U.S. Department of Transportation
United States Coast Guard

Commandant
U.S. Coast Guard

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COMDTINST M6000
March 27, 2002
CANCELLED:
March 27, 2003

COMMANDANT NOTICE 6000

Subj: CH-17 TO MEDICAL MANUAL, COMDTINST M6000.1B

1. PURPOSE. This Notice publishes revisions to Medical Manual, COMDTINST M6000.1B. Intended user of this directive are all Coast Guard Units that maintain Medical Manuals.

2. ACTION. Area and district commanders, commanders of maintenance and logistics commands, commanding officers of Headquarters units, Assistant Commandants for directorates, Chief Counsel and special staff offices at Headquarters shall ensure compliance with the provisions of this Notice.

3. DIRECTIVES AFFECTED. Medical Manual, COMDTINST M6000.1B.

4. SUMMARY. Newly revised material and editorial changes are denoted by a line on the outside of the page. Enclosure (1) summarizes the substantial changes throughout the Manual provided as enclosure (2).

5. PROCEDURES. No paper distribution will be made of this Manual. Official distribution will be via the Coast Guard Directives System CD-ROM and the Department of Transportation Website http://isddc.dot.gov/. An electronic version will also be made available via the Commandant (G-WK) Publications and Directives website (see # 6, below).

   a. Remove and insert the following pages

Remove	Insert
Chapter 1 CH-16 pg 39-40	Chapter 1 CH-17 pg 39-40
Chapter 2 CH-16 pg 9-10	Chapter 2 CH-17 pg 9-10
Chapter 3 CH-16	Chapter 3 CH-17
Chapter 4 CH-16	Chapter 4 CH-17
Chapter 7 CH-15	Chapter 7 CH-17
Chapter 8 CH-15 pg 13-14	Chapter 8 CH-17 pg 13-14

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	a	b	c	d	e	f	g	h	i	j	k	l	m	n	o	p	q	r	s	t	u	v	w	x	y	z
A	1	1	1		2	2	2	1					1		1						3					
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NON-STANDARD DISTRIBUTION:

Chapter 10 CH-15 pg 17-18	Chapter 10 CH-17 pg 17-18
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Chapter 12 CH-16	Chapter 12 CH-17
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Chapter 13 CH-13 pg 27-28	Chapter 13 CH-17 pg 27-28
Chapter 13 CH-13 pg 97-104	Chapter 13 CH-17 pg 97-104
	Chapter 14 CH-17

6. FORMS AVAILABILITY. All forms listed in this Manual with the exception noted in this paragraph are available from stock points listed in the Catalog of Forms, COMDTINST 5213.6. Local reproduction authorized for the Modified Physical Examination. Availability of DD-2808 Report of Medical Examination and DD-2807-1 Report of Medical History is only by .pdf format, a web link is provided on the Pubs and Directives web page. Some forms referenced in this Manual are also available on SWSIII Jet Form Filler. Web links to forms in .pdf format have been provided on the Pubs and Directives page; http://www.uscg.mil/hq/g-w/g-wk/g-wkh/g-wkh-1/Pubs/Pubs.Direct.htm.

JOYCE M. JOHNSON
Director of Health and Safety

Encl (1) Summary of substantial changes
(2) CH-17 to Medical Manual, COMDTINST M6000.1B

CH-17 to Medical Manual, COMDTINST M6000.1B

Chapter 1	
Chapter 1-B-21	Adds new sub-section 1-B-21, and provides guidance for (Volunteers).
Chapter 2	
Chapter 2-A-6-(4)	Provides clarification of Elective Health Care and fitness for duty.
Chapter 3	
Chapter 3-A-7-d	Provides new guidelines for Overseas Transfer, Sea Duty Deployment and Port Security Units.
Figure 3-A-1	Revised Modified Physical Exam Form. Form authorized for local reproduction.
Chapter 3-C	Section revised to match sequence of the new DD-2808 (Report of Medical Exam) and 2807-1 (Report of Medical History). No content was changed.
Chapter 3-B-1&2	Revised paragraphs to reflect new physical exam forms.
Chapter 3-C-21-b(9)(b)4	Revised paragraph to read HIV testing is every 5 years.
Chapter 3-C-21-b(9)(b)8	Added new sub-paragraph to identify tuberculin reactors.
Chapter 3-C-21-b(i)	Removed reference to Reportable Disease Data Base (RDDB) no longer used.
Chapter 3-C-20-b(9)(e)	Revised paragraph to provide narrative summary to be obtained by the referring medical officer.
Chapter 3-C-22.j(1)(a)(5)	Revised paragraph to reflect update to the process of color perception testing.
Chapter 3-F-2	Provides new guidance for the List of Disqualifying Conditions and Defects.
Chapter 3-F-22	Revised definition for Human Immunodeficiency Virus (HIV)
Chapter 3 –G-4-d.	Added required self-balancing test for aviation physicals.
	Replaced all references to the new DD-2808 (Report of Medical Examination) and DD-2807-1 (Report of Medical History)
Chapter 3	Chapter layout re-formatted.
Chapter 4	
Chapter 4-A-6-b	Provides guidance for the transfer of Active Duty Health records.
Chapter 4-A-2(5)(g)	Updated section to provide placement of the audiogram microprocessor test strip in the Health Record.
Chapter 4-B-6	Revised section to delete form SF-88 (Report of Medical Examination) and replaced form with new form DD-2808 (Report of Medical Examination)
Chapter 4-B-7	Revised section to delete form SF-93 (Report of Medical History) and replaced form with DD-2807-1 (Report of Medical History).
Chapter 4-D-8-b	Provides guidance for the transfer of Dependant Health Records
Chapter 4-B-3-b(2)	Revised section to include NKDA (no known allergies) in section 1-a of the DD-2766 (Adult Preventive and Chronic Care Flowsheet)
Chapter 4-B-9&10	Revised section to make the DD-2215 (Reference audiogram and DD-2216 (Hearing Conservation Data Sheet and optional form.
Chapter 4-B-11	Updated section to include placement of audiogram results into the health record.
Chapter 4-	Reformatted Chapter 4 adding (Enclosure (1) Medical/Dental Record

Enclosure (1)	Forms(.jpegs)). Developed this new enclosure to prevent having to download forms, when new text is added to Chapter 4.
Chapter 7	
Chapter 7-B-2-b(3)	Revised paragraph to send a Coast Guard intranet e-mail message Disease Alert report.
Figure 7-B-1	Revised List of Reportable Conditions.
Chapter 7-B-3-b	Revised subsection (1) to submit Initial Report to MLC(k), copy to WKH-1.
Figure7-B-3	Revised line 5 to read: Laboratory test done, if any, and results.
Chapter 7-C-4-f	Revised paragraph for the administration of vaccines.
	Re-formatted Chapter 7 page numbers have changed.
Chapter 8	
Chapter 8-E-3.b(2)	Removed Optical Fabrication Laboratory form table.
Chapter 10	
Chapter 10-B-2-b(1)(a)	Revised paragraph to reduce letters of designation for the Controlled Substance Audit Board.
Chapter11	
Chapter 11-C-3-a(1)	Removed reference to CG-5534 (Non-Fed Med form) form removed with CH-16
Chapter11-C-5-b(2)	Removed reference to CG-5534 (Non Fed Med form) form removed with CH-16
	Chapter reviewed for accuracy and re-formatted.
Chapter12	
	All references to the SF-88 Medical Examination & SF-93 Medical History have been removed. These forms are replaced with the DD-2808 Report of Medical Examination and DD-2807-1 Report of Medical History
Chapter12-A-2-c(3)	Revised text to include new (Note) section to cover new OMSEP enrollees.
Chapter 12-C-3-d(2)b.c.d.	Revised text to provide new guidelines for acute exposure examination.
Figure12-C-2	Revised text to include: blood or breath benzene level (optional-if available)
Chapter12-C-7-d-(5)	Revised paragraph to clarify guidance for audiogram STS.
Chapter 12-C-9-d	Paragraph revised to clarify Examination protocol.
	Chapter12 re-issued, page numbers have changed.
Chapter13	
Chapter –13-B-4-f	Revised section to provide guidelines for: Proof of current competences.
Chapter 13-B-5-b(4)	Revised section to submit documentation of CME credentials every other year.
Chapter 3-G-1-c(2)	Revised paragraph to increase “other element” from 60% to 80%.
Chapter 13-M-2-c(4)	Deleted Practicum Guide for HS’s
Chapter 14	
Introducing new Chapter 14 - Medical Information System (MIS) Plan	

patient transport via gurney or wheelchair within the clinic; assessing and properly recording temperature, respiratory rate, heart rate, and blood pressure; acting as a chaperone during exams or treatment; assisting in specialty areas, i.e., laboratory (with appropriate additional training and supervision); answering telephones, filing and other clerical duties; cleaning and wrapping instruments.

b. Supervision. Supervision of Red Cross volunteers is the responsibility of the Clinic Administrator and may be delegated.

c. Orientation. Each volunteer must have an initial orientation to the clinic documented. Orientation shall include at least the following topics:

(5) Fire Safety,

(6) Emergency procedures (bomb threats, mass casualty, power outages, hurricanes/tornadoes),

(7) Universal precautions and infection control,

(8) Proper handling of telephone emergency calls,

(9) Phone etiquette, paging, proper message taking,

(10) Patient Bill of Rights and Responsibilities, to include confidentiality, and chaperone duties in accordance with Chapter 2-J-3-b of this Manual.

21. Volunteers

a. Volunteer health care workers (HCW) who are not health care providers and who are members of the U. S. Public Health Service (USPHS), Department of Defense (DOD) or Coast Guard Auxiliary (AUX) shall work under the supervision of clinic staff and will provide support services that include but are not limited to: patient transport via gurney or wheelchair within the clinic, assessing and recording vital signs, acting as a chaperone during examination or treatment, clerical duties such as answering telephone or filing, cleaning and wrapping instruments, etc.

b. Health care providers who are members of the USPHS or DOD who volunteer to work in Coast Guard clinics for up to fourteen days per year will not be required to apply to G-WK for clinical privileges.

(1) Volunteer providers in this category will submit a copy of a current active state license, copy of current clinical privileges and a current CPR card to the local clinic when they report in. They will also complete a request for clinical privileges appropriate to their category and submit to the local SMO/SDO. Volunteer providers can also submit a Credentials Transfer Brief in lieu of their license and CPR card.

(2) The SMO/SDO will evaluate the clinical privileges requested and by signing the request will authorize the provider to perform those health care services.

c. Health care providers who are members of the USPHS or DOD who volunteer to work in Coast Guard clinics for more than fourteen days per year will be required to apply for clinical privileges from G-WK as described in Chapter 13-B, and C of this Manual.

d. Health care providers who are members of the AUX will be required to apply for clinical privileges from G-WK as described in Chapter 13-B, and C of this Manual.

e. Volunteer providers will work under the direct or indirect supervision of Coast Guard clinic providers.

f. Each volunteer must have an initial orientation to clinic standard operating procedures which must be documented and must include at the minimum:

   (1) Fire safety

   (2) Emergency procedures (e.g., bomb threats, mass casualty, power outages, hurricanes/tornadoes)

   (3) Universal precautions and infection control

   (4) Proper management of telephone calls, emergency calls

   (5) Telephone etiquette, paging, taking messages

   (6) Patient sensitivity and confidentiality

(2) Coast Guard health care facilities are not required to provide such information under the law. Clinics may elect to provide standardized information to patients on request. Information given out shall conform to the implementing laws of the state in which the clinic is located. Clinics providing such information shall notify patients of its availability either by posted notice or via patient handout materials.

(3) Clinic staff members usually do not have the required training and experience to advise patients on the legal issues concerning creation of advance directives. Patients shall be referred to the appropriate source of legal support, e.g., command or district legal officers.

(4) Clinic staff members, where allowed by state law, may serve as witnesses to advance directive signatures.

(5) Advance directive documents shall be held by the member and/or the member's next of kin. Advance directive documents shall not be filed in the member's health record since health records are not universally available 24 hours a day, seven days a week, for reference by a treating hospital.

5. Elective Surgery for Pre-Existing Defects.

a. General. In many medical/dental procedures undertaken to correct defects that existed prior to entrance (EPTE) into the Service, the likelihood of return to full duty is questionable. In addition, such cases have often resulted in long periods of convalescence with subsequent periods of limited duty, outpatient care, and observation which render the Government liable for benefits by reason of aggravation of these defects.

b. Criteria. The following conditions must be met before attempting surgical correction of an EPTE defect.

(1) It interferes with the member's ability to perform duty.

(2) The procedure being considered is an accepted one, carries a minimal risk to life, and is not likely to result in complications.

(3) There should be a 90 percent chance that the procedure will correct the defect and restore the member to full duty within a reasonable time (three months) without residual disability. If the defect does not meet the above conditions and the member is, in fact, unfit to perform the duties of grade or rate, action shall be taken to separate the member from the Service.

c. Discussion. Whether elective medical/dental care should be undertaken in any particular case is a command decision which should be decided using the above guidelines. In questionable cases, the member may be referred to a medical board for final decision prior to undertaking elective treatment for an EPTE defect.

6. Elective Health Care.

a. Medical/Dental treatment not required to maintain the member's fitness for duty is elective in nature and is not authorized for payment by the Coast Guard. If the member's condition does not interfere with their ability to perform duty, the treatment shall be considered elective.

(1) Elective care may be obtained, if available, from USMTF's.

(2) If obtained from nonfederal providers, payment is the member's responsibility. In addition, the member is financially responsible for any care arising from complications that require additional treatment, even if it is non-elective.

(3) Because complications could lead to subsequent action by the Physical Disability Evaluation System (PDES), and to protect the interests of both the service member and the Coast Guard, the member's health record must contain a SF-600 entry detailing:

(a) the personnel action to be taken by the command regarding the granting of absence;

(b) that the service member was counseled regarding the provisions contained herein and other applicable directives. Counseling will be provided at the local Coast Guard primary care facility, or if there is no near by Coast Guard primary care facility, then the cognizant MLC (k) via phone. SF-600 will be faxed to the cognizant MLC (k) for appropriate entries, then faxed or mailed back to the unit for incorporation into the member's health record.

(c) that the service member must obtain copies of all treatment records from the provider for inclusion into the Coast Guard health record, including initial evaluation, treatment plan, progress notes, and follow-up care.

(4) Members shall understand that once they have received an elective treatment or procedure, they may be adversely effected for present or future assignments or specialized duty. For example, Laser In-situ Keratomileusis (LASIK) is disqualifying for divers, aviation personnel, and landing signal officers (LSO).

7. Other Health Insurance (OHI)

a. General. In some situations a member may desire to utilize their spouses' health insurance (OHI) to obtain health care outside of the Military Health Care System. Whether elective health care or all other areas of health care, this decision has an impact on the command and possibly on a member's access to the Physical Disability Evaluation System (PDES).

b. Criteria. The following conditions must be met before utilizing a spouse's health insurance or OHI,

visual acuity check is required and indicates the current prescription is inadequate, and obtain a refraction.

a. Available Eyewear and Standard Eyewear Sources of Supply.

(1) These types of eyewear are available:

Type of Correction	Cellulose acetate frame	
	Glass Lens	**Plastic Lens**
Single Vision, white [1]	X	X
Single Vision, tinted [1, 2]	X	X
Bifocal, 25mm segment, white [1]	X	X
Bifocal, 25mm segment, tinted [1, 2]	X	X
Trifocal, white	X	
Cataract Aspheric		X
Trifocal, white and tinted [1, 2]		X
(1) Eyewear provided in FG-58 (Flight Goggle) mounting for authorized personnel (2) Only N-15 and N-32 tints authorized		

(2) Process all requests for standard prescription eyewear through the below military optical laboratory; this is the only optical laboratory from which Coast Guard units are authorized to order standard prescription eyewear.

Naval Ophthalmic Support and Training Activity Yorktown, VA 23691-5071

(a) The Coast Guard pays only for glasses ordered and processed for Coast Guard active duty or retired personnel; therefore, it is extremely important to properly complete the DD-771 service identification block to indicate the patient's service affiliation.

(3) Procurement Procedures. Order all prescription eyewear using DD-771, Eyewear Prescription. It is extremely important to accurately complete the prescription form. If the prescription is wrong, the patient is inconvenienced; the Coast Guard is required to pay for eyewear even if it cannot be used; and the supply activity will reject an improperly prepared prescription, resulting in delay. Use these guidelines to prepare DD-771. See Section 4-B for more detailed instructions.

(a) Use a separate DD-771 for each type of eyewear.

(b) If no health services personnel are available at the unit, send the prescription obtained from the health record or local civilian source to the health record custodian to prepare and submit the DD-771.

(c) Submit all three DD-771 copies to the approving authority or supply activity; disregard the distribution instructions. Remove all carbon sheets before submission. File a photocopy of the DD-771 in the member's health record.

(d) TRACEN Cape May shall send recruits' eyewear prescriptions separately and mark the envelope, "RECRUIT—PLEASE EXPEDITE".

(e) Report delays longer than eight weeks in receiving eyeglasses to the appropriate MLC (k).

(4) Health Record Entries. Record on a separate DD-771 the current prescription, including frame measurements and all other data necessary to reorder eyewear, for each individual requiring eyeglasses.

4. Aviation Prescription Lenses. These personnel are authorized two pair of clear aviation spectacles (FG-58) and one pair of tinted spectacles (N-15) in matte chrome only:

a. Aviators Engaged in Actual Flight Operations. Aviation spectacles may be ordered for distant vision correction , or for distant vision and near vision correction (bifocal lenses). Those aviation personnel engaged in flight operation who desire near vision only correction in aviation frames must order bifocal lenses containing plano top portion and the near vision correction on the bottom. Spectacles containing only near vision correction are not authorized in aviation frames. This type correction will only be order in cellulose acetate frames.

b. Landing Signal Officers (LSO).

c. Coast Guard Ceremonial Honor Guard personnel.

d. Small Boat Crew required to wear a helmet while performing their assigned duties.

5. Contact Lenses. Contact lenses are issued only to active duty personnel for postocular surgical difficulties or to enable a member to overcome a handicapping disease or impairment. MLC (k) will not approve contact lenses solely for cosmetic reasons.

Section B- Controlled Substances

1. General.

   a. Controlled substances, as used here, are defined as:

      (1) drugs or chemicals in DEA Schedules I-V: (for example, the manufacturers label for Acetaminophen with Codeine #3(30 mg.) carries the DEA symbol for Schedule III (C-III) and will be treated as a Schedule III by Coast Guard units.)

      (2) precious metals;

      (3) ethyl alcohol (excluding denatured);

      (4) other drugs or materials the local commanding officer or Pharmacy and Therapeutics Committee determine to have significant abuse potential.

   b. Coast Guard authorized uses for controlled substances are:

      (1) medicinal purposes;

      (2) retention as evidence in legal or disciplinary actions; or

      (3) other uses CG Regulations specifically authorize.

   c. Quantity Definitions. Due to the potential for abuse and associated audits required, Coast Guard units should strive to minimize the quantities of controlled substances used. Two types of quantities are recognized for controlled substances:

      (1) Working Stock. Working stock is defined as a 30 day supply (under routine conditions) of a controlled substance or limited amounts of emergency drug as might be required. For smaller facilities, with limited quantities of controlled substances, working stock may surpass the 30 day limit when quantities are less than 1000 dosage units (tablets, capsules, etc.). It is also acceptable for partial containers to temporarily surpass this 1000 dosage unit limit.

      (2) Bulk Stock. Bulk stock is defined as a larger quantity beyond the normal working stock quantity. Bulk stock should primarily be sealed in sealed manufacturer's containers.

2. Custody and Controlled Substance Audits.

   a. Controlled Substance Custodian (CSC).

      (1) Pharmacy officers, when assigned, shall be appointed in writing as the CSC by the commanding officer.

      (2) In the absence of a pharmacy officer, COs shall designate the clinic administrator as CSC.

      (3) Medical and dental officers may serve as alternate CSCs.

      (4) Temporarily assigned personnel shall not serve as CSCs or alternates.

      (5) Under Coast Guard Regulations, COMDTINST M5000.3A, Chapter 6-2-3-A.(6), the Executive Officer is directly responsible for medical matters if a

medical officer is not assigned. For sickbays, the CO shall designate a commissioned officer as the CSC.

(6) CSCs may permit Health Services Technicians to assume custody of a "working stock" quantity of controlled substances.

(7) An audit of all controlled substances (working and bulk stock) is required when the CSC is changed. The results of this inventory shall be filled in the command's permanent file and in the Health Services Log. All keys should be transferred and/or combination locks changed at the time of this inventory.

b. Unit Controlled Substance Audits.

(1) Controlled Substance Audit Boards (CSAB). Each unit procuring, storing, or dispensing controlled substances shall have a CSAB.

(a) Membership: The CSAB shall consist of two or more disinterested officers or if unavailable, two or more disinterested senior petty officers (E-6 or above). Designated in writing by the Commanding Officer. CSAB letters of designation will remain in effect until the members are relieved in writing or detached from the command. In no case may the controlled substance custodian be a member of the CSAB.

(b) The CSAB shall conduct monthly audits of controlled substances at clinics (quarterly at ashore or afloat sickbays) and submit its report to the commanding officer within 5 working days after its audit. Commands shall maintain these reports for three years after which they may be destroyed.

(c) Monthly CSABs shall audit all working and bulk stock of C-II through C-V controlled substances, precious metals, ethyl alcohol, and drugs or other items locally designated as controlled substances due to abuse potential and report all quantities on CG-5353, Monthly Report for Narcotics and Other Controlled Drugs.

(d) During monthly audits, CSABs shall inspect controlled substances for expiration, deterioration, and inadequate or improper labeling. Expired products or those with other discrepancies shall be removed for disposal.

(e) The CSAB shall count required controlled substances; review a representative random sample of prescriptions, receipts, and issue documents; and report the results on Monthly Report for Narcotics and Other Controlled Drugs, CG-5353. For sealed containers, a bottle count is sufficient; for open containers an exact count is required. For open liquid containers, an estimate other than an exact volume measurement is adequate. CSABs may use tamper-proof seals on open containers to avoid future counting of partial quantities.

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d. Copies of state licenses for all states in which the practitioner is licensed (active or inactive), current renewal certificates, and Educational Commission for Foreign Medical Graduates (ECFMG) certification if the practitioner graduated from a medical school not in the Continental U. S., Hawaii, Alaska, or from a medical school not accredited by the American Association Liaison Committee on Medical Education in Puerto Rico. The practitioner must attach a statement of explanation for lapsed state licenses or those subject to disciplinary action. The primary source must verify all licenses or renewal certificates.

e. Copies of specialty board and fellowship certificates with primary source verification of these documents.

f. Proof of current (within one year) competence, i.e., two letters of reference for initial appointment and a description of recent clinical privileges held (practitioner's supervisor must note concurrence with and approval of privilege performance).

(1) The official reviewing letters of reference is authorized to contact the author of the letters to verify authorship and authenticity of letters. The official is also authorized to request a second letter of reference from an author when the first letter is deemed unclear. The official reviewing a letter of reference is authorized to contact the author via telephone in cases in which the author declines to respond in writing. In such cases, the official will document in a telephone log the site, date, time, identity of call participants and a detailed description of the conversation.

g. A statement explaining any involvement in malpractice cases and claims, including a brief review of the facts about the practitioner's involvement.

h. A statement about any hospitals', licensing boards', or other agencies' disciplinary action.

i. A copy of current certification in Cardiopulmonary Resuscitation from the American Heart Association or American Red Cross.

j. Copies of all current and prior Drug Enforcement Agency (DEA) registration, as appropriate.

k. National Practitioner Data Bank (NPDB) query.

5. Documentation.

a. Documents will be placed into a U. S. Coast Guard Training Record (CG-5285) folder. Commandant (G-WKH-2) will maintain files in a locked cabinet. PCFs and their contents are Class III (maximum security) records and protected from disclosure under the Privacy Act. Do not release documents in the PCF to any other individual or entity unless the provider has given express written permission.

b. Place documents in the six-section folder are as follows:

(1) Section One: Coast Guard clinical privilege documents.

(2) Section Two: Reference letters.

(3) Section Three: Adverse actions, malpractice documents, proof of malpractice coverage, statements about adverse information or malpractice claims.

(4) Section Four: Copies of CPR certification cards, continuing education certificates (CME), other military or civilian courses other than initial qualifying degree.

(a) By 31 December **every other year**, each provider shall submit a summary of CME completed during the **prior 2 years** to Commandant (G-WKH-2).

(b) The CME summary will be in the form of a list in tabular format and will include the name of the course, date taken, sponsoring organization and CME earned.

(c) Providers who are members of the professional organizations that maintain transcripts can submit a transcript in lieu of a summary of CME.

