4

Application of narcotic and licensing laws to DC officers • 2-9, page 4

Section III

VETERINARY CORPS, page 4

Composition • 2-10, page 4

Duties of VC officers • 2-11, page 4

Utilization of VC officers • 2-12, page 4

Title of VC officers • 2-13, page 4

Section IV

MEDICAL SERVICE CORPS, page 4

Composition • 2-14, page 4

Duties of MSC officers • 2-15, page 5

Utilization of MSC officers • 2-16, page 5

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

Contents—Continued

Section V

ARMY NURSE CORPS, page 5

Composition. • 2-17, page 5

Duties of ANC officers. • 2-18, page 5

Utilization of ANC officers. • 2-19, page 5

Section VI

ARMY MEDICAL SPECIALIST CORPS, page 5

Composition. • 2-20, page 5

Duties of AMSC officers. • 2-21, page 6

Utilization of AMSC officers. • 2-22, page 6

Chapter 3

ARMY MEDICAL DEPARTMENT WARRANT OFFICERS,

page 6

Physician assistant, military. • 3-1, page 6

Biomedical equipment repair technician. • 3-2, page 6

Food inspection technician. • 3-3, page 6

Chapter 4

ARMY MEDICAL DEPARTMENT CIVILIAN PERSONNEL,

page 7

Civilian employees. • 4-1, page 7

Contract surgeons. • 4-2, page 7

Professional consultants. • 4-3, page 8

Administrative procedures for professional consultants. • 4-4,
page 8

Appendixes

A. References, page 10

B. SUGGESTED STATEMENT OF WORK FOR FULL-TIME
CONTRACT SURGEON CONTRACT (DUTIES TO BE
PERFORMED AT A GOVERNMENT FACILITY,
page 10

C. SUGGESTED STATEMENT OF WORK FOR PART-TIME
CONTRACT SURGEON CONTRACT DUTIES TO BE
PERFORMED AT A GOVERNMENT FACILITY,
page 11

D. SUGGESTED STATEMENT OF WORK FOR PART-TIME
CONTRACT SURGEON CONTRACT DUTIES TO BE
PERFORMED OUTSIDE GOVERNMENT FURNISHED
FACILITY, page 12

E. PROCESSING PROCEDURES FOR APPLICATIONS FOR
EMPLOYMENT AS SOCIAL WORKERS AND
PSYCHOLOGISTS, page 12

F. SUGGESTED REQUEST FOR OFF-DUTY
REMUNERATIVE PROFESSIONAL CIVILIAN
EMPLOYMENT, page 12

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 overseas 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 ensuring 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 oversea 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 qualified 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) *Oversea 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 oversea 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 oversea 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 Units 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. 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)
1st Ind

date

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.



DEPARTMENT OF THE ARMY
SOUTHERN REGIONAL MEDICAL COMMAND
4070 STANLEY ROAD SUITE 121
JBSA FORT SAM HOUSTON, TEXAS 78234-6200

REPLY TO
ATTENTION OF:

MCSR-JA

8 November 2013

MEMORANDUM FOR COL Investigating Officer Reynolds Army Community Hospital, 4301
Wilson Street, Fort Sill, Oklahoma 73503-9042

SUBJECT: Whistleblower Investigation - Immunization Practices at Occupational Health
Clinic, Carl R. Darnall Army Medical Center, Fort Hood, Texas

1. References:

a. Secretary of the Army Memorandum subject: Whistleblower Investigation- Immunization
Practices at Occupational Health Clinic, Carl R. Darnall Army Medical Center, Fort Hood, Texas
- (Office of Special Counsel File Number DI 13-4218)

b. U. S. Office of Special Counsel Letter dated 29 October 2013, Subject: OSC File No. DI-
13-4218

2. You are hereby appointed as an investigating officer pursuant to Army Regulation (AR) 15-6,
Procedures for Investigating Officers and Boards of Officers, to conduct an informal
investigation into whistleblower's allegations of violations of laws, rules and regulations and a
substantial and specific danger to public health at Carl R. Darnall Army Medical Center
(CRDAMC). The purpose of your investigation is to determine the validity of the
whistleblower's allegations and make findings concerning whether any wrongdoing occurred,
and if so, by whom, and whether adequate policies and procedures are in place to preclude any
recurrence of any improprieties, irregularities, or misconduct disclosed during your inquiry.

3. You will review the allegations and background information provided in the OSC referral
letter, Reference 1.b., and ensure your investigation and the resulting Report of Investigation
(ROI) addresses not only the three allegations (specifically addressed below at paragraphs 4a, 4b
and 4c), but also each of the issues addressed in the OSC's background information portion.

4. You will specifically investigate and address in the ROI the following allegations:

a. Whether clinic nurses assigned to the CRDAMC Occupational Health Clinic (OHC)
regularly record or chart patient immunizations prior to administration of the immunizations in
violation of agency policy?



MCSR-JA

SUBJECT: Appointment of Investigating Officer

(1) What is the applicable federal law, DOD policy or regulation, US Army regulation, US Army Medical Command (MEDCOM) regulation, and published CRDAMC regulation on administering and charting immunizations and does CRDAMC's OHC comply with it?

(2) If CRDAMC OHC does not follow the current law, regulations, or guidance on administering and charting immunizations, have there been recent changes in the law or regulations that account for the CRDAMC OHC not having incorporated those changes into their policies, and thus, are in violation of the current law, regulations, or guidance?

(3) If CRDAMC OHC does violate the law, regulations, or guidance on administering and charting immunizations, how long has the clinic been in violation; and who initiated the change in the policy or practice?

(4) If CRDAMC OHC does violate the law, regulations, or guidance on administering and charting immunizations, what is the Clinic's justification/rationale for being in violation of that requirement?

(5) If CRDAMC OHC does violate the law, regulations, and guidance on administering and charting immunizations; who in the clinic or hospital chain of command has knowledge of the law and regulatory policies; when were they notified of the violations; and what corrective actions, if any, did they take?

(6) By name, which clinic nurses are allegedly violating the policy or practice on administering and charting immunizations?

(7) At any time were the clinic nurses, who allegedly violated the policy or practice, notified of the violations? If so, by whom? Did any of those clinic nurses who were put on notice of the violation take any action based on that notice; and if so, what action did they take?

(8) Has any violation posed a situation which has or may pose a danger to the health of both the patient and the public because of the possibility of infection in the patient who is incorrectly recorded as having received immunizations?

b. Whether patients frequently leave the OHC prior to receiving immunizations, resulting in incorrect charts and placing patients at risk for later complications as a result of not receiving the immunization.

(1) Does the nurse who administers the immunization confirm that a patient was screened and the immunization was properly recorded? If so, how does the nurse verify the immunization was properly charted?

(2) Have there been any patient reports or complaints that they did not receive immunizations after the immunization was recorded as being administered?

(3) Have any patients become ill or injured as the result of these alleged violations in procedures?

(4) Have there been *any* negative outcomes as a result of patients not receiving immunizations that their records indicate they received?

c. Whether clinic physician assistants regularly sign charts for patients whom they do not treat in violation of agency policy.

(1) What is the applicable federal law, DOD policy or regulation, US Army regulation, US Army Medical Command (MEDCOM) regulation, and published CRDAMC regulation on providers entering treatment information in patient medical records and does CRDAMC's OHC comply with it?

(2) If CRDAMC OHC does not follow the current law, regulations, or guidance on providers entering treatment information in patient medical records have there been recent changes in the law or regulations that account for the CRDAMC OHC not having incorporated those changes into their policies, and thus, are in violation of the current law, regulations, or guidance?

(3) If CRDAMC OHC does violate the law, regulations, or guidance on providers entering treatment information in patient medical records, how long has the clinic been in violation and who initiated the change in the policy or practice?

(4) If CRDAMC OHC does violate the law, regulations, or guidance on providers entering treatment information in patient medical records, what is the Clinic's justification/rationale for being in violation of that requirement?

(5) If CRDAMC OHC does violate the law, regulations, or guidance on providers entering treatment information in patient medical records; who in the clinic or hospital chain of command has knowledge of the law and regulatory policies; when were they notified of the violations; and what corrective actions, if any, did they take?

(6) By name, which clinic Physician Assistants are allegedly violating the policy on providers entering treatment information in patient medical records?

(7) At any time were the Physician Assistants, who allegedly violated the policy, notified of the violations? If so by whom? Did any of those clinic nurses who were put on notice of the violation take any action based on that notice; and if so, what action did they take??

d. Do any of the procedures at CRDAMC Occupational Health Clinic constitute a substantial and specific danger to public health or safety?

MCSR-JA

SUBJECT: Appointment of Investigating Officer

5. This investigation takes priority over all normal duties, TDY and leave. You are directed to start this investigation upon receipt of this notice. In conducting this investigation, use the informal procedures of AR 15-6, Chapter 4. Upon completing your investigation, make appropriate findings and recommendations, including corrective and/or disciplinary actions, and report them to me through the Office of the Staff Judge Advocate, U.S. Army Medical Command.

6. In your investigation you are not limited to the issues and questions listed above. You will investigate any relevant and related matters that you may discover that fall under the areas for investigation described above. You are advised not to investigate matters that do not fall within the areas for investigation described above. If you are in doubt about the relevance of a matter, you will consult your legal advisor, (b) (6) who can be contacted at (b) (6) or (b) (6). You will consult with your legal advisor prior to beginning your investigation. Before beginning your investigation, you will receive a legal briefing for further guidance and additional information about how you should proceed from your legal advisor.

7. If you obtain or are provided evidence from other investigative reports, you may consider the exhibits collected by the investigator(s), but you may not consider another investigator's conclusions as evidence.

8. Conduct this investigation using the informal procedures of AR 15-6, Chapter 4.

9. In your investigation, you will make such findings as are relevant and supported by the facts. You will also make such recommendations as are appropriate and are supported by the facts. In compiling your report of investigation, consider carefully that information contained therein will be subject to public disclosure and release.

10. This investigation has been directed by the Office of Special Counsel (OSC) pursuant to a whistleblower complaint.

11. You should contact witnesses you consider relevant during the course of your investigation. Your investigation will require findings and recommendations related to the nursing and immunology areas of practice. You should contact the Chief Consultant to The Army Surgeon General, COL (b) (6) at (b) (6) who will refer you to the appropriate subject matter experts in these areas of practice. As you develop new facts, you should interview any individuals that you deem necessary to complete a thorough investigation. Obtain sworn statements from all witnesses whom you determine may have information relevant to this investigation. Document all statements in writing, preferably on a DA Form 2823 (Sworn Statement), and have witnesses verify their statements when final. You should conduct separate interviews for each witness and conduct the interviews in person if practical. In addition, you must provide all persons interviewed with a Privacy Act statement before you solicit any information. At a minimum, you will interview the following personnel:

MCSR-JA

SUBJECT: Appointment of Investigating Officer

- a. CRDAMC Chief of Preventive Medicine
- b. Officer in Charge, Occupational Health Clinic
- c. OHC Immunization Nurse(s)
- d. All OHC Nurses alleged to be charting immunizations
- e. COL (b) (6) CRDAM Deputy Commander for Nursing (DCN).
- f. COL (b) (6) former CRDAMC DCN.
- g. (b) (6) CRDAMC Chief, Quality Management Services
- h. COL (b) (6) CRDAMC Deputy Commander for Clinical Services

12. Caution all individuals that they must not discuss the subject matter of the investigation with anyone other than a properly detailed investigator. If in the course of your investigation, you suspect certain people may have committed criminal conduct, you must advise them of their right under Article 31, UCMJ or the Fifth Amendment, U.S. Constitution, as appropriate. In such case, waivers must be documented using DA Form 3881, Rights Warning Procedure/Waiver Certificate. If you believe the scope of your investigation should be expanded beyond its current focus, please report back to me so that I may take appropriate action. Consult your legal advisor if you have any questions regarding these procedures.

13. During the course of your investigation, you will find it necessary to interview civilian employees. Generally speaking civilian employees are required to cooperate with official investigations. There are some exceptions.

a. Civilian employees who are members of a bargaining unit have a right to union representation at any interview with management if they reasonably believe the interview could result in a disciplinary action against them. Should a bargaining unit employee seek to invoke this right, simply reschedule the interview for at least 24 hours to allow the employee time to arrange for union representation. The Civilian Personnel Advisory Center can tell you whether any particular employee you wish to interview is a member of the bargaining unit. Once you have scheduled any bargaining unit employees for an interview, contact your legal advisor for guidance in notifying the appropriate union representative.

b. Civilian employees who reasonably believe that information they provide during an official investigation may be used against them in a criminal proceeding, may refuse to cooperate without a grant of immunity. Should any civilian employee decline to cooperate for any reason, suspend the interview and seek guidance from your legal advisor on how to proceed.

MCSR-JA

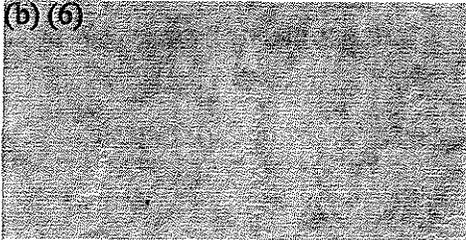
SUBJECT: Appointment of Investigating Officer

- c. If the matter you are investigating involves a grievance, a personnel practice or policy or other conditions of employment, you may be required to notify the union of any interviews you have scheduled with bargaining unit employees and afford the union the opportunity to be present. Check with your legal advisor to determine if this rule applies in your case and how to proceed if it does.
- d. You have no authority to compel the cooperation of contractor employees. If you find it necessary to interview contractor employees, you must contact the contracting officer for the applicable contract to request cooperation.
14. If, in the course of your investigation, you suspect wrongdoing or neglect on the part of a person senior to you, inform me so that a new investigating officer may be appointed. An investigating officer may not, absent military exigency, investigate someone senior to himself or herself.
15. If you believe the scope of your investigation should be expanded beyond its current focus, please report back to me so that I may take appropriate action. Consult your legal advisor if you have any questions regarding these procedures.
16. Your legal advisor during the course of your investigation will be (b) (6) at (b) (6) or (b) (6). Consult with him prior to beginning your investigation for further guidance and additional information about how you should proceed. You may consult the legal advisor at any time during the investigation and you will consult the legal advisor before warning any witness as a suspect and before putting your report in final form.
17. In your investigation, you will make such findings as are relevant and supported by the facts. You will also make such recommendations as are appropriate and are supported by the facts. In compiling your report of investigation, consider carefully that information contained therein will be subject to public disclosure and release.
18. Make specific findings and recommendations. If certain evidence conflicts with other evidence, state what you believe and why. Reference your analysis and findings to the specific evidence upon which you rely. Recommend remedial measures, to include any personnel or disciplinary actions you deem appropriate.
19. You will submit your completed investigation on a DA Form 1574 with a table of contents and enclosures. The enclosures will include all documentary materials considered by you. Make two copies of your report of investigation (ROI). Provide an index and clearly tab the original ROI, to include your findings and recommendations on DA Form 1574, with appropriate enclosures and forward the entire package to me, through the Southern Regional Medical Command's Office of the Command Judge Advocate by 27 November 2013.

MCSR-JA
SUBJECT: Appointment of Investigating Officer

20. If you require additional time to complete your investigation, you must request an extension in writing stating the reason(s) for your request and an approximate completion date and send it directly to me for approval. I must personally approve any extensions.

FOR THE COMMANDER:



Encls

Colonel, US Army
Chief of Staff

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



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.

Contents (Listed by paragraph and page number)

Chapter 1

Introduction, page 1

Purpose • 1-1, page 1

References • 1-2, page 1

Explanation of abbreviations and terms • 1-3, page 1

Responsibilities • 1-4, page 1

Types of investigations and boards • 1-5, page 1

Function of investigations and boards • 1-6, page 1

Interested persons • 1-7, page 2

Respondents • 1-8, page 2

Use of results of investigations in adverse administrative actions • 1-9, page 2

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

Contents—Continued

Chapter 2

Responsibilities of the Appointing Authority, page 2

Appointment • 2-1, page 2

Administrative support • 2-2, page 6

Action of the appointing authority • 2-3, page 7

Chapter 3

General Guidance for Investigating Officers and Boards, page 8

Section I

Conduct of the Investigation, page 8

Preliminary responsibilities • 3-1, page 8

Oaths • 3-2, page 8

Challenges • 3-3, page 8

Counsel • 3-4, page 8

Decisions • 3-5, page 8

Presence of the public and recording of proceedings • 3-6, page 8

Rules of evidence and proof of facts • 3-7, page 13

Witnesses • 3-8, page 14

Communications with the appointing authority • 3-9, page 15

Section II

Findings and Recommendations, page 15

Findings • 3-10, page 15

Recommendations • 3-11, page 15

Deliberation • 3-12, page 16

Voting • 3-13, page 16

Section III

Report of Proceedings, page 16

Format • 3-14, page 16

Enclosures • 3-15, page 16

Exhibits • 3-16, page 16

Authentication • 3-17, page 17

Safeguarding a written report • 3-18, page 17

Submission • 3-19, page 17

Action of the appointing authority • 3-20, page 17

Chapter 4

Informal Investigations and Boards of Officers, page 17

Composition • 4-1, page 17

Procedure • 4-2, page 17

Interested persons • 4-3, page 17

Chapter 5

Formal Boards of Officers, page 18

Section I

General, page 18

Members • 5-1, page 18

Attendance of members • 5-2, page 19

Duties of recorder • 5-3, page 19

Section II

Respondents, page 20

Designation • 5-4, page 20

Contents—Continued

- Notice • 5-5, *page 20*
- Counsel • 5-6, *page 20*
- Challenges for cause • 5-7, *page 21*
- Presentation of evidence • 5-8, *page 21*
- Argument • 5-9, *page 22*
- After the hearing • 5-10, *page 22*

Appendixes

- A. References, *page 23*
- B. Guidance for Preparing Privacy Act Statements, *page 24*

Glossary

Index

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 5-8*a*.)
- 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.

Index

This index is organized alphabetically by topics and subtopics. Topics and subtopics are identified by subsection or paragraph number.,

Administrative matters, 3-5, 5-1

Administrative support, 2-2, 5-3

Adverse actions,

against DA civilians, 1-9, 3-8

basis for, 1-7, 1-8, 2-1, 2-3

definition, 1-3

not basis for respondent designation,, 5-4

Appointing authority,

action,, 2-3, 3-20

communication with, 3-8

errors, 2-3

responsibilities, 2-1 through 2-3

submission of report to, 3-19

Argument, 5-9

Boards of officers,

advisory members, 5-1

alternate members, 5-2, 5-7

appointment to, 2-1

attendance, 5-2, 5-3

authorization, 1-1, 2-1

definition, 1-5

duties and functions, 1-6

guidance to, 3-2 through 3-20

members, 2-1, 5-1, 5-2

president, 3-9, 3-15, 3-20, 5-1, 5-8

purpose and scope, 2-1

recommendations, 2-3

voting, 5-1

See also Judge advocate; Legal advisor,

Challenges, 3-3, 3-5, 5-7

Civilian employees, DA,

as counsel, 5-6

as reporters, 2-2

as witnesses, 3-8, 5-3, 5-8

controlled by CPR, 1-9

counsel for, 3-4, 3-8, 5-6

Civilian Personnel Regulations (CPR), 2-3

Classified material, 5-5

Closed session, 3-12

Communication, 3-7, 3-9, 3-15

Confession, 3-7

Counsel,

communication with client, 3-7

entitlement to, 5-6

failure to cite errors, 2-3

for civilian employees, 3-4, 3-8, 5-6

present at consultation, 3-12, 5-1

records provided to, 5-3

right to, 2-3, 3-4, 5-6

types of, 5-6

Decisions, 2-3, 3-5

Deliberations, 3-11
Disciplinary action. See Adverse actions,
Disease or injury, 3-7
Enclosures, 3-14, 3-15, 5-10
Errors, 2-3
Evidence,
 as exhibits, 3-16
 discussion of, 3-8
 documentary, 3-16, 5-8
 introduction of, 5-8
 presentation of, 5-3, 5-8
 real (physical), 3-16, 5-3, 5-8
 rules of, 3-7
 weight of, 3-10
Exhibits, 3-8, 3-14, 3-16, 5-10
Federal Personnel Manual, 1-9
Findings,
 affected by error, 2-3
 definition, 3-10
 evidence for, 3-10
 form of, 3-10
 required, 2-1
 supporting recommendations, 3-10
 use of, 1-9
Formal boards. See Boards of officers,
Formal procedures,
 definition, 1-5
 not mandatory, 1-5
 use of, 1-5
General courts-martial (GCM), 2-2, 5-1, 5-2
General officers, 1-5, 2-1
Hearings, 5-10
Immunity, 3-7
Informal boards, 4-1 through 4-3
Informal investigations, 2-1, 4-1-4-3
Informal procedures, 1-5
Inspectors general, 3-7
Instructions, 1-1, 2-1, 3-11, 3-12
Interested persons, 1-7, 4-3
Investigations,
 appointment to, 2-1
 authorization, 1-1
 boards for, 4-1
 composition of, 4-1
 conduct of, 3-1 through 3-9
 duties during, 1-6
 function of, 1-6
 guidance for, 3-2 through 3-20
 informal, 4-1-4-3
 preliminary, 1-5
 purpose and scope, 2-1
 recommendations of, 2-3
 results of, 1-9
 types of, 1-5

Involuntary admission, 3-7

Judge advocate (JA),

advises on appointments, 2-1
advises on Privacy Act, 3-8
advises on procedure, 1-5, 2-1, 2-2
consulted, 5-1
determines public interest, 3-6
reviews counsel's conduct, 5-6
reviews reports, 2-3
rules on self-incrimination, 3-7

Legal advisor,

appointment to formal board, 2-1
civilians (JA) as, 5-1
decision making, 3-5
forming findings and recommendations, 3-12
functions, 5-1
protection of witnesses, 3-7, 3-8

See also Judge advocate

Legal review, 2-3

Letter of notification, 5-5

Memorandum of appointment,

appoints members, 2-1
as enclosure to report of proceedings, 3-15
defines findings and recommendations required, 2-1
designates recorders, 5-1
designates respondents, 5-4
provides authority, 1-1
read by recorder and participants, 5-3
specifies purpose and scope, 2-1

Military exigency, 1-3, 2-1, 5-1

Minority report, 3-13, 3-17

MRE (Military Rules of Evidence), 3-7

News media, 3-6

Notices to individuals,, 1-9, 3-15, 5-3

Oaths, 3-2, 5-3

Objections, 2-3, 3-5, 3-16

Official notice, 3-7, 3-16

Off the record, 3-7

Physical evidence, 3-16, 5-3, 5-8

Privacy Act, 3-8, 3-15, 5-3, appendix B

Privileged communications, 3-7, 5-8

Procedural matters, 3-5

Proceedings,

additional, 3-20
definition, 1-5
public presence at, 3-6
recording, 3-6

See also Report of proceedings

Proof of facts, 3-7. *See also* Standard of proof,

Publicity, 3-6

Quorum, 5-2, 5-7

Real evidence. *See* Physical evidence

Recommendations,

- affected by error, 2-3
- nature and extent, 3-11
- required, 2-1
- supported by findings, 2-3, 3-10

Recorder,

- as board member, 2-1, 5-1
- authenticates report, 3-17
- duties, 5-3
- rules on relevance, 5-8
- supervision of, 5-1

Reporters, 2-2

Report of proceedings,

- action taken upon, 3-20
- authentication of, 3-17
- enclosures to, 3-15, 5-10
- exhibits attached to, 3-16, 5-10
- format, 3-14
- minority, 3-13, 3-17
- safeguarding of, 3-18
- submission of, 3-19, 5-1, 5-3, 5-10

Respondents,

- assistance to, 5-8
- as witnesses, 5-8
- challenges by, 5-7
- counsel for, 5-6
- designation of, 1-8, 1-8, 5-4
- notice to, 5-5
- recording of procedures, 3-6
- records provided to, 5-3, 5-5
- rights of, 5-8, 5-10

Rules of evidence, 3-7

Security classification, 3-18, 5-6, 5-10

Self-incrimination, 3-7

Senior Executive Service, 1-5

Standard of proof, 3-10. *See also* Proof of facts

State Adjutant General, 2-1

Statements,

- as argument, 5-9
- as exhibits, 3-16
- examined by respondent, 5-8
- off the record, 3-7
- regarding disease or injury, 3-7
- self-incriminating, 3-7
- taken by counsel, 5-6
- taking of, 3-8
- written, 5-4

Technical knowledge, 5-1

Testimony. *See* Statements

Travel orders, 3-8, 5-3, 5-8

Uniform Code of Military Justice (UCMJ), 1-3, 2-3, 3-2, 3-7

United States Code, 5-6

Unlawful search, 3-7

Verbatim record, 2-1, 3-8, 3-16

Voting, 3-13, 4-1, 5-1

Warrant officers, 2-1, 5-1

Witnesses,

arranging presence of, 5-3

authority to subpoena, 3-8

civilian employees as, 3-8, 5-3, 5-8

examination of, 5-3

interviewed, 1-5

ordered to testify, 3-7

protection of, 3-7, 3-8

respondents as, 5-8

self-incriminating, 3-7

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



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).

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 1992.

Contents (Listed by paragraph and page number)

Chapter 1

Introduction, page 1

Purpose • 1-1, page 1

References • 1-2, page 2

Explanation of abbreviations and terms • 1-3, page 2

Chapter 2

U.S. Army Forces Command, page 2

Mission • 2-1, page 2

Functions • 2-2, page 2

Command and staff relationships • 2-3, page 2

Chapter 3

U.S. Army Training and Doctrine Command, page 3

Mission • 3-1, page 3

Functions • 3-2, page 3

Command and staff relationships • 3-3, page 3

Chapter 4

U.S. Army Materiel Command, page 4

Mission • 4-1, page 4

Functions • 4-2, page 4

Command and staff relationships • 4-3, page 4

Chapter 5

U.S. Army Europe, page 4

Mission • 5-1, page 4

Functions • 5-2, page 5

Command and staff relationships • 5-3, page 5

Chapter 6

U.S. Army Central, page 5

Mission • 6-1, page 5

Functions • 6-2, page 5

Command and staff relationships • 6-3, page 6

Chapter 7

U.S. Army North, page 6

Mission • 7-1, page 6

Functions • 7-2, page 6

Command and staff relationships • 7-3, page 7

Chapter 8

U.S. Army South, page 7

Mission • 8-1, page 7

Functions • 8-2, page 7

Command and staff relationships • 8-3, page 7

Chapter 9

U.S. Army Pacific, page 8

Mission • 9-1, page 8

Functions • 9-2, page 8

Contents—Continued

Command and staff relationships • 9-3, *page 8*

Chapter 10

U.S. Army Special Operations Command, *page 9*

Mission • 10-1, *page 9*

Functions • 10-2, *page 9*

Command and staff relationships • 10-3, *page 9*

Chapter 11

Military Surface Deployment and Distribution Command, *page 10*

Mission • 11-1, *page 10*

Functions • 11-2, *page 10*

Command and staff relationships • 11-3, *page 10*

Chapter 12

U.S. Army Space and Missile Defense Command/Army Strategic Command, *page 11*

Mission • 12-1, *page 11*

Functions • 12-2, *page 11*

Command and staff relationships • 12-3, *page 12*

Chapter 13

Eighth Army, *page 12*

Mission • 13-1, *page 12*

Functions • 13-2, *page 12*

Command and staff relationships • 13-3, *page 13*

Chapter 14

U.S. Army Network Enterprise Technology Command/9th Signal Command (Army), *page 13*

Mission • 14-1, *page 13*

Functions • 14-2, *page 13*

Command and staff relationships • 14-3, *page 14*

Chapter 15

U.S. Army Medical Command, *page 15*

Mission • 15-1, *page 15*

Functions • 15-2, *page 15*

Command and staff relationships • 15-3, *page 16*

Chapter 16

U.S. Army Intelligence and Security Command, *page 16*

Mission • 16-1, *page 16*

Functions • 16-2, *page 16*

Command and staff relationships • 16-3, *page 18*

Chapter 17

U.S. Army Criminal Investigation Command, *page 18*

Mission • 17-1, *page 18*

Functions • 17-2, *page 18*

Command and staff relationships • 17-3, *page 19*

Chapter 18

U.S. Army Corps of Engineers, *page 20*

Mission • 18-1, *page 20*

Functions • 18-2, *page 20*

Command and staff relationships • 18-3, *page 21*

Contents—Continued

Chapter 19

U.S. Army Military District of Washington, page 21

Mission • 19-1, page 21

Functions • 19-2, page 21

Command and staff relationships • 19-3, page 22

Chapter 20

U.S. Army Test and Evaluation Command, page 22

Mission • 20-1, page 22

Functions • 20-2, page 22

Command and staff relationships • 20-3, page 23

Chapter 21

United States Military Academy, page 23

Mission • 21-1, page 23

Functions • 21-2, page 23

Command and staff relationships • 21-3, page 23

Chapter 22

U.S. Army Reserve Command, page 24

Mission • 22-1, page 24

Functions • 22-2, page 24

Command and staff relationships • 22-3, page 24

Chapter 23

U.S. Army Acquisition Support Center, page 24

Mission • 23-1, page 24

Functions • 23-2, page 25

Command and staff relationships • 23-3, page 25

Chapter 24

U.S. Army Installation Management Command, page 25

Mission • 24-1, page 25

Functions • 24-2, page 25

Command relationships and responsibilities • 24-3, page 26

Appendix A. References, page 27

Glossary

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

"Cure" for meeting on Friday (18 NOV 2013)

This is to advise you that the purpose of this investigation is to establish facts relating to the immunization practices at the CRDAMC Occupational Health Clinic. All personnel are expected to testify truthfully based on their own knowledge.

Any prior directive, instruction, or agreement to testify falsely or in an untruthful manner is not lawful and is void. Failure to respond truthfully to my question is ground for adverse disciplinary action.

Do you understand? Do you have any questions?

Were you present at a meeting with [redacted] on Friday (15 Nov 13) where documentation of work load or encounters was discussed?

Who if anyone else was present?

What time was this meeting held and where? Was this the only time you discussed this issue with [redacted] [redacted]?

What if anything was said by [redacted] at the meeting?

At any time during the meeting, were you instructed to give false or misleading testimony to me or any other investigator?

TAB 1



REPLY TO
ATTENTION OF:

DEPARTMENT OF THE ARMY
CARL R. DARNALL ARMY MEDICAL CENTER
36000 DARNALL LOOP
FORT HOOD, TEXAS 76544-4752

MCXI-CO

2 December 2013

MEMORANDUM FOR Personnel of Carl R. Darnall Army Medical Center

SUBJECT: Occupational Health Clinic Investigation

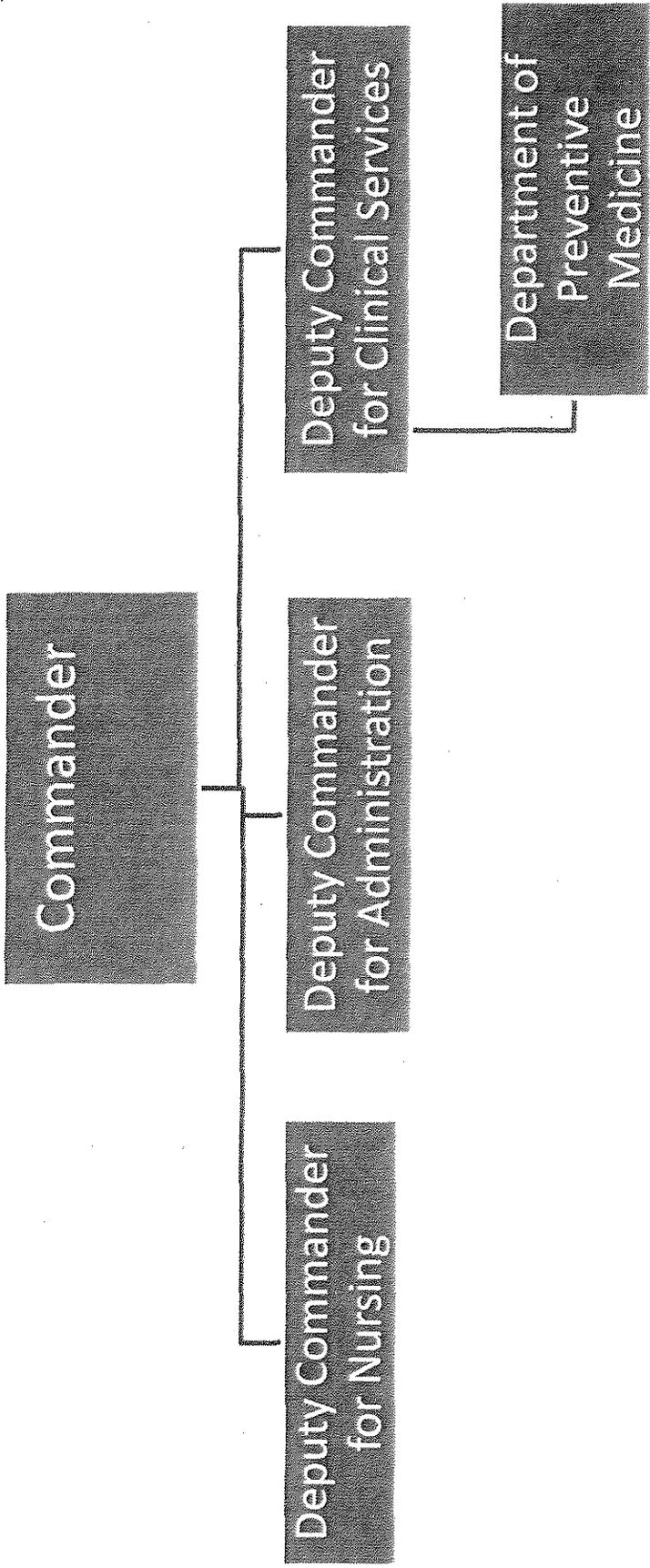
1. It has come to my attention that a member of this command may have attempted to discuss an ongoing investigation into allegations referred by the Office of Special Counsel (OSC) to the Army regarding the Occupational Health Clinic here at Darnall Army Medical Center with other employees who may be potential witnesses in this matter. As soon as this command became aware of this possible discussion, we temporarily suspended interviews with potentially affected witnesses. Our purpose in doing this was to ensure that we took appropriate action to address what may have occurred and to ensure that the testimony of any potential witness who may have been present during any discussions, participated in them, or even heard about them, was not improperly influenced. This letter is part of my personal outreach in this regard and I ask that you give this memorandum your close attention.
2. I expect that our investigation of the matters referred by OSC will restart in the Occupational Health Clinic beginning on Tuesday, December 3, 2013. I want you to know that I speak for the chain of command in its entirety in stating that we believe it imperative that all members of this command cooperate fully with the investigating officer. If we have a problem here at Darnall, we can identify and solve it only if each of us provides honest and candid information to the investigating officer. This investigation is an opportunity for us to do exactly that. Your truthful testimony is critical to ensuring that the investigating officer can make an accurate determination about the matters at issue.
3. Please be assured that no matter what you may or may not have heard about this investigation, there will be no negative or adverse consequences associated with providing truthful testimony to the investigating officer. If you have been previously contacted about this investigation or about your testimony, by anyone other than the investigating officer, or should you be contacted at any time in the future, I ask that you report this information immediately to the investigating officer.
4. If you feel that you have been reprimed against because of your truthful testimony to, and open cooperation with, the investigating officer, or if you feel that you are reprimed against at any time in the future, I ask and encourage you to report your concerns immediately to the investigating officer, the Office of Special Counsel at (b) (6), the Inspector General's Office at (b) (6) or to your chain of command.
5. Thank you for your attention to this important matter.

(b) (6)

COL, MS
Commanding

TAB 2

CRDAMC



TAB 3

Skip to Main Content

PAO — Medical Center Facts

Resources 128 surgical beds and bassinets (staffed)
2,453 staff members and employees (907 civilians, 609 military, 950 contractors, 95 volunteers)

Eligible Beneficiaries 177 counties north of Austin, TX
345,000 beneficiaries

Catchment Area 40-mile catchment area: 160,300 beneficiaries
(30% military, 38% family members, 32% retired military and their family members)
Serves 10% of the Army, 1/6 of Army pediatric population

Daily Averages
(Based on 5 days)

Encounters	4,258
Prescriptions	4,160
Lab tests	4502
ER visits	226
X-rays	5,140
Surgeries	19
Babies	8
Medical SRP	144
Daily Admissions	28
Average Daily Census	66.23

TRICARE 114,188 enrolled in the military health plan, TRICARE Prime

Additional Assets

- 9 Labor and Delivery Beds
- 24 Mother/Baby Unit Beds
- 24 MBU Bassinets
- 12 Neonatal ICU Beds
- 12 Pediatrics Ward Beds
- 8 Intensive Care Unit Beds
- 27 Medical/Surgical Beds
- 12 Psychiatric Ward Beds
- Video Teleconferencing, Telemedicine, Teleradiology, Telepathology
- Magnetic Resonance Imaging (MRI), CAT Scanner
- Level II Neonatal Intensive Care Unit (12 beds)
- Composite Health Care System (automated appointment and information system)
- Robertson Blood Center (largest in DoD)
- Offices for Red Cross, Inspector General, Patient Advocates
- Automated Medical Material Distribution System
- Pharmacy Robotics
- Affiliated with The Texas A&M University Health Science Center's College of Medicine
- Graduate Medical Education programs

Graduate Medical Education Programs

- Family Practice Residency Program
- Emergency Medicine Residency Program
- Affiliated GME: Internal Medicine & OB/GYN Residency Programs with Brooke Army Medical Center and Wilford Hall Air Force Medical Center



Phase II Certified Registered Nurse Anesthetist Program
5 primary care clinics, 4 Troop Medical Clinics, 22 specialty clinics

Tertiary Care

Brooke Army Medical Center, Wilford Hall Air Force Medical Center, surrounding civilian hospitals

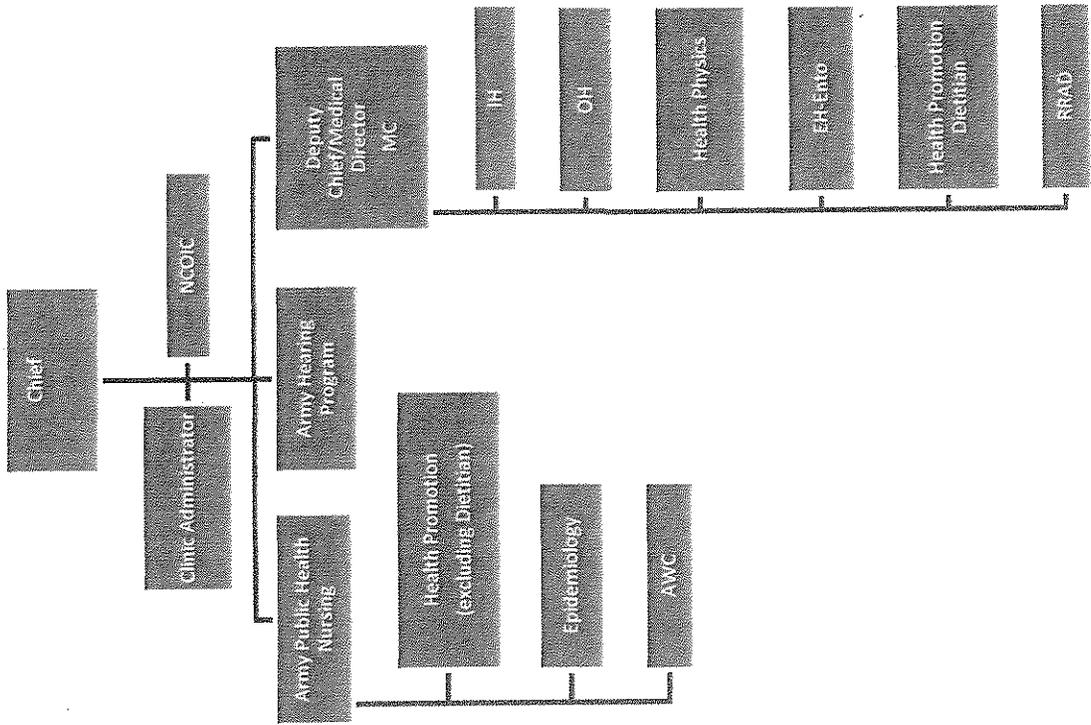
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page last modified on: 10/23/2013

36000 Darnall Loop Fort Hood, Texas 76544-4752 | Phone: (b) (6) Today is Saturday, December 28, 2013

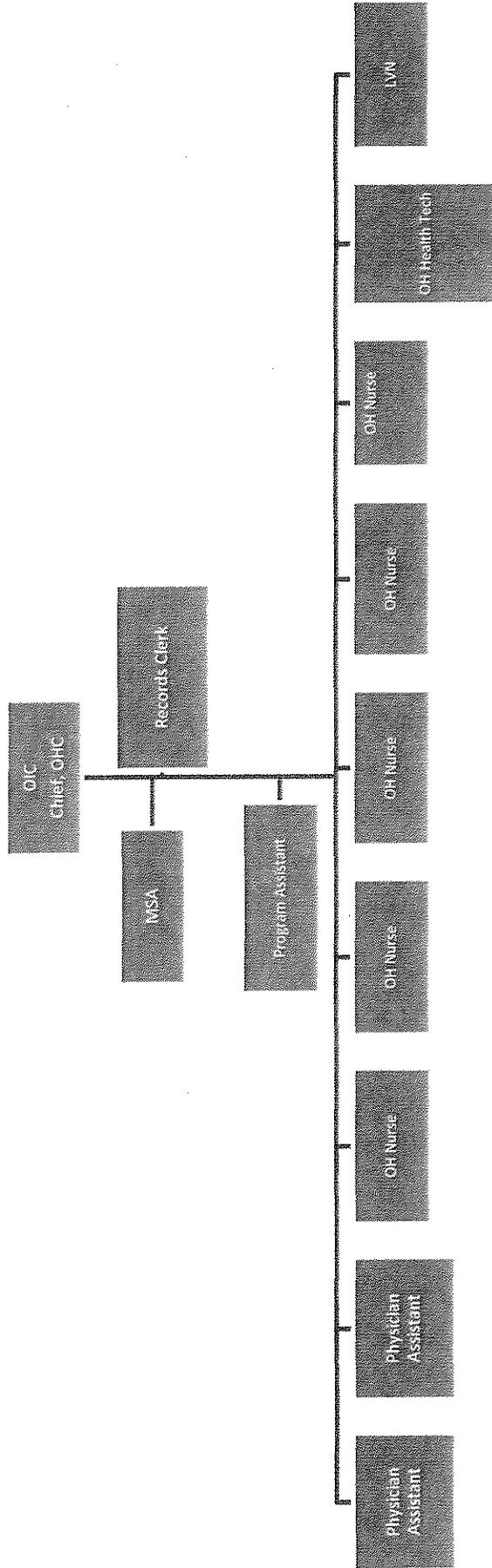
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Department of Preventive Medicine



TAB 5

Occupational Health Clinic



TAB 6

[Skip to Main Content](#)

Occupational Health Clinic — Fort Hood

Hours and Location

Contact Us		Hours of Operation
Main: (b) (6)		Monday – Friday: 7:00 a.m. – 11:00 a.m. and Noon (12:00 p.m.) – 4:00 p.m.
FAX: (b) (6)		
Location		
Building 36001 Across from the Emergency Department Fort Hood, TX 76544		

Services and Eligible Personnel

Pre-placement and annual health assessments:

- For Department of the Army and Non-Appropriated Fund Civilians

Job Injury Reporting:

- For civilian employees assigned to Medical, Dental, and VETCOM Activities only
- All other Department of the Army civilian employees must contact the Civilian Personnel Advisory Center
- Contract employees must contact their employers

Workers Compensation Claims:

- Department of the Army Civilians who work for the Medical and Dental Activities file claims with their immediate supervisor. Employee then should take original signed copy to CPOC and bring a copy to Occupational Health.
- Non-Appropriated Fund and other Department of the Army Civilians file claims at the Civilian Personnel Advisory Center
- Contract employees file claims with their employers

Pregnancy Surveillance:

- All pregnant soldiers, Department of the Army Civilians and Non-Appropriated Fund employees attend a briefing to have their work evaluated to ensure a safe work environment during their pregnancy. Classes are held every Thursday at 10:00 am at the Occupational Health Clinic.

Respirator Clearance:

- All of Fort Hood Department of the Army Civilians and Non-Appropriated Fund employees and Medical Activity active duty receive medical evaluations prior to respirator fit testing.

Sharps/Splash Injuries:

- In the event of a splash/sharp injury, the employ should notify the supervisor and report to the emergency room department with the completed Staff Incident/Injury Report- CRDAMC Form 413 (REV) within one hour of the incident.
- All of Fort Hood Active Duty, Department of the Army Civilians and Non-Appropriated Fund employees receive counseling and are followed at 6 weeks, 3 months, and 6 months after a contaminated sharp or splash injury.

Worksite/Ergonomic Evaluations

- All of Fort Hood Department of the Army Civilians and Non-Appropriated Fund employees and Medical Activity active duty may request a worksite or ergonomic evaluation.

What We Do

The Occupational Health Clinic works to reduce the risk and incidence of work related illnesses and injuries for Department of Defense personnel at Fort Hood by focusing on three areas:

- Primary Prevention – Prevention of exposures that cause occupational illnesses or injuries.
- Secondary Prevention – Early intervention strategies to prevent at-risk individuals from developing clinical symptoms or diseases.
- Tertiary Prevention – The detection and limitation of nonreversible health effects.

The Occupational Health Clinic performs many functions, including:

- Medical surveillance and interventions
- Pre-employment physicals
- Health hazard education
- Vision conservation
- Immunizations and prophylaxis



- Reproductive health
- Epidemiological investigations
- Data collection
- Deployment readiness, planning and support
- Worker's compensation
- Worksite evaluations
- Counseling and education for sharps/splash injuries
- Hearing conservation
- Respirator medical clearance
- Laser surveillance
- Injury prevention and control
- Chronic disease education and prevention
- Recordkeeping and reporting

Data Acquisition and Health Maintenance

Integrated Occupational Health Information for assessing the worker and worker population. Employees are encouraged to schedule an appointment on their birth month for an annual evaluation. This evaluation includes:

- Hearing conservation
- Vision screening
- Immunizations
- Vital signs
- Laboratory testing
- Pulmonary function testing
- Radiology reports

Sharp/Splash Injuries

- When a sharps or splash injury occurs go to the emergency department at CRDAMC within one of the incident. Active Duty and Department of the Army Civilians should follow-up with the Occupational Health Clinic (OHC) within 72 hours of the incident. Please bring the completed CRDAMC Form 413 (Rev) and the source patient's information. Contracting employee's follow-up with their contracting employers.

Data Analysis And Intervention

Follow-up exams and testing will be scheduled as necessary

Worksite Health Hazard Evaluation

- Pregnancy Surveillance
- Ergonomics
- Hazardous/Medical Waste
- Worksite Visits - When notified of a potential worksite hazard, Occupational Health and Industrial Hygiene personnel visit the site to identify the hazard and recommend corrective action.

page last modified on: 10/11/2013

36000 Darnall Loop Fort Hood, Texas 76544-4752 | Phone: (b) (6) | Today is Saturday, December 28, 2013

This website contains official Government information

DEPARTMENT OF ARMY
HEADQUARTERS, CARL R. DARNALL U.S.ARMY MEDICAL CENTER
36000 DARNALL LOOP
FORT HOOD, TX 76544-4752

MCXI-DPM-OH

18 November 2013

MEMORANDUM FOR RECORD

SUBJECT: Five year Roster of OHC with Access to Immunization Room.

1. The following personnel have had access to the Immunization Room:

a. PRIMARY:

LVN1 [REDACTED]

b. ALTERNATES:

PA1 [REDACTED]
PA2 [REDACTED]
RN3 [REDACTED]
LVN2 [REDACTED]
RN4 [REDACTED]
RN5 [REDACTED]
RN2 [REDACTED]
RN1 [REDACTED] (No longer at OCC Health)
(b) (6) [REDACTED] RN (No longer at OCC Health)

c. SUPERVISORS

Chief, OHC [REDACTED]
MAJ (b) (6) [REDACTED] PA (No longer at OCC Health)
(b) (6) [REDACTED] NP (No longer at OCC Health)
(b) (6) [REDACTED] (No longer at OCC Health)

2. POC for this memorandum is the undersigned @ (b) (6) [REDACTED]

Chief, OHC
[REDACTED]

Chief, Occupational Health

TAB 8

Current

DEPARTMENT OF ARMY
HEADQUARTERS, CARL R. DARNALL U.S. ARMY MEDICAL CENTER
36000 DARNALL LOOP
FORT HOOD, TX 76544-4752

MCXI-DPM-OH

4 September 2013

MEMORANDUM FOR RECORD

SUBJECT: Access to Occupational Health Clinic Immunization Room and Sharps.