(5) Section Five: JCAHO-accredited hospital letter on admitting privileges, privileges granted by other or previous institutions, curriculum vitae.

(6) Section Six: Copies of license(s), diploma(s) or degree certificates, ECFMG certificate (if applicable), Internship certificate, Residency Certificate, Fellowship documents, and Board Certification. Primary sources must verify all documents in Section Six.

c. See Figure 13-B-1 for a list of required documents by provider category.

6. Verification.

a. To verify education, training, licensure or registration, certification, ECFMG and board certification, obtain either an original letter from the educational institution or certifying body attesting to successful completion of specialty training, or verify by telephone call between the Coast Guard representative and educational institution or specialty board. Record telephone verification on the document itself and on official letterhead signed and dated by the person making the call. Place all verification documents with their source documents in PCF Section Six.

b. Commandant (G-WKH) will verify uniformed services persons before appointment.

c. Before selection of Civil Service and contract providers, there will be a verification of education, training, licensure, experience, certification or registration, and current competence.

d. To verify experience and current competence requires at least two recommendation letters from appropriate sources as listed below. Commandant (G-WKH-2) or the appropriate MLC shall receive direct letters from the person providing the reference. Verify descriptions of recent clinical privileges as above.

(1) A letter either from the hospital chief of staff, clinic administrator, professional head, or department head if the individual has professional or clinical privileges or is associated with a hospital or clinic; or

(2) A letter from the director or a faculty member of the individual's training program if he or she has been in a training program in the previous two years; or

(3) A letter from a practitioner in the appointee's discipline who is in a position to evaluate the appointee's peer and a professional association or society association (mandatory if the appointee is self-employed).

7. Contract Provider Credentials Review.

a. All contract providers who perform any part of their work in a Coast Guard health care facility will submit credentials documents to the appropriate MLC per Paragraph 13.B.6. above and MLC SOPs.

b. The contracting officer will verify documents

c. At the contracting officer's request, MLC (K) will perform a technical review of the providers' credentials.

8. Reverification.

a. These credentials are renewable and will be primary source on renewal: License, PA certification, Board certification, and contract providers' malpractice coverage. Reverify contract providers' credentials at contract renewal.

b. Reverify these credentials by original letter or telephone contact The person making the call will record telephone contact on the document and by a separate, signed memorandum.

9. National Practitioner Data Bank.

c. Commandant (G-WK) possesses sole authority to report to the National Practitioner Data Bank. Commandant (G-WKH-2) is designated as the appropriate entity for National Practitioner Data Bank queries. Coordinate all queries for patient care providers through this branch.

d. A reply from the NPDB is not required before the practitioner begins providing services. However, any provider whose credential verification is not fully completed will be considered to have a conditional appointment until all credentials are verified as required.

FIGURE 13-B-1

REQUIRED CREDENTIALS BY PROVIDER CATEGORY

	A	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**	**J**	**K**
Physicians	X	X	X	X	X	X	X	X	X	X	X
General Practice Physicians*	X	X	X	X		X	X	X	X	X	X
Dentists	X	X	X	X			X	X	X	X	X
Physician Assistants	X	X	X	X			X	X	X		X
Nurse Practitioners	X	X	X	X			X	X	X		X
Optometrists	X	X		X			X	X	X		X
Physical Therapists	X	X	X	X			X	X	X		X
Dental Hygienists	X	X		X			X	X	X		X

A. Current curriculum vitae

B. Copies of qualifying educational degrees

C. Copies of required postgraduate training certificates for the area of work; for example, internship, residency, fellowship, nurse practitioner or physician assistant schooling

D. Copies of state license(s)

E. Copies of specialty board certification and fellowship certificates

F. Proof of current competence, recent clinical privileges

G. Proof of malpractice coverage (contractors only)

H. Statement explaining malpractice claims, other adverse actions

I. CPR certification

J. DEA certification

K. NPDB query

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* General Practitioners. Physicians who have completed one year of Graduate Medical Education (Internship) and have not completed a full residency in a medical specialty.

Section G - Coast Guard Clinic Certification and Accreditation

1. Clinic Certification Program.

   a. Background. Commandant (G-WK) must certify all Coast Guard clinics with assigned medical and dental officers to provide health services. Clinic certification is based on complying with standards set forth in the Medical Manual, COMDTINST M6000.1 (series), and MLC Quality Assurance (QA) Checklists. Commandant (G-WK) certifies facilities based on the results of Quality Assurance site surveys conducted by Maintenance and Logistics Commands.

   b. Responsibility.

      (1) Unit. The unit commanding officer is responsible for ensuring the command's health care facility complies with standards set forth in the Coast Guard Medical Manual and MLC QA Checklists and for meeting the minimum requirements set forth for clinic certification.

      (2) Maintenance and Logistics Command. Chief, Health and Safety Division is responsible for developing and coordinating QA Checklists and periodically conducting Quality Assurance Site Surveys at facilities in their area of responsibility. These surveys will assess compliance with existing directives and recommend the facility's certification status based on survey results.

      (3) Headquarters. Chief, Office of Health and Safety coordinates and directs the certification program, issues certificates to certified clinics, adjudicates appeals, and promulgates appropriate standards governing Coast Guard providers' delivery of health care and policies on managing and operating Coast Guard health care facilities.

   c. Certification Standards.

      (1) Certified. Commandant (G-WK) will certify clinics complying with at least 90% of both key elements and all other elements on the QA Checklist. Clinics must earn re-certification every three years.

      (2) Provisionally Certified. Commandant (G-WK) will provisionally certify clinics complying with at least 80% of key elements and at least 80% of all other elements on the QA Checklist. MLC Health and Safety Divisions will annually re-survey provisionally certified facilities until they attain full certification.

      (3) Not Certified. A facility failing to achieve either certification or provisional certification under this Section's provisions will be subject to a follow-up MLC QA site survey within 180 days after notice of non-certification. During this remedial period, the MLC will assist the facility to promptly address QA survey discrepancies and may impose restrictions

limiting the scope of services the facility can provide. The facility must request a follow-up survey during this period. If the facility does not receive at least provisional certification

(a) MLC will notify the Commanding Officer the health care facility is not certified by letter through the chain of command and detail appropriate specific restrictions on care delivery in that facility.

(b) The Commanding Officer shall submit weekly message reports of progress attained in eliminating disqualifying discrepancies to the cognizant MLC (k), with an information copy to Commandant (G-WKH), through the chain of command.

d. Notice of Certification Status. The Maintenance and Logistics Command will send each surveyed facility a copy of the survey report and recommendations for corrective action within 6 weeks of the site survey. If a facility is not certified, the MLC(k) will send the survey report or an interim action report within two weeks of the site survey. Certified and provisionally certified facilities will receive certificates which they are to display prominently within.

e. Appeal of Certification Status. A Unit Commanding Officer (CO) may appeal the certification status awarded as a result of the MLC Quality Assurance site survey within 30 days of the site survey report date. The Commanding Officer appeals in writing to Commandant (G-WK) through the chain of command; the appeal must specify the particular disputed QA checklist elements and reasons for the appeal. The CO must not base the appeal on corrective actions taken after the QA site survey or local misinterpretation of QA checklist elements or Medical Manual guidelines. Commandant (G-WK) will consider the appeal and render a final verdict on certification status within 30 days of receiving the appeal.

2. Clinic Accreditation Program.

a. All Coast Guard-certified health care facilities with four or more medical officers assigned are expected to pursue accreditation from an external accrediting organization such as the Joint Commission on Accreditation of Health Care Organizations. The cognizant MLC and G-WKH must approve pursuit of this accreditation. Once a clinic achieves full or provisional external accreditation, that facility will automatically receive Coast Guard certification and be required to maintain external accreditation. A non-scored MLC QA survey will also be performed to ensure compliance with Coast Guard regulations and compliance with G-WK quality assurance program standards.

b. The respective Maintenance and Logistics Command will provide any technical and professional assistance the health care facility requires to prepare for external accreditation. On the command's letter request, Commandant G-WK will provide funding for external accreditation surveys through the respective MLC (K).

b. In-service training must include these topics, among others:

(1) Quality Assurance Implementation Guide Exercises;

(2) Annual review of clinic protocols on suicide, sexual assault, and family violence;

(3) Patient satisfaction issues;

(4) Patient sensitivity;

(5) Emergency I.V. therapy;

(6) Pneumatic anti-shock garment (MAST) review;

(7) Emergency airway management;

(8) Cardiac monitor and defibrillator familiarization;

(9) Cervical spine immobilization and patient transport equipment;

(10) Emergency vehicle operator's training (where operated);

(11) Section 13-K infection control policy and procedures.

c. The Chief, Health Services Division, must designate in writing a Health Services Training Coordinator (HSTC) who coordinates clinic in-service training, distributes a quarterly training schedule, and maintains the unit's health services training record. The HSTC's responsibilities include these:

(1) Establishes and maintains a Health Services Training Record to document all training conducted within the clinic. Records should include presentation outline, title, program date, name of presenter, and list of attendees. Maintain training records for 3 years from the date on which training occurred.

(2) Ensures all emergency medical training is documented in the individual's Coast Guard Training Record (CG-5285) for credit toward the 48-hour National Registry EMT continuing education requirement.

(3) Maintains a Training Record section that records personnel certifications including CPR, ACLS, EMT, and flight qualifications, including expiration dates and copies of the current certificate. The HSTC should ensure assigned personnel obtain recertification before current certificates expire.

3. Emergency Medical Training Requirements.

a. All active duty, civilian, and contract civilian personnel working in Coast Guard clinics and sick bays shall maintain current CPR certification at the health care provider level (AHA "C" Course or equivalent).

b. Every Health Services Technician who participates in SAR or MEDEVAC operations must be a currently certified EMT. At least one currently certified EMT will staff Coast Guard emergency vehicles. Unit commanding officers

shall ensure HSs are trained in sufficient numbers under Section 13-M-3.h to meet this requirement.

c. At least one medical officer per clinic will maintain current ACLS certification.

d. Only licensed or certified physicians, nurse practitioners, physician assistants, or Nationally Registered advanced life support providers (EMT-P and EMT-I) will perform ALS procedures, except as Section 13-M-3.e stipulates. Paramedics may perform functions authorized by their certifying jurisdiction's protocols with written medical officer authority.

e. Other than those permitted in the Standardized Health Services Technician Formulary, (COMDTINST 6570.1), an HS in SAR or MEDEVAC situations may provide ALS procedures and medications only if his or her supervising medical officer authorizes such provision in writing and assumes responsibility for those procedures and medications. In emergencies, the supervising medical officer may so authorize by radio.

f. Other than those described in Sections 13-M-3.d and 13-M-3.e, persons who have completed an ACLS course should note certification means only they have completed the course and does not convey a license to perform any skill. Individuals completing ACLS courses shall serve as a clinic resource on current standards for pre-hospital care in training and equipment areas.

g. Emergency vehicles shall be equipped to provide basic life support (BLS) only. The clinic shall maintain equipment (monitor-defibrillator, advanced airway kit etc.) and medications to provide ALS services at in a reserve status and add them when necessary if authorized ALS providers are available.

h. To obtain required EMT training (basic course or recertification), commands shall use local military sources if available. Usually most public service training agencies or community colleges offering training can accept Coast Guard personnel. If the required training is not available from a civilian or military source within a 50-mile radius, commands may use other cost-effective training sources. Submit requests through the chain of command to Commandant (G-WKH) with these items:

   (1) CG-5223, Short-Term Resident Training Request;

   (2) SF-182, Request, Authorization, Agreement and Certification of Training;

   (3) Requests for training outside a 50-mile radius which incur per diem expense require the unit commanding officer's or officer-in-charge's statement local training sources are unavailable.

4. Health Services Technician "A" School.

a. The Office of Personnel and Training operates the 20-week introductory course for Health Services Technicians, including the Emergency Medical Technician (EMT) course, at TRACEN Petaluma. As program manager, Commandant (G-WKH) provides professional comments to the TRACEN on curriculum and qualifying requirements. Commandant (G-PRF) controls HS "A" School personnel quotas. The Training and Education Manual, COMDTINST M1500.1 (series), outlines selection requirements and procedures.

5. Health Services Technician "C" Schools.

   a. Due to the specialized nature of health care, the Coast Guard requires health services technicians to complete training in medical specialty fields such as aviation medicine, preventive medicine, medical and dental equipment repair, physical therapy, eye specialist, laboratory, radiology, pharmacy, and independent-duty specialties. The usual sources are Department of Defense training programs.

   b. Selection for HS "C" Schools is based on qualification code requirements for HS billets at clinics and independent duty sites as specified in personnel allowance lists. Secondary selection criteria include command requests, personnel requests, and deficiencies noted on MLC Quality Assurance Site Surveys.

   c. HS personnel should submit a CG-5223, Short-Term Resident Training Request, with Command endorsement to Commandant (G-WKH) through the appropriate chain of command. Commandant (G-WKH) must receive this request at least 45 days before the training convening date.

   d. HS personnel wishing to pursue "C" school training in courses of 20 weeks or longer require a permanent change of duty station coordinated by Military Personnel Command (CGPC). Submit requests on CG-3698A, Assignment Data Form, to Military Personnel Command (CGPC-emp).

6. Continuing Education Programs.

   a. All U.S. Public Health Service Officers and Coast Guard physician assistants must maintain active professional licenses and/or certification to practice their professional specialty while assigned to the Coast Guard. Licensing and/or recertification requirements often demand continuing professional education, which enhances the practitioner’s skills and professional credentials.

   b. The Office of Health and Safety attempts to fund one continuing education course annually for all licensed health services professionals. The program coordinator for an applicant's professional specialty must approve all training requests. Generally training should provide at least six documentable continuing education credits per day pertinent to the applicant's Coast Guard

billet. Personnel should obtain training at the nearest possible geographic location.

c. Medical and dental officers' licensing and certification exams will not be funded as continuing education. Coast Guard-sponsored Physician Assistant (PA) programs' graduates may request funding for examination fees (primary care only), travel to the testing site nearest their current duty station, and per diem associated with obtaining initial certification from the National Commission on Certification of Physician Assistants. The Coast Guard funds this one-time exception because it sponsors the PA training program and requires certification for employment. PAs may take the recertification examination in conjunction with the annual physician assistant conference. Travel and per diem will be authorized as annual CME. The member pays recertification examination fees.

d. Except for Health Service Technician "C" School applicants, Health and Safety Program personnel requesting continuing education must follow these procedures:

(1) Each person requesting training must complete CG-5223, Short-Term Resident Training Request, with proper endorsements.

(2) Accompany each training request with course literature (e.g., a descriptive brochure) or a brief written description.

(3) Submit SF 182, Request, Authorization, Agreement and Certification of Training (10 parts) with proper endorsements if using a government purchase order to pay tuition or fees.

(4) Send all completed forms to Commandant (G-WKH) for processing. Send one information copy of the Short Term Training Request to the appropriate Maintenance and Logistics Command, Quality Assurance Branch.

(5) Training requests must arrive at Commandant (G-WKH) *8 weeks* before the anticipated training convening date. Coast Guard Training Quota Management Center (TQC), Portsmouth, VA, processes approved requests and issues orders.

7. Long-Term Training Programs.

a. Long-Term Post-graduate Training for Medical Officers (Physicians, Physician Assistants, and Nurse Practitioners). This 1- to 2-year program for medical officers principally emphasizes primary care (family practice, general internal medicine, and pediatrics). Consideration may be given for non-primary care specialties such as occupational health, public health, and preventive medicine. Training in orthopedics is a potential option for mid-level practitioners only. The Health Services Program Manager will consider non-primary care post-graduate medical training only when needed. Applicants also must have applied to their chosen training program and meet

its requirements before requesting training. Applicants should have served with the Coast Guard Health Services Program for at least 2 years for each year of training received. For physician applicants, highest consideration will be given first to those who have not completed an initial medical residency. Commandant (G-WKH) has more information.

b. Advanced Dental Training Programs. This 2-year program provides dental officers advanced training in general dentistry, enabling them to give more effective, comprehensive dental care to Coast Guard beneficiaries. The Department of the Navy, Naval Medical Command, Bethesda, MD, conducts the training, designed to qualify dental officers to meet the American Dental Association and Federal Services Board of General Dentistry requirements for specialty board examination. Dental officers chosen for this program are expected to pursue board certification. For program prerequisites and applications procedures, see the Coast Guard Training and Education Manual, COMDTINST M1500.1 (series).

c. Health Services Administration. This program provides instruction in facility and personnel management, program planning, cost containment, quality assurance, third-party payment and liability, and medical-legal issues. The program provides training at the undergraduate (bachelor's degree) level for Chief Warrant Officers and senior enlisted HS personnel (Medical Administrators) and post-graduate (master's degree) level for officers in grades O-2, O-3, and O-4. See the Coast Guard Training and Education Manual, COMDTINST M1500.1 (series) for eligibility requirements, prerequisites, and application procedures.

d. Physician Assistant Program. Conducted at the U.S. Intra-service Physician Assistant Program, Fort Sam Houston TX, this program trains Coast Guard personnel interested in becoming Physician Assistants. Program graduates receive a baccalaureate degree from the University of Nebraska. If they meet eligibility requirements, graduates are offered a direct commissions as ensigns as described in the Personnel Manual, COMDTINST M1000.6 (series), Article 1.A.7. Each year three Coast Guard students are selected for training based on Service needs. Training at other institutions is not authorized. See the Coast Guard Training and Education Manual, COMDTINST M1500.1 (series) for eligibility requirements, prerequisites, and application procedures.

Section N - Patient Affairs Program

1. Patient Sensitivity.

   a. The Coast Guard considers patient sensitivity issues of paramount importance in delivering health care. Important issues in this area include medical record confidentiality, privacy during medical examination and treatment, respect for patient concerns, and enhancing the patient's perception of the quality of services delivered.

   b. All clinics shall conduct continuing patient sensitivity training. The "Treat Everyone As Myself" (TEAM) Program, developed by the U.S. Navy and Service Quality Institute available through each MLC Health and Safety Division, is the recommended course. It provides the structure for an internal review of patient-provider interaction and suggestions on ways to improve this relationship.

2. Patient Advisory Committee (PAC).

   a. The Coast Guard's health services program provides primary health care to a wide array of beneficiaries authorized by law and regulation. Medical Treatment Facilities (MTFs) often are unaware of their population's health problems until patients voice complaints or criticisms to the command. To enable beneficiaries to express their concerns, a PAC must be available to open lines of communication between health care providers and care recipients.

   b. Each Coast Guard MTF shall establish a PAC and specify criteria for committee functions. PACs shall include one officer and one enlisted member not assigned to the clinic; an active duty representative from each Coast Guard command in the clinic's service area; an active duty representative from each of the other uniformed services using the MTF; a retired representative; and an active duty dependent representative from both officer and enlisted communities.

   c. MTF shall conduct PAC meetings at least quarterly.

   d. The Chief, Health Services Division or his or her designee shall chair the meeting. Meeting minutes shall include recommended actions and an attendance list; and will be forwarded to the commanding officer with a copy to each PAC member. Specific PAC objectives include:

      (1) Advise the Chief, Health Services Division on the range of services the beneficiary population requires;

      (2) Serve as a communications link between the MTF and the beneficiaries the members represent;

(3) Serve as a patient advocacy group to assure all patients are accorded their rights as described in the Commandant's Patient Bill of Rights and Responsibilities;

(4) Assist the Chief, Health Services Division in advising patients of their responsibilities as described in the Commandant's Patient Bill of Rights and Responsibilities;

(5) Assist the Chief, Health Services Division in establishing patient education programs; and

(6) Advise the Chief, Health Services Division on the acceptability and convenience of the services provided.

3. Patient Satisfaction Assessment.

a. Assessing patient satisfaction through patient satisfaction surveys has become an effective, efficient method to investigate and measure the quality of the Coast Guard health care delivery system from the patient's perspective.

b. A patient satisfaction survey form shall be available to every patient who receives care at a Coast Guard facility.

c. Satisfaction surveys will be conducted annually for all patient visits during a randomly selected one-week period.

d. Locally prepared patient satisfaction surveys are authorized for use.

e. Patient satisfaction survey results shall be provided to the quality assurance focus group for discussion and action and documented in meeting minutes. Survey results shall report and recommended actions to the unit commanding officer.

f. Persons distant from a Coast Guard clinic can comment about care received from civilian providers by sending a mail-in Maintenance and Logistics Command survey form available from unit Health Services Technicians.

4. Patient Grievance Protocol.

a. The Coast Guard expects health services personnel to maintain a professional attitude at all times. Our goal to provide the highest quality health care within allotted resources to all beneficiaries with the least personal inconvenience. Despite our best efforts, occasionally a patient will be dissatisfied with the care received.

b. Whenever possible individuals with grievances should seek out or be referred to the clinic supervisor, health benefits advisor (HBA), or clinic administrator (CA) for complaint resolution before leaving the clinic. Refer written or telephone complaints to the appropriate clinic staff member. At a minimum, the complainant shall be given the name of his or her unit Patient Advisory

Committee representative and advise the complainant of the time and place of the next PAC meeting.

c. If the clinic supervisor, HBA, or CA cannot resolve the complaint, he or she shall refer the complainant to the senior medical or dental officer as appropriate.

d. Refer the complainant to the commanding officer or higher authority only if the patient believes the clinic or PAC has not resolved the complaint.

e. MLC (kqa) shall review concerns reported on forms mailed to the Maintenance and Logistics Command for quality assurance purposes, action, or referral to an appropriate level for resolution and follow up.

5. Congressional Inquiries.

a. Occasionally, circumstances arise in which beneficiaries exercise their right to solicit assistance from their elected Congressional Representative to resolve their complaint with the Coast Guard health care system.

b. The Coast Guard maintains a Congressional liaison staff to direct inquiries to the appropriate Headquarters office that can best address the issue and respond satisfactorily. Normally Commandant (G-WK) replies to health care problems.

c. Congressional inquiries require a complete investigation of the circumstances surrounding the issues the beneficiary addresses. To this end, the command, health care facility, and individuals involved must supply supporting documentation and/or statements to assist in the investigation.

6. Patient Bill of Rights and Responsibilities. Each Coast Guard health care facility shall conspicuously display the Commandant's "Patient Bill of Rights and Responsibilities."

CHAPTER 3

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CHAPTER 3. PHYSICAL STANDARDS AND EXAMINATIONS

Section A - Administrative Procedures.

1. Applicability of Physical Standards.

   a. The provisions of this chapter apply to all personnel of the Coast Guard and Coast Guard Reserve on active or inactive duty and to commissioned officers of the Public Health Service assigned to active duty with the Coast Guard.

   b. Members of the other Armed Forces assigned to the Coast Guard for duty are governed by the applicable instructions of their parent Service for examination standards and for administrative purposes.

2. Prescribing of Physical Standards.
   Individuals to be enlisted, appointed, or commissioned in the Coast Guard or Coast Guard Reserve must conform to the physical standards prescribed by the Commandant. Separate standards are prescribed for various programs within the Service.

3. Purpose of Physical Standards.
   Physical standards are established for uniformity in procuring and retaining personnel who are physically fit and emotionally adaptable to military life. These standards are subject to change at the Commandant's direction when the needs of the Coast Guard dictate.

4. Application of Physical Standards.

   a. Conformance with Physical Standards Mandatory. To determine physical fitness, the applicant or member shall be physically examined and required to meet the physical standards prescribed in this chapter for the program or specialty and grade or rate involved. An examinee who does not meet the standards shall be disqualified.

   b. Evaluation of Physical Fitness. The applicant's total physical fitness shall be carefully considered in relation to the character of the duties to that the individual may be called upon to perform. Physical profiling is not a Coast Guard policy. Members shall be considered fit for unrestricted worldwide duty when declared physically qualified. The examiner must be aware of the different physical standards for various programs. Care shall be taken to ensure an examinee is not disqualified for minor deviations that are clearly of no future significance with regard to general health, ability to serve, or to cause premature retirement for physical disability. However, conditions that are likely to cause future disability or preclude completing a military career of at least twenty years, whether by natural progression or by recurrences, are also disqualifying. This policy shall be followed when an authentic history of such a condition is established, even though clinical signs may not be evident during the physical examination.

5. Interpretation of Physical Standards. Examiners are expected to use discretion in evaluating the degree of severity of any defect or disability. They are not authorized to disregard defects or disabilities that are disqualifying in accordance with the standards found in this chapter.

6. Definitions of Terms Used in this Chapter.

   a. Officers. The term "officers" includes commissioned officers, warrant officers, and commissioned officers of the Public Health Service.

   b. Personnel. The term "personnel" includes members of the Coast Guard and Coast Guard Reserve, and the PHS on active duty with the Coast Guard.

   c. Medical and Dental Examiners. Medical and dental examiners are medical and dental officers of the uniformed services, contract physicians and dentists, or civilian physicians or dentists who have been specifically authorized to provide professional services to the Coast Guard. Some USMTFs have qualified enlisted examiners who also conduct medical examinations and their findings require countersignature by a medical officer.

   d. Flight Surgeons and Aviation Medical Officers. Officers of a uniformed service who have been so designated because of special training.

   e. Command/Unit. For administrative action required on the Report of Medical Examination (DD-2808), the command/unit level is the unit performing personnel accounting services for the individual being physically examined.

   f. Reviewing Authority. Commander Coast Guard Personnel (CGPC-adm) and MLC (K) are responsible for approval of physical examinations as outlined herein. Clinic Administrators may act as reviewing authority for physical examinations performed in their AOR as designated by the cognizant MLC, except for those that are aviation or dive related. Reviewing authority shall not be delegated below the HSC level. Medical Administrative Officers (LDO and CWO-Meds) may review physical examinations performed by contract physicians and USMTFs within their AOR.

   g. Convening Authority. Convening Authority is an individual authorized to convene a medical board as outlined in Physical Disability Evaluation System, COMDTINST M1850.2 (series).

   h. Time Limitation. The time limitation is the period for which the physical examination remains valid to accomplish its required purpose. The time limitation period begins as of the day after the physical examination is conducted.

7. Required Physical Examinations and Their Time Limitations.

   a. Enlistment. A physical examination is required for original enlistment in the Coast Guard and the Coast Guard Reserve. This physical examination will usually be performed by Military Entrance Processing Stations (MEPS) and is valid for twenty-

four months. Approved MEPS physicals do not require further review. Recommendations noted on separation physical examinations from other services must have been resolved with an indication that the individual meets the standards. A certified copy of that physical examination must be reviewed and endorsed by the reviewing authority Commander (CGRC). The reviewing authority must indicate that the applicant meets the physical standards for enlistment in the USCG.

(1) Recruiters who believe that applicants have been erroneously physically disqualified by MEPS, may submit the DD-2808 and DD-2807-1 (original or clean copies) along with supporting medical records to Commander (CGRC) for review.

(2) Waiver of physical standards for original enlistment may also be submitted as above, and in accordance with paragraph 3-A-8 of this instruction.

(3) Separation physical examinations from any Armed Service may be used for enlistment in the Coast Guard, provided the examination has been performed within the last twelve (12) months. The physical examination must be as complete as a MEPS exam, include an HIV antibody test date (within the last 24 months) and result, and a Type II dental examination. An DD-2807-1 must also be included with elaboration of positive medical history in the remarks section (item #25). Forward all documents for review by Commander (CGRC).

(4) Prior Service enlisted aviation personnel must obtain an aviation physical examination from a currently qualified uniformed services flight surgeon or AMO within the previous 12 months. This physical examination will be submitted with the rate determination package to Commander (CGRC).

(5) Occasionally, applicants for initial entry into the Coast Guard will need to be examined at Coast Guard MTFs. In these cases, the physical examination will be performed per section 3-C. The examining medical officer may defer item #46 of the DD-2808 to the Reviewing Authority. Otherwise, the physical standards for entry (sections 3-D and 3-E, as appropriate) must be meticulously applied when completing this item. The completed DD-2808 and DD-2807-1 will be forwarded to the reviewing authority, Commander (CGRC).

b. Pre-Commissioning/Appointments. A physical examination is required within 12 months prior to original appointment as an officer in the Coast Guard or Coast Guard Reserve for personnel in the following categories:

(1) appointment to Warrant Grade, except that physical examinations for members of the Coast Guard Ready Reserve must be within 24 months prior to the date of execution of the Acceptance and Oath of Office, form CG-9556.

(2) appointment of a Licensed Officer of the U. S. Merchant Marine as a commissioned officer (examination required within 6 months); and

(3) upon graduation from the Coast Guard Academy.

c. Separation from Active Duty.

(1) A complete physical examination is required within 12 months for retirement, involuntary separation, or release from active duty (RELAD) into the Ready Reserves (selected drilling or IRR). The physical examination shall follow the guidelines set forth for quinquennial physicals.

(2) Other members separating from the Coast Guard e.g., discharge or transfer to standby reserve (non-drilling) may request a medical and/or dental examination. The medical examination must include: notation of any current problems, a blood pressure measurement, and address items on the preventive medicine stamp. In addition to the above, the practitioner shall ascertain the health needs of the member and undertake measures deemed necessary to meet those needs. The dental examination, if requested, must at least be a Type III exam. These examinations may be annotated on a SF-600, and upon completion, do not require approval.

(3) For members enrolled in the Occupational Medical Surveillance and Evaluation Program (OMSEP), see chapter 12 of this Manual for guidance.

(4) See chapter 12 of the Personnel Manual, COMDTINST M1000.6(series), for amplification on administrative discharge procedures.

d. Overseas Transfer, Sea Duty Deployment and Port Security Unit (PSU) Health Screening. A modified physical examination, utilizing Figure 3-A-1, is required for all personnel departing for an overseas assignment for 60 consecutive days or greater, PCS transfer to an icebreaker, vessel deployment for 60 consecutive days or or more (out of 365), and annually for PSU personnel. This will help identify and resolve health related issues prior to transfer or deployment, if no significant medical status changes have occurred. Members who are transferring from one overseas assignment to another overseas assignment do not require another overseas physical examination. The completed modified physical examination and a copy of the last completed/approved Report of Physical Examination (DD-2808) and Report of Medical History (DD-2807-1), shall be submitted to the Reviewing Authority. The modified physical examination will include the following:

(1) a health history completed by the evaluee. (The evaluee will certify by signature that all responses are true);

(2) documentation of the previous approved physical examination to include the status of recommendations and summary of significant health changes;

(3) review of the health record to ensure routine health maintenance items are up-to-date to include: routine gynecologic examinations, two pairs of glasses and gas mask inserts for PSU personnel if required to correct refractive error, DNA sampling, G-6-PD screening, immunizations, and a Type 2 dental examination;

(4) review malaria chemoprophylaxis, PPD, and special health concern requirements. Contact the Center for Disease Control and Prevention (CDC) at http://www.cdc.gov or http://www.travel.state.gov for information;

(5) if PCS transferring to a foreign country [refer to 3-C.20.b(9)(b)], HIV antibody test must have been conducted within the past 6 months with results noted prior to transfer;

(6) if an evaluee is enrolled (or will be enrolled based on new assignment) in the Occupational Medical Surveillance and Evaluation Program (OMSEP), ensure appropriate periodic/basic examination is performed.

e. Applicant.

(1) Commissioning Programs. A physical examination is required for applicants for entry into the Coast Guard as follows:

(a) Coast Guard Academy: DODMERB physical examination within 24 months;

(b) Officer Candidate School: MEPS physical within 24 months of entry date, except:

1 Coast Guard personnel on active duty may obtain the physical examination at a USMTF within 24 months of entry date, and

2 Members of other Armed Services may submit a physical examination from a USMTF provided the examination has been performed within the past twelve (12) months and is as complete as a MEPS physical examination.

(c) Direct commission: MEPS physical within 24 months of entry date or oath of office for Ready Reserve Direct Commission, except aviation programs, where examination by a uniformed service flight surgeon or AMO is required within 12 months of entry date.

(2) Aviation. An aviation physical examination is required for applicants for training in all categories of aviation specialties. This physical examination is valid for 24 months for Class II applicants and 12 months for pilot applicants.

(3) Diving. A physical examination is required for all applicants for duty involving diving, and is valid for twelve months.

f. Pre-Training Screening Examinations. A screening examination is required within 1 week of reporting to the Coast Guard Academy, Officer Candidate School, Direct Commission Officer orientation, or the Recruit Training Center. This screening examination shall be sufficiently thorough to ensure that the person is free from communicable and infectious diseases, and is physically qualified. The results of this examination shall be recorded on an SF-600 and filed in the health record.

g. Retired Members Recalled to Active Duty. A physical examination is required for retired personnel who are recalled to active duty. This physical examination is valid for twelve months. A physical examination performed for retirement may be used

for recall providing the date of recall is within six months of the date of the physical examination.

h. Annual. An annual physical examination is required on all active duty personnel who are 50 years of age or older and all air traffic controllers.

i. Biennial.

(1) Biennial physical examination is required every 2 years after initial designation, until age 48, for the following:

(a) all aviation personnel (except air traffic controllers); and

(b) all Landing Signal Officers (LSO).

(2) The biennial exam will be performed within 90 days before the end of the birth month. The period of validity of the biennial physical will be aligned with the last day of the service member's birth month. (Example: someone born on 3 October would have August, September, and October in which to accomplish his/her physical. No matter when accomplished in that time frame, the period of validity of that exam is until 31 October two years later.)

(3) This process of aligning the biennial exam with the birth month is a new process effective immediately. In order to phase in this process the valid period of future biennial exams may be extended up to a total of thirty months (6 months from the current valid date) to align the valid date with the birth month. (See Table 3-A-1).

(a) Example 1: A member with an October birth month accomplishes biennial exam in May 2000 (previously valid until May 2002). Biennial exam is now valid until October 2002 (29 months total) to allow the member to align biennial exam with birth month.

(b) Example 2: A member with a June birth month accomplishes a biennial exam in October of 1999 (previously valid until October 2001). Biennial exam is now valid until June 2001 (20 months total) to allow the member to align biennial exam with birth month.

(4) The requirement to perform a biennial exam will not be suspended in the event of training exercises or deployment. Aircrew with scheduled deployment during their 90 day window to accomplish their biennial exam may accomplish their biennial exam an additional 90 days prior and continue with the same valid end date. This may result in a member having a valid biennial for 30 months. Members unable to accomplish a biennial exam prior to being deployed will be granted an additional 60 days upon return in which to accomplish their physical. Align subsequent biennial exam with the aircrew member's birth month using Table 3-A-1.

(5) Additionally, a comprehensive physical may be required during a post-mishap investigation, FEB, or as part of a work-up for a medical disqualification.

(6) Personnel designated as aircrew are expected to maintain a biennial exam schedule regardless of current aviation duty status.

Table-3-A-1

Number of months for which a biennial exam is valid

	Month in which last biennial exam was given											
Birth Month	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
JAN	24	23	22	21	20	19	30	29	28	27	26	25
FEB	25	24	23	22	21	20	19	30	29	28	27	26
MAR	26	25	24	23	22	21	20	19	30	29	28	27
APR	27	26	25	24	23	22	21	20	19	30	29	28
MAY	28	27	26	25	24	23	22	21	20	19	30	29
JUN	29	28	27	26	25	24	23	22	21	20	19	30
JUL	30	29	28	27	26	25	24	23	22	21	20	19
AUG	19	30	29	28	27	26	25	24	23	22	21	20
SEP	20	19	30	29	28	27	26	25	24	23	22	21
OCT	21	20	19	30	29	28	27	26	25	24	23	22
NOV	22	21	20	19	30	29	28	27	26	25	24	23
DEC	23	22	21	20	19	30	29	28	27	26	25	24

Notes:

Read down the left column to the examinee's birth month; read across to month of last biennial exam; intersection number is the maximum validity period. When last biennial exam was within the 3 month period preceding the end of the birth month, the validity period will normally not exceed 27 months. When the last biennial exam was for entry into aviation training, for FEB, post-accident, post-hospitalization, etc., the validity period will range from 19 to 30 months. Validity periods may be extended by 1 month only for completion of an examination begun before the end of the birth month.

j. Quinquennial/Quinquennial Diving. A physical examination is required every five (5) years after entry on all active duty personnel, age 25 through age 50, and for all personnel maintaining a current diving qualification (also note "Diving" in item #5 of DD-2808). Quinquennial physical examinations are also required for:

(1) all Selected Reservists within 30 days of their birth date starting at age 25 continuing until retirement, and

(2) reserve officers assigned to the Individual Ready Reserve (IRR) who are on a promotion list.

(3) Officers in 3-A-7.e.(1)(a) and (b) above must have a current approved physical examination documented by PMIS data base entry prior to being promoted (i.e., a quinquennial physical examination within the last 5 years).

k. Occupational Medical Surveillance and Evaluation Program (OMSEP). Those individuals who are occupationally exposed to hazardous substances, physical energies, or employed in designated occupations must undergo physical examinations as required by Chapter 12 of this Manual.

l. Miscellaneous Physical Examinations.

(1) Retention. This examination is done at the direction of the commanding officer when there is substantial doubt as to a member's physical or mental fitness for duty.

(2) Pre-confinement Physical Screening. In general, personnel who are presented for this screening, who do not require acute medical treatment or hospitalization, are fit for confinement. Cases where a member requires more than routine follow-up medical care, or has certain psychiatric conditions, that may make them unfit for confinement, should be discussed with the chief medical officer (or his/her representative) at the confining facility. Personnel requiring detoxification for alcohol or drug dependency are not fit for confinement; however, members that have been detoxified or that may require rehabilitation alone are fit for confinement. This screening shall be recorded on an SF-600 (per FIGURE 3-A-1) and, together with a copy of the last complete and approved Report of Physical Examination (DD-2808) and Report of Medical History (DD-2807-1), shall be submitted to the Reviewing Authority.

(3) Post Confinement Physical Examination. Ensure a separation physical examination has been completed prior to the member departing the confining facility. The separation physical shall meet the standards of section 3-F and must be approved by the appropriate MLC(k).

(4) Reservists. A district commander may require any reservist attached to a command within that area to undergo a complete physical examination if reasonable doubt exists as to the reservist's physical or mental fitness for duty.

(5) Non-Fitness for Duty Determination Physical Examinations. The Chief of Health Services retains the authority and responsibility to determine capability and capacity to conduct non-fitness for duty physical examinations for all eligible beneficiaries.

m. Annual Command Afloat Medical Screening. Officers and enlisted personnel scheduled to assume command afloat shall undergo a medical screening prior to assignment. The initial screening may be conducted by a medical officer where applicable, or an HS not in the prospective chain of command of the member being screened. Thereafter, all commanding officers and officers-in-charge of afloat units will have an annual command afloat medical screening. This screening will also be performed by a medical officer where available, otherwise, the screening may be performed by a Health Services Technician who IS NOT in the chain of command of

the person being screened. The screening process will include a medical history completed by the member, a visual acuity check, blood pressure measurement, and a thorough review of interval history in the member's health record. Results are to be recorded using the format in Figure 3-A-2. The medical screening form (Figure 3-A-2) and a copy of the last approved DD-2808 and DD-2807-1 shall then be forwarded to the appropriate MLC (kma) for review. The MLC (kma) will approve or disapprove the screening using section 3-F (retention standards) as the guiding directive. If a question arises as to the fitness of the individual, the MLC (kma) may request additional information from the examining unit. If the MLC (kma) is unable to render a decision as to the fitness for command, the entire command afloat screening package will be forwarded to Commandant (G-WKH) for final action. The reviewed form shall be returned to the member's command for filing in the member's health record.

n. Dental Examinations. Annual Type II dental examinations are required for all active duty personnel assigned to commands collocated with dental examiners (i.e., Coast Guard DOs, DOD DOs, or civilian contract dentists).

8. Waiver of Physical Standards.

a. Definition of Waiver. A waiver is an authorization to change a physical standard when an individual does not meet the physical standards prescribed for the purpose of the examination.

(1) Normally, a waiver will be granted when it is reasonably expected that the individual will remain fit for duty and the waiver is in the best interests of the Coast Guard. A service member will not be granted a waiver for a physical disability determined to be not fit for duty by a physical evaluation board approved by the Commandant. In these cases, the provisions for retention on active duty contained in the Physical Disability Evaluation System, COMDTINST M1850.2 (series), and the Personnel Manual, COMDTINST M1000.6 (series) apply.

(2) If a member is under consideration by the physical disability evaluation system, no medical waiver request shall be submitted for physical defects or conditions described in the medical board. All waiver requests received for conditions described in the medical board will be returned to the member's unit without action.

(3) A waiver of a physical standard is not required in a case where a Service member's ability to perform on duty has been reviewed through the physical disability evaluation system and the approved finding of the Commandant is fit for duty.

b. Authority for Waivers. Commander CGPC-epm (enlisted), CGPC-opm (officers), and CGPC-rpm (reserve) have the sole authority to grant waivers. The decision to authorize a waiver is based on many factors, including the recommendations of the Chief, Office of Health and Safety; the best interest of the Service; and the

individual's training, experience, and duty performance. Waivers are not normally authorized but shall be reviewed by Commander (CGPC) for the following:

(1) original enlistment in the regular Coast Guard of personnel without prior military service;

(2) appointment as a Cadet at the Coast Guard Academy; and

(3) training in any aviation or diving category specialty.

c. Types of Waivers.

(1) Temporary. A temporary waiver may be authorized when a physical defect or condition is not stabilized and may either progressively increase or decrease in severity. These waivers are authorized for a specific period of time and require medical reevaluation prior to being extended.

(2) Permanent. A permanent waiver may be authorized when a defect or condition is not normally subject to change or progressive deterioration, and it has been clearly demonstrated that the condition does not impair the individual's ability to perform general duty, or the requirements of a particular specialty, grade, or rate.

d. Procedures for Recommending Waivers.

(1) Medical Officer. A medical officer who considers a defect disqualifying by the standards, but not a disability for the purpose for which the physical examination is required, shall:

(a) enter a detailed description of the defect in Item 77 of the DD-2808; and

(b) indicate that either a temporary or permanent waiver is recommended.

(2) Command/Unit Level. When the command receives a Report of Medical Examination (DD-2808) indicating that an individual is not physically qualified, the command shall inform the individual that he/she is not physically qualified. The individual shall inform the command via letter of his/her intentions to pursue a waiver. The medical officer is required to give a recommendation on whether the waiver is appropriate and if the individual may perform his/her duties with this physical defect. This recommendation shall be completed on an (SF-502) Narrative Summary. A cover letter stating the command's opinion as to the appropriateness of a waiver, the individual's previous performance of duty, special skills, and any other pertinent information, shall accompany the medical officers report. The waiver request package shall be forwarded directly from the member's unit to Commander CGPC-epm or opm, or Commandant (CGPC-rpm) as appropriate.

e. Command Action on Receipt of a Waiver Authorization. A command receiving authorization from the Commander CGPC-epm/opm/rpm for the waiver of a physical standard shall carefully review the information provided to determine any duty limitation imposed and specific instructions for future medical evaluations.

Unless otherwise indicated in the authorization, a waiver applies only to the specific category or purpose for which the physical examination is required. A copy of the waiver authorization shall be retained in both the service and health records for the period for which the waiver is authorized. Copies of future DD-2808's for the same purpose shall be endorsed to indicate a waiver is or was in effect.

9. Substitution of Physical Examinations.

   a. Rule for Substitution of Physical Examinations. In certain circumstances, a physical examination performed for one purpose or category may be substituted to meet another requirement provided the following criteria are met:

      (1) the examinee was physically qualified for the purpose of the previous examination and all the required tests and recommendations have been completed;

      (2) the DD-2808 used for substitution bears an endorsement from the Reviewing Authority or Commandant (G-WKH), as appropriate, indicating that the examinee was qualified for the purpose of the previous examination;

      (3) there has been no significant change in the examinee's medical status since the previous examination;

      (4) a review of the report of the previous examination indicates that the examinee meets the physical standards of the present requirement;

      (5) the date of the previous examination is within the validity period of the present requirement; and

      (6) all additional tests and procedures to meet the requirements of the current physical examination have been completed.

   b. No substitutions are authorized for the following physical examinations:

      (1) enlistment;

      (2) pre-training; and

      (3) applicants for or designated personnel in special programs (aviation, diving, Academy).

   c. Procedures for Reporting Substitution. Substitutions of a physical examination shall be reported by submitting a copy of the DD-2808 and DD-2807-1 being used to meet the present requirements with the endorsement illustrated in FIGURE 3-A-1, parts A, B, and C. Retain a copy of the substitution endorsement in the health record.

FIGURE 3-A-1 (revised 02/02)

MODIFIED PHYSICAL EXAMINATION FOR:

SUBSTITUTION/OVERSEAS ASSIGNMENT/SEA DUTY/PSU HEALTH SCREENING

This form is subject to the Privacy Act Statement of 1974.

A. EVALUEE DATA

LAST NAME - FIRST NAME - MIDDLE INITIAL	RATE/RANK	SOCIAL SECURITY NUMBER

UNIT	EXAMINING FACILITY

PURPOSE OF EXAMINATION	TRANSFER/DEPLOYMENT LOCATION	DATE

B. HEALTH HISTORY (completed by examinee)

1. Would you say your health in general is: [ ] Excellent [ ] Good [ ] Fair [ ] Poor
2. Do you have any medical or dental problems or concerns? [ ] No [ ] Yes
3. Do you have any health related duty limitations? [ ] No [ ] Yes
4. Could you be pregnant? (females request HCG if needed) [ ] N/A [ ] Unknown [ ] No [ ] Yes
5. Are you taking prescription medications? (request refills if needed) [ ] No [ ] Yes
6. During the past year, have you sought or required counseling or mental health care? [ ] No [ ] Yes
7. Explain any "fair, poor, yes, or unknown" responses:_____

_____

8. Have you been hospitalized since your last physical? Yes / No. If (Yes) explain._____

I certify that responses above are true: (signature of examinee)_____

C. PHYSICAL EXAMINATION REVIEW (current approved physical examination required)

9. Date and type of current approved physical examination:_____

10. Status of recommendations or further specialist examination:_____

_____

11. Summary of significant health history since last physical examination:_____

_____

D. HEALTH RECORD REVIEW

12. Have routine gynecologic (pap) examinations been completed in past year? (females) [ ] N/A [ ] No [ ] Yes
13. Does examinee have two pair of glasses? (if required to correct refractive error) [ ] N/A [ ] No [ ] Yes
14. Does PSU examinee have a gas mask insert? (if required to correct refractive error) [ ] N/A [ ] No [ ] Yes
15. Has DNA sampling been completed and documented? (once per career) [ ] No [ ] Yes
16. Has G-6-PD screening been completed and documented? (once per career) [ ] No [ ] Yes
17. Are immunizations up-to-date and meet requirements for destination? [ ] No [ ] Yes
18. Has an HIV AB test been drawn in the past 6 months? (foreign country PCS only) [ ] N/A [ ] No [ ] Yes
19. Are malaria chemoprophylaxis, PPD, and special health concern requirements met? [ ] No [ ] Yes
    Contact the Center for Disease Control and Prevention at http://www.cdc.gov for information.
20. Has a Type 2 dental examination been completed in the past year and is examinee "Class 1 or 2"? [ ] No [ ] Yes
21. Explain any "no" answers:_____

_____

E. SIGNATURE AND APPROVAL/DISAPPROVAL

Medical Officer signature/stamp:_____ Date:_____

Dental Officer signature/stamp:_____ Date:_____

Reviewing/approving authority:_____ **[ ] Approved** **[ ] Disapproved**

FIGURE 3-A-2 (revised 2/99)

ANNUAL COMMAND AFLOAT MEDICAL SCREENING

Name:_____ Rank/Grade:_____

SSAN:_____ Date of Birth:_____ Work Telephone:_____

Unit OPFAC:_____ Unit Name:_____ Date of Screening:_____

To be completed by the member: (use reverse side as needed)

List any significant medical history since your last physical examination or medical screening (describe any illnesses, injuries, etc.):_____

_____

_____

_____

Have you experienced any significant changes in stress level, mood, or family life? YES NO

If yes, describe:_____

_____

_____

_____

Do you have any alcohol-related problems (including DWI)? YES NO

If yes, describe: _____

_____

_____

Are you presently taking any medication (including over-the-counter)? YES NO

If yes, list: _____

_____

_____

The information I have provided above is complete and accurate.

_____Date:_____

(Signature of member)

The following section is to be completed by health services personnel:

Review of Health Record performed. Significant findings are:_____

_____

_____

Best Distant Visual Acuity (with correction, if required): R:_____ L:_____

Sitting blood pressure:_____ _____

NOTE: ATTACH A COPY OF LAST APPROVED DD-2808 AND DD-2807-1

_____ UNIT: _____Date: _____

(Signature/Title of medical reviewer)

_____Date: _____

(Signature/MLC reviewer

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Section B - Reporting, Reviewing, Recommendations, and Actions to be Taken on Reports of Medical Examination (DD-2808) and Medical History (DD-2807-1).

1. DD-2808 (Report of Medical Examination).

   a. DD-2808 (July 2001) is the proper form for reporting a complete physical examination. DD-2808 revised (July 2001) is the newest version of the physical examination report and can be obtained from the WKH-1 Publications and Directives web site at http://www.uscg.mil/hq/G-W/g-wk/g-wkh/g-wkh-1/Pubs/Pubs.Direct.htm or by http://www.dior.whs.mil/forms/DD2808.PDF directly from the DOD forms web site.

   b. Detailed instructions for the preparation and distribution of this form are contained in section 4-B of this Manual.