1. The following personnel have unrestricted access to the Immunization Room:

a. PRIMARY:

LVN1

b. ALTERNATES:

PA1

PA2

RN3

LVN2

RN4

RN5

RN2

2. POC for this memorandum is the undersigned @ (b) (6)

Chief, OHC

Chief, Occupational Health

(b) (6)

LUNA (b) (6)

Position Description

PD#: EF276085

Replaces PD#:

Sequence#: 1420029

PRACTICAL NURSE

GS-0620-05

Servicing CPAC: FORT HOOD, TX

Agency: ARMY

Installation: EFMCW2M5AASZC

MACOM: MEDCOM

MEDCOM
CRDAMC
DEPARTMENT OF PREVENTIVE MEDICINE
OCC HLTH SVC
FORT HOOD, TX 76544 SZC

Command Code: MC
US ARMY MEDICAL
COMMAND

Region: WEST

Citation 1: OPM PCS MEDICAL, HOSPITAL, DENTAL & PUBLIC HEALTH GROUP, MAY 2001

PD Library PD: NO

COREDOC PD: NO

Classified By: LTC (b) (6)

Classified Date: 03/10/2008

FLSA: NON-EXEMPT

Drug Test Required: YES *

DCIPS PD: NO

Career Program: 00

Financial Disclosure Required: NO

Acquisition Position: NO

Functional Code: 00

Requires Access to Firearms:

Interdisciplinary: NO

Competitive Area: FD

Position Sensitivity: 2

Target Grade/FPL: 05

Competitive Level: 0000

Emergency Essential: N

Career Ladder PD: NO

Bus Code: 5130

PD Status: VERIFIED

Duties:

Performs paraprofessional nursing duties in the Occupational Health (OH) Program. Functions to facilitate the rapid administrative processing of employees of Fort Hood with medical screening; surveillance, placement, pre-placement, retirement, termination and fitness for duty exams. Measures height and weight, takes blood pressure and pulse on scheduled patients and as requested by the Occupational Health Physician (OHP) in a timely manner. Performs spirometry, audiograms, visual acuity, color exams and administers immunizations. Maintains clear daily calibration records on spirometer, and audiometer. Is able to identify those employees working in areas with eye hazards who are eligible for safety glasses (Special Interest Group S). Coordinates between EENT, OH, and logistics in obtaining S/G. Maintains accurate log of employees needing SIG, orders, arrivals, and picked up by

7169a

employee distribution. Refers for further evaluation, employees who do not meet minimal visual standards to their civilian optometrist or ophthalmologist. Annually reviews with supervisor the Installation Eye Conservation Regulations. Notifies receptionist if patient needs follow-up audiogram or appointment with audiologist. Completes consult (SF 513) for OHP review prior to audiologist referral. Refers employees to military audiologist when appropriate. Ability to use otoscope to examine ear canals for the possibility of blockage of the ear canal, or for the presence of a reddened canal. Orders, obtains and maintains supplies and equipment for Occupational Health. Participates in Health Fairs when scheduled in various roles. Functions as a team member conferring with Occupational Health Nurse (OHN) and OHP on a daily basis for test results not within normal limits, concerns, problems, and time away from duties. Fits ear plugs and records type of protections used. Reviews health history using responses to SF 93 items when requested by OHP. Attends training sessions as approved by the OHP or OHN to maintain skills as required by OSHA and DA. Out of state travel for training and medical surveillance of more than a day possible. Initiates and maintains records IAW AR 40-66. Records immunization, files lab, dosimetry badge reports, and workman's compensation forms. Enters clinic information into Composite Health Care System computer and Defense Occupational & Environmental Health Readiness System (DOEHRS). Assists in record maintenance and information management of FECA Workmans Compensation claims through EDI. Assist in developing, organizing, and conducting Occupational Health Programs. HRA counseling.

100%

PERFORMS OTHER DUTIES AS ASSIGNED.

NOTE: Maintains National Institute of Occupational Safety & Health (NIOSH) approved spirometry certification.

NOTE: Individual must be licensed to administer immunizations.

NOTE: Knowledge and skill is reflected by a current license to practice as a practical or vocational nurse in a State or Territory of the United States or the District of Columbia with at least one year of nursing experience.

FACTOR 1 KNOWLEDGE REQUIRED BY THE POSITION FL 1-3 350 PTS

Knowledge of basic practical nursing procedures, terminology and record keeping procedures to record information in employee records as needed.

Knowledge of cardiopulmonary resuscitation.

Knowledge and skill sufficient to understand and describe the human body structure, function, illnesses and diseases, and skill sufficient to communicate with patients, medical staff and family members.

Knowledge and skill sufficient to give injections for immunizations.

Ability to take medical histories, Able to complete the Master Problem List and review and complete the Immunization Record (SF 60 1).

Ability to operate an Audiometer, Orthorater, Titmus, Spirometer, IVAC Vital Check, and computer. Skill to perform supporting administrative and clerical procedures (e.g., prepare reports, forms and request documents). Ability to work in the Composite Health Care System (CHCS) computer and DOEHRs system.

Ability to provide individual health education regarding the hearing Conservation Program

and other health education previously approved by the Program Director.

Knowledge of Occupational Health and Safety Administration (OSHA) and Department of the Army (DA) standards.

Knowledge and skill in performing a variety of procedures in support of Occupational Health (OH), to include height, weight, blood pressure, pulse, hearing, vision, and pulmonary testing.

FACTOR 2 SUPERVISORY CONTROLS FL 2-2 125 PTS

Works under the general supervision of the Occupational Health Nurse and Program Manager. Routine recurring duties are performed independently within established guidelines. Work is reviewed by observation, evaluation of patient satisfaction, and timeliness and efficiency of care provided to employees and co-workers.

FACTOR 3 GUIDELINES FL 3-2 125 PTS

Guidelines used include instruction for the Program Director, Industrial Hygienist, Supervisor, OSHA guidelines, DA regulations, Audiologist, client medical histories, and procedural manual. Employee varies the order and sequence of procedures and uses judgment in selecting the most appropriate application of the guidelines based on the patient's job and hazards. Unusual developments are referred to the Supervisor and/or Program Director.

FACTOR 4 COMPLEXITY FL 4-2 75 PTS

Work involves a number of related steps including taking blood pressure, evaluating the blood pressure to determine if a Pulmonary Function Test (PAT) can be done. Screening employees for eligibility for safety glasses, i.e., hearing test, and using otoscope to verify the patency of the external ear canal. Cleaning and disinfecting equipment. Coordinating with the EENT Clinic for safety glass eye exams, and with logistics for the ordering, return, and distribution of glasses. Involves performing follow-up audiograms at 15 and 40 hour noise free, and notification of supervisors about employees with hearing loss.

FACTOR 5 SCOPE AND EFFECT FL 5-2 75 PTS

The purpose of the work is to assist the OH staff in the medical screening, placement, and pre-placement examinations and medical surveillance evaluations. The results of this work can influence the retention, dismissal or medical retirement of an employee. It also has a profound effect on the general health of the employees, especially those working in hazardous areas. This work facilitates the mission of the OH section and contributes to the good health and welfare of all employees.

FACTOR 6&7 PERSONAL/PURPOSE OF CONTACTS FL 2B 75 PTS

Contacts are with employees, Supervisors, Active Component, National Guard (NG) and U S. Army Reserve (USAR) members, Audiologist, Optometrist and Ophthalmologists, Civilian Personnel officials, professional and paraprofessional personnel (e.g., physicians, nurses, dietitian, supply personnel, etc.).

Contacts with employees are to perform health evaluations by recording blood pressure, pulse, audiometry, spirometry, visual acuity, and color vision testing. Contact with Active Component, NG and USAR is done for the purpose of bringing those persons to Fort Hood Occupational Health for medical surveillance. Audiologist, Optometrist, or Ophthalmologist is for referral for employees who are, below the standard in their test results.

FACTOR 8 PHYSICAL DEMANDS FL 8-2 20 PTS

The work involves standing and bending in the process of performing the hearing, vision, and breathing test. In demonstrating for instructing the employee, re: Spirometry testing; a long sustained breath is exhaled. Prolonged standing while doing spirometry. Hearing testing is done in another clinic so that scheduling and coordination are needed, plus absence from the duty clinic is common.

FACTOR 9 WORK ENVIRONMENT FL 9-2 20 PTS

The work requires job site visits, carrying retiring and terminating records to CPO, exposure to contagious diseases is possible, and the potential of hazards while doing site work visits.

TOTAL POINTS: 865

POINT RANGE: 855-1100

GS-05

* This position is subject to drug testing if the incumbent:

1. Has direct patient contact or performs diagnostic or therapeutic functions
2. Extracts or works with patients' body fluids or tissues; prepares patient specimens for examination, performs specialized or non-routine tests on body fluids or tissue samples, or confirms patients' test results
3. Maintains, stores, safeguards, inputs, fills or distributes drugs and medicines

Evaluation:

Not Listed

(b) (6)

(LVN2)

Export to MS Word

Position Description

PD#: EF397129

Replaces PD#:

Sequence#: VARIES

OCCUPATIONAL HEALTH TECHNICIAN

GS-0640-07

Servicing CPAC: FORT HOOD, TX

Agency: VARIES

Army Command: VARIES

Command Code: VARIES

Region: WEST

Citation 1: OPM PCS HLTH AID & TECHNICIAN SERIES, 640, SEP 88

Citation 2: OPM PCS MEDICAL, HOSPITAL, DENTAL & PUBLIC HEALTH GROUP, MAY 2001

Classified By: COL (b) (6)
(b) (6)

Classified Date: 05/01/2012

FLSA: NON-EXEMPT

FLSA Worksheet: NON EXEMPT

FLSA Appeal: NO

Drug Test Required: VARIES

DCIPS PD: NO

Career Program: VARIES

Financial Disclosure Required: NO

Acquisition Position: NO

Functional Code: 00

Requires Access to Firearms: VARIES

Interdisciplinary: NO

Competitive Area: VARIES

Position Sensitivity: VARIES

Security Access: VARIES

Competitive Level: VARIES

Target Grade/FPL: 07

Career Ladder PD: NO

Emergency Essential:
[]

Bus Code: VARIES

Personnel Reliability Position: VARIES

Information Assurance: N

Influenza Vaccination: YES

Army Enterprise Position: VARIES

Supervisor Status: VARIES

Position Designation: VARIES

PD Status: VERIFIED

Position Duties:

This position is located in the Occupational Health Clinic, Carl R. Darnall Army Medical Center (CRDAMC), Fort Hood, Texas which is one of the most complex and challenging referral centers in the Department of Defense (DOD). The incumbent provides routine Occupational Health (OH) care for all employees of the hospital, the garrison, and tenant units. Duties are related to the identification and evaluation of conditions in the work place which may

78696

adversely affect the health of employees. Duties include patient and staff education and specialized care delivery. Incumbent performs a variety of screening tests in support of the Occupational Health Program for civilians and military personnel to include updates Occupational Health related databases.

SUPERVISORY CONTROLS:

The incumbent works for the Chief, Occupational Health Clinic in collaboration with the entire clinic staff. The incumbent is expected to independently accomplish administrative duties with recourse to supervisors only in unusual circumstances. Work is evaluated on the basis of the job description, annual competency review, and daily performance of administrative and technical nursing duties. After selection incumbent must complete hearing conservation training with Preventive Medicine's Hearing Conservation section.

MAJOR DUTIES

The incumbent serves as the Occupational Health Technician for CRDAMC Occupational Health Clinic. Performs a variety of duties that require understanding of human anatomy and physiology in the performance of multiple occupational health screening functions. Screens adult employees to obtain and review medical and occupational health histories, updates employee medical records through use of written documentation, conducts tests, conducts screenings and examinations; assists professional staff in health education programs and medical surveillance programs; advises on use and care of protective equipment; schedules appointments as required; answers phones. Reviews pertinent data and determines requirements for ancillary testing.

30%

Triages patients as they arrive and coordinates patient flow throughout the clinic. Performs screening utilizing computer-linked equipment for vision screening, obtains vital signs and height/weight measurements; evaluates patient, and refers patients to the nurse, physician's assistant or physician as indicated. Advises the Occupational Health Nurse or other provider of any situations requiring immediate attention. In the absence of nurse or provider, acts promptly and thinks clearly in the case of medical emergency. Provides first aid care for diagnoses including, but not limited to abrasions, minor burns, and dressing changes. Assists providers in direct physical examinations, minor procedures, emergency care to include CPR, and other clinical duties. Documents all pertinent data in the medical record and maintains medical records in accordance with applicable regulations.

30%

Counsels patients regarding test results, health promotion topics and workplace health hazards. Deals with difficult (angry, frustrated, defensive, argumentative) clients in a tactful, professional and efficient manner. Provides patient privacy at all times. Coordinates Occupational Health issues with employees, Safety personnel, Industrial Hygiene, Civilian Personnel and supervisors. Performs worksite visits in conjunction with other Occupational Health providers. Responsible for the safe and effective operation of medical equipment and contributes to a safe working environment. This includes safe practices of emergency procedures, proper handling of hazardous materials and maintaining physical security. Responsible for compliance with infection control guidelines and practicing standard precautions.

20%

Provides orientation to new Occupational Health Technicians and administrative staff working in the Occupational Health Clinic. Provides administrative support including; patient scheduling, database management, compilation of statistical reports, supply ordering, maintenance of medical records, logs and tracking systems, initiation of monthly chart audit,

and distribution of monthly reports.
20%

PERFORMS OTHER DUTIES AS ASSIGNED.

NOTE: THIS POSITION IS A TESTING DESIGNATED POSITION (TDP) SUBJECT TO APPLICANT TESTING AND RANDOM DRUG TESTING. APPLICANTS WITH VERIFIED POSITIVE TEST RESULTS SHALL BE REFUSED EMPLOYMENT.

NOTE: THIS POSITION HAS A MANDATORY SEASONAL INFLUENZA VACCINATION REQUIREMENT AND IS, THEREFORE, SUBJECT TO ANNUAL SEASONAL INFLUENZA VACCINATIONS.

FACTOR 1 KNOWLEDGE REQUIRED BY THE POSITION FL 1-5 750 PTS

Knowledge of a variety of accrediting agency policies, procedures and requirements such as JCAHO, OSHA, Department of Army, MEDCOM, and CRDAMC regulations. Comprehensive knowledge of the Army Occupational Health programs that include various medical surveillance programs. Must possess the ability to use judgment when placing employees in surveillance programs.

Broad general knowledge of professional healthcare principles and procedures and their applications in the occupational health clinic setting. Ability to interpret Industrial Hygiene reports.

Knowledge of diseases and illnesses (such as diabetes and hypertension) sufficient to identify conditions requiring referral to an advanced care provider. Must be able to recognize impending emergencies such as heart attacks, seizures, hyperventilation, anaphylaxis, and pulmonary distress. Must be able to perform emergency first aid until additional medical support arrives. Maintains current Basic Life Support (BLS) certification. Knowledge of patient triage.

Ability to use specialized medical equipment and perform screening tests: pulmonary function tests, and various vision screening tests. Knowledge of established normal values. Technical proficiency in the safe operation and calibration of various pieces of specialized medical equipment.

Ability to assess and interpret vital signs and laboratory results. Knowledge of abnormal and critical values and appropriate interventions. Knowledge of medical-legal documentation and record-keeping requirements. Ability to function independently, and as a member of the healthcare team.

Knowledge of health promotion and wellness principles and ability to provide counseling on healthy lifestyles. Must take into consideration the age, mental, emotional, and social factors of the patient.

Ability to collect, organize, record and communicate, in a meaningful way, data relevant to primary health assessments including a detailed family, medical and occupational exposure history, a physical examination and selected special tests or studies. Ability to communicate both orally and in writing with all levels of staff. Knowledge of principles of good customer service, telephone courtesy, and taking accurate phone messages.

Knowledge and skill in utilizing computers for input/retrieval of medical information (i.e. CHCS, ADS, AHLTA, DOEHRIS, and MEDPROSE. Knowledge of the proper procedures for

handling, storage and disposal of infectious waste. Knowledge of various precautions procedures to prevent the spread of infections. Knowledge of the requirements specified in the Infection Control Manual.

Knowledge of the general procedures for safe work performance, including general safety procedures, identification, handling and storage of hazardous material, physical security and the reporting of incidents.

FACTOR 2 SUPERVISORY CONTROLS FL 2-3 275 PTS

Works under the supervision of the Chief, Occupational Health who assigns the work by defining the objectives and priorities. Independent judgment is used to solve most problems, receiving assistance only in unusual situations. Completed work is reviewed for appropriateness and adherence to policies and procedures.

FACTOR 3 GUIDELINES FL 3-2 125 PTS

Functions within the established guidelines of the Occupational Health Program, Department of Army, MEDCOM and CRDAMC. Significant deviations from these must be authorized in advance. The technician uses independent judgment to identify, select and implement the most appropriate guide for the application to specific cases.

FACTOR 4 COMPLEXITY FL 4-3 150 PTS

Performs a wide variety of duties of a technical nature including performance of various screening tests, patient assessments, triage, and health education. This involves the blending of established procedures with independent judgment and decision making in the evaluation of each patient and the analysis of work history and workplace hazards.

FACTOR 5 SCOPE AND EFFECT FL 5-3 150 PTS

Services provided are vital elements in the success of the CRDAMC Occupational Health program and readiness. The services also directly affect the health of Department of Army employees.

FACTOR 6&7 PERSONAL/PURPOSE OF CONTACTS FL 2B 75 PTS

Contacts are with military/civilian employees and their supervisors; management officials at the installation, Safety, CPO, Industrial Hygiene and with various medical professionals, including higher level officials outside the agency.

Contacts with patients are for the purpose of eliciting compliance with medical surveillance or job certification requirements, providing counseling on workplace health hazards, reinforcing safety practices, promoting healthy behaviors, and assisting with triage and treatment of occupational medical problems. Occasionally the patients are upset, nervous or uncooperative. These are skills required to gain their cooperation and explain procedures. Contacts with Medical Departments, Safety, Industrial Hygiene, supervisors and civilian personnel staff are for coordinating the care of the patients or for problem solving.

FACTOR 8 PHYSICAL DEMANDS FL 8-2 20 PTS

The work requires considerable standing, walking, sitting, bending and some moderately heavy lifting (i.e. assisting patients). May occasionally include climbing of ladders and circumventing of obstacles. Must be able to hear, have use of fingers and hands and have rapid mental and muscular coordination to simultaneously operate emergency equipment (life

support) if needed. Emotional stability and intense concentration is required while maintaining composure in stressful situations.

FACTOR 9 WORK ENVIRONMENT FL 9-2 20 PTS

Work is usually conducted in a health care setting that is adequately lighted, heated, and ventilated but may require some outside work during worksite safety visits. There is occasional exposure to infectious diseases and potential safety hazards including slippery or uneven walking surfaces, hazardous chemicals and waste. Must follow infection control guidelines and wear personal protective equipment as required and provided by the employer.

TOTAL POINTS: 1565
POINT RANGE: 1355-1600
GRADE: GS-07

GS-08 1600

This position has a mandatory seasonal influenza vaccination requirement and is therefore subject to annual seasonal influenza vaccinations. Applicants tentatively selected for appointment to this position will be required to sign a statement (Condition of Employment) consenting to seasonal influenza vaccinations.

Fair Labor Standards Act (FLSA) Determination = (NON EXEMPT)

FLSA Comments/Explanations:

DOES NOT FULLY MEET ANY OF THE EXEMPTION CRITERIA.

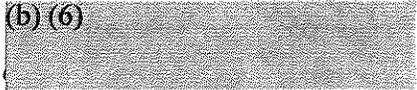
Position Evaluation:

Not Listed

Position Competencies:

6
7
8
9

(b) (6)



RN3

Export to MS Word

Position Description

PD#: EF80135

Replaces PD#:

Sequence#: 2418076

CLINICAL NURSE (COMM-OCC HEALTH)

GS-0610-10

Servicing CPAC: FORT HOOD, TX
Installation: EFMCW2M5AATABQF
MEDCOM
CRDAMC
OFC OF THE DCCS
CHIEF DEPT OF PREVENTIVE MED
OCC HLTH CLIN SVC
FORT HOOD, TX 76544 TABQF

Agency: ARMY
Army Command: MC
Command Code: MC
US ARMY MEDICAL
COMMAND
Region: WEST

Citation 1: OPM PCS NURSE SERIES, GS-610, JUN 77

Classified By: HOOD

Classified Date: 10/31/1997

FLSA: EXEMPT

FLSA Worksheet:

FLSA Appeal: NO

Drug Test Required: AGENCY
REQ DRUG TEST OF INCUMBENT
(TIER ONE) *

DCIPS PD: NO

Career Program: 53

**Financial Disclosure
Required:** NO

Acquisition Position: NO

Functional Code: 81

**Requires Access to
Firearms:** NO

Interdisciplinary: NO

Competitive Area: FD

Position Sensitivity:
NONSENSITIVE (NS)
NATIONAL SECURITY RISK

Security Access: No Access
Required; ENTNAC/NAC

Competitive Level: 0A00

Target Grade/FPL: 10

Career Ladder PD: NO

Emergency Essential: No

[N: Position Not Designated
Emergency-Essential Or Key]

Bus Code: 8888

**Personnel Reliability
Position:** Not Valid PRP Code

Information Assurance: N

Influenza Vaccination: YES

Army Enterprise Position:

Supervisor Status: Non-
Supervisory

Position Designation:

PD Status: VERIFIED

Position Duties:

CL: 0A00



Assists in coordination and implementation of the Occupational Health Program (OHP) for Fort Hood, ensuring the objectives of the OHP as mandated in AR 40-5 are met within available resources and that federal, state, local and OSHA regulatory guidance are also met within these same resources. Provides a wide range of professional nursing and health care services, counseling, education and training to the military and civilian workforce relative to their occupations and working environments, to include the care and treatment of employee illnesses and injuries. The total authorized military strength is excess of 45,000 including tenant and support forces and there is a 5000 member civilian workforce. The OHP includes but is not limited to the following programs: coordination with the Industrial Hygiene (IH) Office and III Corps Safety Office in the identification of personnel exposed to environmental and physical hazards; the performance of preplacement, administrative, retirement and job related health assessments; reproductive hazards (pregnancy surveillance); chronic disease detection; hearing and vision conservation; respiratory protection; asbestos surveillance; radiation protection; bloodborne pathogen exposure; immunizations; evaluation of occupational illness/injury and referral as appropriate; job-related medical surveillance; counseling services for military and civilian personnel; job-related hazard and general health education; work-site visits/evaluations; ergonomic evaluations; epidemiological investigations; Occupational Health Management Information System (OHMIS) support. Independently accomplishes work using professional judgment in carrying out duties.

Develops goals, objectives, standards and policies for assigned segments of the OHP. Collaborates with the supervisor, OH to ensure the occupational health services provided are in accordance with medical, legal and regulatory requirements.

Performs health assessments for preplacement, retirement, disability, and job related medical surveillance and uses professional judgment to make recommendations for proper placement consistent with job requirements. Obtains health and occupational history and determines if health of employee is or will be compromised by the functional or environmental requirements of job. Recognizes physical, emotional or mental problems that could compromise the health and safety of the individual or his/her co-workers during the performance of duties. Independently determines and orders tests appropriate to job-hazard, health history and occupational history, interprets results, discusses/interprets findings with employee, initiates follow-up if indicated and makes referral to appropriate specialty clinic or primary health care provider as appropriate. Conducts pulmonary function tests and vision screening tests, interprets results and refers to appropriate specialty if needed. Performs Respirator Clearance Exams, i.e., auscultates chest for heart and lung sounds, inspects tympanic membrane for perforation, performs pulmonary function tests, reviews results and determines if employee is physically capable of wearing a respirator. Coordinates with facility managers to ensure that employees are provided appropriate personal protective equipment.

Provides emergency care or crisis intervention including life saving emergency procedures in order to stabilize a patient for transport to the nearest MTF.
45%

Conducts studies and surveys of work sites. Applies basic knowledge of IH and toxicology principles to recognize health hazards in the work environment, i.e. how the hazard enters the body and what body systems or target organs may be affected. Determines appropriate medical tests/evaluation specific to the workplace hazardous exposure for early detection of job-related disease and prevention of further insult to the employee's health. Makes proper recommendations for corrective actions within the worksite and coordinates these actions with IH, Safety, DPW, etc., when appropriate.

Conducts investigations of individual work sites of pregnant personnel to identify any environmental or physical hazards which might be detrimental to the developing fetus or well-being of the mother. Reports findings, with recommendations, to the OH supervisor and

the employee's personal physician.

Performs ergonomic investigations and epidemiological studies. Collects and analyzes data and uses professional knowledge to make recommendations for the development, expansion or improvement of health programs and/or worksite modifications.

30%

Plans and implements formal and informal health education programs and individual/group counseling. Develops occupational health educational materials and training programs to promote awareness of health hazards and to assist Fort Hood in complying with federal law (e.g., bloodborne pathogen training, tuberculosis, hearing conservation, respiratory protection, immunizations, etc.). Uses professional judgment to determine the level of understanding of each audience and adjust the teaching methods and course material accordingly.

15%

Ensures proper initiation, maintenance and disposition of employee medical records.