2. DD-2807-1 (Report of Medical History).

   a. DD-2807-1 (July 2001) is the proper form for reporting a member's medical history. DD-2807-1 revised (July 2001)) is the newest version of the medical history report and can be obtained from the WKH-1 Publications and Directives web site at http://www.uscg.mil/hq/G-W/g-wk/g-wkh/g-wkh-1/Pubs/Pubs.Direct.htm or by http://www.dior.whs.mil/forms/DD2807-1.PDF directly from the DOD forms web site.

   b. Detailed instructions on the preparation and distribution of this form are contained in section 4-B of this Manual.

3. Review and Action on Findings and Recommendations of Report of Medical Examination (DD-2808).

   a. Action by the Medical Examiner.

      (1) Review of Findings and Evaluation of Defects. When the results of all tests have been received and evaluated, and all findings recorded, the examiner shall consult the appropriate standards of this chapter to determine if any of the defects noted are disqualifying for the purpose of the physical examination. When physical defects are found that are not listed in the standards as disqualifying, but that, in the examiner's opinion, would preclude the individual from performing military service or the duties of the program for which the physical examination was required, the examiner shall state that opinion on the report indicating reasons. If in the examiner's opinion, a defect listed as disqualifying is not disabling for military service, or a particular program, the examiner shall indicate the basis for this opinion and recommend a waiver in accordance with the provisions of section A of this chapter.

      (2) Remediable Defects. When the physical examination of active duty personnel indicates defects that are remediable or that may become potentially disabling unless a specific medical program is followed, the examiner shall clearly state any recommendations. If the examining facility has the capability of correcting the defect or providing extended outpatient follow-up or medical

care, tentative arrangements for care shall be scheduled, subject to the approval of the examinee's command. If the examining facility does not have the capabilities of providing the necessary care, tentative arrangements for admission or appointment at another facility shall be scheduled, again subject to the approval of the individual's command.

(3) Advising the Examinee. After completing the physical examination, the medical examiner will advise the examinee concerning the findings of the physical examination. At the same time, the examinee shall be informed that the examiner is not an approving authority for the purpose of the examination and that the findings must be approved by proper authorities.

(4) Disposition of Reports. The original DD-2808 and the original DD-2807-1, together with any reports of consultations or special testing reports not entered on the DD-2808 or DD-2807-1, shall be forwarded to the activity that referred the individual for the physical examination.

b. Review and Action on Reports of Physical Examination by Command.

(1) Command Responsibility.

(a) The command has a major responsibility in ensuring the proper performance of physical examinations on personnel assigned and that physical examinations are scheduled sufficiently far in advance to permit the review of the findings and correction of medical defects prior to the effective date of the action for which the examination is required. The command is also responsible to ensure that the individual complies with the examiner's recommendations and to initiate any administrative action required on a Report of Medical Examination.

(b) All DD-2808's shall be reviewed by commanding officers, or their designee, to determine that the prescribed forms were used and that all necessary entries were made.

(c) When the medical examiner recommends further tests or evaluation, or a program of medical treatment (such as hearing conservation, periodic blood pressure readings, etc.), the command will ensure that these tests or examinations are completed or that the individual is directed to and does comply with the recommended program. When a necessary test, evaluation, or program can be completed within a 60 day period, the unit may hold the DD-2808 to permit the forwarding of results. In all cases the command shall endorse the DD-2808 to indicate what action has been taken and forward the report to the reviewing authority if the 60 day period cannot be met or has elapsed.

(d) Disposition of Reports.

1 If a physical examination is accomplished for a purpose for which the command has administrative action, the original DD-2808 and

DD-2807-1 and a return self-addressed envelope shall be forwarded to the reviewing authority. No action will be taken to accomplish the purpose for which the physical examination was taken until the endorsed original of the report is returned by the reviewing authority indicating the examinee meets the physical standards for the purpose of the examination.

2 Approved MEPS physicals do not require further review. The original physical (DD-2808 and DD-2807-1) will be carried to the training center by the individual.

3 If the physical examination is for a purpose requiring the consent or approval of the MLC commander, or Commandant, the procedures previously described for command review and action will be accomplished, except rather than forwarding the report of the examination directly to the reviewing authority, it will be included with other supporting documents (letters, recommendations, etc.) and forwarded through the chain of command.

4 Units not using a CGMTF shall send physical examinations to the appropriate CG Clinic (as designated by the cognizant MLC), MLC (k), or CGPC (adm) as appropriate.

c. Action by the Reviewing Authority.

(1) The Commandant is the final reviewing authority for all physical examinations, except for applicants to the Coast Guard Academy.

(2) Administratively, MLC (k) acts as the reviewing authority for physical examinations performed on personnel assigned to their Areas except as in (4) and (5) below.

(3) Another exception to this rule pertains to those flight physicals performed on aviation school students during training that are reviewed and approved by the Navy Operational Medicine Institute (NOMI). NOMI, not MLC (k) will be the approving authority for these physicals. CGPC will remain the waiver approval authority for these physicals, when a waiver is required prior to final approval. Upon completion of flight training and assignment to a Coast Guard unit, the NOMI approved physical will be considered valid until the last day of the member's next birth month. The unit flight surgeon will clear the aviator for all flight related duties based on the NOMI approved flight physical.

(4) Commander Coast Guard Personnel Command (CGPC-adm) is the reviewing authority for aviator candidate, flight officer candidate, aircrew candidate, and diving candidate physical examinations. Commandant (G-WKS) is also the reviewing authority for OMSEP physical examinations. Commander (CGPC-adm) shall review disapproved MEPS physicals to ensure proper application of physical standards.

(5) The Department of Defense Medical Examination Review Board (DoDMERB) is the reviewing authority for physical examinations performed on Academy applicants. MEPS is the reviewing authority for physical examinations performed in their facilities.

(6) Each DD-2808 shall be carefully reviewed to determine whether the findings reported indicate the examinee does or does not meet the appropriate physical standards. If further medical evaluation is required to determine that the examinee does meet the standards, or to resolve doubtful findings, the reviewing authority shall direct the commanding officer or recruiting station to obtain the evaluation and shall provide such assistance as may be required.

(7) The reviewing authority shall endorse the original of the DD-2808 indicating whether the examinee does or does not meet the physical standards required. If the examinee does not meet the physical standards, the endorsement shall indicate the particular disqualifying defect or defects. Endorsements can be in the format contained in FIGURE 3-B-1 or use of blocks #74.a, #77 and signature in block #81.a, of the DD-2808.

(8) The endorsed original of the physical examination shall be forwarded to the individual's unit for filing in the member's health record.

(9) Input of physical examination status of personnel into the PMIS system is required. Reviewing Authorities shall collect and submit data regarding all physical examinations/screenings (per paragraph 3-A-7, except subparagraph 3-A-7.f) they review to the appropriate PERSRU on a monthly basis. Data to be collected for transmittal to the PERSRUs is as follows:

(a) Member's name;

(b) Member's rank/rate;

(c) Member's SSAN;

(d) Member's unit OPFAC;

(e) Date of physical examination;

(f) Purpose of examination;

(g) Date acted upon by Reviewing Authority; and

(h) Status code for physical examination. Status codes are as follows:

1 Code A- member qualified for periodic (biennial, quinquennial, etc.) physical examination.

2 Code D- member qualified for RELAD/discharge/retirement.

3 Code O- member qualified for overseas duty.

4 Code N- member not physically qualified.

d. Disposition of Reports.

(1) When the individual meets the appropriate physical standards, forward the physical examination as indicated in FIGURE 3-B-2.

(2) When the individual does not meet the appropriate physical standards and a waiver has been recommended, endorse the physical examination and forward it in accordance with section 3-A-8.

(3) When the individual is not physically qualified for the purpose of the examination and a waiver is not recommended, the reviewing authority will arrange for the examinee to be evaluated by a medical board and provide administrative action as outlined in Physical Disability Evaluation System, COMDTINST M1850.2(series).

4. Correction of Defects Prior to Overseas Transfer or Sea Duty Deployment.

a. Medical Defects. Before an individual departs for an overseas assignment for 60 consecutive days or greater days, to permanent assignment aboard a Polar Icebreaker, or to a vessel deploying from its home port for 60 consecutive days or greater, all remediable medical defects, such as hernias, pilonidal cysts or sinuses requiring surgery, etc., must be corrected. Those defects that are not easily corrected will be referred to Commander CGPC for consideration. These procedures also apply to personnel presently assigned to such vessels. In these cases all necessary corrective measures or waivers will be accomplished prior to the sailing date.

b. Dental Defects. All essential dental treatment shall be completed prior to overseas transfer or sea duty deployment except those described in 4-C-3.c.(3)(b). Essential dental treatment constitutes those procedures necessary to prevent disease and disabilities of the jaw, teeth, and related structures. This includes extractions, simple and compound restorations, and treatment for acute oral pathological conditions such as Vincent's stomatitis, acute gingivitis, and similar conditions that could endanger the health of the individual during a tour of duty. Missing teeth are to be replaced when occluding tooth surfaces are so depleted that the individual cannot properly masticate food. Elective dental procedures (those that may be deferred for up to twelve months without jeopardizing the patient's health, i.e., Class II patient) need not be completed prior to overseas transfer providing both of the following conditions exist:

(1) completion of such elective procedures prior to transfer would delay the planned transfer; and

(2) adequate Service dental facilities are available at the overseas base.

c. Vision Defects. A refraction shall be performed on all personnel whose visual acuity is less than 20/20 in either eye (near or distant) or whose present eyewear prescription does not correct their vision to 20/20. All personnel requiring glasses

for correction shall have a minimum of two pair prior to overseas transfer or sea duty deployment. All personnel requiring corrective lenses shall wear them for the performance of duty.

5. Objection to Assumption of Fitness for Duty at Separation.

   a. Any member undergoing separation from the service who disagrees with the assumption of fitness for duty and claims to have a physical disability as defined in section 2-A-38 of the Physical Disability Evaluation System, COMDTINST M1850.2(series), shall submit written objections, within 10 days of signing the Chronological Record of Service (CG-4057), to Commander CGPC. Such objections based solely on items of medical history or physical findings will be resolved at the local level. The member is responsible for submitting copies of the following information along with the written objections:

      (1) Report of Medical Examination (DD-2808);

      (2) Report of Medical History (DD-2807-1);

      (3) signed copy of the Chronological Record of Service (CG-4057);

      (4) Appropriate consultations and reports; and

      (5) "other pertinent documentation."

      (6) The rebuttal is a member's responsibility and command endorsement is not required.

   b. The file shall contain thorough documentation of the physical examination findings, particularly in those areas relating to the individual's objections. Consultations shall be obtained to thoroughly evaluate all problems or objections the examinee indicates. Consultations obtained at the examinee's own expense from a civilian source shall also be included with the report.

   c. Commander (CGPC) will evaluate each case and, based upon the information submitted, take one of the following actions:

      (1) find separation appropriate, in which case the individual will be so notified and the normal separation process completed;

      (2) find separation inappropriate, in which case the entire record will be returned and appropriate action recommended; or

      (3) request additional documentation before making a determination.

6. Separation Not Appropriate by Reason of Physical Disability. When a member has an impairment (in accordance with section 3-F of this Manual) an Initial Medical Board shall be convened only if the conditions listed in paragraph 2-C-2.(b), Physical Disability Evaluation System, COMDTINST M1850.2(series), are also met. Otherwise the member is suitable for separation.

7. Procedures for Physical Defects Found Prior to Separation.

a. Policy. No person shall be separated from the Service with any disease in a communicable state until either rendered noninfectious, or until suitable provisions have been made for necessary treatment after separation.

b. Remediable Non-Disqualifying Defects. Remediable physical defects that would not normally prevent the individual from performing the duties of grade or rate shall be corrected only if there is reasonable assurance of complete recovery and sufficient time remaining prior to separation.

FIGURE 3-B-1

DATE REVIEWERS UNIT _____

Does/does not meet the physical standards for (title or category or purpose of examination), as prescribed in (appropriate section of Medical Manual, COMDTINST M6000.1 (series)).

Disqualifying Defects:

Signature and Title of Reviewer

FIGURE 3-B-2

Physical Exam Purpose	Note:	Original to:	Reviewing Authority:
Aviator Candidate	(1,2)	CGPC-opm	CGPC-adm
Aircrew Candidate	(1,2)	CGPC-epm	“
Diving Candidate	(1,2)	CGPC	"
Enlistment	(2)	CGRC	"
Flight Surgeon (FS)		MLC (k)	MLC (k)
FS Candidate	(1)	G-WKH-1	G-WKH-1
Aviator	(1)	MLC (k)	MLC (k)
Aircrew	(1)	MLC (k)	MLC (k)
Diving	(1)	MLC (k)	MLC (k)
Flight Officer	(1)	MLC (k)	MLC (k)
Annual	(1)	MLC (k)	MLC (k)
LSO	(1)	or	or
Quinquennial	(1)	Clinic	Clinic
Overseas/Sea Duty	(1)	Administrator	Administrator
Retention	(1)	"	"
Retirement	(1,4)	"	"
Involuntary			
Separation	(1,4)	"	"
RELAD	(1,4)	"	"
Precom/Appts	(1)	"	"
Direct Commission	(1,5)	CGRC	CGPC-adm
OCS	(1,5)	CGRC	CGPC-adm
Physician Assistant Candidate	(1,5)	CGPC-opm	CGPC-adm

NOTES:

CGRC address: CG Recruiting Command, 4200 Wilson Blvd., Suite 450, Arlington, VA. 22203-1804

(1) The reviewing authority shall review, endorse and return the original to the member's unit for filing in the member's or applicant's health record.

(2) Forward the unendorsed physical to the appropriate Headquarters Office (as listed above) with the application/training request package. That Office will forward the physical to Coast Guard Personnel Command for review.

(3) Forward the original and one copy to Commandant (G-WKH) for review

(4) Ensure that a completed CG-4057 accompanies the completed DD-2808 and DD-2807-1.

(5) Reviewing authority for current USCG or USCGR members only. For all others, Note (2) above applies. Forward a copy of the first/front page of the DD-2808 with endorsement to the appropriate Headquarters office with the application package.

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Section C - Medical Examination Techniques And Lab Testing Standards.

1. Scope.
   This section is a medical examination technique guide applicable for all physical examinations.

2. Speech Impediment.
   Administer the "Reading Aloud Test" (RAT) as listed.

   a. Have the examinee stand erect, face you across the room and read aloud, as if confronting a class of students.

   b. If the individual pauses, even momentarily, on any phrase or word, immediately and sharply say, "What's that?", and require the examinee to start over again with the first sentence of the test.

   c. On the second trial, The person who truly stammers usually will halt again at the same word phonetic combination often revealing serious stammering. Examinees who fail to read the test without stammering after three attempts will be disqualified.

   d. READING ALOUD TEST "You wished to know all about my grandfather. Well, he is nearly 93 years old; he dresses himself in an ancient black frock coat usually minus several buttons; yet he still thinks as swiftly as ever. A long, flowing beard clings to his chin, giving those who observe him a pronounced feeling of the utmost respect. When he speaks, his voice is just a bit cracked and quivers a trifle. Twice each day he plays skillfully and with zest upon our small organ. Except in the winter when the ooze or snow or ice is present, he slowly takes a short walk in the open air each day. We have often urged him to walk more and smoke less, but he always answers, 'Banana Oil.' Grandfather likes to be modern in his language."

3. Head, Face, Neck, and Scalp (Item 17 of DD-2808).

   a. Head and Face. Carefully inspect and palpate the head and face for evidence of injury, deformity, or tumor growth. Record all swollen glands, deformities, or imperfections noted. Inquire into the cause of all scars and deformities. If a defect is detected such as moderate or severe acne, cysts, or scarring, make a statement as to whether this defect will interfere with wearing military clothing and equipment.

   b. Neck. Carefully inspect and palpate for glandular enlargement, deformity, crepitus, limitations of motion, and asymmetry; palpate the parotid and submaxillary regions, the larynx for mobility and position, the thyroid for size and nodules, and the supraclavicular areas for fullness and masses. If enlarged lymph nodes are detected describe them in detail with a clinical opinion of their etiology.

   c. Scalp. Examine for deformities such as depressions and exostosis.

4. Nose, Sinuses, Mouth, and Throat (Item 19, 20 of DD-2808).

   a. If there are no nasal or sinus complaints, simple anterior rhinoscopy will suffice, provided that in this examination, the nasal mucous membrane, the septum, and the turbinates appear normal. If the examinee has complaints, a more detailed examination is required. Most commonly, these complaints are external nasal deformity, nasal obstruction, partial or complete on one or both sides; nasal discharge; postnasal discharge; sneezing; nasal bleeding; facial pain; and headaches.

   b. Abnormalities in the mucous membrane in the region of the sinus ostia, the presence of pus in specific areas, and the cytologic study of the secretions may provide valuable information regarding the type and location of the sinus infection. Evaluate tenderness over the sinuses by transillumination or x-ray. Examination for sinus tenderness should include pressure applied over the anterior walls of the frontal sinuses and the floors of these cavities and also pressure over the cheeks. Determine if there is any tenderness to percussion beyond the boundaries (as determined by x-ray) of the frontal sinuses. Note any sensory changes in the distribution of the supra-orbital or infra-orbital nerves that may indicate the presence of neoplasm. Note any external swelling of the forehead, orbit, cheek, and alveolar ridge.

   c. Many systemic diseases manifest themselves as lesions of the mouth and tongue; namely leukemia, syphilis, agranulocytosis, pemphigus, erythema multiform, and dermatitis medicamentosa. Note any abnormalities or lesions on lips or buccal mucous membrane, gums, tongue, palate, floor of mouth, and ostia of the salivary ducts. Note the condition of the teeth. Pay particular attention to any abnormal position, size, or the presence of tremors or paralysis of the tongue and the movement of the soft palate on phonation.

   d. Record any abnormal findings of the throat. If tonsils are enucleated, note possible presence and position of residual or recurrent lymphoid tissue and the degree of scarring. If tonsils are present, note size, presence of pus in crypts, and any associated cervical lymphadenopathy. Note presence of exudate, ulceration, or evidence of neoplasm on the posterior pharyngeal crypts. Describe any hypertrophied lymphoid tissue on the posterior pharyngeal wall or in the lateral angle of the pharynx and note if there is evidence of swelling that displaces the tonsils, indicating possible neoplasm or abscess. Perform direct or indirect laryngoscopy if the individual complains of hoarseness.

5. Ears (General) and Drums (Item 21, 22 of DD-2808). Inspect the auricle, the external canal, and the tympanic membrane using a speculum and good light. Abnormalities (congenital or acquired) in size, shape, or form of the auricles, canals, or tympanic membranes must be noted, evaluated, and recorded.

   a. Auricle. Note deformities, lacerations, ulcerations, and skin disease.

   b. External canal. Note any abnormality of the size or shape of the canal and inspect the skin to detect evidence of disease. If there is material in the canal, note whether it is normal cerumen, foreign body, or exudate. Determine the source of any exudate

in the canal. If this exudate has its origins in the middle ear, record whether it is serous, purulent, sanguinous, or mucoid; whether it is foul smelling; and, whether it is profuse or scanty.

c. Tympanic membrane. Remove all exudate and debris from the canal and tympanic membrane before examination. Unless the canal is of abnormal shape, visualize the entire tympanic membrane and note and record the following points.

(1) List any abnormality of the landmarks indicating scarring, retraction, bulging, or inflammation.

(2) Note whether the tympanum is air containing.

(3) List any perforations, giving size and position, indicating whether they are marginal or central, which quadrant is involved, and whether it is the flaccid or the tense portion of the membrane that is included.

(4) Attempt, if the tympanic membrane is perforated, to determine the state of the middle ear contents, particularly concerning hyperplastic tympanic mucosa, granulation tissue, cholesteatoma, and bone necrosis. Do the pathological changes indicate an acute or chronic process? This clinical objective examination should permit evaluating the infectious process in the middle ear and making a reasonably accurate statement regarding the chronicity of the infection; the extent and type of involvement of the mastoid; the prognosis regarding hearing; and, the type of treatment (medical or surgical) that is required.

(5) Note, for all aviation and dive physical examinations, whether the examinee can properly auto insufflate tympanic membrane.

6. Eyes (General), Ophthalmoscopic, and Pupils (Item 23, 24, 25 of DD-2808). External and ophthalmoscopic examinations of the eyes are required on all examinations. Contact lenses shall not be worn during any part of the eye examination, including visual acuity testing. It is essential that such lenses not be worn for 72 hours preceding examination. The strength of the contact that an examinee may possess shall not be accepted as the refraction nor will it be entered as such in Item 60, DD-2808. The general examination shall include the following specific points and checks:

a. General.

(1) Bony abnormality or facial asymmetry.

(2) Position of the eyes.

(3) Exophthalmus.

(4) Manifest deviation of the visual axis.

(5) Epiphora or discharge.

(6) Position of puncta or discharge when pressure exerted over lacrimal sac.

b. Lids.

(1) Ptosis.

(2) Position of lashes, eversion or inversion.

(3) Inflammation of margins.

(4) Cysts or tumors.

c. Conjunctiva. Examine the palpebral and bulbar conjunctiva by:

(1) eversion of upper lid;

(2) depression and eversion of lower lid; and

(3) manually separating both lids.

d. Pupils.

(1) Size.

(2) Shape.

(3) Equality.

(4) Direct, consensual, and accommodative reactions.

e. Directly and obliquely examine the:

(1) Cornea. For clarity, discrete opacities, superficial or deep scarring, pannus, vascularization, pterygium, and the integrity of the epithelium.

(2) Anterior Chamber. For depth, alteration of normal character of the aqueous humor, and retained foreign bodies.

(3) Iris. For abnormalities and pathologic changes.

(4) Crystalline Lens. For clouding or opacities.

f. Ophthalmoscopic.

(1) Media. Examine with a plano ophthalmoscopic lens at a distance of approximately 18 to 21 inches from the eye. Localize and describe any opacity appearing in the red reflex or direct examination or on eye movement.

(2) Fundus. Examine with the strongest plus or weakest minus lens necessary to bring optic nerve into sharp focus. Pay particular attention to the color, surface, and margin of the optic nerve, also record any abnormality of the pigmentation or vasculature of the retina.

(3) Macula. Examine for any change.

7. Ocular Motility (Item 26 of DD-2808).

   a. Ascertain the motility of the eyeballs by testing for binocular eye movement (ductions and versions) in the cardinal positions of gaze. If any abnormalities are suspected, verify with the cover/uncover test.

   b. Observe if the eyes move together and whether there is loss of motion in any direction (paralysis or paresis), or absence of muscle balance, whether latent (heterophoria) or manifest (strabismus). Have the examinee look at a test object and alternately cover and uncover one eye leaving the other uncovered and observe the movement, if any, in each eye. In heterophoria movement occurs only in the eye that is covered and uncovered; on being covered, it deviates and on being uncovered, it swings back into place to take up fixation with the other eye that has remained uncovered.

8. Heart and Vascular System (Item 27 of DD-2808).

   a. General. In direct light, have the examinee stand at ease, with arms relaxed and hanging by sides. Do not permit the examinee to move from side to side or twist to assist in the examination, as these maneuvers may distort landmarks: and increase muscular resistance of the chest wall. Examine the heart by the following methods: inspection, palpation, auscultation, and when considered necessary, by mensuration.

   b. Inspection. Begin from above and go downward, with special reference to the following:

      (1) any malformation that might change the normal relations of the heart;

      (2) pulsations in the suprasternal notch and in the second interspaces to the right and left of the sternum;

      (3) character of the precordial impulse; or

      (4) epigastric pulsations.

   c. Palpation. First palpate to detect thrills over the carotids, thyroid glands, suprasternal notch, apex of the heart, and at the base. Use palms of hands in palpating and use light pressure, as hard pressure may obliterate a thrill. To locate the maximum cardiac impulse, have the examinee stoop and throw the shoulders slightly forward, thus bringing the heart into the closest possible relation with the chest wall. Palpate both radial arteries at the same time for equality in rate and volume. Run the finger along the artery to note any changes in its walls. Place the palm of one hand over the heart and fingers of the other over the radial artery to see if all ventricular contractions are transmitted. Palpate to determine the degree of tension or compression of the pulse. In an estimate of pulse rate, the excitement of undergoing a physical examination must be considered.

   d. Auscultation. In auscultating the heart, bear in mind the four points where the normal heart sounds are heard with maximum intensity:

(1) Aortic area, second interspace to right of sternum. Here the second sound is distinct.

(2) Tricuspid area, junction of the fifth right rib with the sternum. Here the first sound is distinct.

(3) Pulmonic area, second interspace to left of sternum. Here the second sound is most distinct.