5%

Performs a variety of automation duties that include all the functional aspects of the automated occupational health surveillance system known as OHMIS. Inputs and retrieves data, produces statistical graphs, tables, trend analysis and a variety of reports. Supports and actively participates in the Performance Improvement (PI) program.

5%

PERFORMS OTHER DUTIES AS ASSIGNED.

NOTE: THIS POSITION IS COVERED BY THE CIVILIAN DRUG ABUSE TESTING PROGRAM. INCUMBENT IS REQUIRED TO SIGN A DA FORM 5019-R, AND/OR DA FORM 7412 "CONDITION OF EMPLOYMENT FOR CERTAIN CIVILIAN POSITIONS IDENTIFIED AS CRITICAL UNDER THE DRUG ABUSE TESTING PROGRAM," OR A MEMORANDUM OF UNDERSTANDING (MOU).

NOTE: MAINTAINS CURRENT NURSING LICENSE, CPR CERTIFICATION AND BMAR TRAINING.

FACTOR 1 KNOWLEDGE REQUIRED BY THE POSITION FL 1-7 1250 PTS

Professional knowledge of a wide range of nursing concepts, principles and practices; industrial hygiene, safety, ergonomics, toxicology, epidemiology, management; allied disciplines; and current adult nursing theory and practice which enables the OHN to independently perform nursing assignments and procedures for worker populations.

Knowledge and skill to illicit medical and occupational histories and conduct health assessments; sound medical and professional judgment in interpreting results and determining the need for additional diagnostic procedures and/or referral.

Knowledge of adult epidemiology and prevention of vaccine-preventable diseases and skill in the administration of vaccines.

Skill to interact with other medical professionals, commanders, civilian and military groups, civilian and public health agencies in coordinating patient care, disease and injury control, and workforce education groups.

Knowledge of pharmacology dosage, administration and side effects of medications.

Thorough knowledge of anatomy and physiology of organ systems and the ability to recognize normal from abnormal.

Ability to distinguish normal from abnormal laboratory findings.

Knowledge and skill to recognize health hazards in the work environment; routes of exposure of hazardous chemicals/compounds and target organs affected by these substances and to determine the appropriate evaluation/test specific to body organ/chemical relationship.

Knowledge of the appropriate personal protective equipment required for specific hazards.

Knowledge of the directives governing the care and treatment of authorized civilian and military personnel and of pertinent governmental regulations and policies requiring compliance.

Ability to operate and maintain specialized testing equipment and interpret results.

Knowledge of educational theory/practice and skill in a variety of teaching approaches specific to learning needs of employees at all levels of experience and education, i.e., high school grad or less, manager/administer level, groups and individuals, Ability to recognize and prepare for level of education/understanding of target audience is critical.

Knowledge and skill in counseling techniques and behavior modification is fundamental to the achievement of the health goals of employees contacted.

Knowledge and skill in planning, implementing, coordinating, and evaluating delegated programs.

Knowledge and skill in the operation and maintenance of computer systems to perform data entry/retrieval and to prepare reports.

FACTOR 2 SUPERVISORY CONTROLS FL 2-3 275 PTS

Receives general supervision from the Occupational Health Supervisor who: (1) defines overall objectives within the available resources; (2) relies on the incumbent to independently plan, coordinate, and perform assigned tasks; to establish/adjust schedules to complete tasks in a timely manner and to resolve most problems on own initiative. However supervisor is available to provide advice and guidance as needed and to discuss progress of assigned area of responsibility and reviews work for effectiveness in meeting program goals, objectives, and requirements; reviews reports and records for professional adequacy and soundness of judgment.

FACTOR 3 GUIDELINES FL 3-3 275 PTS

Works within a framework of established medical directives, MEDDAC, MEDCOM and DA policies/regulations, clinic SOP's, federal, state and local laws, Army Regulations, OSHA standards, and information provided through actual surveys and inspections.

Independent professional judgment is required to select and apply the guidelines appropriate to the situation in developing recommendations for the OHP; in recognizing deviations from criteria established as normal; in determining the extent of seriousness of illness, injury, or potential health problems and whether referral to a physician or other medical facility is appropriate.

FACTOR 4 COMPLEXITY FL 4-3 150 PTS

The work is an independent assignment requiring the nurse to combine a wide range of professional and organizational skills, health assessment skills, and the full range of occupational health nursing knowledge in designing and implementing diversified program elements. The program requires constant analysis to evaluate effectiveness and responsiveness to worker population health needs and cost efficiency. The work involves providing direct health services and education to workers, coordinating health care delivery within military and civilian resources, assessing Fort Hood needs and collaborating with other health care and occupational health entities in planning, developing, delivering and evaluating the local program. The incumbent analyses data, recognizes trends and makes recommendations regarding implementation of appropriate nursing strategies and corrective action.

FACTOR 5 SCOPE AND EFFECT FL 5-3 150 PTS

The work impacts the physical and emotional well-being of installation employees and their families. Works reflects directly on the installation by assisting Fort Hood to meet federal and OSHA regulations; by ensuring that all eligible personnel are physically, mentally and emotionally suited to their work at the time of assignment; that physical and mental health are monitored to detect early deviations from the optimum; assures that personnel are protected against adverse effects of health and safety hazards in the work environment; assures proper medical care and rehabilitation of the occupational ill and injured. Through ongoing medical surveillance, counseling and education, the nurse identifies soldiers and civilian employees with health problems and increases awareness of job hazards and protective measures thereby contributing toward a more effective workforce, increased combat readiness and reduction in federal employee compensation costs.

FACTOR 6&7 PERSONAL/PURPOSE OF CONTACTS FL 2C 145 PTS

Contacts are with all levels of medical and non-medical personnel within the Army organization, soldiers, civilian employees, supervisors, management officials, union representatives, health care providers, and community/local representatives.

Contacts with management officials/supervisors (military and civilian) are to determine occupational health needs and to evaluate and provide occupational health services; to obtain cooperation; to provide information on occupational health programs; to schedule health screening; to advise on specific health and safety concerns of employees and to advise on potential job-related hazards/preventive medicine aspects of OHP. Contacts with employees/soldiers are to influence/motivate to good safety and health practices; to deliver health care; and to provide safety and health education/training. Contacts with other federal agencies and professional organizations are to exchange ideas, keep current on occupational health and safety issues and to upgrade delivery of occupational health services. Contacts with community agencies and health care providers are for referral and follow-up and to coordinate health care of employees/soldiers.

FACTOR 8 PHYSICAL DEMANDS FL 8-2 20 PTS

Work involves standing and bending in the assessment of patients and considerable walking and traveling to and from work sites.

Wears personal protective equipment as necessary when visiting work sites, i.e., hearing and vision protection, hard hat, steel-toed shoes, respirator.

FACTOR 9 WORK ENVIRONMENTS FL 9-2 20 PTS

Work is performed primarily in a clean health clinic but requires potential exposure to contagious or infectious disease during examination procedures and potential exposure to physical, biological and chemical hazards during work site visits. May be required to wear protective clothing or equipment.

TOTAL POINTS: 2285
POINT RANGE: 2105-2350
GRADE: GS-10

* This position is subject to drug testing if the incumbent:

1. Has direct patient contact or performs diagnostic or therapeutic functions
2. Extracts or works with patients' body fluids or tissues; prepares patient specimens for examination, performs specialized or non-routine tests on body fluids or tissue samples, or confirms patients' test results
3. Maintains, stores, safeguards, inputs, fills or distributes drugs and medicines

This position has a mandatory seasonal influenza vaccination requirement and is therefore subject to annual seasonal influenza vaccinations. Applicants tentatively selected for appointment to this position will be required to sign a statement (Condition of Employment) consenting to seasonal influenza vaccinations.

Fair Labor Standards Act (FLSA) Determination = ()

FLSA Comments/Explanations:

Not Listed

Position Evaluation:

Not Listed

Position Competencies:

(b) (6)

RN4

Export to MS Word

Position Description

PD#: EF80135

Replaces PD#:

Sequence#: 2350315

CLINICAL NURSE (COMM-OCC HEALTH)

GS-0610-10

Servicing CPAC: FORT HOOD, TX
Installation: EFMCW2M5AATABQF
MEDCOM
CRDAMC
OFC OF THE DCCS
CHIEF DEPT OF PREVENTIVE MED
OCC HLTH CLIN SVC
FORT HOOD, TX 76544 TABQF

Agency: ARMY
Army Command: MC
Command Code: MC
US ARMY MEDICAL
COMMAND
Region: WEST

Citation 1: OPM PCS NURSE SERIES, GS-610, JUN 77

Classified By: HOOD

Classified Date: 10/31/1997

FLSA: EXEMPT

FLSA Worksheet:

FLSA Appeal: NO

Drug Test Required: AGENCY
REQ DRUG TEST OF INCUMBENT
(TIER ONE) *

DCIPS PD: NO

Career Program: 53

**Financial Disclosure
Required:** NO

Acquisition Position: NO

Functional Code: 81

**Requires Access to
Firearms:** NO

Interdisciplinary: NO

Competitive Area: FD

Position Sensitivity:
NONSENSITIVE (NS)
NATIONAL SECURITY RISK

Security Access: No Access
Required; ENTNAC/NAC

Competitive Level: 0A00

Target Grade/FPL: 10

Career Ladder PD: NO

Emergency Essential: No

[N: Position Not Designated
Emergency-Essential Or Key]

Bus Code: 8888

**Personnel Reliability
Position:** Not Valid PRP Code

Information Assurance: N

Influenza Vaccination: YES

Army Enterprise Position:

Supervisor Status: Non-
Supervisory

Position Designation:

PD Status: VERIFIED

Position Duties:

CL: 0A00

Assists in coordination and implementation of the Occupational Health Program (OHP) for



Fort Hood, ensuring the objectives of the OHP as mandated in AR 40-5 are met within available resources and that federal, state, local and OSHA regulatory guidance are also met within these same resources. Provides a wide range of professional nursing and health care services, counseling, education and training to the military and civilian workforce relative to their occupations and working environments, to include the care and treatment of employee illnesses and injuries. The total authorized military strength is excess of 45,000 including tenant and support forces and there is a 5000 member civilian workforce. The OHP includes but is not limited to the following programs: coordination with the Industrial Hygiene (IH) Office and III Corps Safety Office in the identification of personnel exposed to environmental and physical hazards; the performance of preplacement, administrative, retirement and job related health assessments; reproductive hazards (pregnancy surveillance); chronic disease detection; hearing and vision conservation; respiratory protection; asbestos surveillance; radiation protection; bloodborne pathogen exposure; immunizations; evaluation of occupational illness/injury and referral as appropriate; job-related medical surveillance; counseling services for military and civilian personnel; job-related hazard and general health education; work-site visits/evaluations; ergonomic evaluations; epidemiological investigations; Occupational Health Management Information System (OHMIS) support. Independently accomplishes work using professional judgment in carrying out duties.

Develops goals, objectives, standards and policies for assigned segments of the OHP. Collaborates with the supervisor, OH to ensure the occupational health services provided are in accordance with medical, legal and regulatory requirements.

Performs health assessments for preplacement, retirement, disability, and job related medical surveillance and uses professional judgment to make recommendations for proper placement consistent with job requirements. Obtains health and occupational history and determines if health of employee is or will be compromised by the functional or environmental requirements of job. Recognizes physical, emotional or mental problems that could compromise the health and safety of the individual or his/her co-workers during the performance of duties. Independently determines and orders tests appropriate to job-hazard, health history and occupational history, interprets results, discusses/interprets findings with employee, initiates follow-up if indicated and makes referral to appropriate specialty clinic or primary health care provider as appropriate. Conducts pulmonary function tests and vision screening tests, interprets results and refers to appropriate specialty if needed. Performs Respirator Clearance Exams, i.e., auscultates chest for heart and lung sounds, inspects tympanic membrane for perforation, performs pulmonary function tests, reviews results and determines if employee is physically capable of wearing a respirator. Coordinates with facility managers to ensure that employees are provided appropriate personal protective equipment.

Provides emergency care or crisis intervention including life saving emergency procedures in order to stabilize a patient for transport to the nearest MTF.
45%

Conducts studies and surveys of work sites. Applies basic knowledge of IH and toxicology principles to recognize health hazards in the work environment, i.e. how the hazard enters the body and what body systems or target organs may be affected. Determines appropriate medical tests/evaluation specific to the workplace hazardous exposure for early detection of job-related disease and prevention of further insult to the employee's health. Makes proper recommendations for corrective actions within the worksite and coordinates these actions with IH, Safety, DPW, etc., when appropriate.

Conducts investigations of individual work sites of pregnant personnel to identify any environmental or physical hazards which might be detrimental to the developing fetus or well-being of the mother. Reports findings, with recommendations, to the OH supervisor and the employee's personal physician.

Performs ergonomic investigations and epidemiological studies. Collects and analyzes data and uses professional knowledge to make recommendations for the development, expansion or improvement of health programs and/or worksite modifications.

30%

Plans and implements formal and informal health education programs and individual/group counseling. Develops occupational health educational materials and training programs to promote awareness of health hazards and to assist Fort Hood in complying with federal law (e.g., bloodborne pathogen training, tuberculosis, hearing conservation, respiratory protection, immunizations, etc.). Uses professional judgment to determine the level of understanding of each audience and adjust the teaching methods and course material accordingly.

15%

Ensures proper initiation, maintenance and disposition of employee medical records.

5%

Performs a variety of automation duties that include all the functional aspects of the automated occupational health surveillance system known as OHMIS. Inputs and retrieves data, produces statistical graphs, tables, trend analysis and a variety of reports. Supports and actively participates in the Performance Improvement (PI) program.

5%

PERFORMS OTHER DUTIES AS ASSIGNED.

NOTE: THIS POSITION IS COVERED BY THE CIVILIAN DRUG ABUSE TESTING PROGRAM. INCUMBENT IS REQUIRED TO SIGN A DA FORM 5019-R, AND/OR DA FORM 7412 "CONDITION OF EMPLOYMENT FOR CERTAIN CIVILIAN POSITIONS IDENTIFIED AS CRITICAL UNDER THE DRUG ABUSE TESTING PROGRAM," OR A MEMORANDUM OF UNDERSTANDING (MOU).

NOTE: MAINTAINS CURRENT NURSING LICENSE, CPR CERTIFICATION AND BMAR TRAINING.

FACTOR 1 KNOWLEDGE REQUIRED BY THE POSITION FL 1-7 1250 PTS

Professional knowledge of a wide range of nursing concepts, principles and practices; industrial hygiene, safety, ergonomics, toxicology, epidemiology, management; allied disciplines; and current adult nursing theory and practice which enables the OHN to independently perform nursing assignments and procedures for worker populations.

Knowledge and skill to illicit medical and occupational histories and conduct health assessments; sound medical and professional judgment in interpreting results and determining the need for additional diagnostic procedures and/or referral.

Knowledge of adult epidemiology and prevention of vaccine-preventable diseases and skill in the administration of vaccines.

Skill to interact with other medical professionals, commanders, civilian and military groups, civilian and public health agencies in coordinating patient care, disease and injury control, and workforce education groups.

Knowledge of pharmacology dosage, administration and side effects of medications.

Thorough knowledge of anatomy and physiology of organ systems and the ability to recognize normal from abnormal.

Ability to distinguish normal from abnormal laboratory findings.

Knowledge and skill to recognize health hazards in the work environment; routes of exposure of hazardous chemicals/compounds and target organs affected by these substances and to determine the appropriate evaluation/test specific to body organ/chemical relationship.

Knowledge of the appropriate personal protective equipment required for specific hazards.

Knowledge of the directives governing the care and treatment of authorized civilian and military personnel and of pertinent governmental regulations and policies requiring compliance.

Ability to operate and maintain specialized testing equipment and interpret results.

Knowledge of educational theory/practice and skill in a variety of teaching approaches specific to learning needs of employees at all levels of experience and education, i.e., high school grad or less, manager/administer level, groups and individuals, Ability to recognize and prepare for level of education/understanding of target audience is critical.

Knowledge and skill in counseling techniques and behavior modification is fundamental to the achievement of the health goals of employees contacted.

Knowledge and skill in planning, implementing, coordinating, and evaluating delegated programs.

Knowledge and skill in the operation and maintenance of computer systems to perform data entry/retrieval and to prepare reports.

FACTOR 2 SUPERVISORY CONTROLS FL 2-3 275 PTS

Receives general supervision from the Occupational Health Supervisor who: (1) defines overall objectives within the available resources; (2) relies on the incumbent to independently plan, coordinate, and perform assigned tasks; to establish/adjust schedules to complete tasks in a timely manner and to resolve most problems on own initiative. However supervisor is available to provide advice and guidance as needed and to discuss progress of assigned area of responsibility and reviews work for effectiveness in meeting program goals, objectives, and requirements; reviews reports and records for professional adequacy and soundness of judgment.

FACTOR 3 GUIDELINES FL 3-3 275 PTS

Works within a framework of established medical directives, MEDDAC, MEDCOM and DA policies/regulations, clinic SOP's, federal, state and local laws, Army Regulations, OSHA standards, and information provided through actual surveys and inspections.

Independent professional judgment is required to select and apply the guidelines appropriate to the situation in developing recommendations for the OHP; in recognizing deviations from criteria established as normal; in determining the extent of seriousness of illness, injury, or potential health problems and whether referral to a physician or other medical facility is appropriate.

FACTOR 4 COMPLEXITY FL 4-3 150 PTS

The work is an independent assignment requiring the nurse to combine a wide range of professional and organizational skills, health assessment skills, and the full range of occupational health nursing knowledge in designing and implementing diversified program elements. The program requires constant analysis to evaluate effectiveness and responsiveness to worker population health needs and cost efficiency. The work involves providing direct health services and education to workers, coordinating health care delivery within military and civilian resources, assessing Fort Hood needs and collaborating with other health care and occupational health entities in planning, developing, delivering and evaluating the local program. The incumbent analyses data, recognizes trends and makes recommendations regarding implementation of appropriate nursing strategies and corrective action.

FACTOR 5 SCOPE AND EFFECT FL 5-3 150 PTS

The work impacts the physical and emotional well-being of installation employees and their families. Work reflects directly on the installation by assisting Fort Hood to meet federal and OSHA regulations; by ensuring that all eligible personnel are physically, mentally and emotionally suited to their work at the time of assignment; that physical and mental health are monitored to detect early deviations from the optimum; assures that personnel are protected against adverse effects of health and safety hazards in the work environment; assures proper medical care and rehabilitation of the occupational ill and injured. Through ongoing medical surveillance, counseling and education, the nurse identifies soldiers and civilian employees with health problems and increases awareness of job hazards and protective measures thereby contributing toward a more effective workforce, increased combat readiness and reduction in federal employee compensation costs.

FACTOR 6&7 PERSONAL/PURPOSE OF CONTACTS FL 2C 145 PTS

Contacts are with all levels of medical and non-medical personnel within the Army organization, soldiers, civilian employees, supervisors, management officials, union representatives, health care providers, and community/local representatives.

Contacts with management officials/supervisors (military and civilian) are to determine occupational health needs and to evaluate and provide occupational health services; to obtain cooperation; to provide information on occupational health programs; to schedule health screening; to advise on specific health and safety concerns of employees and to advise on potential job-related hazards/preventive medicine aspects of OHP. Contacts with employees/soldiers are to influence/motivate to good safety and health practices; to deliver health care; and to provide safety and health education/training. Contacts with other federal agencies and professional organizations are to exchange ideas, keep current on occupational health and safety issues and to upgrade delivery of occupational health services. Contacts with community agencies and health care providers are for referral and follow-up and to coordinate health care of employees/soldiers.

FACTOR 8 PHYSICAL DEMANDS FL 8-2 20 PTS

Work involves standing and bending in the assessment of patients and considerable walking and traveling to and from work sites.

Wears personal protective equipment as necessary when visiting work sites, i.e., hearing and vision protection, hard hat, steel-toed shoes, respirator.

FACTOR 9 WORK ENVIRONMENTS FL 9-2 20 PTS

Work is performed primarily in a clean health clinic but requires potential exposure to contagious or infectious disease during examination procedures and potential exposure to physical, biological and chemical hazards during work site visits. May be required to wear protective clothing or equipment.

TOTAL POINTS: 2285
POINT RANGE: 2105-2350
GRADE: GS-10

Fair Labor Standards Act (FLSA) Determination = ()

FLSA Comments/Explanations:

Not Listed

* This position is subject to drug testing if the incumbent:

1. Has direct patient contact or performs diagnostic or therapeutic functions
2. Extracts or works with patients' body fluids or tissues; prepares patient specimens for examination, performs specialized or non-routine tests on body fluids or tissue samples, or confirms patients' test results
3. Maintains, stores, safeguards, inputs, fills or distributes drugs and medicines

This position has a mandatory seasonal influenza vaccination requirement and is therefore subject to annual seasonal influenza vaccinations. Applicants tentatively selected for appointment to this position will be required to sign a statement (Condition of Employment) consenting to seasonal influenza vaccinations.

Position Evaluation:

Not Listed

Position Competencies:

Position Description

(b) (6)

(b) (6)

RN5

Position Description

PD#: EF80135

Sequence#: 1210327

Replaces PD#:

NURSE (CLINICAL/COMM-OCC HLTH)

YH-0610-02

Servicing CPAC: FORT HOOD, TX

Installation: EFMCW2M5AASZC

MEDCOM
CRDAMC
DEPARTMENT OF PREVENTIVE MEDICINE
OCC HLTH SVC
FORT HOOD, TX 76544 SZC

Agency: ARMY

MACOM: MEDCOM

Command Code: MC
US ARMY MEDICAL
COMMAND

Region: WEST

Citation 1: OPM PCS NURSE SERIES, GS-610, JUN 77

PD Library PD: NO

COREDOC PD: NO

Classified By: HOOD

Classified Date: 10/31/1997

FLSA: E

Career Program: 00

Functional Code: 81

Competitive Area:

Competitive Level:

Bus Code: 8888

PD Status: VERIFIED

Drug Test Required: YES

Financial Disclosure Required: NO

Requires Access to Firearms:

Position Sensitivity: 1

Emergency Essential: N

DCIPS PD: NO

Acquisition Position: NO

Interdisciplinary: NO

Target Grade/FPL: 02 ←

Career Ladder PD: NO

Duties:

MAJOR DUTIES

Assists in coordination and implementation of the Occupational Health Program (OHP) for Fort Hood, ensuring the objectives of the OHP as mandated in AR 40-5 are met within available resources and that federal, state, local and OSHA regulatory guidance are also met within these same resources. Provides a wide range of professional nursing and health care services, counseling, education and training to the military and civilian workforce relative to their occupations and working environments, to include the care and treatment of employee illnesses and injuries. The total authorized military strength is excess of 45,000 including tenant and support forces and there is a 5000 member civilian workforce. The OHP includes

AB9e

but is not limited to the following programs: coordination with the Industrial Hygiene (IH) Office and III Corps Safety Office in the identification of personnel exposed to environmental and physical hazards; the performance of preplacement, administrative, retirement and job related health assessments; reproductive hazards (pregnancy surveillance); chronic disease detection; hearing and vision conservation; respiratory protection; asbestos surveillance; radiation protection; bloodborne pathogen exposure; immunizations; evaluation of occupational illness/injury and referral as appropriate; job-related medical surveillance; counseling services for military and civilian personnel; job-related hazard and general health education; work-site visits/evaluations; ergonomic evaluations; epidemiological investigations; Occupational Health Management Information System (OHMIS) support. Independently accomplishes work using professional judgment in carrying out duties.

Develops goals, objectives, standards and policies for assigned segments of the OHP. Collaborates with the supervisor, OH to ensure the occupational health services provided are in accordance with medical, legal and regulatory requirements.

Performs health assessments for preplacement, retirement, disability, and job related medical surveillance and uses professional judgment to make recommendations for proper placement consistent with job requirements. Obtains health and occupational history and determines if health of employee is or will be compromised by the functional or environmental requirements of job. Recognizes physical, emotional or mental problems that could compromise the health and safety of the individual or his/her co-workers during the performance of duties. Independently determines and orders tests appropriate to job-hazard, health history and occupational history, interprets results, discusses/interprets findings with employee, initiates follow-up if indicated and makes referral to appropriate specialty clinic or primary health care provider as appropriate. Conducts pulmonary function tests and vision screening tests, interprets results and refers to appropriate specialty if needed. Performs Respirator Clearance Exams, i.e., auscultates chest for heart and lung sounds, inspects tympanic membrane for perforation, performs pulmonary function tests, reviews results and determines if employee is physically capable of wearing a respirator. Coordinates with facility managers to ensure that employees are provided appropriate personal protective equipment.

Provides emergency care or crisis intervention including life saving emergency procedures in order to stabilize a patient for transport to the nearest MTF.
45%

Conducts studies and surveys of work sites. Applies basic knowledge of IH and toxicology principles to recognize health hazards in the work environment, i.e. how the hazard enters the body and what body systems or target organs may be affected. Determines appropriate medical tests/evaluation specific to the workplace hazardous exposure for early detection of job-related disease and prevention of further insult to the employee's health. Makes proper recommendations for corrective actions within the worksite and coordinates these actions with IH, Safety, DPW, etc., when appropriate.