(4) Mitral area, fifth interspace to left of sternum. Here the first sound is most clearly heard.

e. Blood Pressure.

(1) Only the sitting blood pressure is required.

(2) Other positions required only if sitting blood pressure exceeds **159/90 (140/90** for aviation personnel**)**.

(3) Take the sitting blood pressure with the examinee comfortably relaxed in a sitting position with legs uncrossed and the arm placed on a rest at the horizontal level of the heart. The condition of the arteries, the tenseness of the pulse, and the degree of accentuation of the aortic second sound must be taken into consideration, as well as the relation between the systolic and diastolic pressure.

(4) Personnel recording blood pressure must be familiar with situations that result in spurious elevation. A medical officer shall repeat the determination in doubtful or abnormal cases and ensure that the proper recording technique was used.

(5) Artificially high blood pressure may be observed as follows.

(a) If the compressive cuff is too loosely applied.

(b) If the compressive cuff is too small for the arm size. Cuff width should be approximately one-half arm circumference. In a very large or very heavily muscled individual, this may require an "oversize" cuff.

(c) If the blood pressure is repetitively taken before complete cuff deflation occurs. Trapping of venous blood in the extremity results in a progressive increase in recorded blood pressure.

(6) At least five minutes of rest should precede the blood pressure recording. Due regard must be given to physiologic effects such as excitement, recent exercise, smoking or caffeine within the preceding thirty minutes, and illness.

(7) No examinee shall be rejected based on the results of a single recording. If **2** out of the 3 positions exceed **159/90**, the disqualifying blood pressures will be rechecked for 3 consecutive days in the morning and afternoon of each day and carefully recorded. The first determination shall be recorded in Item 58 and the repeat determinations in Item 73 of DD-2808.

(8) While emphasizing that a diagnosis of elevated blood pressure not be prematurely made, it seems evident that a single "near normal" level does not negate the significance of many elevated recordings.

f. Blood Pressure Determination.

(1) Use procedures recommended by the American Heart Association.

(2) Take the systolic reading as either the palpatory or auscultatory reading depending on which is higher. In most normal subjects, the auscultatory reading is slightly higher.

(3) Record diastolic pressure as the level at which the cardiac tones disappear by auscultation. In a few normal subjects, particularly in thin individuals and usually because of excessive stethoscope pressure, cardiac tones may be heard to extremely low levels. In these instances, if the technique is correct and there is no underlying valvular defect, a diastolic reading will be taken at the change in tone.

(4) Note variations of blood pressures with the position change if there is a history of syncope or symptoms to suggest postural hypertension.

(5) Obtain blood pressure in the legs when simultaneous palpation of the pulses in upper and lower extremities reveals a discrepancy in pulse volume.

g. Pulse Rate.

(1) Determine the pulse rate immediately after the blood pressure. Only the sitting position is required.

(2) In the presence of a relevant history, arrhythmia, or a pulse of less than **50** or over **100**, all pulses shall be determined and an electrocardiogram obtained.

h. Interpretation of Abnormal Signs and Symptoms. The excitement of the examination may produce violent and rapid heart action often associated with a transient systolic murmur. Such conditions may erroneously be attributed to the effects of exertion; they usually disappear promptly in the recumbent posture. Try to recognize the excitable individuals and take measures to eliminate psychic influences from the test.

i. Hypertrophy-Dilitation. An apex beat located at or beyond the left nipple line, or below the sixth rib, suggests an enlargement sufficient to disqualify for military service. Its cause, either valvular disease or hypertension in the majority of cases, should be sought. A horizontal position of the heart must be distinguished from left ventricular enlargement. EKG, ultrasound studies, fluoroscopy, and chest x-ray may be indicated for diagnosis.

j. Physiological Murmurs. Cardiac murmurs are the most certain physical signs by which valvular disease may be recognized and its location determined. The discovery of any murmur demands diligent search for other evidence of heart

disease. Murmurs may occur, however, in the absence of valvular lesions or other cardiac disease. Such physiological murmurs are not causes for rejection.

(1) Characteristics. The following characteristics of physiological murmurs will help differentiate them from organic murmurs.

(a) They are always systolic in time.

(b) They are usually heard over a small area, the most common place being over the pulmonic valve and mitral valve.

(c) They change with position of the body, disappearing in certain positions. They are loudest usually in the recumbent position and are sometimes heard only in that position.

(d) They are transient in character, frequently disappearing after exercise.

(e) They are usually short, rarely occupying all of the systole, and are soft and of blowing quality.

(f) There is no evidence of heart disease or cardiac enlargement.

(2) Most Common Types. The most common types of physiological murmurs are:

(a) Those heard over the second and third left interspaces during expiration, disappearing during forced inspiration. These are particularly common in individuals with flexible chests, who can produce extreme forced expiration. Under such circumstances, murmurs may be associated with a vibratory thrust.

(b) Cardio-respiratory murmurs caused by movements of the heart against air in a part of the lung overlapping the heart. They usually vary in different phases of respiration and at times disappear completely when the breath is held.

(c) Prolongations of the apical first sound, that are often mistaken for murmurs.

(3) Diagnosis. An EKG, chest x-ray, and echocardiogram are usually indicated to firmly establish the true cause of a murmur and should be done if there is any question of abnormality.

k. Electrocardiograms. Use standard positions for precordial leads when completing electrocardiograms.

9. Lungs and Chest (Item 28 of DD-2808).

a. A thorough examination includes a complete history (DD-2807-1) careful physical examination, and necessary x-ray and laboratory studies. In screening examinations,

the history and x-ray studies are the most immediately revealing examination techniques.

b. Remember that several disqualifying diseases such as tuberculosis and sarcoidosis may not be detectable by physical examination and the absence of abnormal physical signs does not rule out disqualifying pulmonary disease. Such diseases, as well as others (neopasms and fungus infections), may be detected only by chest x-ray.

(1) Conduct the physical examination in a thorough, systematic fashion. Take particular care to detect pectus abnormalities, kyphosis, scoliosis, wheezing, persistent rhonchi, basilar rales, digital clubbing, and cyanosis. Any of these findings require additional intensive inquiry into the patient's history if subtle functional abnormalities or mild asthma, bronchitis, or bronchiectasis are to be suspected and evaluated. The physical examination shall include the following.

(a) Inspection. The examinee should be seated in a comfortable, relaxed position with the direct light falling upon the chest. Careful comparison of the findings elicited over symmetrical areas on the two sides of the chest gives the most accurate information regarding condition of the underlying structures. Observe for asymmetry of the thoracic cage, abnormal pulsation, atrophy of the shoulder girdle or pectoral muscles, limited or lagging expansion on forced inspiration. The large, rounded relatively immobile "barrel" chest suggests pulmonary emphysema.

(b) Palpation.

1 Observe for tumors of the breast or thoracic wall, enlarged cervical, supraclavicular, or axillary lymph nodes, suprasternal notch, and thrills associated with respiration or the cardiac cycle.

2 In addition to the breast examinations with periodic physical examinations, an annual clinical breast examination is required for all active duty females aged 40 and above. Monthly self-examination is recommended for all adult female patients.

(c) Auscultation. Instruct the examinee to breathe freely but deeply through the mouth. Listen to an entire respiratory cycle before moving the stethoscope bell to another area. Note wheezing, rales, or friction rubs. Compare the pitch and intensity of breath sounds heard over symmetrical areas of the two lungs. Instruct the examinee to exhale during this process. Note any rales, paying particular attention to moist rales that "break" with the cough or fine rales heard at the beginning of inspiration immediately after cough.

(2) Do not hesitate to expand the history if abnormalities are detected during examination or in repeating the examination if chest film abnormalities are detected.

c. There are three conditions that are most often inadequately evaluated and result in unnecessary and avoidable expense and time loss. These three are asthma (to include "asthmatic bronchitis"), bronchiectasis, and tuberculosis.

(1) Asthma. In evaluating asthma, a careful history is of prime importance since this condition is characteristically intermittent and may be absent at the time of examination. Careful attention to a history of episodic wheezing with or without accompanying respiratory infection is essential. If documentation of asthma after age 12 is obtained from the evaluee's physician, this shall result in rejection even though physical examination is normal. Ask about the use of prescription or over-the-counter bronchodilators.

(2) Bronchiectasis. Individuals who report a history of frequent respiratory infections accompanied by purulent sputum or multiple episodes of pneumonia should be suspected of bronchiectasis. This diagnosis can be further supported by a finding of post-tussive rales at one or both bases posteriorly or by a finding of lacy densities at the lung base on the chest film. If bronchiectasis is considered on the basis of history, medical findings or chest film abnormalities, seek confirmatory opinion from the examinee's personal physician or refer the examinee to the appropriate chest consultant for evaluation and recommendations.

(3) Tuberculosis (TB).

(a) Active TB is often asymptomatic and not accompanied by abnormal physical findings unless the disease is advanced. If only such manifestations as hemoptysis or draining sinuses are looked for, most cases of TB will be missed.

(b) The most sensitive tool for detecting early TB is the PPD.

(c) If positive, evaluate the chest film for any infiltrate, cavity, or nodular lesion involving the apical or posterior segments of an upper lobe or superior segment of a lower lobe. Many tuberculosis lesions may be partially hidden or obscured by the clavicles. When any suspicion of an apical abnormality exists, an apical lordotic view must be obtained for clarification.

(d) It is neither practical nor possible, in most instances, to determine whether or not a TB lesion is inactive on the basis of a single radiologic examination. Therefore, refer any examinee suspected of TB to a chest consultant or to an appropriate public health clinic for evaluation.

(e) An initial PPD is mandatory and shall be made a part of the physical examination for all personnel entering on active duty for a period of 30 days or more.

(f) See Chapter 7 for complete details of the Tuberculosis Control Program.

10. Anus and Rectum (Item 30 of DD-2808). All examinations shall include a visual inspection of the anus. Perform a digital rectal examination and test for fecal occult blood on all personnel beginning at age 40 and at any time history or physical exam findings indicate. When anorectal disease is suspected a complete exam should be performed which may include proctosigmoidoscopy as indicated.

11. Abdomen and Viscera (Item 31 of DD-2808).

    a. Examine the abdomen with the examinee supine, as well as standing to detect hernias.

    b. Use appropriate clinical laboratory, radiologic, and endoscopic examinations to confirm a diagnosis.

12. Genitourinary System (Item 32 of DD-2808).

    a. General. All physical examinations shall search for evidence of STD or malformation.

    b. Instructions for examination according to sex.

        (1) Females. The examination shall include:

            (a) inspection of the external genitalia;

            (b) either a vaginal or rectal bimanual palpation of the pelvic organs; and

            (c) Papanicolaou (PAP) testing and visualization of the cervix and vaginal canal by speculum in accordance with section 3-C-20.f.

        (2) Males. The glans penis and corona will be exposed. The testes and scrotal contents will be palpated and the inguinal lymph nodes will be examined for abnormalities. Palpate the inguinal canals while having the patient perform a valsalva.

13. Extremities (Item 33, 34, 35 of DD-2808). Carefully examine the extremities for deformities, old fractures and dislocations, amputations, partially flexed or ankylosed joints, impaired functions of any degree, varicose veins, and edema. In general the examination shall include:

    a. Elbow. With the examinee holding the upper arms against the body with the forearms extended and fully supinated, observe for the presence of normal carrying angle. Have the examinee flex the elbows to a right angle and keeping the elbows against the body, note ability to fully supinate and pronate the forearms. Test medial and lateral stability by placing varus and valgus strain on the joint with the elbow extended. Test the power of the flexor, extensor, supinator, and pronator muscles by having the examinee contract these muscles against manual resistance. If indicated, x-rays should include antero-posterior and lateral views.

    b. Foot.

(1) Examine the feet for conditions such as flatfoot, corns, ingrown nails, bunions, deformed or missing toes, hyperhidrosis, color changes, and clubfoot.

(2) When any degree of flatfoot is found, test the strength of the feet by requiring the examinee to hop on the toes of each foot for a sufficient time and by requiring the examinee to alight on the toes after jumping up several times. To distinguish between disqualifying and nondisqualifying degrees of flatfoot, consider the extent, impairment of function, appearance in uniform, and presence or absence of symptoms. Remember, it is usually not the flatfoot condition itself that causes symptoms but an earlier state in which the arches are collapsing and the various structures are undergoing readjustment of their relationships. Report angles of excursion or limitation; comparative measurements; use of orthotics or other supports; and x-ray results if indicated.

c. Hip.

(1) With the examinee standing, observe the symmetry of the buttocks, the intergluteal clefts, and infragluteal fold. Palpate the iliac crest and greater trochanters for symmetry.

(2) If abnormalities are suspected, have the examinee stand first on one foot and then the other, flexing the nonweight bearing hip and knee and observing for ability to balance as well as for instability of the joint, as indicated by dropping downward of the buttock and pelvis of the flexed (non-weight bearing) hip. Such a positive Trendelenburg sign necessitates x-ray evaluation.

(3) While supine have the examinee flex the hip, abduct and adduct the hip and rotate the leg inward. Observe for hesitancy in performing these motions, incomplete range of motion, or facial evidence of pain on motion. Test muscle strength in each position.

(4) With examinee prone, test for ability to extend each leg with knee extended and test for power in each hip in extension.

(5) If abnormalities are detected requiring x-rays, obtain an antero-posterior and a lateral view of each hip for comparison.

d. Knee.

(1) With trousers (skirt/dress), shoes, and socks removed, observe general muscular development of legs, particularly the thigh musculature.

(2) Have examinee squat, sitting on heels, and observe for hesitancy, weakness, and presence or absence of pain or crepitus.

(3) With examinee sitting, test for ability to fully extend the knee and test power in extension by applying pressure to the lower leg with knee extended. Compare equality of power in each leg. With knee flexed, test for hamstring power by attempting to pull leg into extension; compare equality of strength in each leg. Palpate entire knee for tenderness. With examinee still sitting on the table edge, sit and grasp the heel between the knees; then test for cruciate ligament

stability by first pulling the tibia anteriorly on the femur and by then pushing the tibia posteriorly on the femur ("Drawer Sign").

(4) With the examinee supine, mark on each leg a distance of 1 inch above the patella and 6 inches above the patella, making sure this is done with muscles relaxed. Measure circumferences at these levels and note presence or absence of atrophy. Test the medial and lateral collateral ligaments by placing varus and valgus strain on the extended knee. Manipulate the knee through a complete range of flexion and extension, noting any difference between the sides and any abnormal restriction.

(5) If there is a history of knee injury assess muscular strength, ligamentous stability, and range of motion. Also look for evidence of inflammatory or degenerative processes.

(6) In the presence of any history of "locking," recurrent effusion, or instability, or when atrophy measured is more than 3/8 inch or when limitation of motion or ligamentous instability is detected, obtain x-rays including an antero-posterior, lateral, and intercondylar view.

(7) An orthopedic evaluation is required on all recruit physicals if there is evidence of any abnormality.

e. Shoulder.

(1) With the examinee stripped to the waist, inspect both anteriorly and posteriorly for asymmetry, abnormal configuration, or muscle atrophy.

(2) From the back, with the examinee standing, observe the scapulohumeral rhythm as the arms are elevated from the sides directly overhead, carrying the arms up laterally. Any arrhythmia may indicate shoulder joint abnormality and is cause for particularly careful examination. Palpate the shoulders for tenderness and test range of motion in flexion, extension, abduction, and rotation. Compare each shoulder in this respect.

(3) Test muscle power of abductors, flexors, and extensors of the shoulder, as well as power in internal and external rotation. Have the examinee attempt to lift a heavy weight with arms at the side to establish integrity of the acromioclavicular joint.

f. Wrist and Hand.

(1) Palpate the wrist for tenderness in the anatomical snuff box often present in undiscovered fractures of the carpal navicular. Observe and compare muscle strength and range of motion, flexion, extension, radial, and ulnar deviation.

(2) Inspect the palms and extended fingers for excessive perspiration, abnormal color or appearance, and tremor, indicating possible underlying organic disease.

(3) Have the examinee flex and extend the fingers making sure interphalangeal joints flex to allow the finger tips to touch the flexion creases of the palm.

(4) With the hands pronated, observe the contour of the dorsum of the hands for atrophy of the soft tissues between the metacarpals seen in disease or malfunction of peripheral nerves.

(5) With the fingers spread, test for strength, and interosseous muscle function by forcing the spread fingers against the resistance of the examinee.

(6) If indicated, obtain antero-posterior and lateral x-rays of the wrist, as well as antero-posterior and oblique views of the hand.

14. Spine and Other Musculoskeletal (Item 36 of DD-2808). Carefully examine for evidence of intervertebral disc syndrome, myositis, and traumatic lesions of the low back (lumbosacral and sacroiliac strains). If there is any indication of congenital deformity, arthritis, spondylolisthesis, or significant degree of curvature, obtain orthopedic consultation and x-rays.

(1) Back. With the examinee stripped and standing, note the general configuration of the back, the symmetry of the shoulders, iliac crests and hips, and any abnormal curvature. Palpate the spinous processes and the erector spinae muscle masses for tenderness. Determine absence of pelvic tilt by palpating the iliac crests. Have examinee flex and extend spine and bend to each side, noting ease with which this is done and the presence or absence of pain on motion. Test rotary motion by gripping the pelvis on both sides and having the examinee twist to each side as far as possible.

(2) With the examinee sitting on the examining table, test patellar and ankle reflexes and fully extend the knee, note complaints of pain (this corresponds to a 90 degree straight leg raising test in supine position).

(3) With the examinee supine, test dorsiflexor muscle power of the foot and toes, with particular attention to power of the extensor hallucis longus. Weakness may indicate nerve root pressure on Sl. Flex hip fully on abdomen and knee flexed and determine presence or absence of pain on extremes of rotation of each hip with hip flexed to 90 degrees. Frequently, in lumbosacral sprains of chronic nature, pain is experienced on these motions. Place the heel on the knee of the opposite extremity and let the flexed knee fall toward the table. Pain or limitation indicates either hip joint and/or lumbosacral abnormality.

(4) While prone, have the examinee arch the back and test strength in extension by noting the degree to which this is possible.

(5) If pain is experienced on back motions in association with these maneuvers or if there is asymmetry or abnormal configuration, back x-rays, including pelvis, should be obtained. These should include antero-posterior, lateral, and oblique views.

15. Identifying Body Marks, Scars, and Tattoos (Item 37 of DD-2808).

a. Examination. Carefully inspect the examinee's body, front and rear, on each side of the median line separately, commencing with the scalp and ending at the foot. Record under the "Notes" section on the face of the DD-2808 all body marks, tattoos, and scars useful for identification purposes. Also state if no marks or scars are found.

b. Description of Body Marks, Scars, and Tattoos.

(1) Indicate the size, location, and character of scars, moles, warts, birthmarks, etc.

(2) When recording the location of a tattoo, include narrative description of the design. Tattoo transcriptions of words or initials shall be recorded in capital letters. Describe the size of a tattoo regarding its general dimensions only. A statement relative to color or pigment is not required.

(3) Note amputations and losses of parts of fingers and toes showing the particular digit injured and the extent or level of absence.

c. Abbreviations for Body Marks, Scars, and Tattoos.

(1) The following are authorized abbreviations for the descriptions or conditions indicated:

Amp.-amputation	m. -mole	w. -wart
f. -flat	p. -pitted	VSULA-
fl. fleshy	r. -raised	vaccination scar
s. -scar smooth	l. -linear	upper left arm
v. -vaccination	o. -operative	h. -hairy

(2) Combinations of the above abbreviations are permissible: p.s. 1/2d. - pitted scar 1/2 inch diameter; f.p.s. lxl/2 - flat pitted scar l inch long and 1/2 inch wide; r.h.m. 1/4d. - raised hairy mole 1/4 inch diameter.

(3) Do not use abbreviations when describing tattoos since they are likely to be mistaken as signifying tattooed letters.

16. Neurologic (Item 39 of DD-2808). Conduct a careful neurological examination being attentive to the following:

a. Gait. The individual shall: walk a straight line at a brisk pace with eyes open, stop, and turn around; (Look for spastic, ataxic, incoordination, or limping gait; absence of normal associated movements; deviation to one side or the other; the presence of abnormal involuntary movement; undue difference in performance with the eyes open and closed.)

(1) stand erect, feet together, arms extended in front; (Look for unsteadiness and swaying, deviation of one or both of the arms from the assumed position, tremors, or other involuntary movements.)

(2) touch the nose with the right and then the left index finger, with the eyes closed. (Look for muscle atrophy or pseudohypertrophy, muscular weakness, limitation of joint movement, and spine stiffness.)

b. Pupils. Look for irregularity, inequality, diminished or absent contraction to light or lack of accommodation.

c. Deep Sense (Romberg). Negative, slightly positive, or pronouncedly positive.

d. Deep Reflexes: Patellar, Biceps, etc. Record as absent (o), diminished (-), normal (+), hyperactive (++), and exaggerated (+++).

e. Sensory Disturbances. Examine sensation by lightly pricking each side of the forehead, bridge of the nose, chin, across the volar surface of each wrist, and dorsum of each foot. Look for inequality of sensation right and left. If these sensations are abnormal, vibration sense should be tested at ankles and wrists with a tuning fork. With eyes closed, the examinee shall move each heel down the other leg from knee to ankle. Test sense of movement of great toes and thumb. Look for diminution or loss of vibration and plantar reflexes. When indicated, perform appropriate laboratory tests and x-ray examinations.

f. Motor Disturbances. Evidence of muscle weakness, paresis, or any other abnormality.

g. Muscular Development. Evidence of atrophy, compensatory hypertrophies, or any other abnormality.

h. Tremors. State whether fine or coarse, intentional or resting, and name parts affected.

i. Tics. Specify parts affected. State whether they are permanent or due to fatigue or nervous tension.

j. Cranial Nerves. Examine carefully for evidence of impaired function or paresis. Remember that some of the cranial nerves are subject to frequent involvement in a number of important diseases, such as syphilis, meningitis, encephalitis lethargica, and injuries to the cranium.

k. Psychomotor Tension. Test the ability to relax voluntarily by having the examinee rest the forearm upon your palm then test the forearm tendon reflexes with a percussion hammer.

l. Peripheral Circulation. Examine for flushing, mottling, and cyanosis of face, trunk, and extremities. Question as to the presence of localized sweating (armpits and palms) and cold extremities. Carefully study any abnormalities disclosed on the neurological examination and express an opinion as to their cause and significance and whether they are sufficient cause for rejection.

17. Psychiatric (Item 40 of DD-2808).

a. Personality Evaluation. In order to evaluate the adequacy of the examinee's personality for adjustment to the conditions of military service:

(1) estimate the examinee's capacity coupled with real respect for personality and due consideration for feelings;

(2) conduct the examination in private to encourage open and honest answers; and

(3) attempt to discover any difficulties that the examinee may have had with interpersonal relationships at work or during leisure activities.

b. Diagnosis of Psychiatric Disorders. The diagnosis of most psychiatric disorders depends upon an adequate longitudinal history, supplemented by information obtained from other sources, such as family, physicians, schools, churches, hospitals, social service or welfare agencies, and courts.

c. Telltale Signs of Psychiatric Disorders. Be watchful for any of the following: inability to understand and execute commands promptly and adequately; lack of normal response; abnormal laughter; instability; seclusiveness; depression; shyness; suspicion; over boisterousness; timidity; personal uncleanliness; stupidity; dullness; resentfulness to discipline; a history of enuresis persisting into late childhood or adolescence; significant nail biting; sleeplessness or night terrors; lack of initiative and ambition; sleep walking; suicidal tendencies, whether bona fide or feigned. Abnormal autonomic nervous system responses (giddiness, fainting, blushing, excessive sweating, shivering or goose flesh, excessive pallor, or cyanosis of the extremities) are also occasionally significant. Note also the lack of responses as might reasonably be expected under the circumstances.

d. Procedures for Psychiatric Examination.

(1) Mental and personality difficulties are most clearly revealed when the examinee feels relatively at ease. The most successful approach is one of straightforward professional inquiry, coupled with real respect for the individual's feelings and necessary privacy. Matters of diagnostic significance are often concealed when the examinee feels the examination is being conducted in an impersonal manner or without due concern for privacy.

(2) Pay close attention to the content and implication of everything said and to any other clues, and in a matter-of-fact manner, follow-up whatever is not self-evident nor commonplace.

e. Aviation only.

(1) Although this phase of the examination is routinely performed only on candidates for flight training, it may be made part of any aviation physical examination. The objective is to determine the examinee's basic stability, motivation, and capacity to react favorably to the special stresses encountered in flying. Report any significant personality change in an experienced aviator.

(2) Following the completion of the general examination:

(3) study carefully the examinee's family history; and

(4) determine the family's attitude towards flying and the examinee's reaction to the stresses of life in general and emotional response and control.