Conducts investigations of individual work sites of pregnant personnel to identify any environmental or physical hazards which might be detrimental to the developing fetus or well-being of the mother. Reports findings, with recommendations, to the OH supervisor and the employee's personal physician.

Performs ergonomic investigations and epidemiological studies. Collects and analyzes data and uses professional knowledge to make recommendations for the development, expansion or improvement of health programs and/or worksite modifications.
30%

Plans and implements formal and informal health education programs and individual/group counseling. Develops occupational health educational materials and training programs to promote awareness of health hazards and to assist Fort Hood in complying with federal law (e.g., bloodborne pathogen training, tuberculosis, hearing conservation, respiratory protection, immunizations, etc.). Uses professional judgment to determine the level of understanding of each audience and adjust the teaching methods and course material accordingly.

15%

Ensures proper initiation, maintenance and disposition of employee medical records.

5%

Performs a variety of automation duties that include all the functional aspects of the automated occupational health surveillance system known as OHMIS. Inputs and retrieves data, produces statistical graphs, tables, trend analysis and a variety of reports. Supports and actively participates in the Performance Improvement (PI) program.

5%

Performs other duties as assigned.

Incumbent may be subject to drug testing.

Factor 1, Knowledge Required by Position FL 1/7 - 1250 PTS

Professional knowledge of a wide range of nursing concepts, principles and practices; industrial hygiene, safety, ergonomics, toxicology, epidemiology, management; allied disciplines; and current adult nursing theory and practice which enables the OHN to independently perform nursing assignments and procedures for worker populations.

Knowledge and skill to illicit medical and occupational histories and conduct health assessments; sound medical and professional judgment in interpreting results and determining the need for additional diagnostic procedures and/or referral.

Knowledge of adult epidemiology and prevention of vaccine-preventable diseases and skill in the administration of vaccines.

Skill to interact with other medical professionals, commanders, civilian and military groups, civilian and public health agencies in coordinating patient care, disease and injury control, and workforce education groups.

Knowledge of pharmacology dosage, administration and side effects of medications.

Thorough knowledge of anatomy and physiology of organ systems and the ability to recognize normal from abnormal.

Ability to distinguish normal from abnormal laboratory findings.

Knowledge and skill to recognize health hazards in the work environment; routes of exposure of hazardous chemicals/compounds and target organs affected by these substances and to determine the appropriate evaluation/test specific to body organ/chemical relationship.

Knowledge of the appropriate personal protective equipment required for specific hazards.

Knowledge of the directives governing the care and treatment of authorized civilian and military personnel and of pertinent governmental regulations and policies requiring

compliance.

Ability to operate and maintain specialized testing equipment and interpret results.

Knowledge of educational theory/practice and skill in a variety of teaching approaches specific to learning needs of employees at all levels of experience and education, i.e., high school grad or less, manager/administer level, groups and individuals, Ability to recognize and prepare for level of education/understanding of target audience is critical.

Knowledge and skill in counseling techniques and behavior modification is fundamental to the achievement of the health goals of employees contacted.

Knowledge and skill in planning, implementing, coordinating, and evaluating delegated programs.

Knowledge and skill in the operation and maintenance of computer systems to perform data entry/retrieval and to prepare reports.

Factor 2, Supervisory Controls FL 2/3 - 275 PTS

Receives general supervision from the Occupational Health Supervisor who: (1) defines overall objectives within the available resources; (2) relies on the incumbent to independently plan, coordinate, and perform assigned tasks; to establish/adjust schedules to complete tasks in a timely manner and to resolve most problems on own initiative. However supervisor is available to provide advice and guidance as needed and to discuss progress of assigned area of responsibility and reviews work for effectiveness in meeting program goals, objectives, and requirements; reviews reports and records for professional adequacy and soundness of judgment.

Factor 3, Guidelines FL 3/3 - 275 PTS

Works within a framework of established medical directives, MEDDAC, MEDCOM and DA policies/regulations, clinic SOP's, federal, state and local laws, Army Regulations, OSHA standards, and information provided through actual surveys and inspections.

Independent professional judgment is required to select and apply the guidelines appropriate to the situation in developing recommendations for the OHP; in recognizing deviations from criteria established as normal; in determining the extent of seriousness of illness, injury, or potential health problems and whether referral to a physician or other medical facility is appropriate.

Factor 4, Complexity FL 4/3 - 150 PTS

The work is an independent assignment requiring the nurse to combine a wide range of professional and organizational skills, health assessment skills, and the full range of occupational health nursing knowledge in designing and implementing diversified program elements. The program requires constant analysis to evaluate effectiveness and responsiveness to worker population health needs and cost efficiency. The work involves providing direct health services and education to workers, coordinating health care delivery within military and civilian resources, assessing Fort Hood needs and collaborating with other health care and occupational health entities in planning, developing, delivering and evaluating the local program. The incumbent analyses data, recognizes trends and makes recommendations regarding implementation of appropriate nursing strategies and corrective action.

Factor 5, Scope and Effect FL 5/3 - 150 PTS

The work impacts the physical and emotional well-being of installation employees and their families. Work reflects directly on the installation by assisting Fort Hood to meet federal and OSHA regulations; by ensuring that all eligible personnel are physically, mentally and emotionally suited to their work at the time of assignment; that physical and mental health are monitored to detect early deviations from the optimum; assures that personnel are protected against adverse effects of health and safety hazards in the work environment; assures proper medical care and rehabilitation of the occupational ill and injured. Through ongoing medical surveillance, counseling and education, the nurse identifies soldiers and civilian employees with health problems and increases awareness of job hazards and protective measures thereby contributing toward a more effective workforce, increased combat readiness and reduction in federal employee compensation costs.

Factor 6, Personal Contacts FL 6/2 - 25 PTS

Contacts are with all levels of medical and non-medical personnel within the Army organization, soldiers, civilian employees, supervisors, management officials, union representatives, health care providers, and community/local representatives.

Factor 7, Purpose of Contacts FL 7/3 - 120 PTS

Contacts with management officials/supervisors (military and civilian) are to determine occupational health needs and to evaluate and provide occupational health services; to obtain cooperation; to provide information on occupational health programs; to schedule health screening; to advise on specific health and safety concerns of employees and to advise on potential job-related hazards/preventive medicine aspects of OHP. Contacts with employees/soldiers are to influence/motivate to good safety and health practices; to deliver health care; and to provide safety and health education/training. Contacts with other federal agencies and professional organizations are to exchange ideas, keep current on occupational health and safety issues and to upgrade delivery of occupational health services. Contacts with community agencies and health care providers are for referral and follow-up and to coordinate health care of employees/soldiers.

Factor 8, Physical Demands FL 8/2 - 20 PTS

Work involves standing and bending in the assessment of patients and considerable walking and traveling to and from work sites.

Wears personal protective equipment as necessary when visiting work sites, i.e., hearing and vision protection, hard hat, steel-toed shoes, respirator.

Factor 9, Work Environment FL 9/2 - 20 PTS

Work is performed primarily in a clean health clinic but requires potential exposure to contagious or infectious disease during examination procedures and potential exposure to physical, biological and chemical hazards during work site visits. May be required to wear protective clothing or equipment.

TOTAL POINTS: 2285 (point range of 2105-2350) equates to GS-10

NOTE: Assignment to duties other than those described above for a period of 30 days (five days for bargaining unit employees) constitutes a misassignment and must be corrected immediately by the Operating Official submitting the Personnel Request to either detail, temporarily promote or permanently assign the employee to the appropriate job.

NOTE: Maintains current nursing license, CPR certification and BMAR training

Evaluation:

CL:0A00
PSC:NS

(b) (6)

RN

Position Description

PD#: EF80135

Replaces PD#:

Sequence#: 1210327

NURSE (CLINICAL/COMM-OCC HLTH)

YH-0610-02

Servicing CPAC: FORT HOOD, TX

Installation: EFMCW2M5AASZC

MEDCOM
CRDAMC
DEPARTMENT OF PREVENTIVE MEDICINE
OCC HLTH SVC
FORT HOOD, TX 76544 SZC

Agency: ARMY

MACOM: MEDCOM

Command Code: MC
US ARMY MEDICAL
COMMAND

Region: WEST

Citation 1: OPM PCS NURSE SERIES, GS-610, JUN 77

PD Library PD: NO

COREDOC PD: NO

Classified By: HOOD

Classified Date: 10/31/1997

FLSA: E

Drug Test Required: YES

DCIPS PD: NO

Career Program: 00

Financial Disclosure Required: NO

Acquisition Position: NO

Functional Code: 81

Requires Access to Firearms:

Interdisciplinary: NO

Competitive Area:

Position Sensitivity: 1

Target Grade/FPL: 02

Competitive Level:

Emergency Essential: N

Career Ladder PD: NO

Bus Code: 8888

PD Status: VERIFIED

Duties:

MAJOR DUTIES

Assists in coordination and implementation of the Occupational Health Program (OHP) for Fort Hood, ensuring the objectives of the OHP as mandated in AR 40-5 are met within available resources and that federal, state, local and OSHA regulatory guidance are also met within these same resources. Provides a wide range of professional nursing and health care services, counseling, education and training to the military and civilian workforce relative to their occupations and working environments, to include the care and treatment of employee illnesses and injuries. The total authorized military strength is excess of 45,000 including tenant and support forces and there is a 5000 member civilian workforce. The OHP includes

but is not limited to the following programs: coordination with the Industrial Hygiene (IH) Office and III Corps Safety Office in the identification of personnel exposed to environmental and physical hazards; the performance of preplacement, administrative, retirement and job related health assessments; reproductive hazards (pregnancy surveillance); chronic disease detection; hearing and vision conservation; respiratory protection; asbestos surveillance; radiation protection; bloodborne pathogen exposure; immunizations; evaluation of occupational illness/injury and referral as appropriate; job-related medical surveillance; counseling services for military and civilian personnel; job-related hazard and general health education; work-site visits/evaluations; ergonomic evaluations; epidemiological investigations; Occupational Health Management Information System (OHMIS) support. Independently accomplishes work using professional judgment in carrying out duties.

Develops goals, objectives, standards and policies for assigned segments of the OHP. Collaborates with the supervisor, OH to ensure the occupational health services provided are in accordance with medical, legal and regulatory requirements.

Performs health assessments for preplacement, retirement, disability, and job related medical surveillance and uses professional judgment to make recommendations for proper placement consistent with job requirements. Obtains health and occupational history and determines if health of employee is or will be compromised by the functional or environmental requirements of job. Recognizes physical, emotional or mental problems that could compromise the health and safety of the individual or his/her co-workers during the performance of duties. Independently determines and orders tests appropriate to job-hazard, health history and occupational history, interprets results, discusses/interprets findings with employee, initiates follow-up if indicated and makes referral to appropriate specialty clinic or primary health care provider as appropriate. Conducts pulmonary function tests and vision screening tests, interprets results and refers to appropriate specialty if needed. Performs Respirator Clearance Exams, i.e., auscultates chest for heart and lung sounds, inspects tympanic membrane for perforation, performs pulmonary function tests, reviews results and determines if employee is physically capable of wearing a respirator. Coordinates with facility managers to ensure that employees are provided appropriate personal protective equipment.

Provides emergency care or crisis intervention including life saving emergency procedures in order to stabilize a patient for transport to the nearest MTF.

45%

Conducts studies and surveys of work sites. Applies basic knowledge of IH and toxicology principles to recognize health hazards in the work environment, i.e. how the hazard enters the body and what body systems or target organs may be affected. Determines appropriate medical tests/evaluation specific to the workplace hazardous exposure for early detection of job-related disease and prevention of further insult to the employee's health. Makes proper recommendations for corrective actions within the worksite and coordinates these actions with IH, Safety, DPW, etc., when appropriate.

Conducts investigations of individual work sites of pregnant personnel to identify any environmental or physical hazards which might be detrimental to the developing fetus or well-being of the mother. Reports findings, with recommendations, to the OH supervisor and the employee's personal physician.

Performs ergonomic investigations and epidemiological studies. Collects and analyzes data and uses professional knowledge to make recommendations for the development, expansion or improvement of health programs and/or worksite modifications.

30%

Plans and implements formal and informal health education programs and individual/group counseling. Develops occupational health educational materials and training programs to promote awareness of health hazards and to assist Fort Hood in complying with federal law (e.g., bloodborne pathogen training, tuberculosis, hearing conservation, respiratory protection, immunizations, etc.). Uses professional judgment to determine the level of understanding of each audience and adjust the teaching methods and course material accordingly.

15%

Ensures proper initiation, maintenance and disposition of employee medical records.

5%

Performs a variety of automation duties that include all the functional aspects of the automated occupational health surveillance system known as OHMIS. Inputs and retrieves data, produces statistical graphs, tables, trend analysis and a variety of reports. Supports and actively participates in the Performance Improvement (PI) program.

5%

Performs other duties as assigned.

Incumbent may be subject to drug testing.

Factor 1, Knowledge Required by Position FL 1/7 - 1250 PTS

Professional knowledge of a wide range of nursing concepts, principles and practices; industrial hygiene, safety, ergonomics, toxicology, epidemiology, management; allied disciplines; and current adult nursing theory and practice which enables the OHN to independently perform nursing assignments and procedures for worker populations.

Knowledge and skill to illicit medical and occupational histories and conduct health assessments; sound medical and professional judgment in interpreting results and determining the need for additional diagnostic procedures and/or referral.

Knowledge of adult epidemiology and prevention of vaccine-preventable diseases and skill in the administration of vaccines.

Skill to interact with other medical professionals, commanders, civilian and military groups, civilian and public health agencies in coordinating patient care, disease and injury control, and workforce education groups.

Knowledge of pharmacology dosage, administration and side effects of medications.

Thorough knowledge of anatomy and physiology of organ systems and the ability to recognize normal from abnormal.

Ability to distinguish normal from abnormal laboratory findings.

Knowledge and skill to recognize health hazards in the work environment; routes of exposure of hazardous chemicals/compounds and target organs affected by these substances and to determine the appropriate evaluation/test specific to body organ/chemical relationship.

Knowledge of the appropriate personal protective equipment required for specific hazards.

Knowledge of the directives governing the care and treatment of authorized civilian and military personnel and of pertinent governmental regulations and policies requiring

compliance.

Ability to operate and maintain specialized testing equipment and interpret results.

Knowledge of educational theory/practice and skill in a variety of teaching approaches specific to learning needs of employees at all levels of experience and education, i.e., high school grad or less, manager/administer level, groups and individuals, Ability to recognize and prepare for level of education/understanding of target audience is critical.

Knowledge and skill in counseling techniques and behavior modification is fundamental to the achievement of the health goals of employees contacted.

Knowledge and skill in planning, implementing, coordinating, and evaluating delegated programs.

Knowledge and skill in the operation and maintenance of computer systems to perform data entry/retrieval and to prepare reports.

Factor 2, Supervisory Controls FL 2/3 - 275 PTS

Receives general supervision from the Occupational Health Supervisor who: (1) defines overall objectives within the available resources; (2) relies on the incumbent to independently plan, coordinate, and perform assigned tasks; to establish/adjust schedules to complete tasks in a timely manner and to resolve most problems on own initiative. However supervisor is available to provide advice and guidance as needed and to discuss progress of assigned area of responsibility and reviews work for effectiveness in meeting program goals, objectives, and requirements; reviews reports and records for professional adequacy and soundness of judgment.

Factor 3, Guidelines FL 3/3 - 275 PTS

Works within a framework of established medical directives, MEDDAC, MEDCOM and DA policies/regulations, clinic SOPs, federal, state and local laws, Army Regulations, OSHA standards, and information provided through actual surveys and inspections.

Independent professional judgment is required to select and apply the guidelines appropriate to the situation in developing recommendations for the OHP; in recognizing deviations from criteria established as normal; in determining the extent of seriousness of illness, injury, or potential health problems and whether referral to a physician or other medical facility is appropriate.

Factor 4, Complexity FL 4/3 - 150 PTS

The work is an independent assignment requiring the nurse to combine a wide range of professional and organizational skills, health assessment skills, and the full range of occupational health nursing knowledge in designing and implementing diversified program elements. The program requires constant analysis to evaluate effectiveness and responsiveness to worker population health needs and cost efficiency. The work involves providing direct health services and education to workers, coordinating health care delivery within military and civilian resources, assessing Fort Hood needs and collaborating with other health care and occupational health entities in planning, developing, delivering and evaluating the local program. The incumbent analyses data, recognizes trends and makes recommendations regarding implementation of appropriate nursing strategies and corrective action.

Factor 5, Scope and Effect FL 5/3 - 150 PTS

The work impacts the physical and emotional well-being of installation employees and their families. Work reflects directly on the installation by assisting Fort Hood to meet federal and OSHA regulations; by ensuring that all eligible personnel are physically, mentally and emotionally suited to their work at the time of assignment; that physical and mental health are monitored to detect early deviations from the optimum; assures that personnel are protected against adverse effects of health and safety hazards in the work environment; assures proper medical care and rehabilitation of the occupational ill and injured. Through ongoing medical surveillance, counseling and education, the nurse identifies soldiers and civilian employees with health problems and increases awareness of job hazards and protective measures thereby contributing toward a more effective workforce, increased combat readiness and reduction in federal employee compensation costs.

Factor 6, Personal Contacts FL 6/2 - 25 PTS

Contacts are with all levels of medical and non-medical personnel within the Army organization, soldiers, civilian employees, supervisors, management officials, union representatives, health care providers, and community/local representatives.

Factor 7, Purpose of Contacts FL 7/3 - 120 PTS

Contacts with management officials/supervisors (military and civilian) are to determine occupational health needs and to evaluate and provide occupational health services; to obtain cooperation; to provide information on occupational health programs; to schedule health screening; to advise on specific health and safety concerns of employees and to advise on potential job-related hazards/preventive medicine aspects of OHP. Contacts with employees/soldiers are to influence/motivate to good safety and health practices; to deliver health care; and to provide safety and health education/training. Contacts with other federal agencies and professional organizations are to exchange ideas, keep current on occupational health and safety issues and to upgrade delivery of occupational health services. Contacts with community agencies and health care providers are for referral and follow-up and to coordinate health care of employees/soldiers.

Factor 8, Physical Demands FL 8/2 - 20 PTS

Work involves standing and bending in the assessment of patients and considerable walking and traveling to and from work sites.

Wears personal protective equipment as necessary when visiting work sites, i.e., hearing and vision protection, hard hat, steel-toed shoes, respirator.

Factor 9, Work Environment FL 9/2 - 20 PTS

Work is performed primarily in a clean health clinic but requires potential exposure to contagious or infectious disease during examination procedures and potential exposure to physical, biological and chemical hazards during work site visits. May be required to wear protective clothing or equipment.

TOTAL POINTS: 2285 (point range of 2105-2350) equates to GS-10

NOTE: Assignment to duties other than those described above for a period of 30 days (five days for bargaining unit employees) constitutes a misassignment and must be corrected immediately by the Operating Official submitting the Personnel Request to either detail, temporarily promote or permanently assign the employee to the appropriate job.

NOTE: Maintains current nursing license, CPR certification and BMAR training

Evaluation:

CL:0A00
PSC:NS

(b) (6)

PA 2

Position Description

PD#: EF390330

Replaces PD#:

Sequence#: 2369998

PHYSICIAN ASSISTANT (OCCUPATIONAL HEALTH)

GS-0603-12

Servicing CPAC: FORT HOOD, TX

Agency: ARMY

Installation: EFMCW2M5AATABQFMEDCOMCRDAMCOFC
OF THE DCCSCHIEF DEPT OF PREVENTIVE
MEDOCC HLTH CLIN SVC FORT HOOD, TX
76544 TABQF

Army Command: MC
Command Code: MC
US ARMY MEDICAL
COMMAND

Region: WEST

Citation 1: PHYSICIAN ASSISTANT SER, HDBK OF OCC GROUPS & FAMS, JAN 2008

Classified By: (b) (6)
(b) (6), COL

Classified Date: 01/10/2011

FLSA: EXEMPT

FLSA Worksheet:
EXEMPT

FLSA Appeal: NO

Drug Test Required: POSN
NOT REQ DRUG TEST *

DCIPS PD: NO

Career Program: 53

Financial Disclosure
Required: NO

Acquisition Position: NO

Functional Code: 00

Requires Access to
Firearms: NO

Interdisciplinary: NO

Competitive Area: FD

Position Sensitivity:
NONSENSITIVE (NS)
NATIONAL SECURITY
RISK

Security Access: No Access
Required; ENTNAC/NAC

Competitive Level: 0C00

Target Grade/FPL: 12

Career Ladder PD: NO

Emergency Essential: No

[N: Position Not Designated
Emergency-Essential Or Key]

Bus Code: 8888

Personnel Reliability
Position: Not Valid PRP
Code

Information Assurance: N

Influenza Vaccination: YES



Army Enterprise Position: **Supervisor Status:** Non-Supervisory **Position Designation:**
PD Status: VERIFIED

Position Duties:

CL: 0C00

1. OCCUPATIONAL HEALTH: Maintains the medical examination program under the supervision of an Occupational Physician, which may include, but not limited to: pre-employment/inprocessing evaluations, baseline health examinations, periodic non-occupational and occupational medical surveillance, pre-travel examinations and administrative examinations, such as fitness-for-duty, return to work, short and long term disability and disability retirement examinations.

Performs pre-placement evaluations from a standpoint of prevention of occupational injuries and illnesses including the detection of pre-existing conditions that might be aggravated by a particular assignment and to determine whether the individual is physically, mentally, and emotionally capable of performing a particular job or assignment with an acceptable degree of efficiency and without endangering their own health and safety or that of their fellow employees. Evaluates individuals with disabilities to determine if they can perform the essential job functions and makes recommendation for reasonable accommodations.

Designs and conducts a comprehensive program of occupational medical surveillance examinations based on the real and potential health hazards encountered in the workplace. Performs evaluations on individuals who have been absent from the workplace for a specified period of time due to illness, injury, or other reasons; for temporary or permanent reassignment; and for a variety of other reasons to ensure they are physically and/or emotionally fit for duty. Performs evaluations and provides medical preparations for employees traveling to other parts of the world. Performs physical examinations/evaluations and laboratory tests appropriate to the various occupational exposures encountered by employees; treating job-related injuries and illnesses of the employees, and prescribes further care and treatment as appropriate.

Refers employees to their private health care provider for follow-up or further evaluation of non job-related medical problems encountered in the various physical examinations. Examines employees with personal medical conditions, which interrupt or interfere with their work. Makes diagnosis and evaluates patient's condition on the basis of examination, reports, and medical experience. For intermediate, long-term care, for personal health, refers patients to medical specialists or to their family health care provider. Provides for reproductive hazard and pregnancy surveillance. Assures appropriate immunizations are provided employees potentially exposed to infectious disease because of work environment or required foreign travel.

Provides first aid or one-time palliative treatment to civilian employees who require

medical attention during duty hours, which is beyond the scope of the normal delegated authority of the nursing staff. Advise employees of additional medical attention needed. Provides treatment for minor injuries or refers injured person to appropriate medical treatment facility or private health care provider.

Maintains liaison with private health care providers to ensure proper placement of individuals in positions compatible with their physical capabilities. Coordinates with treating health care providers, civilian personnel, supervisors, FECA coordinator, and others to expedite early, safe return of injured workers. Facilitates light duty programs and participates in other aspects of worker's compensation case management. Accumulates/obtains occupational injury and illness data and analyzes to determine trends and to make recommendations for improvement.

Assists the Occupational Health Physician as consultant to the supported activity commanders and staff, advising on medical, occupational health, industrial hygiene matters. Also assists the Occupational Health Physician as consultant to health education and worksite wellness staff to ensure that programs meet quality medical standards. Assists with Soldier Readiness Program Processing and Demobilization processing/Deployment Cycle Support activities.

ENVIRONMENTAL HEALTH AND INDUSTRIAL HYGIENE: Assists the Occupational Health Physician with monitoring oversight of the work environment by performing worksite visits and by coordination/evaluation of industrial hygiene, environmental science, safety and other surveys and inspections. Participates in making recommendations for improvements/resolutions. Conducts on-site surveys of work areas and obtains first-hand information concerning the nature of various work operations and the potential hazard exposure. Hazards encountered may include chemicals, pesticides, ionizing and non-ionizing radiation, noise hazards, eye hazards, biological hazards and other environmental conditions. Reviews the health hazard inventory of each operation and determines specific medical monitoring examination requirements for pre-placement and periodic job-related examinations. Maintains liaison with employees, supervisors and safety personnel. Conducts and/or arranges for ergonomic evaluations of the worksite. Assists the Occupational Health Physician with medical counsel to command in environmental issues such as water quality testing for serviced activities drinking and recreational water; air pollution; monitoring climatic conditions to assist in the prevention of climatic injuries; epidemiologic investigations of food- and waterborne-disease outbreaks; field sanitation; sanitary inspections of on-post food service facilities, child development centers, barber and beauty shops, sports facilities, swimming pools, and recreation areas; assisting with radiation protection activities; administering the pest management program including routine medically important pest surveillance, West Nile Virus surveillance and rabies reduction.

80%

2. ADMINISTRATION & SUPERVISION: Interprets regulations and directives. Assists the Occupational Health Physician with standing operating procedures and medical directives for all elements of the Occupational Health Program are written and updated as

changes occur. Assists the Occupational Health Physician with reviewing policies and procedures on an annual basis to ensure JCHAO compliance. May serve as intermediate supervisor during short absences of the Occupational Health Physician at the discretion of the Chief of the Department of Preventive Medicine/Occupational Health Physician. Assists the Occupational Health Physician as requested with recommending personnel or position actions; develops or participates in the development of work performance plans, oversees workers' performance, and periodically evaluates employee performance; identifies training needs, and stimulates self-improvement. Treats coworkers as individuals and promotes teamwork. Places exceptional emphasis on implementing and administering regulations governing the safeguarding of patient information. Complies with the provisions of security and safety regulations. Promotes acceptance and adherence to provisions of such programs as Equal Opportunity, Federal Women's Program, physically handicapped, labor-management relations, and other similar special emphasis programs.
10%

3. Soldier Readiness Program Processing (SRP) and Demobilization processing/Deployment Cycle Support activities. When needed by the Chief of the Department of Preventive Medicine, serve as a provider for other Preventive Medicine missions to include Army Public Health tuberculosis management, Epidemiology STD and HIV provider, and Health Promotion and Wellness Tobacco Cessation Program.
5%

4. Assist with C.R. Darnall Army Medical Center Occupational Health missions at Ft. Hood, West Ft. Hood, North Ft. Hood, and other CRDAMC tenant activities as necessary.
5%

PERFORMS OTHER DUTIES AS ASSIGNED.

FACTOR 1. KNOWLEDGE REQUIRED BY THE POSITION FL 1-7 1250 PTS

Comprehensive knowledge of OM to administer and provide occupational health services, determines those services when necessary within regulatory guidelines for a large, highly diversified population of military and civilian employees working with a large range of potential hazards. Occupational health services are defined in Federal law, Department of Defense Instructions, AR 40-5, and various TB MEDS.

Professional knowledge of a wide range of nursing concepts, principles, and practices to perform comprehensive, highly specialized occupational medical health examinations involving, e.g. physical evaluations, laboratory tests, and diagnosis on the basis of extended medical training and experience.

Professional knowledge is used to:

a. Conduct job related medical examinations including pre-placement, pre-assignment, and periodic job related medical surveillance will be provided to military and civilian employees based on the potential for exposure to a job related hazard. Results of these

evaluations will be clearly documented and appropriate actions taken to protect the employee, the co-workers, or the U.S. Government if abnormal results are found.

b. Conduct medical examinations, makes diagnoses, administer treatment, including performance of minor surgery (e.g. lacerations; contusions, and fractures), and provide advisory service in connection with occupational illnesses, injuries, and emergency disabilities sustained by employees. Provides technical guidance to other staff members.

c. Develop and maintain familiarity with occupational hazards through regular visits to work sites, and review of Industrial Hygiene reports and information. Conduct job related clinical examinations of military and civilian employees such as pre-employment, periodic in regard to hazard exposure, fitness for duty, disability retirement, and health clearances before returning to work after certain illnesses and injuries. Advise Civilian Personnel Advisory Center (CPAC) regarding qualifications or disposition of applicants and employees.

d. Apply epidemiological techniques to study occupational injury or illness, including possible illness suggested by results of routine examinations. Refers data suggesting the need for environmental corrections to the Environmental Health Section, Preventive Medicine Service or the Post Safety Officer.

e. Promote, and participate in, a program of health education focused upon protection against occupational health hazards. Selects and prepares health education material and presents information to employees in classes/briefings.

f. Maintain familiarity with, and participates in, other functions of the Occupational Health Clinic including special programs in hearing conservation, occupational vision, immunization, alcohol and drug abuse control, pregnancy surveillance, chronic disease surveillance, and nuclear/biological/chemical surety. Provide treatment of illness and injury within the scope of the Occupational health Clinic mission. Completes required records, reports, and quality assurance reviews pertaining to the Occupational Health Clinic.

g. Provide medical input and coordination to unit and installation boards and committees as assigned. h. Determine the need for and requests consultations from other medical or surgical specialties or supporting services. Completes all medical documentation in accordance with current policies. Participates in quality assurance, utilization review, risk management, and peer review activities.

Attend Federal Employees Compensation Act (FECA) meetings as required. Knowledge to ensure adequate support to the chemical/nuclear/biological surety mission (if applicable) by assisting the Occupational Health Physician with:

a. Providing medical review of Personnel Reliability Program PRP personnel.

b. Ensuring maintenance of PRP records in accordance with regulations. Applicant should

be a US citizen, with at least a bachelors degree; a graduate of a training program accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA), with current certification by the National Commission on Certification of Physician Assistants (NCCPA).

FACTOR 2. SUPERVISORY CONTROLS FL 2-4 450 PTS

The supervisor sets overall objectives and resources available. Works alone, or as part of a team, treats patients and solves all but the most acute problems on own initiative. Consults with supervisor on work and develop decisions together. Plans and performs work independently, resolves most conflicts, and coordinates with others. Work is reviewed for effectiveness.

FACTOR 3. GUIDELINES FL 3-4 450 PTS

Guidelines consist of Federal standards, general administrative policies, technical literature, professional journals and established practice. Since many problems arise for which established practice is not applicable, the employee must apply experienced judgment in order to deal with unusual situations. For special studies and projects, incumbent researches trends and patterns to develop new methods and criteria.

FACTOR 4. COMPLEXITY FL 4-4 225 PTS

The work involves independent assessment of each aspect of the installations OM/IH program. Physician Assistant evaluates the effectiveness of OM/IH programs that may require special studies. Provides program guidance in the form of education to occupational health nurses, consultants, managers, and safety professionals. Assignments require performing a broad range of management functions involving program development, administration and recommendations for maintaining optimal health. Develops standard procedures, model administrative documents, and informational material which require defining the problem or need, planning and conducting studies and/or background investigations, documenting findings, and preparing reports outlining suggested solutions. Plans, coordinates, and conducts training courses and develops instructional material in the area of OM. This requires assessment of training needs and in-depth knowledge of its impact on OM programs. The Physician Assistant is also responsible for gathering and disseminating new information for use by occupational health professionals.

FACTOR 5. SCOPE AND EFFECT FL 5-4 225 PTS

SCOPE: The purposes of the work are to:

(1) evaluate patients eligible for care in the OM program. (2) Document all medical appointments in the appropriate records. (3) Maintain all Employee Medical Files in accordance with the Privacy Act of 1973, AR 40-66, and Health Insurance Portability and Privacy Act of 2003. evaluate OM programs and make recommendations to ensure

programs meet the criteria and are in compliance with regulations and laws; (4) identify and make recommendations for correction of unusual conditions and critical problems encountered.

EFFECT: Work affects how the U.S. Army is perceived/regarded by the military and civilian populations served.

FACTOR 6. PERSONAL CONTACTS FL 6-3 60 PTS

Personal contacts include officials of state and federal agencies, high ranking military personnel, contractors and consultants, representatives of professional societies and associations, engineers, industrial hygienists, union officials and OH nurses of other military facilities and services.

FACTOR 7. PURPOSE OF CONTACTS FL 7-3 120 PTS

The purpose of the contacts are to explain and define program policies and objectives, ensure regulatory compliance, promote effective OM practices, and; to influence and motivate patients to follow OH practices. Patients undergoing examinations/evaluations to determine if ill or well, are to some degree fearful, hesitant or skeptical and require a very skillful approach.

FACTOR 8. PHYSICAL DEMANDS FL 8-1 5 PTS

Work is typically sedentary, however, there may be some walking, standing, bending and carrying light objects such as books and moderately heavy objects such as boxes of printed materials. Travel may be required.

FACTOR 9. WORK ENVIRONMENT FL 9-2 20 PTS

Environmental health and industrial hygiene worksite visits involve moderate risks to hazards encountered: chemicals, pesticides, ionizing and non-ionizing radiation, noise hazards, eye hazards, biological hazards and other environmental conditions. Protective clothing and gear required.

TOTAL POINTS: 2805

POINT RANGE: 2755-3150

FINAL GRADE: 12

Fair Labor Standards Act (FLSA) Determination = (EXEMPT)

Executive Exemption:

* Exercises appropriate management responsibility (primary duty) over a recognized organizational unit with a continuing function, AND

Professional Exemption:

* Professional work (primary duty)

* Learned Professional, (See 5 CFR, 551.208) (Registered Nurses, Dental Hygienists, Physician's Assistants, Medical Technologists, Teachers, Attorneys, Physicians, Dentists, Podiatrists, Optometrists, Engineers, Architects, and Accountants at the independent level as just some of the typical examples of exempt professionals). Or

Administrative Exemption:

* Primary duty consistent with 5 CFR 551 (e.g.; non-manual work directly related to the management or general business operations of the employer or its customers), AND job duties require exercise of discretion & independent judgment.

FLSA Comments/Explanations:

EXEMPT.

* This position is subject to drug testing if the incumbent:

1. Has direct patient contact or performs diagnostic or therapeutic functions
2. Extracts or works with patients' body fluids or tissues; prepares patient specimens for examination, performs specialized or non-routine tests on body fluids or tissue samples, or confirms patients' test results
3. Maintains, stores, safeguards, inputs, fills or distributes drugs and medicines

This position has a mandatory seasonal influenza vaccination requirement and is therefore subject to annual seasonal influenza vaccinations. Applicants tentatively selected for appointment to this position will be required to sign a statement (Condition of Employment) consenting to seasonal influenza vaccinations.

Position Evaluation:

Not Listed

Position Competencies:

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USC > Title 42 > Chapter 6A > Subchapter XIX > Part 2 >
Subpart c > § 300aa-25

PREV NEXT

42 USC § 300aa-25 - Recording and reporting of information

USC-prelim US Code Notes Updates Authorities (CFR)

USC Prelim is a preliminary release and may be subject to further revision before it is released again as a final version.

Current through Pub. L. 112-238. (See [Public Laws for the current Congress.](#))

(a) General rule

Each health care provider who administers a vaccine set forth in the Vaccine Injury Table to any person shall record, or ensure that there is recorded, in such person's permanent medical record (or in a permanent office log or file to which a legal representative shall have access upon request) with respect to each such vaccine—

- (1) the date of administration of the vaccine,
- (2) the vaccine manufacturer and lot number of the vaccine,
- (3) the name and address and, if appropriate, the title of the health care provider administering the vaccine, and
- (4) any other identifying information on the vaccine required pursuant to regulations promulgated by the Secretary.

(b) Reporting

- (1) Each health care provider and vaccine manufacturer shall report to the Secretary—
 - (A) the occurrence of any event set forth in the Vaccine Injury Table, including the events set forth in section [300aa-14 \(b\)](#) of this title which occur within 7 days of the administration of any vaccine set forth in the Table or within such longer period as is specified in the Table or section,
 - (B) the occurrence of any contraindicating reaction to a vaccine which is specified in the manufacturer's package insert, and
 - (C) such other matters as the Secretary may by regulation require.

Reports of the matters referred to in subparagraphs (A) and (B) shall be made beginning 90 days after December 22, 1987. The Secretary shall publish in the Federal Register as soon as practicable after such date a notice of the reporting requirement.

(2) A report under paragraph (1) respecting a vaccine shall include the time periods after the administration of such vaccine within which vaccine-related illnesses, disabilities, injuries, or conditions, the symptoms and manifestations of such illnesses, disabilities, injuries, or conditions, or deaths occur, and the manufacturer and lot number of the vaccine.

(3) The Secretary shall issue the regulations referred to in paragraph (1)(C) within 180 days of December 22, 1987.

(c) Release of information

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(1) Information which is in the possession of the Federal Government and State and local governments under this section and which may identify an individual shall not be made available under section 552 of title 5, or otherwise, to any person except—

(A) the person who received the vaccine, or

(B) the legal representative of such person.

(2) For purposes of paragraph (1), the term "information which may identify an individual" shall be limited to the name, street address, and telephone number of the person who received the vaccine and of that person's legal representative and the medical records of such person relating to the administration of the vaccine, and shall not include the locality and State of vaccine administration, the name of the health care provider who administered the vaccine, the date of the vaccination, or information concerning any reported illness, disability, injury, or condition resulting from the administration of the vaccine, any symptom or manifestation of such illness, disability, injury, or condition, or death resulting from the administration of the vaccine.

(3) Except as provided in paragraph (1), all information reported under this section shall be available to the public.

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USC > Title 42 > Chapter 6A > Subchapter XIX > Part 2 > [PREV](#) [NEXT](#)
 Subpart a > § 300aa-14 >

42 USC § 300aa-14 - Vaccine Injury Table

[US Code](#) [Notes](#) [Updates](#) [Authorities \(CFR\)](#)

Current through Pub. L. 113-36. (See [Public Laws for the current Congress.](#))

(a) Initial table

The following is a table of vaccines, the injuries, disabilities, illnesses, conditions, and deaths resulting from the administration of such vaccines, and the time period in which the first symptom or manifestation of onset or of the significant aggravation of such injuries, disabilities, illnesses, conditions, and deaths is to occur after vaccine administration for purposes of receiving compensation under the Program:

VACCINE INJURY TABLE											
I.	<p>DTP; P; DTP/Polio Combination; or Any Other Vaccine Containing Whole Cell Pertussis Bacteria, Extracted or Partial Cell Bacteria, or Specific Pertussis Antigen(s). Illness, disability, injury, or condition covered:</p> <table border="0" style="width: 100%;"> <tr> <td style="width: 50%;">A. Anaphylaxis or anaphylactic shock</td> <td style="width: 50%;">24 hours</td> </tr> <tr> <td>B. Encephalopathy (or encephalitis)</td> <td>3 days</td> </tr> <tr> <td>C. Shock-collapse or hypotonic-hyporesponsive collapse</td> <td>3 days</td> </tr> <tr> <td>D. Residual seizure disorder in accordance with subsection (b)(2)</td> <td>3 days</td> </tr> <tr> <td>E. Any acute complication or sequela (including death) of an illness, disability, injury, or condition referred to above which illness, disability, injury, or condition arose within the time period prescribed</td> <td>Not applicable</td> </tr> </table>	A. Anaphylaxis or anaphylactic shock	24 hours	B. Encephalopathy (or encephalitis)	3 days	C. Shock-collapse or hypotonic-hyporesponsive collapse	3 days	D. Residual seizure disorder in accordance with subsection (b)(2)	3 days	E. Any acute complication or sequela (including death) of an illness, disability, injury, or condition referred to above which illness, disability, injury, or condition arose within the time period prescribed	Not applicable
A. Anaphylaxis or anaphylactic shock	24 hours										
B. Encephalopathy (or encephalitis)	3 days										
C. Shock-collapse or hypotonic-hyporesponsive collapse	3 days										
D. Residual seizure disorder in accordance with subsection (b)(2)	3 days										
E. Any acute complication or sequela (including death) of an illness, disability, injury, or condition referred to above which illness, disability, injury, or condition arose within the time period prescribed	Not applicable										
II.	<p>Measles, mumps, rubella, or any vaccine containing any of the foregoing as a component; DT; Td; or Tetanus Toxoid.</p>										

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	<p>A. Anaphylaxis or anaphylactic shock</p> <p>B. Encephalopathy (or encephalitis)</p> <p>C. Residual seizure disorder in accordance with subsection (b)(2)</p> <p>D. Any acute complication or sequela (including death) of an illness, disability, injury, or condition referred to above which illness, disability, injury, or condition arose within the time period prescribed</p>	<p>24 hours</p> <p>15 days (for mumps, rubella, measles, or any vaccine containing any of the foregoing as a component). 3 days (for DT, Td, or tetanus toxoid).</p> <p>15 days (for mumps, rubella, measles, or any vaccine containing any of the foregoing as a component). 3 days (for DT, Td, or tetanus toxoid).</p> <p>Not applicable</p>	<p>FIND A LAWYER</p> <p><u>All lawyers</u></p> <p>LAW ABOUT... ARTICLES FROM WEX</p> <ul style="list-style-type: none"> • <u>Involuntary civil commitment</u> • <u>Able to work</u> • <u>Workers compensation</u> • <u>attractive nuisance</u> • <u>Disability law</u>
<p>III.</p>	<p>Polio Vaccines (other than Inactivated Polio Vaccine).</p> <p>A. Paralytic polio</p> <p>—in a non-immunodeficient recipient</p> <p>—in an immunodeficient recipient</p> <p>—in a vaccine-associated community case</p> <p>B. Any acute complication or sequela (including death) of an illness, disability, injury, or condition referred to above which illness, disability, injury, or condition arose within the time period prescribed</p>	<p>30 days</p> <p>6 months</p> <p>Not applicable</p> <p>Not applicable</p>	<p>[LII]</p>
<p>IV.</p>	<p>Inactivated Polio Vaccine.</p> <p>A. Anaphylaxis or anaphylactic shock</p> <p>B. Any acute complication or sequela (including death) of an illness, disability, injury, or condition referred to above which illness, disability, injury, or condition arose within the time period prescribed</p>	<p>24 hours</p> <p>Not applicable</p>	

(b) Qualifications and aids to interpretation

The following qualifications and aids to interpretation shall apply to the Vaccine Injury Table in subsection (a) of this section:

(1) A shock-collapse or a hypotonic-hyporesponsive collapse may be evidenced by indicia or symptoms such as decrease or loss of muscle tone, paralysis (partial or complete), hemiplegia or hemiparesis, loss of color or turning pale white or blue, unresponsiveness to environmental stimuli, depression of consciousness, loss of consciousness, prolonged sleeping with difficulty arousing, or cardiovascular or respiratory arrest.

(2) A petitioner may be considered to have suffered a residual seizure disorder if the petitioner did not suffer a seizure or convulsion unaccompanied by fever or accompanied by a fever of less than 102 degrees Fahrenheit before the first seizure or convulsion after the administration of the vaccine involved and if—

(A) in the case of a measles, mumps, or rubella vaccine or any combination of such vaccines, the first seizure or convulsion occurred within 15 days after administration of the vaccine and 2 or more seizures or convulsions occurred within 1 year after the administration of the vaccine which were unaccompanied by fever or accompanied by a fever of less than 102 degrees Fahrenheit, and

(B) in the case of any other vaccine, the first seizure or convulsion occurred within 3 days after administration of the vaccine and 2 or more seizures or convulsions occurred within 1 year after the administration of the vaccine which were unaccompanied by fever or accompanied by a fever of less than 102 degrees Fahrenheit.

(3)

(A) The term "encephalopathy" means any significant acquired abnormality of, or injury to, or impairment of function of the brain. Among the frequent manifestations of encephalopathy are focal and diffuse neurologic signs, increased intracranial pressure, or changes lasting at least 6 hours in level of consciousness, with or without convulsions. The neurological signs and symptoms of encephalopathy may be temporary with complete recovery, or may result in various degrees of permanent impairment. Signs and symptoms such as high pitched and unusual screaming, persistent inconsolable crying, and bulging fontanel are compatible with an encephalopathy, but in and of themselves are not conclusive evidence of encephalopathy. Encephalopathy usually can be documented by slow wave activity on an electroencephalogram.

(B) If in a proceeding on a petition it is shown by a preponderance of the evidence that an encephalopathy was caused by infection, toxins, trauma, or metabolic disturbances the encephalopathy shall not be considered to be a condition set forth in the table. If at the time a judgment is entered on a petition filed under section 300aa-11 of this title for a vaccine-related injury or death it is not possible to determine the cause, by a preponderance of the evidence, of an encephalopathy, the encephalopathy shall be considered to be a condition set forth in the table. In determining whether or not an encephalopathy is a condition set forth in the table, the court shall consider the entire medical record.

(4) For purposes of paragraphs (2) and (3), the terms "seizure" and "convulsion" include grand mal, petit mal, absence, myoclonic, tonic-clonic, and focal motor seizures and signs. If a provision of the table to which paragraph (1), (2), (3), or (4) applies is revised under subsection (c) or (d) of this section, such paragraph shall not apply to such provision after the effective date of the revision unless the revision specifies that such paragraph is to continue to apply.

(c) Administrative revision of table

(1) The Secretary may promulgate regulations to modify in accordance with paragraph (3) the Vaccine Injury Table. In promulgating such regulations, the Secretary shall provide for notice and opportunity for a public hearing and at least 180 days of public comment.

(2) Any person (including the Advisory Commission on Childhood Vaccines) may petition the Secretary to propose regulations to amend the Vaccine Injury Table. Unless clearly frivolous, or initiated by the Commission, any such petition shall be referred to the Commission for its recommendations. Following—

(A) receipt of any recommendation of the Commission, or

(B) 180 days after the date of the referral to the Commission,

whichever occurs first, the Secretary shall conduct a rulemaking proceeding on the matters proposed in the petition or publish in the Federal Register a statement of reasons for not conducting such proceeding.

(3) A modification of the Vaccine Injury Table under paragraph (1) may add to, or delete from, the list of injuries, disabilities, illnesses, conditions, and deaths for which compensation may be provided or may change the time periods for the first symptom or manifestation of the onset or the significant aggravation of any such injury, disability, illness, condition, or death.

(4) Any modification under paragraph (1) of the Vaccine Injury Table shall apply only with respect to petitions for compensation under the Program which are filed after the effective date of such regulation.

(d) **Role of Commission**

Except with respect to a regulation recommended by the Advisory Commission on Childhood Vaccines, the Secretary may not propose a regulation under subsection (c) of this section or any revision thereof, unless the Secretary has first provided to the Commission a copy of the proposed regulation or revision, requested recommendations and comments by the Commission, and afforded the Commission at least 90 days to make such recommendations.

(e) **Additional vaccines**

(1) **Vaccines recommended before August 1, 1993**

By August 1, 1995, the Secretary shall revise the Vaccine Injury Table included in subsection (a) of this section to include—

(A) vaccines which are recommended to the Secretary by the Centers for Disease Control and Prevention before August 1, 1993, for routine administration to children,

(B) the injuries, disabilities, illnesses, conditions, and deaths associated with such vaccines, and

(C) the time period in which the first symptoms or manifestations of onset or other significant aggravation of such injuries, disabilities, illnesses, conditions, and deaths associated with such vaccines may occur.

(2) **Vaccines recommended after August 1, 1993**

When after August 1, 1993, the Centers for Disease Control and Prevention recommends a vaccine to the Secretary for routine administration to children, the Secretary shall, within 2 years of such recommendation, amend the Vaccine Injury Table included in subsection (a) of this section to include—

(A) vaccines which were recommended for routine administration to children,

(B) the injuries, disabilities, illnesses, conditions, and deaths associated with such vaccines, and

(C) the time period in which the first symptoms or manifestations of onset or other significant aggravation of such injuries, disabilities, illnesses, conditions, and deaths associated with such vaccines may occur.

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OCCUPATIONAL HEALTH CLINIC

Standard Operation Procedure #7

6 May 2013

SUBJECT: Booking and AHLTA/Medical Record Documentation of Immunization/PPD Administration or to the health department if they are a contract employee

1. PURPOSE: To provide guidance for the correct procedure for AHLTA /medical record documentation of immunization/PPD administration.
2. SCOPE: This applies to OH Clinic, Fort Hood, TX
3. PROCEDURE:
 - A. MD/PA/RN will send each employee requiring an immunization/PPD to the immunization room with their medical record, OH worksheet or the immunization slip (see attached), indicating what immunization needs to be administered. The LPN will check allergies and contraindications. Then administer required vaccines/PPD as indicated. A Vaccine Information Sheet will be issued to each employee. Instructed to remain in the OHC waiting room for 20 minutes after receiving a vaccine will be given. Encourage each employee to check out with the LPN before leaving the building to ensure no adverse reaction is occurring. Each employee receiving a PPD will be instructed to return within 48-72 hours to see the LPN for a reading. If they don't return within the allotted time a PPD will be repeated. The LPN will document the immunization/PPD administered in AHLTA immunization tab, SF 601 and personal shot records on each employee. The employee's medical record or OH work sheet will be maintained by the LPN until they return for the PPD reading.
 - B. When an employee returns for their PPD reading they will be walked-in for the LPN. If there is a questionable reading of the PPD site have it checked by another nurse. If the PPD reading is 10mm or over, refer the employee to their primary RN with their medical record or OH worksheet and the RN will do the AHLTA encounter, Order the QFT-G blood test. If QFT-G test results are positive the RN will consult to APHN, order required X-ray and labs and transfer the encounter to MD/PA for signature. If contract employee TST is positive they will be referred to PCP/ health dept for follow up.
 - C. When an employee returns for their second PPD or vaccine, they will be walked-in for the LPN. The employee will be given the medical record or OH worksheet and instructed to report directly to the immunization room. The LPN will check allergies and contraindications. Then administer required vaccines/PPD as indicated. A Vaccine Information Sheet will be issued to each employee and instructed to remain in the OHC waiting room for 20 minutes after receiving a vaccine. Each employee will be encouraged to check out with the LPN before leaving the building to ensure no adverse reaction is occurring. The LPN will document the immunization/PPD administered in AHLTA and complete the encounter on each employee then transfer the encounter to the

TAB 12

MD/PA for signature. Each employee receiving a PPD will be instructed to return within 48-72 hours to see the LPN in the immunization room for the PPD reading. If they don't return within the allotted time the PPD will be repeated. The medical record or OH worksheet will be maintained by the LPN if the employee is returning for their second PPD read.