18. Endocrine System. Evaluate endocrine abnormalities during the general clinical examination. Palpate the thyroid for abnormality and observe the individual for signs of hyperthyroidism or hypothyroidism. Observe general habitus for evidence of endocrine dysfunction.

19. Dental (Item 43 of DD-2808).

a. Who May Conduct Dental Examinations.

(1) For Academy, OCS, and direct commission applicants: a Uniformed Services dental officer.

(2) For all aviation, diving, and overseas/sea duty physical examinations: a Uniformed Services dental officer or a contract dentist.

(3) For all others: a Uniformed Services dental officer, a contract dentist, or a medical examiner if a dentist is unavailable.

b. Procedures for Conducting Dental Examinations.

(1) Applicants for Original Entry. Whenever practical, applicants for original entry into the Service shall be given a Type 2 dental examination. Otherwise, the dental officer shall determine the type of examination that is appropriate for each examinee.

(2) Active Duty Personnel.

(a) Members on active duty, who are assigned to locations where Coast Guard, USMTF, or civilian contract dental clinics are available shall be required to have an annual Type 2 dental examination.

(3) Reserve Personnel.

(b) Type 2 dental examination is required for Quinquennial Physical Examinations, and

(c) Type 2 dental examination is required for all entries onto Active Duty (any type) for periods of duty in excess of 139 days.

c. Dental Restorations and Prostheses. The minimum number of serviceable teeth prescribed for entry in various programs of the Service is predicated on having retentive units available to provide for the reception of fixed bridges or partial dentures that may be necessary for satisfactory masticatory or phonetic function. Prostheses already present should be well-designed, functional, and in good condition.

20. Laboratory Findings.

a. Required Tests. Personnel undergoing physical examinations are required to have the following tests performed, except where obtaining them is not possible or expeditious, or incurring charges for them is not authorized. In such cases, these tests shall be obtained at the first duty station where facilities are available. The normal values listed below are for guidance. Abnormal laboratory values alone are not disqualifying; however, the causative underlying condition may be. Minimal deviations may not require further evaluation and this should be noted as NCD (not considered disqualifying) in item 74 by the examiner. Normal variants should be noted as such.

b. Hematology/Serology.

(1) Hematology. Perform a hematocrit (HCT) or hemoglobin (HGB) on all examinees. Perform other hematological studies only as indicated.

(2) Red Blood Cell Measurements.

(3) Hemoglobin - Males 13-18 gm/100ml

(4) Females 11.7-16 gm/100ml

(5) Hematocrit - Males 40-54%, Females 35-47%

If any of these parameters are abnormal, an RBC and indices shall be done. Normal indices are:

RBC-	Males	4.3 to 6.2 million
	Females	3.8 to 5.4 million
	MCV-	82-92 cubic microns
	MCH-	27-32 picograms
	MCHC -	30-36%

(6) Cholesterol Testing. All cadets, officer candidates, and recruits shall be tested for serum cholesterol within a week of their arrival for training. Those persons judged by a medical officer to have cholesterol levels that indicate an increased risk of atherosclerotic vascular disease shall be informed of this and given appropriate counseling by the third week of their training. Lipid panel studies, pharmacological remedial measures, or follow-up appointments may be performed at the discretion of the managing medical officer.

(7) Serological Test for Syphilis (RPR/STS).

(a) Required for entry into the Coast Guard and for all aviation and diving candidate physicals.

(b) Unless there is a documented history of adequately treated syphilis, all examinees testing positive shall have repeat testing three or more days later. Ensure that at the time of obtaining serum the examinee neither has, nor is convalescing from, any acute infectious disease or recent

fever. If available at no charge, the facilities of local or state health departments may be used for performing serological tests. Examinees with a history of treated syphilis should have declining or low titer positive reaction.

(c) If the second test is positive then obtain an FTA/ABS. If the FTA/ABS is positive, further evaluation may be required to determine the appropriate therapy.

(d) Several conditions that are known to give false RPR/STS are infectious mononucleosis, malaria, yaws, pinta, chicken pox, infectious hepatitis, immunization, and atypical pneumonia. The cause of a false positive serological test for syphilis should be explored since many diseases giving a false positive are also disqualifying.

(e) Process all members who are suspected contacts or who have clinical evidence of venereal disease and all personnel with a positive serological test for syphilis in accordance with section 7-B-3 of this Manual.

(8) Sickle Cell Preparation Test. Applicants for aviation and diving training shall be tested for sickling phenomenon, if not previously tested. Evaluate positive sickledex results by a quantitative hemoglobin electrophoresis. Greater than 40 percent Hbs is disqualifying for aviation and diving. Once the test has been completed, the results will be filed in the health record and recorded on the Problem Summary List. The test need never be repeated.

(9) HIV Antibody.

(a) The most recent HIV antibody test date will be recorded in item #49 of the DD-2808 (Report of Medical Examination), on the NAVMED6150/20 (Problem Summary List), and under Remarks on the SF-601 (Immunization Record). Epidemiological information concerning HIV infection will be monitored by Commandant (G-WKH) and the policy concerning routine testing will be revised as necessary.

(b) HIV antibody testing is required as follows (see COMDTINST. 6220.1A):

1 All applicants for regular or reserve programs for enlistment, appointment, or entry on active duty;

2 Candidates for officer service (direct commission, OCS, Academy, MORE, etc.,) as part of pre-appointment or pre-contract physical examination;

3 Cadets at the Coast Guard Academy as part of the physical examination prior to commissioning;

4 All Coast Guard members who have not had at least one documented HIV antibody test in the last **five** years;

5 All members with PCS orders to a foreign country, within six months prior to transfer;

6 During the clinical evaluation of the patients at high risk of HIV infection being seen for other sexually transmitted diseases or as part of prenatal examinations; and

7 Patients being referred to Level II/III alcohol/drug treatment programs must be tested for HIV immediately prior to entering such a program;

8 Newly identified tuberculin reactors.

(c) Accession testing will usually be performed through MEPS examination centers. Other required testing can be done through DOD MTFs or designated Coast Guard HIV Antibody Testing Centers. Other required testing will be done through designated Coast Guard-wide HIV contract laboratory, Viromed laboratories. Commanding Officers may arrange testing with the laboratory directors at local uniformed services medical facilities (USMTFS) or qualified local civilian laboratories, only with the permission of, and prior coordination with, MLC(k). Record keeping and reporting requirements must be met. Liaison with the Department of Defense indicates that there are no prohibitions to testing Coast Guard personnel at these facilities. Contact Commander, MLC(k) for permission to use USMTFS or local civilian facilities to arrange methods for reporting results.

(d) Members who are confirmed HIV antibody positive or indeterminate by Western Blot, by the Coast Guard-wide contract laboratory, will have a second confirmatory specimen drawn and submitted for analysis to the same Coast Guard-wide contract laboratory.

(e) Members who are confirmed HIV antibody positive by the second confirmatory Western Blot, by the Coast Guard-wide contract laboratory, will be referred to a DOD MTF with the capability to perform a complete evaluation. Contact the respective MLC (k), and they will assist in making arrangements for the evaluation. Ensure that both the medical and dental records accompany the member to the DOD MTF for the evaluation. **A narrative summary of this evaluation shall be obtained by the referring medical officer, who shall notify G-WKH via MLC(k) upon receipt**. Initiate a Disease Alert Report IAW Chapter 7 of this Manual.

(f) Once a member has been confirmed HIV positive, arrange immediate medical and social services counseling, using available Coast Guard,

DOD, or civilian resources to ensure that the member understands the clinical implications of the positive test, the purpose of subsequent medical evaluation, and the policies in this instruction.

(g) Members who are confirmed HIV antibody positive shall receive counseling. The individual's command will provide medical and supportive counseling to the member if this has not already been provided by the evaluating facility.

(h) All information surrounding the individual's physical condition is strictly confidential. Only key personnel, with a verifiable "need to know" such as the individual's commanding officer, should be informed of the HIV status.

(i) Coast Guard medical officers requiring HIV antibody testing for clinical diagnosis should direct the Coast Guard HIV Antibody Testing Center to send a shipment to the Coast Guard-wide contract laboratory immediately. Results should ordinarily be available within 48 hours via electronic mail or telephone from Commandant (G-WKH).

(j) HIV antibody testing required by members of other uniformed services (active duty or reserve), or by specific agreement with other Federal agencies (e.g., Department of State), must be performed through a Coast Guard HIV Antibody Testing Center.

(k) Voluntary testing and counseling of dependents, retirees, and civilian employees must be performed through a Coast Guard HIV Antibody Testing Center.

c. Chest X-ray (Item 52 of DD-2808).

(1) Will be accomplished as part of the physical examinations for application for aviation or diving programs. Chest X-rays previously performed within eighteen (18) months of application, with normal results, are acceptable if there is no change in clinical presentation.

(2) Will not be performed for routine screening purposes without a prior clinical evaluation and a specific medical indication. The senior medical officer may authorize an exception to this policy when there are obvious medical benefits to be gained by routine screening x-ray examination (e.g., Asbestos Medical Surveillance Program). Such exceptions should be authorized only after careful consideration of the diagnostic yield and radiation risk of the x-ray study, as well as other significant or relevant costs or social factors. X-ray examinations will not be ordered solely for medical-legal reasons.

d. Electrocardiogram (Item 52 of DD-2808).

(1) Electrocardiograms (ECG) shall be accomplished routinely on the following individuals:

(a) those in whom medical history or clinical findings are suggestive of cardiac abnormalities;

(b) examinees with a sitting pulse rate of less than 50 or more than 100;

(c) examinees who are 40 years old or older;

(d) applicants for aviation and diving training and all designated personnel every four (4) years until age 40, then biennially. For designated aviation personnel on physical examinations where no EKG is required, place the date and results of the last EKG in block #52 (Other) of DD-2808; and

(e) applicants for service academies.

(2) All student and designated aviation personnel shall have an ECG on file in their health record.

(3) All tracings will be compared to the baseline reading in the health record, if one is present. If significant changes are present, obtain a cardiac consultation. A report of the consult shall be submitted for review along with the DD-2808. It is imperative then that proper techniques for recording the ECG be followed.

(a) The routine ECG will consist of 12 leads, namely standard leads 1, 2, 3, AVR, AVL, AVF, and the standard precordial leads V1 through V6.

(b) Take care to properly place the precordial electrodes. It is important that the electrodes across the left precordium are not carried along the curve of the rib but are maintained in a straight line. Be particular in placing the first precordial lead so as to avoid beginning placement in the third interspace rather than the fourth. Do not smear electrode paste from one precordial position to another. Include a standardization mark on each recording.

e. Urinalysis. A urinalysis is required on all physical examinations. The urine shall be tested for specific gravity, glucose, protein, blood, leukocyte esterase, and nitrite by an appropriate dipstick method. A microscopic examination is required only if any of these dipstick tests is abnormal.

(1) Specific Gravity. Normal values are 1.005-1.035. Specific gravity varies with fluid intake, time of day, climate, and medication. As a rule, elevation of the specific gravity reflects only the state of hydration, while a low specific gravity may reflect kidney disease. In evaluating abnormalities, a repeat is generally sufficient, provided the factors above are considered and explained to the individual. Where possible, the repeat should be a first morning specimen which is usually the most concentrated.

(2) Glucose. Any positive test is abnormal. A false positive for glucose may occur in individuals who take Vitamin C or drink large quantities of fruit juice. As soon as practical after discovery of the glycosuria, obtain a fasting blood

glucose. If glycosuria persists or if the fasting blood glucose exceeds 125 mg/100 ml, evaluate the individual for diabetes.

(3) Protein. A trace positive protein is often associated with a highly concentrated (specific gravity 1.024 or greater) early morning specimen and is considered normal and need not be repeated. A one plus or greater protein, or a trace positive in the presence of a dilute urine, should be evaluated by a 24-hour specimen (normal range 10-200 mg protein/24 hours).

(4) Microscopic.

(a) Normal: 0-5 WBC

0-5 RBC (clean catch specimen)

occasional epithelial cells (more may be normal in an otherwise normal urinalysis)

no casts occasional bacteria

(b) Pyuria usually indicates an infection or improper collection techniques. Appropriate follow-up is required, including repeat after the infection has cleared.

(c) Hematuria may normally occur following heavy exercise or local trauma and as a false positive in menstruating females. It always requires evaluation with the minimum being a repeat showing no hematuria.

(d) Casts, heavy bacteria, other organisms, and abnormal cells require further evaluation.

f. PAP Test (Item 52 a. of DD-2808).

(1) A PAP test is required at the following times on female members:

(a) on the pre-training physical examination at time of initial entry into the Coast Guard;

(b) every two years, if on extended active duty; and

(c) with quinquennial examinations, for reserves.

(2) PAP tests and pelvic examinations (by civilian or military practitioners) that have been performed within one year of periodic examinations are acceptable. In any case, results of the pelvic examination and PAP test will be recorded in Item 52 a. The practitioner is responsible for communicating the result of the PAP smear (either positive or negative) to the patient.

(3) To reduce false-negative smears, endocervical sampling shall be done using a cytobrush, provided no contraindication is present (as in pregnancy or cervical stenosis). Laboratories to which smears are sent for interpretation must, as a matter of routine, indicate on their reports whether endocervical sampling was adequate. Where endocervical cell sampling is reported as inadequate, the smear shall be repeated.

g. Pulmonary Function Test (PFT). Perform a PFT on all OMSEP examinations and when clinically indicated.

(1) Screening spirometry should not be performed if the subject:

(a) is acutely ill from any cause;

(b) has smoked or used an aerosolized bronchodilator within the past hour;

(c) has eaten a heavy meal within the previous two hours; or

(d) has experienced an upper or lower respiratory tract infection during the past three weeks.

(2) Explain the procedure to the subject.

(3) Instruct the subject to remove any tight clothing or dentures and to sit or stand comfortably in front of the spirometer. The chin should be slightly elevated with the neck slightly extended. The use of a nose clip is recommended.

(4) Tell the subject to take the deepest possible inspiration, close mouth firmly around the mouthpiece and without further hesitation, blow into the apparatus as hard, fast, and completely as possible. Active coaching throughout the entire duration of the forced expiration must be done to elicit maximum subject effort. Positioning of the lips around the mouthpiece should be checked.

(5) After two practice attempts, three further tracings should be recorded. If the technician believes that the subject has not made a full inspiration prior to the forced expiration, not put forth a maximal effort, or not continued expiration sufficiently long, that particular tracing should be repeated. Repeat attempts marred by coughing. The variation between the largest and smallest FVC of three satisfactory tracings should not exceed 10%.

(6) From the three satisfactory tracings, the FVC, FEV_1, and FEV_1/FVC% should be determined. Use the highest FVC and FEV_1 in the calculations regardless of the curve(s) on which they occur. The tracing itself should also be maintained as part of the medical record.

(7) If the tests are baseline studies, determine the predicted values and calculate the subject's percent of the predicted normal, and transcribe results on the record sheet. In non-Caucasians, the predicted FEV_1 and FVC should be multiplied by 0.85 to adjust for ethnic differences. No correction factor is necessary for the FEV_1/FVC%.

(8) If the tests are follow-up studies, comparison should be made with the previously recorded highest value for each test. This highest value may not necessarily have occurred during baseline tests.

(9) Verify any abnormalities in either baseline or follow-up pulmonary functions by repeating spirometry in two weeks. If abnormalities persist, clinical assessment by a physician qualified to evaluate chest disease is essential. In males, a 30 millimeter annual decline in FEV_1 and 25 millimeters FVC can be attributed to normal aging. In females, it is 25 millimeters in both the FEV_1 and FVC. PFT. Abnormal functions are present when:

(a) FEV-1 or FVC is less than 80% of predicted;

(b) FEV-1/FVC% is less than 69%;

(c) decline in the FEV-1 or FVC greater than 8%;

(d) decrease in the FEV-1/FVC% greater than 6%; and

(e) see the following:

SPIROMETRIC GUIDELINES

	OBSTRUCTIVE DISEASE **FEV-1/FVC**	**RESTRICTIVE DISEASE FCV%** **FCV PREDICTED**
NORMAL	> 0.69	> .80
MILD TO MODERATE	0.45 -0.69	0.51-0.80
SEVERE	< 0.45	<0.51

h. Special Tests. In some cases, information available should be supplemented by additional tests or diagnostic procedures (eye refractions, x-rays, repeated blood pressure readings, etc.), in order to resolve doubts as to whether the examinee is or is not physically qualified. If facilities are available to perform such tests at no cost, they should be obtained as indicated in individual cases. Otherwise, applicants for

original entry in the Service will be required to obtain such tests at their own expense, if they desire further consideration.

i. Laboratory Values (OMSEP). All laboratory values not previously discussed but that accompany a physical examination (e.g., chemistry profiles, etc.,) must have accompanying normals for the laboratory that performed the tests.

j. Mammography. Mammography is required for Coast Guard active duty and reserve females beginning at age 40 and at ages 44, 48, 50, 52, 54, 56, 58, 60, and 62. Clinical findings, family history, and other risk factors may dictate that a mammogram be done at times other than those indicated in this screening schedule. Results should be documented on the routine physical exams. Mammograms done between the required screening ages can be used to satisfy the periodic requirement. This judgment is left to the practitioner. If mammography is not done at the required ages, the reason must be supplied in item 73 of the DD-2808 and should include date and result of the last mammogram. Practitioners are responsible for communicating mammography results (either positive or negative) to the patient.

k. Glucose-6-Phosphate Dehydrogenase (G-6-PD). Qualitative testing (present or not) for G-6-PD deficiency is required at all accession points (TRACEN Cape May, Academy, RTC Yorktown). All other Coast Guard members with no record of testing shall be tested prior to assignments afloat or to malaria-endemic areas. The results of testing shall be annotated on the DD-2766 Adult Preventive and Chronic Care Flowsheet. Once testing is accomplished, it need never be repeated.

21. Height, Weight, and Body Build.

a. Height. Measure the examinee's height in centimeters (inch) to the nearest centimeter (one-half inch), without shoes.

b. Weight.

(1) Weights are with underwear/undergarments only.

(2) Weigh the examinee on a standard set of scales calibrated and accurate. Record the weight to the nearest kilogram (pound). Do not record fractions of kilogram.

c. Frame Size. Using a cloth tape, measure the wrist of the dominant hand, measure all the way around from lateral to medial styloid process. Measure in centimeters (fraction of an inch).

d. Body Fat Percentage. Determined by MEPS.

22. Distant Visual Acuity and Other Eye Tests.

a. Distant Visual Acuity, General. Visual defects are one of the major causes for physical disqualification from the armed services. Methods of testing vision have varied greatly among the armed services and from place to place in each Service. Consequently, visual test results are not always comparable. An examinee

presenting for examination at one place might be qualified for visual acuity, while at another place, disqualified. Although this is an undesirable situation, no practical solution, such as prescribing standards for equipment and conditions (room size, ventilation, paint colors, room illumination, etc.), is available to the Coast Guard as the examinations are obtained from various sources over which the Coast Guard has no control. It is therefore imperative that examiners be especially painstaking to obtain the most accurate results possible.

b. Examination Precautions.

(1) Make every effort to conduct the examination when the examinee is in normal physical condition. Follow the examination routine in the order prescribed in the following instructions. Record the vision for each eye when determined so that errors and omissions will be avoided.

(2) It may be extremely difficult to obtain an accurate measure of visual acuity. Bear in mind that individuals who are anxious to pass visual acuity tests may resort to deception. Similarly, other individuals may attempt to fail a visual acuity test to avoid undesirable duties. Hence, be prepared to cope with either possibility in order to uncover and recognize visual defects without the cooperation of the person being tested.

(3) Refer uncooperative examinees to a medical officer.

c. Examination Procedures.

(1) In order to obtain a more valid evaluation, inform examinees that contact lenses will not be worn during the evaluation and for 72 hours before. Orthokeratotic lenses shall be removed for 14 days or until vision has stabilized for 3 successive examinations.

(2) If the examinee wears glasses, they must be removed before entering the exam room. Test each examinee without unnecessary delay after entering the examining room. In order to prevent personnel from memorizing the charts, permit only one examinee to view the test charts at a time. Keep examinees awaiting testing out of hearing.

(3) Direct the examinee to a line that is 20 feet from the test chart. Hold an occluder so that it covers the examinee's left eye. Instruct the examinee to keep both eyes open and not to squint. The occluder must not be pressed against the eyeball or lids or any part of the eye being shielded, but, should be held in contact with the side of the nose. The eye shielded by the occluder should be left open in order to avoid pressure and to discourage squinting. A rigid occluder, constructed of a material such as wood, translucent plastic, or metal, of a design to discourage cheating shall be used to shield the eye not being tested.

(4) Direct the examinee to begin with the first line and to read as many lines as possible. (Watch the examinee, not the chart that is being read. Hold the occluder so the examinee cannot peep around it. The most frequently used method of increasing visual acuity is to squint. This will not be permitted.

Some examinees with astigmatism will be able to read the letters better by tilting the head to one side; do not allow this. Another well-known method used to pass a visual acuity test is to obtain eyedrops beforehand that contract the pupil; suspect this if the pupils are unusually small.)

(5) Record the smallest line read with no errors on the chart from the 20 foot distance as the vision for the right eye (0.D.).

(6) Test the visual acuity for the left eye (0.S.), preferably using a different chart, record in the same manner.

(7) Test the visual acuity for both eyes (0.U.), preferably with a third chart, record in the same manner.

(8) Test an examinee who wears glasses again with them on. Follow the same procedure as without glasses.

(9) When there is suspicion that the examinee has memorized a chart, a different chart should be used or the letters on the chart should be read in reverse order.

(10) The examinee is expected to read letters promptly. No precise time limit should be applied, but 1 or 2 seconds per letter is ample.

(11) An examinee who fails a letter should not be asked to read it again. If a rapid reader makes an obviously careless mistake, caution the examinee to "slow down" and repeat the test using another chart.

(12) Some examinees give up easily. They may need encouragement to do their best; however, do not coach them.

(13) The effects of fatigue may make a certain amount of retesting necessary. In questionable cases, one retest should be given not less than the day after the initial test.

d. Armed Forces Vision Tester (AFVT). Visual acuity may also be determined with the (AFVT) which consists of two rotating drums holding illuminated slides for testing various facets of vision. The examinee observes the distance slides looking slightly downward with the instrument set and also observes the near slides looking downward at a greater angle. The handles on the side of the instrument rotate the drums to change the slides. Beneath the eye pieces there is a lever that operates an occluder so that each eye can be tested separately. In the case of the slides for muscle balance and stereopsis, the two eyes must be tested together and the occluder should be centered so it occludes neither eye. A scoring key is provided with the instrument. The following slides are available:

(1) Rear Drum (Distance Testing).

(a) Slide 1 - Vertical Phorias.

1 The right eye sees a set of numbered steps, the left sees a dotted line. With both eyes open the examinee is asked which step the dotted line intersects. Interpretation: step l, 2 prism diopters of left hyperphoria; step 2, 1.5 left hyperphoria; step 3, 1.0 left

hyperphoria; step 4, 0.5 left hyperphoria; step 5, orthophoria; step 6, 0.5 prism diopters of right hyperphoria; step 7, 1.0 right hyperphoria; step 8, 1.5 right hyperphoria; step 9, 2.0 right hyperphoria.

2 Detecting Malingerers: i.e., if known that a score of 5 is normal, the examinee could feign a normal phoria. To avoid this, a pair of VARIABLE PRISMS is provided, by which the examiner can raise either the right or the left eye image. The prisms are mounted within the viewing box. The extent of prismatic deviation is governed by the position of two control handles.

3 The correct score--and the only score recorded--is that obtained when both control handles of the VARIABLE PRISM are pushed inward as far as they will go. This is known as the SCORING POSITION. Moving the left handle outward from this position moves the left eye image downward and outward. Similarly, moving the right handle outward moves the right eye image downward and outward.

4 The maximum amount of downward shift provided by each control corresponds to four steps. Moving the right handle outward to its extreme position therefore will change the apparent location of the dotted line from step 1 to step 5, for example, from 6 to above 9, etc. Moving the left control handle outward to its extreme position similarly will change the apparent location of the dotted line from step 5 to step 1, or from step 8 to step 4, etc. Vary the location of the right or left control handle, each time asking the examinee to report the location of the dotted line. Only the answer obtained when both handles are in the SCORING POSITION gives the examinee's test score.

(b) Slide 2 - Horizontal Phorias.

1 The examinee's right eye sees a row of numbered dots, the left eye sees an arrow, with the occluder in the open position, ask the examinee to which numbered dot the arrow is pointing. Interpretation: The reporting value minus 11 equals prism diopters of exophoria; 11 minus the reported value equals the prism diopters of esophoria.