1. PPD's can be read up to 72 hours after placement.
 2. The 2nd PPD can be placed 7 days after the placement of the 1st PPD.
- D. The LPN will administer the PPD - ID in the left forearm, MMR -SC in the upper arm, Hep A, Hep B, Tdap and Flu - IM in the deltoid unless contraindicated or gluteal site if requested. Flu mist will be given intranasal. The LPN will document in AHLTA the location. Printout from ALTHA will be given to all patients after services are completed.
- E. Always have an RN double check the PPD site if there is a questionable reading. If the PPD reading is 10mm or over, immediately refer the employee to their primary RN with their medical record or OH worksheet. The LPN will do the AHLTA encounter. The RN will order a QFT-G. If QFT-G results are positive, make a consult APHN, order required x-rays and labs and refer to their PCM if the PPD is 10mm or over on the 1st PPD. If the employee had a 2nd PPD with a reading less than 10mm on the 1st PPD, then the 2nd PPD will have to be 10mm greater than the 1st PPD reading to be a positive PPD for referral. If employee is contract and second TST is positive they will be referred to the health department and PCP for follow up.

Contraindications: We will order QFT-G

Have schedule that makes skin testing or 2 step skin testing difficult to place and read in appropriate time frame

Have an allergy or allergic sensitivity to tuberculin skin testing protein that may result in a test that is difficult to interpret.

As part of a clinical assessment for employees with history of a positive TST such that repeating test is not advisable.

Have a reactive skin test and history of receiving the BCG vaccination, being a foreign national.

Had a recent reactive TB skin test but more than 12 weeks since known exposure.

Patients with negative Varicella titers or no known history of receiving Varicella vaccine will be referred to Thomas Moore immunization clinic for vaccine administration. HCP should have documentation of 2 doses of Varicella vaccine given at least 28 days apart, history of Varicella or herpes zoster based on HCP diagnosis, laboratory evidence of immunity or laboratory confirmation of disease.

Patients requiring Meningococcal vaccine will be referred to Thomas Moore immunization clinic. MCV4 is preferred for persons younger than age 56 years given IM. MPSV4 is recommended for HCP older than 55; give SC

Rabies vaccine is given at Thomas Moore immunization clinic to Vetcom personnel on a need to have basis only.

ENCL

Initiators:

Approving Official:

(b) (6)

Occupational Health Clinic

(b) (6)

Chief, Occupational Health Clinic

MEDCEN Regulation 40-6

Medical Services

**Required
Immunizations and
Post-Exposure
Prophylaxis Against
Communicable
Disease**

Headquarters
Carl R. Darnall Army Medical Center
Fort Hood, Texas
17 December 2012

TAB 13

SUMMARY of CHANGE

MEDCEN Regulation No. 40-6
Medical Services – Required Immunizations and Post-Exposure Prophylaxis Against
Communicable Disease

This revision dated 17 December 2012

o Para 6.a.(9), added: *****VARICELLAZOSTER VACCINE IS A LIVE VIRUS VACCINE
AND IS CONTRAINDICATED IN PREGNANCY AND IMMUNOCOMPROMISED
PERSONS.*****

o Para 6.a.(10), changed "Nosocomial Hospital acquired infection" to "Hospital acquired
infection".

o Added Appendix A: Civilian Occupations Subject to Mandatory Influenza
Vaccinations

DEPARTMENT OF THE ARMY
HEADQUARTERS, CARL R. DARNALL ARMY MEDICAL CENTER
Fort Hood, TX 76544

MEDCEN Regulation
Number 40-6

17 December 2012

Medical Services
**REQUIRED IMMUNIZATIONS AND POST-EXPOSURE
PROPHYLAXIS AGAINST COMMUNICABLE DISEASE**

1. **PURPOSE.** This regulation prescribes specific guidance for certain immunizations and other prophylaxis against preventable diseases, and post-exposure protocols in the event of non-compliance or highly infectious contact.
2. **SCOPE.** This regulation is applicable to all Medical Center (MEDCEN) and Dental Activity (DENTAC) military, civilian, and contract health care workers, as well as Forces Command (FORSCOM) personnel undergoing medical training and other similar programs, and other personnel as designated below.
3. **DEFINITIONS.** Health Care Worker (HCW) - An employee, volunteer, or student in a health care facility including, but not limited to, nurses, physicians, dentists, other dental workers, optometrists, podiatrists, laboratory and blood bank technologist and technicians, research laboratory scientists, phlebotomists, dialysis personnel, paramedics, emergency medical technicians, medical examiners, morticians, housekeepers, laundry workers, and others whose work may involve direct contact with body fluids from living individuals or corpses.
4. **REFERENCES.**
 - a. AR 40-562, Immunizations and Chemoprophylaxis.
 - b. AR 40-5 Preventive Medicine.
 - c. DoD Directive 6055.5 M, Occupational Health Surveillance Systems.
 - d. 29 CFR, 1910.1030, Occupational Exposures to Blood borne Pathogens.
 - e. DOD Directive 6205.02 Sept 18, 2006, "Policy and Program for Immunizations to Protect the Health of Service Members and Military Beneficiaries.

*This regulation supersedes MEDCEN Regulation 40-6, dated 13 April 2011.

MEDCEN Reg 40-6

f. MMWR, CDC: "Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HIV and Recommendations for Post exposure Prophylaxis," 30 Sept MMWR, Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Healthcare Facility Setting, MMWR, CDC, 30 Dec 2005.

g. MMWR, Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HBV, HCV, and HIV and Recommendations for Post exposure Prophylaxis, June 29, 2001.

h. MMWR, Immunization of Health Care Workers, December 26, 1997.

g. Immunization Action Coalition, Vaccination Information for Healthcare Professionals, <http://www.immunize.org>.

h. Memo, 23 Oct 96, ASoD (HA), Hepatitis B Immunization Policy.

i. "Immunizations for healthcare workers," September 2010, Accessed 21 Feb 2011, website: <http://www.uptodate.com/index>.

5. RESPONSIBILITIES.

a. Preventive Medicine will ensure accuracy and currency of this regulation.

b. The MEDCEN Commander will ensure overall compliance and participation of MEDCEN personnel.

c. The DENTAC Commander will ensure overall compliance and participation of DENTAC personnel.

d. Resource Management Division, Contract Administration Branch, will ensure compliance of contract health care providers with this regulation.

e. Department and Service Chiefs will ensure compliance of their personnel with this regulation.

f. Department of Pathology will provide the serologic testing to determine immunity to specific diseases.

g. Personnel Division will provide Occupational Health with a roster of military and civilian personnel assigned to MEDCEN/DENTAC and a monthly update of arriving and departing personnel.

h. Personnel contracting a communicable disease discussed in this regulation will notify the Infection Control Nurse immediately (DENTAC personnel will notify their designated Infection Control Officer).

i. The Infection Control Nurse/Officer will notify Occupational Health immediately of any personnel contracting or having exposure to diseases discussed in this regulation and will assist in the epidemiological investigation of said diseases.

6. **POLICY.** Because of their contact with patients or infective material from patients, Many HCW are at risk for exposure to and possible transmission of vaccine preventable diseases. All new employees should receive a prompt review of their immunization status prior to starting to care for patients. Employees who had been hired should have an annual review to ensure that immunizations remain up to date. Maintenance of immunity is therefore an essential part of prevention and infection control programs for HCWs. Optimal use of immunizing agents safeguards the health of workers and protects patients from becoming infected through exposure to infected workers. Consistent immunization programs can substantially reduce both the number of susceptible HCWs in hospitals and the attendant risks for transmission of vaccine-preventable diseases to other workers and patients. On the basis of documented nosocomial transmission, HCWs are considered to be at significant risk for acquiring or transmitting hepatitis B, Influenza, measles, mumps, rubella, and varicella. All of these diseases are vaccine preventable. Immunization against preventable diseases are required of and provided to all CRDAMC HCWs, except in the case of contract HCWs. These individuals are provided annual influenza immunization through the CRDAMC Occupational Health clinic at no cost to the contractor or employee, but the contractor is required to provide immunization or show proof of immunity for the other vaccine preventable diseases listed above.

a. Communicable Disease Prophylaxis/Required Immunizations.

(1) Measles, Mumps, Rubella. The risk of acquiring measles among hospital personnel is estimated to be thirteen times greater than for the general population. HCP who work in medical facilities should be immune to measles, mumps, and rubella. All healthcare workers (medical or non medical with and without patient care responsibilities, paid, volunteer, full-time, part-time, student, or non student,) should have a formal assessment of immunity to measles or rubella, regardless of year of birth and those who are susceptible should be immunized. The same recommendation is made for all female healthcare workers with respect to rubella immunity and immunization. Strict definitions of evidence of measles and rubella immunity should be used. Serologic screening before immunization is generally not considered necessary for people who have documentation of appropriate vaccination or other acceptable evidence of immunity to measles and rubella. **MMR IS THE VACCINE OF CHOICE.**

(2) Two doses of the trivalent MMR vaccine are needed for full immunity. However, bivalent or nonvalent vaccines can be used in healthcare workers who have acceptable evidence of immunity to one or two of the viruses. Pregnancy is a contraindication to vaccination against measles and rubella. The pregnancy status of "At Risk" employees, military, or civilian, will be determined prior to immunization with MMR.

(3) Vaccine should not be given to pregnant women. Women should be counseled not to become pregnant for at least three months after vaccination. The vaccine is also contraindicated in persons with immune deficiency disease, suppressed immune responses from malignancy or therapy with immunosuppressive drugs.

(4) Poliovirus - Those individuals who spent their early childhood and attended public school in the United States will be assumed to have had the OPV series. Others should be vaccinated IAW the current ACIP recommendations or provide proof of vaccination.

(5) Hepatitis B - All service members who hold qualifications or assignment in medical or dental career fields and civilian medical health care workers within DoD medical and dental facilities shall be required to complete a series of three immunizations against hepatitis B, or show evidence of prior completion of the three dose series or serologic proof of immunity. This requirement shall also apply to all DOD civilian personnel, trainees, volunteers, contract HCWs, and other temporary staff with duties involving direct patient contact. The Occupational Safety and Health Act of 1991 mandates that hepatitis B vaccine be made available at the employer's expense to all healthcare workers who are occupationally exposed to blood or other infectious materials or sharps.)

(6) Preimmunization serologic screening is generally not considered cost-effective. Protective titers (anti-HBs >10 mIU/mL or a higher titer depending on the test standards the laboratory uses as protective titer) develop in 95 to 99 percent of healthy adults who receive three intramuscular doses of hepatitis B vaccine. The rate decreases with increasing age to 86 percent in the fourth decade and 47 percent in the sixth decade.

(7) Doses are usually administered on a 0, 1, and 6-month schedule in the deltoid, although accelerated schedules of 0, 1, and 4 months or 0, 1, and 2 months may be considered for healthcare workers at highest risk (eg, surgeons and those working in hemodialysis units). Accelerated schedules result in more rapid antibody rise but may result in lower peak titers. A fourth dose of the vaccine at 12 months is recommended for healthcare workers who are immunized using the accelerated schedule. The two available vaccines, Recombivax HB and Energix-B are equally immunogenic and can be used interchangeably to complete the immunization series. Hepatitis B vaccine may be administered with other vaccines and can safely be used during pregnancy.

(a) Hepatitis B Nonresponders — 5 to 21 percent of healthcare workers do not develop a protective level of anti-HBs after three doses of vaccine. Lower rates of seroconversion are associated with increasing age, greater immune compromised states, current smoking and higher body mass indexes. Thus, all healthcare workers should have their anti-HBs level checked one to two months after the third dose of hepatitis B vaccine. Approximately one-half of those who do not respond to the first three doses of the vaccine will respond to additional doses; thus, healthcare workers, who have not developed a protective response may receive up to three additional doses of the vaccine. An adequate antibody response is seen in 15 to 25 percent after one additional dose and in 50 percent after three additional doses. Titers can be checked after the administration of each dose, or at the end of the second three-dose series.

(b) Persistence of low Protective Antibody titers - Healthcare workers who do not respond to a total of six doses of the vaccine are considered NONRESPONDERS and should receive hepatitis B immune globulin (HBIG) for post-exposure prophylaxis. (Dosage recommendation is listed under post exposure prophylaxis section page 8 under Vaccine-induced antibodies to hepatitis B decline over time, and approximately 60 percent of initial responders will have undetectable levels twelve or more years after immunization. Despite declining antibody levels, healthcare workers who initially responded to the vaccine remain protected against clinical disease and viremia. Thus, checking antibody levels more than once and providing booster doses are not recommended. Asymptomatic hepatitis B infections have occurred in vaccinated patients (detected by the presence of antibody to hepatitis B core antigen), but these infections result in long lasting immunity and are not associated with hepatitis B-associated liver disease.

(8) Tuberculosis - An intradermal Tuberculosis Skin Test (TST)-5TU will be administered to all incoming personnel except those who have a previously documented positive TST test or those who have a documented test within the previous 12 months. A two-step baseline will be used for new employees who have an initial negative TST and who have not had a documented negative test result during the preceding 12 months. All negative HCWs, including contract HCWs, will undergo repeat testing at intervals determined by the MEDCEN TB risk assessment. BCG vaccine is not a contraindication to TB skin testing.

(9) Varicella (chickenpox) - Susceptibility to varicella will be determined by medical history at the time of inprocessing of military and civilian personnel as well as contract health care providers. Evidence of immunity in HCP includes documentation of 2 doses of varicella vaccine given at least 28 days apart, history of varicella or herpes zoster based on physician diagnosis, laboratory evidence of immunity, or laboratory confirmation of disease. Serologic testing will be provided for all non-contract personnel with unknown or negative history. Vaccination, with two 0.5 ml subcutaneous doses of varicella zoster live-virus vaccine 4-8

MEDCEN Reg 40-6

weeks apart, will be provided for noncontract HCWs who have a negative serologic test for immunity. *****VARICELLAZOSTER VACCINE IS A LIVE VIRUS VACCINE AND IS CONTRAINDICATED IN PREGNANCY AND IMMUNOCOMPROMISED PERSONS.*****

(10) Influenza - Hospital Acquired infection outbreaks of influenza are reported frequently. All HCWs can transmit influenza virus to the patients while they themselves are incubating infection, experiencing a subclinical infection, or working despite the existence of symptoms. The potential for transmitting influenza can be reduced by vaccinating all CRDAMC employees with direct patient contact. Vaccine will be administered every year preferably between September and November, this is a condition of employment for all HCWs. Live attenuated influenza vaccine (LAIV) may only be given to nonpregnant healthy HCP age 49 years and younger. Inactivated injectable influenza vaccine (TIV) is preferred over LAIV for HCP who will be in close contact with severely immuno suppressed persons (e.g., stem cell transplant patients) when patients require protective isolation.

b. Other Vaccine-Preventable Diseases.

(1) Tetanus-Diphtheria (Td) Tetanus-Diphtheria-Pertussis (Tdap) - Routine booster doses of Td are recommended at ten year intervals after the primary series. One adult dose of Tdap will be given if there was no Tdap in the past. Subsequent booster shots of Td will be given every 10 years. When there had been more than 10 years since his Td booster, a Td vaccine is required or a Tdap (if none was given in the past,).

(2) In Oct 2010, the Advisory Committee on Immunization practices voted the use of Tdap regardless of the interval since the last tetanus or diphtheria containing vaccine and the use also of Tdap in adults age 65 and older. This recommendation was due to the fact that Pertussis remain poorly controlled in the US.

(3) There is lack of data in giving Tdap to pregnant women. Data on safety, immunogenicity and the outcomes of pregnancy are not available for pregnant women who receive Tdap. When Tdap is administered during pregnancy, transplacental maternal antibodies might protect the infant against pertussis in early life. They also could interfere with the infant's immune response to infant doses of DTaP, and leave the infant less well protected against pertussis. In some situations, healthcare providers can choose to administer Tdap instead of Td to add protection against pertussis. When Td or Tdap is administered during pregnancy, the second or third trimester is preferred.

(4) For Tetanus diphtheria (Td) Booster shots will continue every 10 years.

(5) Contract employees should receive this required vaccine through their contractor.

c. Post-Exposure Immunizations and Chemotherapeutic Agents. When a HCW is exposed to an acute communicable disease much anxiety and confusion can be avoided by having accurate immunization records on file for all personnel. The need for emergency vaccinations can often be avoided by maintaining high levels of immunity among workers according to the above recommendations. However, certain situations may require post-exposure immunization of hospital personnel.

(1) Measles (rubella) - Non-pregnant, susceptible persons exposed to measles may be afforded protection if immunized with measles vaccine within 72 hours following exposure. Measles may be prevented or modified in susceptible pregnant personnel by administering immune globulin (IG) within 6 days following exposure.

(2) Rubella or Mumps - It has not been established that the administration of either IG or vaccine prevents rubella or mumps when administered after exposure.

(3) Tetanus-Diphtheria (Td):

(a) Previously vaccinated personnel who sustain a puncture wound or laceration should receive a Td booster (absorbed tetanus toxoid) if 10 years or more have elapsed since their last booster. With the more severe or contaminated wounds, Td boosters should be given to those with a vaccine history indicating greater than 5 years since the last dose.

(b) All hospital personnel who have not had a booster dose of diphtheria toxoid within the last 5 years and have close respiratory contact with pharyngeal secretions of a suspected case of diphtheria should receive an injection of diphtheria toxoid (Adult, normally combined with tetanus toxoid -Td) and be medically examined daily for 7 days for evidence of the disease. A single dose of 1M Benzathine penicillin (1,200,000 units) or a 7-10 day course of oral erythromycin (1g/day) is recommended for all persons exposed to diphtheria, regardless of their immunization status.

(4) Poliomyelitis - HCWs who may have contact with patients excreting wild virus (e.g., imported poliomyelitis case) and laboratory personnel handling specimens containing poliovirus or performing cultures to amplify virus should receive a complete series of polio vaccine if not previously vaccinated; if previously vaccinated, they may require a booster dose of either IPV or OPV. For situations where immediate protection is necessary additional doses of OPV should be given to adults who have previously completed a polio vaccine series. *****OPV IS A LIVE VIRUS AND MAY BE CONTRAINDICATED FOR PREGNANT WOMEN AND ALSO IN PERSONS WHO ARE IMMUNOCOMPROMISED.*****

(5) Hepatitis A - Immune globulin (IG) should not be routinely administered to hospital workers exposed to hepatitis A virus (HAV). IG should be administered only to hospital workers

MEDCEN Reg 40-6

who have had direct fecal/oral or parenteral contamination during the time of the patient's infectivity. Patients with hepatitis A are infectious approximately 2 weeks before and 1 week after the onset of symptoms. A single 1M dose of IG at 0.06 ml/kg of body weight is recommended. IG is most effective if given within 1 week of exposure but can be given up to 2 weeks after the exposure.

(6) Hepatitis B.

(a) For personnel who have not received the vaccine and sustain a parenteral, oral, or mucosal exposure to blood secretions or excretions known to be positive, or considered to be at high risk for hepatitis B infection, a single dose of HBIG (0.06 ml/kg of body weight) will be administered within 24 hours of ocular, needle-stick or mucosal exposure or within 14 days after sexual exposure. This is followed by a complete course of HB vaccine (3-series), with the first dose administered within 7 days after the exposure and the remaining 2 doses given according to the recommended schedule for the vaccine. The first dose of vaccine may be given at the same time as the single dose of HBIG if administered at a different site. However, the HB vaccine must be given into the deltoid rather than the buttocks. If the HB vaccine series is not given then a second dose of HBIG should be administered 25-30 days after the first dose.

(b) For known NONRESPONDERS (previously defined as persistence of low protective antibody titers of anti-HB surface antigen despite receiving 6 doses of HBV vaccine previously), post exposure prophylaxis recommended dose is again 0.06 ml/kg as soon as possible after exposure. A second dose is repeated at 28-30 days after exposure or in patients who refuse vaccination.

(c) For personnel who have received the HB vaccine series and are a known responder or have documented prior hepatitis B infection, no prophylactic therapy is required.

(d) For personnel whose antibody response is unknown, test for anti-HBs and (1) if adequate, no treatment is necessary; (2) if inadequate, treat with 1 dose of HBIG and follow (a) under this heading. **NOTE: IF HBIG IS NOT AVAILABLE, IG CAN BE GIVEN IN THE SAME DOSAGE AND SCHEDULE.**

(7) Tuberculosis Exposure -Personnel exposed to active TB will report the exposure to the Infection Control Nurse and to Occupational Health Clinic as soon as exposure is known. Occupational Health will administer TST to exposed personnel, including contract HCWs, as soon as possible after exposure has occurred and at 12 weeks after exposure if the initial skin test is negative. HCWs who have a documented history of a positive TST test and who have been exposed to an infectious TB patient are required to be clinically evaluated by Occupational Health at the time of exposure and at 12 weeks post exposure for signs and symptoms of the disease. These employees do not require a repeat TST or a CXR. CXR is

ordered only if symptoms are present suggestive of active TB. Department of Army Civilian employee HCWs with a positive result will be referred to the Army Public Health Nurse for clinical evaluation; contract HCWs will be referred to their employer's health care provider.

(8) Varicella - In the event that an exposure occurs, a check of the personal medical record should be sufficient to establish the immune status of the individual. When unvaccinated susceptible personnel are exposed to varicella, they are potentially infectious 10 to 21 days after exposure, and exclusion from duty is indicated from the tenth day after the first exposure through the twenty-first day after the last exposure. The routine post-exposure use of VZIG is not recommended among immune competent personnel. VZIG may be costly, does not necessarily prevent varicella, and may prolong the incubation period by a week or more, thus extending the time that personnel will be restricted from duty. The use of VZIG may be considered for immune compromised or pregnant personnel. For healthy adolescents and adults (persons aged 13 years or older) without evidence of immunity, vaccination within 3-5 days of exposure to rash is beneficial in preventing or modifying varicella. Studies have shown that vaccination administered within 3 days of exposure to rash is 90% or more effective in preventing varicella while vaccination within 5 days of exposure to rash is approximately 70% effective in preventing varicella and 100% effective in modifying severe disease.

7. PROCEDURES.

a. Inprocessing:

(1) All personnel, military, Department of Army civilians, contract HCWs, volunteers, students, etc., will inprocess through Occupational Health upon assignment to MEDCEN/DENTAC.

(2) Inprocessing personnel will provide Occupational Health with any available immunization records and/or lab results of tests done to determine immunity to diseases covered by this regulation.

(3) Contract HCWs must complete the required immunizations discussed in this regulation prior to employment and provide documentation of these immunizations (or serologic proof of immunity) to Occupational Health at the time of inprocessing. The Contract Officer's Representative (COR) in Resource Management Division will be notified of failure to provide this documentation and the hiring action can be delayed until the immunization requirements are met.

b. Immunizations:

MEDCEN Reg 40-6

(1) Occupational Health will provide needed vaccines to soldiers, volunteers, and Department of Army Civilian employees.

(2) The contract HCW will receive the required preplacement immunizations or serologic tests for immunity from a health care provider designated by their employer.

(3) Occupational Health will provide required TB skin tests to all HCWs including contract employees; influenza vaccine will also be provided to all HCWs, including contract workers, as available.

APPENDIX A

CIVILIAN OCCUPATIONS SUBJECT TO MANDATORY INFLUENZA VACCINATIONS

General. This annex provides the list of civilian occupations subject to mandatory influenza vaccinations. Regional Medical Commanders retain the authority to add occupations to this list to fit organizational requirements. Local labor obligations must be completed prior to implementing the requirement for additional positions.