2 DETECTING MALINGERERS: By means of the VARIABLE PRISM previously mentioned, the right and left eye images can both be shifted outward a maximum of seven dots. To produce this outward shift without a downward shift, in this test both control handles are moved outward simultaneously by the same amount. When both handles are shifted as far out as they go, the apparent

position of the arrow is moved seven dots to the left, giving a score seven below the true score.

3 As in previous test, the correct score and the only score recorded is that obtained when the control handles are in the SCORING POSITION.

(c) Slides 3 and 3A - Visual Acuity. With both eyes uncovered the examinee sees a jumble of letters. With one eye covered, the uncovered eye cannot see the letters intended for the opposite eye.

(d) Slides 4 and 4A - Visual Acuity, Large Letters. Separate charts for the left and right eye.

(e) Slides 5 and 5A - Stereopsis. Six groups of horizontal lines, five circles to a line. The groups are numbered A to F. In each horizontal row of circles, one circle stands out closer to the examinee. The degree of difficulty increases from A to F. The examinee calls the circle that stands out. Passing score: There must be no misses in groups A through D. Caution: Ensure that neither eye is inadvertently left occluded when this test is being given. Both eyes must be able to see the circles in order for any stereopsis to occur.

(2) Front Drum (Near Testing).

(a) Slide 6 - Vertical Phorias. Same as slide 1, only this is a near test.

(b) Slide 7 - Horizontal Phorias. Same as slide 2, except subtract 13.

(c) Slide 8 - Near Visual Acuity. This is given in Snellen notations.

(d) Slide 9 - Near Visual Acuity, Large Letters.

e. Score recording. Record vision test scores as a fraction in that the upper number is the distance in feet from the chart and the lower number is the value of the smallest test chart line read correctly. Thus, a person reading at a distance of 20 feet, the 30 foot test chart line is given a score of 20/30. 20/20 indicates that a person reads at a distance of 20 feet the test chart line marked 20. Similarly, 20/200 means a person can read at a distance of 20 feet only the test chart line marked 200.

f. Refraction.

(1) Eye refractions are required:

(a) when applying for flight training (SNA) (This must include cycloplegic.); and

(b) when visual acuity falls below 20/20 in either eye (near or distant).

(2) Subsequent refractions are required only if the visual acuity deteriorates further.

(3) If a cycloplegic is used during the course of refraction, then the examinee must wear dark glasses until the effects disappear. The installation of 1 drop into each eye of 1% solution of pilocarpine hydrochloride in distilled water after completing the examination will constrict the pupil and thus relieve the photophobia.

g. Near Vision. Test near vision on all examinees and record results in Item 61 of DD-2808 using Snellen notations. The examinee should be positioned so that the light source is behind him/her and the near vision test card is well illuminated. The examiner shall instruct the examinee to hold the test card exactly 14 inches/35.5 cm in front of their eyes (measure from the inner aspect of the lower eyelid [corner of the eye] to the face of the card to ensure accurate distance). Test each eye separately. Note the smallest line of type that the examinee is able to read with each eye. Record near vision both with and without corrective lenses if glasses are worn or required. Record corrections worn in Item 73. See the chart below for conversion from the various near point letter nomenclatures to Snellen notations.

CONVERSION TABLE FOR VARIOUS NEAR POINT LETTER NOMENCLATURE

Standard Test Chart	Snellen English Linear	Snellen Metric	Jaegar
14/14	20/20	0.50	J-1
14/17.5	20/25	.62	J-2
14/21	20/30	.75	J-4
14/28	20/40	1.00	J-6
14/35	20/50	1.25	J-8
14/49	20/70	1.75	J-12
14/70	20/100	2.25	J-14
14/140	20/200		

h. Heterophoria.

(1) Except for aviation personnel, special tests for heterophoria are not required unless medically indicated.

(2) Heterophoria is a condition of imperfect muscle balance in which the eyes have a constant tendency to deviate and latent deviation is overcome by muscular effort (fusion to maintain binocular single vision). Fusion is responsible for the two eyes working together in harmony and when anything prevents this, fusion is disrupted and one eye deviates. Since heterophoria is only a tendency of the eyes to deviate, no actual deviation is apparent when the eyes are being used together under ordinary conditions. The deviation becomes visible only when fusion control is weakened or abolished. When deviation occurs, its exact amount can be estimated with some accuracy by neutralizing the deviation with prisms of varying strength. If the eye deviates toward its fellow, the deviation is known as esophoria; if it deviates away from its fellow, the deviation is known as exophoria; if it deviates up or down, the deviation is known as hyperphoria. The condition of perfect muscle balance (no deviation) is orthophoria.

(3) The vertical and horizontal phorias may be tested with the Phoropter or AFVT.

i. Accommodation. There is no requirement to test accommodation unless medically indicated.

j. Color Perception Tests. Examinees are qualified if they pass either the Pseudoisochromatic Plates (PIP) or the Farnsworth Lantern (FALANT) test. Examinees may be found qualified "on record" if a previous certified physical examination that has a passing PIP or FALANT score is available for review. Examinees who fail the PIP are qualified if they pass the FALANT.

(1) Farnsworth Lantern Test.

(a) Administration and Scoring.

1 Instruct the examinee: "The lights you will see in this lantern are either red, green, or white. They look like signal lights at a distance. Two lights are presented at a time--in any combination. Call out the colors as soon as you see them, naming first the color at the top and then the color at the bottom. Remember, only three colors--red, green, and white--and top first."

2 Turn the knob at the top of the lantern to change the lights; depress the button in the center of the knob to expose the lights. Maintain regular timing of about two seconds per exposure.

3 Expose the lights in random order, starting with RG or GR combinations (Nos. 1 or 5), continuing until each of the 9 combinations have been exposed.

4 If no errors are made on the first run of nine pairs of lights, the examinee passes.

5 If any errors are made on the first run, give two more complete exams with one done in the opposite direction (to prevent memorization). Passing score is at least 16 out of 18 correct for the two runs.

6 An error is considered the miscalling of one or both of a pair of lights; if an examinee changes responses before the next light is presented, record the second response only.

7 If an examinee uses glasses for distance, they shall be worn.

8 If an examinee says "yellow," "pink," etc., state, "There are only 3 colors--red, green, and white."

9 If an examinee takes a long time to respond, state, "As soon as you see the lights call them."

(b) Operation of Lantern.

1 Give the test in a normally lighted room; screen from glare; exclude sunlight. The examinee should face the source of room illumination.

2 Test only one examinee at a time (do not allow others to watch).

3 Station the examinee 8 feet from the lantern.

4 The examinee may stand or sit; tilt the lantern so that the aperture in the face of the lantern is directed at examinee's head.

(2) Pseudoisochromatic Plates. When Pseudoisochromatic Plates are used to determine color perception, a color vision test lamp with a daylight filter or a fluorescent light with a daylight tube shall be used for illumination. Do not allow the examinee to trace the patterns or otherwise touch test plates. Show the plates at a distance of 30 inches and allow 2 seconds to identify each plate. If the examinee hesitates, state "read the numbers." If the examinee fails to respond, turn to the next plate without comment. Qualification is ascertained as follows:

(a) 20 plate test set. Examinee must correctly read at least 17, excluding demonstration plates.

(b) 18 plate test set. Examinee must correctly read at least 14, excluding demonstration plates.

(c) 15 plate test set. Examinee must correctly read 10 plates.

k. Depth Perception. Required for all aviation personnel and when medically indicated. The AFVT is the most commonly used method of testing depth perception. When this instrument is not available or the examinee fails the AFVT, use a Verhoeff Stereopter. Results obtained with the Verhoeff are final in resolving all cases of questionable depth perception. The TITMUS device will not be used to determine depth perception.

(1) Findings.

(a) AFVT. An error in group A, B, C, or D is disqualifying.

(b) Verhoeff. Failure to correctly report eight out of eight in two of three trials is disqualifying.

(2) Operating the Verhoeff.

(a) As a preliminary, show target #2 (the second target down when the instrument is upright) at about 40 centimeters and bring it nearer if necessary. This will acquaint the examinee with what is to be observed and at the same time determine whether there is at least a distance, however short, that can be judged correctly.

(b) Show one or two positions at close range to the examinee to clearly demonstrate that one rod is always at difference from the other two. Point out that the size of the rods is not a clue to the relative distance. The examinee is now ready for the test.

(c) Hold the apparatus 1 meter from the examinee.

(d) Eight different rod relations are possible and all eight are shown.

(e) Keep the device centered as a frontal plane normal to the subject's binocular visual midline. To avoid helpful extraneous cues it is highly important to hold the device steady, and particularly not to rotate it on its vertical axis. It is also important not to permit the subject to move the head.

(f) Do not expose the target window while the device is being placed in position or the sets are changed. A convenient method of manipulation is to grasp the device over the target window with the left hand, place the desired set into position with the right hand, then grasp the device below with the right hand and expose the target window by moving the left hand up or down. Thus while the target window is exposed, the device is supported by both hands of the examiner.

(g) The instructions to the subject are: "Report the nearest strip and the farthest strip, unless they all appear to be at the same distance, referring to the strips as 'left,' 'middle,' and 'right'." Only the report concerning the one strip out of plane (farther or nearer than the other two that are in the same plane) is to be considered.

l. Field of Vision.

(1) Except for aviation personnel, special tests for field of vision are not required unless medically indicated.

(2) Procedure.

(a) Face the examinee at a distance of 2 feet.

(b) Close right eye and instruct the examinee to close left eye and focus right eye on your left eye.

(c) Bring fingers in from the periphery, midway between you and the examinee.

(d) Instruct the examinee to say when and how many fingers seen.

(e) Test all cardinal points.

(f) Repeat test for the left eye.

(g) Any evidence of abnormality should be given study on the perimeter.

(3) Normals.

(a) Temporally - 90°.

(b) Superotemporally - 62°.

(c) Superiorly - 52°.

(d) Superonasally - 60°.

(e) Inferonasally - 55°.

(f) Inferiorly - 70°.

(g) Inferotemporally - 85°.

m. Night Vision. A test for night vision (dark adaptation) is not required unless indicated for medical or special reasons.

n. Red Lens Test. The red lens test is required on DODMERB examinations and when medically indicated.

(1) Apparatus. A spectacle trial frame, a red lens from' the trial lens case, a small light such as a muscle balance light, and a metric rule or tape.

(2) Procedure.

(a) Seat the examinee in the darkness facing the dark wall or tangent curtain at 75 cm distance.

(b) Adjust the spectacle trial frame position and place the red lens in one cell of the trial frame.

(c) With the examinee's head in a fixed position, hold the small lamp directly before the center of the dark wall or tangent curtain at 75 cm distance from the eyes. Note the presence or absence of diplopia in this position (primary).

(d) Then slowly move the light from the central position toward the right for a distance of 50 cm in the horizontal plane. In the same manner, move the light in the remaining five cardinal directions.

(e) In the presence of diplopia, note whether it is crossed, homonymous, or vertical and the distance in centimeters from the central position at which diplopia first occurs.

(f) When diplopia is suspected and the examinee has been coached to deny its presence, a prism of 3 or 4 diopters may be placed, either base up or base down, in one cell of the trial frame. If diplopia is still denied, the statement is obviously untrue.

(3) Precautions. The examinee's head must remain fixed and the movement of the light followed only by the eyes. Do not permit tilting or rotating the face.

o. Intraocular Tension.

(1) General. Determine intraocular tension each time an eye refraction is performed, during all annual physical examinations, all aviation physicals, and when medically indicated. Above normal tension is a sign of glaucoma; below normal tension of ten exists in degenerated eyeballs or as a normal finding; alterations in tension are sometimes found in cyclitis. Questionable findings on palpation and ophthalmoscopic examination shall be further evaluated.

(2) Testing Intraocular Tension.

(a) General. Routine tonometry shall be performed by a medical officer, optometrist, or a technician who has received instruction in properly performing and interpreting this test.

(b) Instrument. The tonometer estimates the intraocular pressure (IOP) or tension within the eyeball.

(c) Precaution. Determine intraocular tension after all other eye examinations have been completed. Because of corneal denuding by tonometric measurement, a refraction (cycloplegic or manifest) shall not be performed for at least 24 hours following this procedure.

(d) Readings. Intraocular pressure consistently above 21mm Hg in either eye or a difference of 4 or more between the two eyes, shall be referred for ophthalmologic evaluation.

23. Audiometer.

a. An audiometric examination is required on all physical examinations using frequencies 500, 1000, 2000, 3000, 4000, and 6000 hertz.

b. Obtain reference audiograms on all personnel upon initial entry into the Coast Guard at recruit training and all officer accession points (Academy, OCS, Direct Commission, etc.,), and at first duty station for all others.

24. Psychological and Psychomotor. Psychological and psychomotor testing is not required unless medically indicated.

FIGURE 3-C-1

The following chart enumerates certain conditions, defects, and items of personal history that require thorough evaluation and sets forth the special test, examination, or report desired in each instance.

ITEM:	EXAMINATION AND INFORMATION DESIRED:
ALBUMINURIA, findings of	Repeat test on a second specimen. If still positive do a quantitative 24 hr urine protein.
ASTHMA history of,	Detailed report of asthma and other allergic conditions and a statement from cognizant physician on (1) number and approximate dates of attacks of asthmatic bronchitis or other allergic manifestations; (2) signs, symptoms, and duration of each attack; (3) type and amount of bronchodilating drugs used, and history of any attacks requiring hospitalization.
BACKACHE, back injury or wearing of back strength,	Current orthopedic consultation and report on stability, mobility, and functional brace, history of capacity of back. Report of appropriate x-rays. Transcript of any treatment from cognizant physician.
BLOOD PRESSURE, elevated	Repeat blood pressure (all positions) a.m. and p.m. for 3 consecutive days. Prolonged bed rest shall not precede blood pressure determinations.
CONCUSSIONS	See Head Injury
CONVULSIONS OR SEIZURE	Neurological consultation and electroencephalogram. Transcript of any treatment from cognizant physician.
DIABETES, family history of parent, sibling, or more than one grandparent	Fasting glucose (normal diet with 10-12 but less than 16 hours fast). If elevated, repeat and include 2 hr post prandial.
DIZZINESS or FAINTING SPELLS, history of	Neurological consultation
ENURESIS or history of into late childhood or adolescence (age 12)	Comment on applicant's affirmative reply to question "bed wetting" to include number of past incidents and age at last episode.
FLATFOOT, symptomatic	Current orthopedic consultation with history. Detailed report on strength, stability, mobility, and functional capacity of foot. Report of appropriate x-rays.
GLYCOSURIA, finding or history	See Diabetes.
HAY FEVER, history of	Detailed report of hay fever and other allergic conditions and a statement from personal physician on (1) number, severity, and duration of attacks of hay fever or any other allergic manifestations, and (2) type and amount of drugs used in treatment thereof.
HEADACHES, frequent or severe, history of	Neurological consultation.

FIGURE 3-C-1

HEAD INJURY with loss of consciousness in past 5 years, history of	Neurological consultation; clinical abstract of treatment from physician.
HEMATURIA, history of or finding of	Medical consultation with evaluation report, including appropriate laboratory studies and/or complete urological evaluation if indicated.
HEPATITIS, history of	Serum Bilirubin, SGOT, SGPT, SGT, Anti-HCV,and HB_SAg.
JAUNDICE, history of in past 5 years	Serum Bilirubin, SGOT, SGPT, and SGT.
JOINT, KNEE, internal derangement, history of	Current orthopedic consultation and report of strength, stability, mobility, and functional capacity of knee. Report of appropriate x-rays together with comparative measurement of the thighs, knees, and legs.
JOINT, SHOULDER, dislocation, history of	Current orthopedic consultation and report on strength, stability, mobility, and functional capacity of shoulder. Report of appropriate x-rays.
MALOCCLUSION, TEETH, history of	Report of examination by a dentist with comment as to whether incisal and masticatory function is sufficient for satisfactory ingestion of the ordinary diet, statement as to presence and degree of facial deformity with jaw in natural position and clarity of speech.
MASTOIDECTOMY, bilateral, history of audiogram.	Current ENT consultation to include
MOTION SICKNESS, history of	Detailed report of all occurrences of motion sickness (such as air, train, sea, swing, carnival-ride), and the age at the time of the last occurrence.
NASAL POLYPS, history of	ENT consultation, with comment as to date polyps removed if no longer present. Detailed report by physician on allergic history and manifestation to include required medication.
SKULL FRACTURE, in past 5 years, history of	See Head Injury.
SLEEPWALKING, beyond childhood, history of (age 12)	Detailed comment by physician. Comment on applicant's affirmative reply to question "been a sleepwalker" to include number of incidents and age at last episode.
SQUINT (cross eyed)Examination	for degree of strabismus and presence of complete and continuous 3rd degree binocular fusion. Request completion of DD-2808 Items 62 and 65 and notation of degree of strabismus.
STUTTERING or STAMMERING,	Report of Reading Aloud Test in Section 3-C-2.
VERTEBRA, fracture or dislocation, history of	Current orthopedic consultation and report on strength, stability, mobility, and functional capacity of spine. Report of appropriate x-rays.

FIGURE 3-C-3

HEIGHT STANDARDS		
Category	Minimum (cm/inches)	Maximum (cm/inches)
AVIATION PERSONNEL:		
Candidate for Flight Training	157.4/62	198/78
Class 1 Pilot	157.4/62	198/78
Designated Flight Officer	157.4/62	198/78
Aircrew Candidate	152.5/60	198/78
Designated Aircrew	152.5/60	198/78
ENLISTED PERSONNEL:		
Enlistment in USCG	152.5/60	198/78*
Enlistment in USCG Reserve	152.5/60	198/78*
CANDIDATES FOR:		
USCG Academy	152.5/60	198/78*
Officer Candidate School	152.5/60	198/78*
Appointment of Licensed Officers of U.S. Merchant Marines in the USCG	152.5/60	198/78*
Direct Commission in USCG	152.5/60	198/78*

- MAXIUM HEIGHTS WAIVERABLE TO 203 CM/ 80 INCHES BY COMMANDER COAST PERSONNEL COMMAND (CGPC-adm-1)

NOTES:

1. Heights are without shoes.
2. Metric conversion: 1 inch = 2.54 cm

FIGURE 3-C-4

MINIMUM DISTANT VISUAL ACUITY REQUIREMENTS

CATEGORY	VISION	
A. Aviation Personnel:	Uncorrected	Corrected
1. Candidates for Flight Training	20/50	20/20
2. Pilot, Class	20/200	20/20
3. Pilot, Class 1R	(as waivered)	20/20
4. Designated Flight Officer	20/400	20/20
5. Flight Surgeon, Aviation Medical Examiner or Aviation MEDEVAC Specialist	20/400	20/20
6. Candidate for Aircrew	20/100	20/20
7. Designated Aircrew	20/200	20/20
8. Landing Signal Officer (LSO)	20/200	20/20
9. Air Traffic Controller Candidate	20/100	20/20
10. Designated Air Traffic Controller	20/200	20/20
B. Officers (Note 1):		
1. Commissioned or Warrant in the USCG or USCGR	20/400	20/20
2. Appointment in the USCG of Licensed Officers of the Merchant Marine	20/400	20/20
3. Direct Commission in the USCGR	20/400	20/20
4. Appointment as Cadet	20/400	20/20
5. Precommissioning of Cadets	20/400	20/20
6. OCS Candidates	20/400	20/20
7. Precommissioning of Officer Candidates	20/400	20/20
8. Diving Candidates	20/100	20/20
9. Designated Diver	20/200	20/20
C. Enlisted Personnel:		
1. Enlistment in the USCG or USCGR	See 3.D.13.a	(Note 2)
2. Diving Candidates	(Note 3)	20/20
3. Designated Diver	(Note 3)	20/20

Notes:

1. Refractive error does not exceed plus or minus 8.0 diopters spherical equivalent (sphere + 1/2 cylinder) and that astigmatism does not exceed 3.00 diopters and anisometropia does not exceed 3.50 diopters.

2. Corrected vision shall be 20/40 in the better eye and 20/70 in the other or 20/30 in the better eye and 20/100 in the other, or 20/20 in the better and 20/400 in the other. (Note that near visual acuity must correct to at least 20/40 in the better eye.) Refractive error does not exceed plus or minus 8.00 diopters spherical equivalent (sphere + 1/2 cylinder) and ordinary spectacles do not cause discomfort by reason of ghost images, prismatic displacement, etc.; error must not have been corrected by orthokeratology or keratorefractive surgery.

3. 20/100 in the better eye and 20/200 in the worse eye.

Section D Physical Standards for Enlistment, Appointment, and Induction.

1. Scope. This section implements Department of Defense (DOD) Directive 6130.4 "Physical Standards for Enlistment, Appointment, and Induction," December 14, 2000, which established physical standards for enlistment, appointment, and induction into the Armed Forces of the United States in accordance with section 115, title 10, United States Code (10 USC 133), and by agreement with Secretary, DOT applies to USCG. It is Coast Guard policy to conform, to the maximum extent possible, to common physical standards for the acquisition of personnel among all the Armed Forces.

2. Applicability and Responsibilities.

   a. Applicability.

      (1) This section sets forth the medical conditions and physical defects which are causes for rejection for military service. Those individuals found medically qualified based on the medical standards in effect prior to this regulation will not be reevaluated or medically disqualified solely on the basis of the new standards.

      (2) The standards of this section apply to:

         (a) Applicants for enlistment in the Regular Coast Guard. For medical conditions or physical defects predating original enlistment, these standards are applicable for enlistees' first 6 months of active duty.

         (b) Applicants for enlistment in the Coast Guard Reserve. For medical conditions or physical defects predating original enlistment, these standards are applicable during the enlistees' initial period of active duty for training until their return to Reserve Component units.

         (c) Applicants for reenlistment in the Regular Coast Guard and Coast Guard Reserve after a period of more than 6 months has elapsed since separation.

         (d) Applicants for appointment as commissioned or warrant officers in the Coast Guard and as modified by section 3-E.

         (e) Applicants for the United States Coast Guard Academy (USCGA) and all other special procurement programs, e.g., Officer Candidate School, and as modified by section 3-E.

         (f) Cadets at the United States Coast Guard Academy, except for such conditions that have been diagnosed since entrance into the Academy. With respect to such conditions, upon recommendation of the senior medical officer, USCGA, the fitness standards of section 3-F are applicable for retention in the Academy. However, the standard in paragraph 3-D-39.p applies whether section 3-E or 3-F standards of this regulation are applicable.

(g) Any individuals that may be inducted into the Coast Guard.

(3) All numbers in parentheses refer to the ICD codes.

b. Responsibilities. Commandant (G-WK) will:

(1) Revise Coast Guard policies to conform with the standards contained in DOD Directive 6130.4.

(2) Recommend to the Office of the Assistant Secretary of Defense (Health Affairs) [OASD(HA)] suggested changes in the standards after service coordination has been accomplished.

(3) Review all the standards on a quinquennial basis and recommend changes to the OASD(HA). This review will be initiated and coordinated by the DOD Medical Examination Review Board.

(4) Establish other standards for special programs.

(5) Issue Coast Guard-specific exceptions to these standards, having first submitted these, with justification, for review and approval by the OASD(HA).

3. Abdominal Organs and Gastrointestinal System. The causes for rejection for appointment, enlistment, and induction are authenticated history of:

a. Esophagus. Ulceration, varices, fistula, achalasia, or other dysmotility disorders; chronic, or recurrent esophagitis if confirmed by x-ray or endoscopic examination (530).

b. Stomach and duodenum.

(1) Gastritis, chronic hypertrophic, severe (535).

(2) Ulcer of stomach or duodenum confirmed by x-ray or endoscopy (533).

(3) Congenital abnormalities of the stomach or duodenum causing symptoms or requiring surgical treatment (751), except a history of surgical correction of hypertrophic pyloric stenosis of infancy.

c. Small and large intestine.

(1) Inflammatory bowel disease. Regional enteritis (555), ulcerative colitis (556), or ulcerative proctitis (556).

(2) Duodenal diverticula. That with symptoms or sequelae (hemorrhage, perforation, etc.) (562.02).

(3) Intestinal malabsorption syndromes. Including post surgical and idiopathic (579).

(4) Congenital (751): Condition to include Meckel's diverticulum or functional (564) abnormalities, persisting or symptomatic within the past two years.

d. Gastrointestinal bleeding. History of such, unless the cause shall have been corrected and is not otherwise disqualifying (578).

e. Hepato-pancreatico-biliary tract.

(1) Viral hepatitis (070) or Unspecified hepatitis (570). Hepatitis in the preceding 6 months or persistence of symptoms after 6 months, or objective evidence of impairment of liver function, chronic hepatitis or hepatitis B carriers (070).

(2) Cholecystitis. Acute or chronic, with or without cholelithiasis (574); and other disorders of the gallbladder, including postcholecystectomy syndrome (575); and biliary system (576).