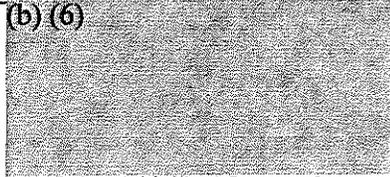
Occupational Title	Job Series
Psychologists	0180
Social Workers	0185
Chiropractors	0601
Physicians	0602
Physician Assistants	0603
Registered Nurses	0610
LPN/LVNs	0620
Nursing Assistants	0621
Nutritionists/Dietitians	0630
Occupational Therapists	0631
Physical Therapists	0633
Health Technician	0640
Nuclear Medicine Technicians	0642
Medical Technologists	0644
Medical Technicians	0645
Diagnostic Radiologic Technicians	0647
Therapeutic Radiologic Technicians	0648
Medical Instrument Technicians	0649
Medical Technician Assistants	0650
Respiratory Therapists	0651
Pharmacists	0660
Pharmacy Technicians	0661
Optometrists	0662
Audiologist	0665
Speech Pathology	0665
Orthotists and Prothetists	0667
Podiatrists	0668
Medical Support Assistant	0679
Dentists	0680
Dental Technicians	0681

MEDCEN Reg 40-6

Dental Hygienists	0682
Dental Lab Aids	0683

The proponent of this regulation is the Occupational Health Section, Department of Preventive Medicine. Users are invited to send comments and suggestions for improvement to: Commander, Carl R. Darnall Army Medical Center, ATTN: MCXI-DPM-OH, Fort Hood, TX 76544.

(b) (6)



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**DEPARTMENT OF THE ARMY
HEADQUARTERS, CARL R. DARNALL ARMY MEDICAL CENTER
Fort Hood, Texas 76544**

MEDCEN Regulation
Number 40-23

3 August 2011

Medical Services
**SCOPE OF PRACTICE FOR REGISTERED NURSES,
LICENSED VOCATIONAL NURSES/68WM6 AND
NURSING ASSISTANTS/68W**

1. REFERENCES.

- a. Army Regulation 40-68, Clinical Quality Management, current edition.
- b. MEDCEN Regulation 600-2, "Management of Human Resources, current edition.
- c. MEDCOM Regulation 40-47, Civilian Unlicensed Assistive Personnel (Nursing), current edition.
- d. Nurse Practice Act. Texas Statutes Regulating the Practice of Professional Nursing as Amended, current edition.
- e. American Nurses Association Standards of Clinical Nursing Practice, current edition.
- f. 2011 Comprehensive Accreditation Manual for Hospitals (CAMH): The Official handbook.

2. PURPOSE. To establish guidelines and standards for the clinical performance of the Registered Nurse (RN), Licensed Vocational Nurse (LVN)/Licensed Practical Nurse (LPN)/68WM6, and Nursing Assistant (NA)/68W. The 68WM6 is the Army's equivalent of the LVN or LPN. The 68W is the Army's equivalent of an Emergency Medical Technician (EMT) trained medic.

- a. As a member of the healthcare team all nursing personnel accept accountability for their individual nursing actions, competence and behavior.

*This regulation supersedes MEDDAC Regulation 40-23, dated 1 August 2009 .



MEDCEN Reg 40-23

b. The registered professional nurse (RN) leads the team of individuals performing nursing care and is responsible for all nursing care that a patient receives under his or her direction regardless of the level of complexity of that care, or the length of stay of the patient. The RN retains professional responsibility for the overall care of the patient.

c. All nursing personnel have a responsibility to ensure that the patient care they provide and/or delegate is within their scope of practice, educational preparation and demonstrated abilities.

d. Section Chiefs/Section Non-Commissioned Officer In Charge (NCOIC)s/Head Nurses/Clinical NCOICs/Officer In Charge (OIC)s (Nurse Administrators) validate and maintain appropriate documentation that their staff is competent to perform the assigned patient care responsibilities. This documentation is kept in the Competency Assessment Folders (CAF).

3. DEFINITIONS.

a. **Standard of Practice:** Establishes the criteria, parameters, or level of performance necessary to meet a standard of care.

b. **Scope of Practice:** Focuses on what nursing personnel are expected to do; identify the expected level of accomplishment, and includes competence, experience and education of the provider within fullest extent of the limitations of their professional licensure.

c. **Standard of Care:** Care that patients and significant others can expect to receive from the nursing staff; focuses on expected patient outcomes and serves as guidelines for the delivery of safe nursing care and the patient's response to that care. Nursing Services has identified standards of nursing care: comfort, assessment, rights, education, and safety.

d. **Initial Assessment:** A systematic, dynamic process by which the registered professional nurse, through interaction with the patient, significant others, and health care providers, collects and analyzes data about the patient to formulate a plan of care to address functional, psychosocial, spiritual and learning needs.

e. **Reassessment:** The process of determining both the patient's progress toward the attainment of expected outcomes developed from the multidisciplinary plan of care, and the effectiveness of nursing care.

f. **Unlicensed Assistive Personnel (NA/68W):** An unlicensed individual who is trained to function in an assistive role to licensed healthcare providers in the provision of patient/client care.

g. Licensed Healthcare Provider: A physician, Certified Nurse Midwife, nurse practitioner, Registered Nurse, physician's assistant, Licensed Vocational (Practical) Nurse or 68WM6.

4. RESPONSIBILITIES.

a. Deputy Commander for Nursing and Patient Services will:

(1) Ensure that adequate environmental working conditions and necessary resources are available to support and facilitate the patient care mission.

(2) Ensure that the knowledge, skills, and abilities of nursing personnel are assessed and that these personnel are assigned to nursing positions appropriate to their demonstrated competence and licensure level (if applicable).

b. Registered Nurse:

(1) Assign patient care responsibilities that are within the scope of an individual's educational preparation, training, experience, and defined scope of practice.

(2) Retain professional responsibility for nursing care when assigning or delegating nursing actions.

(3) Use professional judgment and the guidance of the Board of Nurse Examiners to determine the appropriate activities to assign or delegate. Appropriate activities are based on:

(a) Needs of the patient,

(b) Education, training, experience, and scope of practice of the nursing personnel,

(c) Extent of supervision required, and

(d) Staff workload.

c. Policies and procedures of CRDAMC cannot supersede the Registered Nurse's state Nurse Practice Act. It is the responsibility of the Registered Nurse to know their individual states Nurse Practice Act.

d. Policies and procedures of CRDAMC cannot supersede the Licensed Vocational Nurses State Nurse Practice Act. It is the responsibility of the Licensed Vocational Nurse to know their individual state's Nurse Practice Act.

5. SCOPE OF PRACTICE FOR THE REGISTERED NURSE. The Registered Nurse will:

a. Use a systemic approach to provide individualized, goal-directed nursing care to include:

- (1) Perform nursing assessments regarding the health status of the patient,
- (2) Make nursing diagnoses which serves as the basis for the plan of care,
- (3) Develop a plan of care based on assessment and nursing diagnoses,
- (4) Implement nursing care,
- (5) Evaluate the patient's responses to nursing interventions.

b. Institute appropriate nursing interventions which might be required to stabilize a patient's condition and/or prevent complications

c. Clarify any order or treatment regimen that the nurse has reason to believe is inaccurate, non-efficacious or contraindicated by consulting with the appropriate licensed provider, and notifying the ordering provider when the RN makes the decision not to comply with the order.

d. Know the rationale for and the effects of medications and treatments and correctly administer the same.

e. Accurately report and document the patient's symptoms, responses, and status.

f. Implement measures to promote a safe environment for patients and others.

g. Implement measures to prevent exposure to infectious pathogens and communicable conditions.

h. Respect the patient's rights to privacy by protecting confidential information as outlined by Health Insurance Portability and Accounting Act (HIPAA).

i. Promote and participate in patient education and counseling based on health needs.

k. Collaborate with the patient, members of the health care team, and when appropriate, the patient's significant other in the interest of the patient's health care.

l. Consult with, utilize, and make referrals to appropriate community agencies and health care resources to provide continuity of care.

m. When acting in the role of nurse administrator, ensure that adequate strategies are in place to verify license and competence (hospital and unit specific) of personnel for whom he/she is responsible.

n. Assign patients to others taking into consideration patient safety which is commensurate with the educational preparation, experience, knowledge, and ability of the persons to whom the assignments are made.

o. Supervise nursing care provided by others for whom the RN is administratively or professionally responsible.

p. Accept only those nursing assignments that are commensurate with one's own educational preparation, experience, knowledge, and ability.

q. Obtain instruction and supervision as necessary when implementing nursing procedures or practices.

r. Be responsible for one's own continuing competence in nursing practice and individual professional growth, to include obtaining continuing education credits as needed for re-licensure.

6. SCOPE OF PRACTICE FOR LICENSED VOCATIONAL or PRACTICAL NURSE/68WM6.

a. Patient care responsibilities of the practical nurse will be within the parameters of their scope of practice, educational preparation, demonstrated abilities, and competency based educational programs. The practical nursing program prepares nurses to provide direct nursing care to acutely and chronically ill patients with predictable health outcomes in structured healthcare settings.

b. The Licensed Vocational Nurse or Practical Nurse/68WM6 practicing under the direction of other licensed healthcare provider will:

(1) Contribute to the patient's initial assessment by collecting, reporting, and documenting objective and subjective data on each assigned patient in an accurate and timely manner.

(2) Participate in the development of a patient plan of care which includes the setting of realistic and measurable goals, and nursing interventions.

(3) Perform and document patient reassessment.

(4) Provide nursing care to patients of all ages to include:

(a) Care for patients whose conditions are stable or predictable.

MEDCEN Reg 40-23

(b) Assist with patients whose conditions are critical and/or unpredictable under the direct supervision of other licensed healthcare providers.

(c) Provide an environment conducive to safety and health.

(d) Document nursing care and responses to care.

(e) Communicate nursing interventions and responses to care to appropriate members of the healthcare team.

(f) Participate in discharge planning with the patient, family, and other members of the healthcare team.

(g) Administer scheduled medications IAW Nursing and Hospital policy.

(5) Contribute to the evaluation of the responses to nursing interventions to include:

(a) Monitor the responses to nursing intervention.

(b) Document and communicate collected data to appropriate members of the healthcare team.

(c) Contributing to the update of the patient plan of care based on evaluation of nursing interventions.

c. The LPN / LVN 678WWM6 nurse MAY NOT (list is not all inclusive):

(1) Complete the initial assessment.

(2) Administer blood, blood products, investigational drugs, or anesthetics.

(3) Administer total parenteral nutrition/lipids.

(4) Titrate intravenous medications.

(5) Be responsible for the management of a patient's epidural catheter to include administration of any medications via the epidural catheter.

(6) Prepare intravenous admixtures.

(7) Manage central lines, to include central line dressing changes.

7. SCOPE OF PRACTICE FOR NURSING ASSISTANT/68W.

a. Patient care responsibilities of the nursing assistant/68W will be within the parameters of their scope of practice, educational preparation, demonstrated abilities, and

competency based educational programs. There is a difference in the scope of practice between the 68W Combat Medic and the Nursing Assistant. See Appendix A.

b. The Nursing Assistant/68W practicing under the direction of other licensed healthcare providers will:

(1) Assist in meeting activities of daily living such as feeding, drinking, positioning, ambulating, grooming, toileting, dressing, and socializing; and may involve the collecting, reporting and documentation of information related to these activities.

(2) Focus on maintaining the environment and the systems in which nursing care is delivered. These activities assist in providing a clean, efficient, and safe patient care environment and typically include housekeeping, transporting, clerical stocking, and maintenance of supplies.

MEDCEN Reg 40-23

This side not used.

APPENDIX A NURSING SKILLS MATRIX

The following tasks have been identified as potentially high risk or problem-prone. This document serves to clearly specify which skill level personnel are allowed to perform each task, once they have demonstrated competence in the task. Some skills are restricted to specific areas.

SKILL/TASK	AN / RN	68WM6 / LVN / LPN	68W	NA	SPECIAL INSTRUCTIONS
Accepts telephone orders	X*				
Transcribes physician orders	X	X	X*		
Verifies transcribed orders	X				
Gives telephone advice	X*				Special settings only
Performs initial assessment	X				
Performs reassessment	X	X			
Starts I.V.s / saline locks	X	X	X* **		68W with skills verification
Flushes saline locks	X	X			
Discontinues saline locks	X	X	X*		68W ED / TMC only
Administers Intravenous piggyback medications and Intravenous medications	X	X*			LVN requires skills verification. LVN state NPA must allow.
Prepares IV admixture	X				
Administers TPN / Lipids (with second RN verification)	X				
Administers blood and blood products (with second RN verification)	X				
Sets up PCA pump	X				
Changes out PCA cartridges	X	X			
Performs urinary catheterization	X	X	X* **		
Inserts and maintains NG tubes	X	X	X*		68W in ED only with skill verification
Sutures wounds	AN*	68WM6*			Limited to Military in ED only with skills verification. RN / LVN individual state NPA must allow.
Prepares/administers immunizations	X	X	X*		Trained personnel only
Interprets PPD results	X	X*	X*		With skill verification
Performs venipuncture	X	X	X*		68W with skill verification
Draws blood cultures	X	X	X*		68W with skill verification
Performs EKG	X	X	X	X	
Administers tube feedings	X	X			
Applies / changes simple dressings	X	X	X	X	
Applies / changes complex dressings / irrigates, packs, etc	X	X	X*		68W with skill verification
Administers oxygen therapy	X	X	X		
Administers nebulizer treatment	X	X	X*		68W ED / TMC only with skills verification

MEDCEN Reg 40-23

Obtains ABGs	X*	X***			ED / ICU / NICU only with skill verification
Manages chest tubes	X	X	X*		68W in ED only with skill verification
Performs central line dressing changes	X				
Administers medication through / draws blood from / flushes central lines	X				
Performs eye / ear irrigation	X	X	X		
Inserts PICC line	X*				Certification course required
Administers chemotherapeutic drugs	X*				Special settings only Certification required
Maintain patients with invasive arterial pressure lines	X	X*			ICU only (LVN with skill verification)
Administers IV moderate sedation	X*				Special settings only (ER, ICU, PACU, GI lab, AMP). Must be re-certified annually.

* Requires training

** Adults only

***Requires training, Arterial lines only, & ICU environment

I understand that of all the skills listed above, I will be allowed to perform only those listed for my skill level, after I have successfully demonstrated competence in the task.

Sign:

Date:

Monitors patients who have received moderate sedation	X*	X*			Special settings only LVN in recovery phase ONLY
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The proponent of this regulation is the Deputy Commander for Nursing and Patient Services. Users are invited to send commend and suggestions for improvement to: Commander, Carl R. Darnall Army Medical Center, ATTN: MCXI-NPS, Fort Hood, TX 76544.

(b) (6)

for Colonel, Medical Service Corps
Commanding

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Td or Tdap Vaccine

What You Need to Know

(Tetanus and Diphtheria or Tetanus, Diphtheria and Pertussis)

Many Vaccine Information Statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

1 Why get vaccinated?

Tetanus, diphtheria and pertussis can be very serious diseases.

TETANUS (Lockjaw) causes painful muscle spasms and stiffness, usually all over the body.

- It can lead to tightening of muscles in the head and neck so the victim cannot open his mouth or swallow, or sometimes even breathe. Tetanus kills about 1 out of 5 people who are infected.

DIPHtheria can cause a thick membrane to cover the back of the throat.

- It can lead to breathing problems, paralysis, heart failure, and even death.

PERTUSSIS (Whooping Cough) causes severe coughing spells which can lead to difficulty breathing, vomiting, and disturbed sleep.

- It can lead to weight loss, incontinence, rib fractures and passing out from violent coughing. Up to 2 in 100 adolescents and 5 in 100 adults with pertussis are hospitalized or have complications, including pneumonia and death.

These three diseases are all caused by bacteria. Diphtheria and pertussis are spread from person to person. Tetanus enters the body through cuts, scratches, or wounds.

The United States saw as many as 200,000 cases a year of diphtheria and pertussis before vaccines were available, and hundreds of cases of tetanus. Since then, tetanus and diphtheria cases have dropped by about 99% and pertussis cases by about 92%.

Children 6 years of age and younger get **DTaP** vaccine to protect them from these three diseases. But older children, adolescents, and adults need protection too.

2 Vaccines for adolescents and adults: Td and Tdap

Two vaccines are available to protect people 7 years of age and older from these diseases:

- **Td vaccine** has been used for many years. It protects against tetanus and diphtheria.
- **Tdap vaccine** was licensed in 2005. It is the first vaccine for adolescents and adults that protects against pertussis as well as tetanus and diphtheria.

A Td booster dose is recommended every 10 years. Tdap is given only once.

3 Which vaccine, and when?

Ages 7 through 18 years

- A dose of Tdap is recommended at age 11 or 12. This dose could be given as early as age 7 for children who missed one or more childhood doses of DTaP.
- Children and adolescents who did not get a complete series of DTaP shots by age 7 should complete the series using a combination of Td and Tdap.

Age 19 years and older

- All adults should get a booster dose of Td every 10 years. Adults under 65 who have never gotten Tdap should get a dose of Tdap as their next booster dose. Adults 65 and older may get one booster dose of Tdap.
- Adults (including women who may become pregnant and adults 65 and older) who expect to have close contact with a baby younger than 12 months of age should get a dose of Tdap to help protect the baby from pertussis.
- Healthcare professionals who have direct patient contact in hospitals or clinics should get one dose of Tdap.

Protection after a wound

- A person who gets a severe cut or burn might need a dose of Td or Tdap to prevent tetanus infection. Tdap should be used for anyone who has never had a dose previously. Td should be used if Tdap is not available, or for:
 - anybody who has already had a dose of Tdap,
 - children 7 through 9 years of age who completed the childhood DTaP series, or
 - adults 65 and older.

Pregnant women

- Pregnant women who have never had a dose of Tdap should get one, after the 20th week of gestation and preferably during the 3rd trimester. If they do not get Tdap during their pregnancy they should get a dose as soon as possible after delivery. Pregnant women who have previously received Tdap and need tetanus or diphtheria vaccine while pregnant should get Td.

Tdap or Td may be given at the same time as other vaccines.

4 Some people should not be vaccinated or should wait.

- Anyone who has had a life-threatening allergic reaction after a dose of any tetanus, diphtheria, or pertussis containing vaccine should not get Td or Tdap.
- Anyone who has a severe allergy to any component of a vaccine should not get that vaccine. Tell your doctor if the person getting the vaccine has any severe allergies.
- Anyone who had a coma, or long or multiple seizures within 7 days after a dose of DTP or DTaP should not get Tdap, unless a



U.S. Department of Health and Human Services
Centers for Disease Control and Prevention



cause other than the vaccine was found. These people may get Td.

- Talk to your doctor if the person getting either vaccine:
 - has epilepsy or another nervous system problem,
 - had severe swelling or severe pain after a previous dose of DTP, DTaP, DT, Td, or Tdap vaccine, or
 - has had Guillain-Barré Syndrome (GBS).

Anyone who has a moderate or severe illness on the day the shot is scheduled should usually wait until they recover before getting Tdap or Td vaccine. A person with a mild illness or low fever can usually be vaccinated.

5

What are the risks from Tdap and Td vaccines?

With a vaccine, as with any medicine, there is always a small risk of a life-threatening allergic reaction or other serious problem.

Brief fainting spells and related symptoms (such as jerking movements) can happen after any medical procedure, including vaccination. Sitting or lying down for about 15 minutes after a vaccination can help prevent fainting and injuries caused by falls. Tell your doctor if the patient feels dizzy or light-headed, or has vision changes or ringing in the ears.

Getting tetanus, diphtheria or pertussis disease would be much more likely to lead to severe problems than getting either Td or Tdap vaccine.

Problems reported after Td and Tdap vaccines are listed below.

Mild problems

(Noticeable, but did not interfere with activities)

Tdap

- Pain (about 3 in 4 adolescents and 2 in 3 adults)
- Redness or swelling at the injection site (about 1 in 5)
- Mild fever of at least 100.4°F (up to about 1 in 25 adolescents and 1 in 100 adults)
- Headache (about 4 in 10 adolescents and 3 in 10 adults)
- Tiredness (about 1 in 3 adolescents and 1 in 4 adults)
- Nausea, vomiting, diarrhea, stomach ache (up to 1 in 4 adolescents and 1 in 10 adults)
- Chills, body aches, sore joints, rash, swollen glands (uncommon)

Td

- Pain (up to about 8 in 10)
- Redness or swelling at the injection site (up to about 1 in 3)
- Mild fever (up to about 1 in 15)
- Headache or tiredness (uncommon)

Moderate problems

(Interfered with activities, but did not require medical attention)

Tdap

- Pain at the injection site (about 1 in 20 adolescents and 1 in 100 adults)
- Redness or swelling at the injection site (up to about 1 in 16 adolescents and 1 in 25 adults)
- Fever over 102°F (about 1 in 100 adolescents and 1 in 250 adults)
- Headache (1 in 300)
- Nausea, vomiting, diarrhea, stomach ache (up to 3 in 100 adolescents and 1 in 100 adults)

Td

- Fever over 102°F (rare)

Tdap or Td

- Extensive swelling of the arm where the shot was given (up to about 3 in 100).

Severe problems

(Unable to perform usual activities; required medical attention)

Tdap or Td

- Swelling, severe pain, bleeding and redness in the arm where the shot was given (rare).

A severe allergic reaction could occur after any vaccine. They are estimated to occur less than once in a million doses.

6

What if there is a serious reaction?

What should I look for?

- Look for anything that concerns you, such as signs of a severe allergic reaction, very high fever, or behavior changes.

Signs of a severe allergic reaction can include hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, and weakness. These would start a few minutes to a few hours after the vaccination.

What should I do?

- If you think it is a severe allergic reaction or other emergency that can't wait, call 9-1-1 or get the person to the nearest hospital. Otherwise, call your doctor.
- Afterward, the reaction should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your doctor might file this report, or you can do it yourself through the VAERS web site at www.vaers.hhs.gov, or by calling 1-800-822-7967.

VAERS is only for reporting reactions. They do not give medical advice.

7

The National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines.

Persons who believe they may have been injured by a vaccine can learn about the program and about filing a claim by calling 1-800-338-2382 or visiting the VICP website at www.hrsa.gov/vaccinecompensation.

8

How can I learn more?

- Ask your doctor.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
 - Call 1-800-232-4636 (1-800-CDC-INFO) or
 - Visit CDC's website at www.cdc.gov/vaccines

Vaccine Information Statement (Interim) Td and Tdap Vaccines

1/24/2012

42 U.S.C. § 300aa-26

Office Use Only



LTC Chief, OHC-BAMC

16 DEC 2013

LTC Chief, OHC-BAMC is the Chief of Occupational Medicine at Brooke Army Medical Center. I contacted him for the purpose of comparing this clinic's operations with the clinic at CRDAMC.

Make-up of the clinic includes physicians and nurses. The nurses work fairly independently, within the protocols. They are generally senior experienced nurses. We recommend OH certification, but do not require it. They have to do this on their own time and at their own cost. There are no PAs in this clinic, although he did say they are in the process of hiring one.

Not every client visit to the clinic is referred/transferred to the physicians. Within protocols authorized by the Chief (him), nurses typically perform Part 1 of all pre-employment and employment required health assessments. These are nursing assessments, within the scope of their license. They are allowed to sign off on low risk job series workers, such as day care workers, lifeguards, and food service workers. If they have concerns, they call the physician or set up a separate appointment for a physician to see the patient. Per LTC Chief, OHC-BAMC it depends on what the paperwork says as to if a nurse signature constitutes adequate medical provider assessment. Some of the job series specifically state that a physician must perform the evaluation and sign the paperwork (such as firemen, security guards, anyone who has a physical fitness test requirement). Strictly nursing assessments are generally coded with an administrative V code, to include a part 1 that eventually supports the physician required Part 2. Rarely is the physician able to accommodate the Part 2 on the same day as the Part 1, so the question of which visit gets coded first is moot in this clinic. The BAMC OHC does not have an embedded immunization clinic. Clients requiring immunizations report to the Allergy Immunization Clinic, or if their PCM is with one of the medical homes (entitled military beneficiary) they can go there (for the routine immunizations).

The clinic chief is responsible for ensuring that at least 5% of the charts are audited for completeness IAW BAMC policy. The chart review criteria are found in the specific job series protocol. Physicians and nurses both participate in this function (did not ask where the results go).

Nurses can code 99211 under certain circumstances, but this is the highest code they are allowed to use. One of the OHNs has done 300-400 in processing evaluations per month.

BAMC OHC provides f/u of all BB pathogen exposures, but does not manage medications if required. Client is referred to Infectious Disease Clinic for this. BAMC OHC refers clients with positive PPDs to the Public Health Nurse within the DPM if AD. GS and contractors are given the option to seek further evaluation and care with their PCM, outside of the organization. There is no reporting requirement for +PPDs to the local county health department. (The State of Texas reporting requirements are related to subsequent diagnosis of latency or active disease).



TAB 17

Witness Listing for Army Report --DI-13-4218

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TAB 17