(3) Pancreatitis. Acute (577.0) and chronic (577.1).

f. Anorectal.

(1) Anal fissure if persistent, or anal fistula (565).

(2) Anal or rectal polyp (569.0), stricture (569.2), or incontinence (787.6).

(3) Hemorrhoids. Internal or external, when large, symptomatic, or history of bleeding (455).

g. Spleen.

(1) Splenomegaly. If persistent (789.2).

(2) Splenectomy (P41.5). Except when accomplished for trauma or conditions unrelated to the spleen, or for hereditary spherocytosis (282.0).

h. Abdominal wall.

(1) Hernia. Including inguinal (550) and other abdominal (553), except for small, or asymptomatic umbilical or hiatal.

(2) History of abdominal surgery during the proceding 60 days (P54).

i. Other. Gastrointestinal bypass (P43) or stomach stapling (p44) for control of obesity. Persons with artificial openings (V44).

4. Blood and Blood-Forming Tissue Diseases. The causes for rejection for appointment, enlistment, and induction are:

a. Anemia. Any hereditary (282), acquired (283), aplastic (284), or unspecified (285) anemia that has not been permanently corrected with therapy.

b. Hemorrhagic disorders. Any congenital (286) or acquired (287) tendency to bleed due to a platelet or coagulation disorder.

c. Leukopenia. Chronic or recurrent (288), based on avilable norms for ethnic background.

d. Immunodeficiency (279).

5. Dental. The causes of rejection for appointment, enlistment, and induction are as follows:

   a. Diseases of the Jaw or Associated Tissues That Are Not Easily Remediable, and Will Incapacitate the Individual or Otherwise Prevent the Satisfactory Performance of Duty. Those diseases include temporomandibular disorder (524.6) and/or myofacial pain dysfunction that is not easily corrected, or has the potential for significant future problems with pain and function.

   b. Severe malocclusion (524). That malocclusion which interferes with normal mastication or requires early and protracted treatment; or relationship between mandible and maxilla that prevents satisfactory future prosthodontic replacement.

   c. Insufficient Natural Healthy Teeth (521), or Lack of a Serviceable Prosthesis. Such condition preventing adequate mastication and incision of a normal diet. That includes complex (multiple fixture) dental implant systems that have associated complications that severely limit assignments and adversely affect performance of worldwide duty. Dental implant system must be successfully osseointegrated and completed

   d. Orthodontic Appliancesfor Continued Treatment (V53.4). Attached or Removable. Retainer appliances are permissible, if all active orthodontic treatment has been satisfactorily completed

6. Ears. The causes for rejection for appointment, enlistment, and induction areas follows:

   a. External ear. Atresia or severe microtia (744), acquired stenosis (380.5), severe chronic or acute external (380.2), or severe traumatic deformity (738.7).

   b. Mastoids. Mastoiditis (383), residual of mastoid operation with fistula (383.81), or marked external deformity that prevents or interferes with the wearing of protective mask or helmet (383.3).

   c. Meniere's Syndrome, or Other diseases of the Vestibular System (386).

   d. Middle ear. Acute or chronic otitis media (382), cholesteatoma (385.3), or history of any inner (P20) or middle (P19) ear surgery, excluding myringotomy or successful tympanoplasty.

   e. Tympanic membrane.

7. Hearing. The cause for rejection for appointment, enlistment, and induction is a hearing threshold level greater than that described in 3-D-7-a-(3), below (389):

   a. Audiometric Hearing Levels.

      (1) Audiometers, calibrated to the International Standards Organization (ISO 1964) or the American National Standards Institute (ANSI 1969), shall be used to test the hearing of all applicants.

(2) All audiometric tracings or audiometric readings recorded on reports of medical examinations or other medical records shall be clearly identified.

(3) Acceptable audiometric hearing levels (both ears) are as follows:

(a) Pure tone at 500, 1000, and 2000 cycles per second of not more than 30 dB on the average with no individual level greater than 35 dB at those frequencies.

(b) Pure tone level not more than 45 dB at 3000 cycles per second and 55 dB at 4000 cycles per second.

8. Endocrine and Metabolic Disorders. The cause for rejection for appointment, enlistment, or induction are an authenticated history of the following:

a. Adrenal dysfunction (255). Of any degree.

b. Diabetes Mellitus (250). Of any type.

c. Glycosuria. Persistent, when associated with impaired glucose tolerance (250) or renal tubular defects (271.4

d. Acromegaly. Gigantism, or other disorder of pituitary function (253).

e. Gout (274).

f. Hyperinsulinism (251.1).

g. Hyperparathyroidism (252.0) and hypoparathyroidism (252.1).

h. Thyroid disorders.

(1) Goiter. Persistent or untreated (240).

(2) Hyperthyroidism. Condition uncontrolled by medication (244).

(3) Cretinism (243).

(4) Hypothyroidism (242).

(5) Thyroiditis (245).

i. Nutritional Deficiency Diseases. Such diseases include beriberi (265), pellagra (265.2), and scurvy (267).

j. Other Endocrine or Metabolic Disorders. Such disorders such as cystic fibrosis (277), porphyria (277.1), and amyloidosis (277.3) that prevent satisfactory performance of duty or require frequent or prolonged treatment.

9. Upper Extremities (see also section 3-D-11, below). The causes for rejection for appointment, enlistment, and induction areas follows:

a. Limitation of motion. An individual will be considered unacceptable if the joint ranges of motion are less than the measurements listed below. Methods of measurement appear in EXHIBIT 3-F-1.

(1) Shoulder (726.1).

(a) Forward elevation to 90 degrees.

(b) Abduction to 90 degrees.

(2) Elbow (726.3).

(a) Flexion to 100 degrees.

(b) Extension to 15 degrees.

(3) Wrist (726.4). A total range to 60 degrees (extension plus flexion). Radial and ulnar deviation combined arc 30 degrees.

(4) Hand.

(a) Pronation to 45 degrees.

(b) Supination to 45 degrees.

(5) Fingers and thumb (726.4). Inability to clench fist, pick up a pin, grasp an object or touch tips of at least 3 fingers with thumb.

b. Hand and fingers.

(1) Absence of the distal phalanx of either thumb(885).

(2) Absence of distal and middle phalanx of an index, middle, or ring finger of either hand irrespective of the absence of little finger (866).

(3) Absence of more than the distal phalanx of any two of the following fingers: index, middle finger, or ring finger of either hand (886).

(4) Absence of a hand or any portion thereof (887), except for fingers as noted above.

(5) Polydactyly (755).

(6) Scars and deformities of the fingers or hand (905.2) that are symptomatic, or impair normal function to such a degree as to interfere with the satisfactory performance of military duty.

(7) Intrinsic paralysis or weakness, including nerve palsy (354) sufficient to produce physical findings in the hand such as muscle atrophy or weakness.

c. Wrist, Forearm, Elbow, Arm, and Shoulder. Recovery from disease or injury with residual weakness or symptoms such as to prevent satisfactory performance of duty (905.2), or grip strength of less than 75 percent of predicted normal when injured

hand is compared with the normal hand (nondominant is 80 percent of dominant grip).

10. Lower Extremities (see 3-D-11). The causes for rejection for appointment, enlistment, and induction are as follows:

    a. Limitation of motion. An individual will be considered unacceptable if the joint ranges of motion are less than the measurements listed below. Methods of measurement appear in EXHIBIT 3-F-1.

        (1) Hip. Due to disease(726.5) or injury (905.2).

            (a) Flexion to 90 degrees (minimum).

            (b) No demonstrable flexion contracture.

            (c) Extension to 10 degrees (beyond 0 degree).

            (d) Abduction to 45 degrees.

            (e) Rotation - 60 degrees (internal and external combined).

        (2) Knee. Due to disease (726.7) or injury (905.4).

            (a) Full extension compared with contralateral.

            (b) Flexion to 90 degrees.

        (3) Ankle. Due to disease (726.7) or injury (905.4).

            (a) Dorsiflexion to 10 degrees.

            (b) Plantar flexion to 30 degrees.

            (c) Eversion and inversion (total to 5 degrees).

        (4) Subtalar. Due to disease (726.7) or injury (905.4).

            (a) Eversion and inversion total to 5 degrees.

    b. Foot and ankle.

        (1) Absence of one or more small toes (895). If the function of the foot is poor, or running or jumping is prevented; absence of a foot (896) or any portion thereof except for toes as noted herein.

        (2) Absence of great toe(s) (895). Loss of dorsal and/or planter flexion if the function of the foot is impaired (905.4).

        (3) Deformities of the toes. Either acquired (735) or congental (755.66), including polydactyly (755.02), that prevents the wearing of military footwear, or impairs walking, marching, running, or jumping. That includes hallux valgus (735).

(4) Clubfoot and/or Pes Cavus (754.5). If stiffness or deformity prevents foot function or wearing military footwear.

(5) Symptomatic Pes planus. Acquired (34) or congenital (754.6) or pronounced cases with absence of subtalar motion.

(6) Ingrown toenails (703). If severe.

(7) Planter Fasciitis (728.7). If persistent.

(8) Neuroma (355.6). Confirmed condition and refractory to medical treatment, or will impair function of the foot.

c. Leg, knee, thigh, and hip.

(1) Loose or foreign bodies in the knee joint (717.6). History of surgical correction of knee ligaments.

(2) Physical findings of an unstable or internally deranged joint (717.9). History of uncorrected anterior (717.83) or posterior (717.84) cruciate ligament injury.

(3) Surgical correction of any knee ligaments (P81), if symptomatic or unstable.

(4) History of congenital dislocation of the hip (754.3). Osteochondritis of the hip (Legg-Perthes Disease) (732.1), or slipped femoral epiphysis of the hip (732.2).

(5) Hip dislocation (835). Dislocation within 2 years before examination.

(6) Osteochondritis of the tibial tuberosity (Osgood-Schlatter Disease) (732.4). If symptomatic.

d. General.

(1) Deformities (905.4), disease, or chronic pain (719.4) of one or both lower extremities that have interfered with function to such a degree as to prevent the individual from following a physically active vocation in civilian life; or that would interfere with walking, running, weight bearing, or the satisfactory completion of training or military duty.

(2) Shortening of a lower extremity (736.81), resulting in a noticeable limp or scoliosis.

11. Miscellaneous Conditions of the Extremities. (see 3-D-9 and 3-D-10). The causes for rejection for appointment, enlistment, and induction areas follows:

a. Arthritis.

(1) Active, subactive, or chronic arthritis (716).

(2) Chronic osteoarthritis (715.3) or traumatic arthritis (716.1) of isolated joints of more than a minimal degree, that has interfered with the following of a physically active vocation in civilian life or that prevents the satisfactory performance of military duty.

b. Chronic retropatellar knee pain syndrome with or without confirmatory arthroscopic valuation (717.7).

c. Dislocation, if unreduced; or recurrent dislocations of any major joint. Such as, shoulder (831), hip (835), elbow (832), knee (836); or stability of any major joint (shoulder(718.1), elbow (718.3, or hip(718.5)).

d. Fractures.

(1) Malunion or non-union of any fracture (733.8). Except ulnar styloid process.w

(2) Orthopedic hardware (733.99). hardware including plates, pins, rods, wires, or screws used for fixation and left in place; except that a pin, wire or screw not subject to easy trauma is not disqualifying.

e. Injury of a bone or joint. An injury of more than a minor nature, with or without fracture or dislocation, which occurred in the preceding 6 weeks (upper extremity (923), lower extremity (924), or rib and clavicle (922)).

f. Joint replacement (V43.6).

g. Muscular paralysis, contracture, or atrophy (728). If progressive or of sufficient degree to interfere with military service, and muscular dystrophies (359).

h. Osteochondritis dessicans (732.7).

i. Osteochondromatosis or multiple cartilaginous exostoses (727.82).

j. Osteomyelitis (730). Active or recurrent

k. Osteoporosis (733).

l. Scars (709.2). Extensive, deep, or adherent to the skin and soft tissues that interfere with muscular movements.

m. Implants. Silastic or other devices implanted or correct orthopedic abnormalities (V43).

12. Eyes. The cause for rejection for appointment, enlistment, or induction are as follows

a. Lids.

(1) Blepharitis (373). Chroniccondition, of more than mild degree.

(2) Blepharospasm (333.81).

(3) Dacryocystitis. Acute or chronic (375.3).

(4) Deformity of the lids (374.4). Complete or extensive lid deformity, sufficient to interfere with vision or impair protection of the eye from exposure.

b. Conjunctiva.

(1) Conjunctivitis. Chronic condition (372.1), including trachoma (076), and allergic conjunctivitis (372.13).

(2) Ptergium (372.4). If condition encroaching on the cornea in excess of 3 millimeters, interfering with vision, progressive (372.42) or recurring after two operative procedures (372.45).

(3) Xerophthalmia (372.53).

c. Cornea.

(1) Dystrophy. Corneal dystrophy, of any type (371.5), including, keratoconus (371.6) of any degree.

(2) Keratorefractive surgery. History of lamellar (P11.7) and/or penetrating keratoplasty (P11.6). Laser surgery or appliance utilized to reconfigure the cornea is also disqualifying.

(a) Waivers for Photorefractive Keratectomy (PRK) and Laser In-situ Keratomileusis (LASIK) will be considered if the following criteria are met:

1 Pre-operative refractive error did not exceed +8.00 to-8.00 diopters (spherical equivalent) in either eye.

2 At least 12 months since surgery or last enhancement.

3 Refractive stability as demonstrated by less than 0.50 diopter change in either eye over two separate exams at least three months apart.

4 All pre-operative, operative and post-operative records are submitted for review.

5 No complications or side effects as a result of the surgery such as decreased night vision, glare sensitivity, halos around light or worsening of the pre-operative best vision due to scar formation.

6 Accession standards outlined in section 3-D and 3-E are met.

(b) PRK and LASIK are disqualifying for aviation duty and landing signal officer duty.

(c) LASIK is disqualifying for diving duty.

(3) Keratitis (370). Acute or chronic keratitis, which includes recurrent corneal ulcers, erosions (abrasions), or herpetic ulcers (054.42).

(4) Vascularization (370.6) or opacification (371) of the cornea. Condition from any cause that is progressive or reduces vision below the standards prescribed in 3-D-13.

d. Uveitis (364) or Iridocyclitis.

e. Retina.

(1) Angiomatoses (759.6). Or other congenito-hereditary retinal dystrophy (362.7) that impairs visual function.

(2) Chorioretinitis (363). Unless single episode that has healed and does not interfere with vision.

(3) Congenital or degenerative changes of any part of the retina (362).

(4) Detachment of the retina (361). A history of surgery for same, or peripheral retinal injury or degeneration likely to cause retinal detachment.

(5) Chorioretinis or inflammation of the retina (363). Condition including (histoplasmosis, toxoplasmosis or vascular conditions of the eye to include Coats' disease, Eales' disease, and retinitis proliferans), unless a single episode known cause that has healed and does not interfere with vision.

f. Optic nerve.

(1) Optic neuritis (377.3). Neuroretinitis, or secondary optic atrophy or documented history of attacks of retrobulbar neuritis.

(2) Optic atrophy (377.1) or Cortical Blindness (377.7).

(3) Papilledema (377.0).

g. Lens.

(1) Aphakia (379.3). Lens implant, or dislocation of a lens.

(2) Opacities of the lens (366). Those conditions that interfere with vision or that are considered to be progressive.

h. Ocular mobility and motility.

(1) Diplopia (368.2). Documented, constant or intermittent.

(2) Nystagmus (379.5).

(3) Strabismus (378). Uncorrectable by lenses to less than 40 diopters or accompanied by diploplia.

(4) Strabismus. Corrective surgery (P15) in the preceding 6 months.

(5) See section 3-E for additional standards for officer programs.

i. Miscellaneous defects and diseases.

(1) Abnormal visual fields due to diseases of the central nervous system (368.4), or trauma (368.9). Meridian specific visual field minimums areas follows:

(a) Temporal: 85 degrees.

(b) Superior temporal: 55 degrees.

(c) Superior: 45 degrees.

(d) Superior nasal: 55 degrees.

(e) Nasal: 60 degrees.

(f) Inferior nasal: 50 degrees.

(g) Inferior: 65 degrees.

(h) Inferior temporal: 85 degrees.

(2) Absence of an eye. Congenital (743) or acquired (360.8).

(3) Asthenopia (368.13). Severe.

(4) Exophthalmos (376). Unilateral or bilateral, non-familial.

(5) Glaucoma (365). Primary, or secondary, or pre-glaucoma as evidenced by intraocular pressure above 21 mm/Hg, or the secondary changes in the optic disc or visual field loss associated with glaucoma.

(6) Loss of normal pupillary reflex reactions to light or accommodation (367.5) or light (379.4), including Adie's syndrome.

(7) Night blindness (368.6).

(8) Retained introcular foreign body (360).

(9) Tumors. Growths or tumors of the eyelid, other than small basal cell tumors that may be cured by treatment, and small nonprogressive asymptomatic benign lesions.

(10) Any organic disease of the eye (360) or adnexa (376) not specified above, that threatens vision or visual function.

13. Vision. The cause of medical rejection for appointment, enlistment, and induction are listed below. (See section 3-E for additional standards for officer programs.)

a. Distant visual acuity. Distant visual acuity of any degree that does not correct with spectacle lenses to at least one of the following (367):

(1) 20/40 in one eye and 20/70 in the other eye.

(2) 20/30 in one eye and 20/100 in the other eye.

(3) 20/20 in one eye and not exceeding 20/400 in the other eye.

b. Near visual acuity. Near visual acuity of any degree that does not correct to 20/40 in the better eye (367).

c. Refractive error (Hyperopia 367.0, Myopia 367.1, Astigmatism 367.2). Any refractive error in spherical equivalent of worse than - 8.00 or + 8.00 diopters; or if

ordinary spectacles cause discomfort by reason of ghost images, prismatic displacement; or if corrected by orthokeratology or keratorefractive surgery.

d. Contact lenses. Complicated cases requiring contact lenses for adequate correction of vision such as corneal scars (371) and irregular astigmatism (367.2).

e. Color vision. (368.5). All applicants for initial entry into the Coast Guard, all officer candidates, all commissioning candidates, and all aviation candidates shall be tested for color vision. There is NO requirement for enlisted personnel to demonstrate normal color vision. A listing of current enlisted specialties that require normal color vision can be obtained from unit personnel offices or departments. Normal color vision IS required for all officer candidates and some commissioned warrant specialties (check with unit personnel offices for current listing).

14. Female Genitalia. The causes for rejection for appointment, enlistment, and induction areas follows:

a. Abnormal uterine bleeding (626.2). Including such bleeding as menorrhagia, metrorrhagia or polymenorrhea.

b. Amenorrhea (626.0). Unexplained

c. Dysmenorrhea (625.3). Incapacitating to a degree recurrently necessitating absences of more than a few hours from routine activities.

d. Endometriosis (617).

e. Hermaphroditism (752.7).

f. Menopausal Syndrome (627). If manifested by more than mild constitutional or mental symptoms or artificial menopause less than a 1-year duration.

g. Ovarian Cysts (620). Persistent or clinically significant.

h. Pelvic Inflammatory disease (614). Acute or chronic.

i. Pregnancy (V22).

j. Uterus. Congenital absence of (752.3) or enlargement due to any cause (621.2).

k. Vulvar or Vagina Ulceration (616.5). Including herpes genitalis (054.11) and condyloma acuminatum (078.11): acute or chronic, not amenable to treatment. Such treatment must be given and demonstrated effective prior to accession.

l. Abnormal Pap Smear (795). Graded LGSIL or higher severity; or any smear in which the descriptive terms carcinoma-in-situ, invasive cancer, condyloma accuminatum, human papilloma virus, or dysplasia are used.

m. Major abnormalities and defects of the genitalia, such as a change of sex (P64.5). A history thereof, or dysfunctional residuals from surgical correction of these conditions.

15. Male Genitalia. The cause of medical rejection for appointment, enlistment, or induction are:

a. Absence of both testicles. Congenital (752.8) or acquired (878.2), or unexplained absence of a testicle.

b. Epispadias or Hypospadias (752.6). when accompanied by evidence of infection of the urinary tract, or if clothing is soiled when voiding.

c. Undiagnosed enlargement or mass of testicleor epididymis (608.9).

d. Undescended testicle(s) (752.5).

e. Orchitis (604). Acute, or chronic epididymitis.

f. Penis. Amputation of (878), if the resulting stump is insufficient to permit micturition in a normal manner.

g. Penile infectious lesions. Including herpes genitalis (054.1) and condyloma acuminatum (078.11): acute or chronic, not amenable to treatment. Such treatment must be given and demonstrated effective prior to accession.

h. Prostatitis (601). Acute or chronic condition.

i. Hydrocele (603.9). Left varicocele (if painful), or any right varicocele (456.4)

j. Major abnormalities and defects of the genitalia, such as a change of sex (P64.5). A history thereof, or dysfunctional residuals from surgical correction of these conditions.

16. Urinary System The causes for rejection for appointment, enlistment, and induction are:

a. Cystitis (595).

b. Urethritis (597).

c. Enuresis. (788.3) or incontinence of urine beyond age 12 (788.3).

d. Hematuria, Pyuria, or other findings indicative of urnnary tract disease (599).

e. Urethral stricture (598) or fistula (599.1).

f. Kidney.

(1) Absence of one kidney. Congenital (753.0) or acquired (593.89).

(2) Infections. Acute or chronic infections (590).

(3) Polycystic kidney (753.1). Confirmed history of such a condition.

(4) Horseshoe kidney (753.3).

(5) Hydronephrosis (591).

(6) Nephritis. Acute (580) or chronic (582).

(7) Proteinuria (791). Under normal activity (at least 48 hours after strenuous exercise) greater than 200 mg/24 hours, or a protein to creatinine ratio greater than 0.2 in a random urine sample, unless nephrologic consultation determines the condition to be benign orthostatic proteinuria.

(8) Renal Calculus (592). Within the previous 12 months, recurrent calculus, nephrocalcinosis, or bilateral renal calculi at any time.

17. Head. The causes for rejection for appointment, enlistment, and induction are:

a. Injuries. Including severe contusions and other wounds of the scalp (920) and cerebral concussion (850), until a period of 3 months has elapsed. (See 3-D-27).

b. Deformities of the skull, face, or jaw (754.0). Such deformities of a degree that will prevent the individual from wearing a protective mask or military headgear.

c. Defects (756.0). Loss, or congenital absence of the bony substance of the skull not successfully corrected by reconstructive materials, or leaving residual defect in excess of one square inch (6.45cm) or the size of a 25-cent piece.

18. Neck. The causes of rejection for appointment, enlistment, and induction are:

a. Cervical ribs (756.2). If symptomatic, or so obvious that they are found on routine physical examination. (Detection based primarily on x-rays is not considered to meet this criterion.)

b. Congential cysts (744.4). Those cysts of branchial cleft origin or those developing from the remnants of the thyroglossal duct, with or without fistulous tracts.

c. Contraction (723.8). Contraction of the muscles of the neck, spastic or non-spastic, or cicatricial contracture of the neck to the extent that it interferes with the wearing of a uniform or military equipment, or is so disfiguring as to impair military bearing.

19. Heart. The causes for rejection for appointment, enlistment, and induction are:

a. All valvular heart diseases. Congenitial (746) or acquired (394), including those improved by surgery, except mitral valve prolapse and bicuspid aortic valve. Those latter two conditions are not reasons for rejection unless there is associated tachyarrhythmia, mitral regurgitation, aortic stenosis, insufficiency, or cardiomegaly.

b. Coronary heart disease (410).

c. Symptomatic arrhythmia or (electrocardiographic evidence of arrhythmia). A history of such condition.

(1) Supraventricular tachycardia (427.0). Or any dysrhythia originating from the atrium or sinoatrial node, such as atrial flutter, and atrial fibrillation unless there has been no recurrence during the preceding 2 years while off all medications. Premature atrial or ventricular contractions are disqualifying when sufficiently symptomatic to require treatment or result in physical or psychological impairment

(2) Ventricular Arrythmias (427.1). Those arrythmias including ventricular fibrillation, tachycardia, and multifocal premature ventricular contractions. Occasional asymptomatic premature ventricular contractions are not disqualifying.

(3) Ventricular Conduction disorders. Such disorders with left bundle branch block (426.2), Mobitz type II second degree AV block (426.12). third degree AV block (426.0). Wolff-Parkinson-White syndrome (426.7) and Lown-Ganong-Levine Syndrom (426.81) associated with an arrhythmia are also disqualifying.

(4) Conduction Disturbances. Conduction disturbances such as first degree AV block (426.11), left anterior hemiblock (426.2), right bundle branch block (426.4) or Mobitz type I second degree AV block (426.13) are disqualifying when symptomatic or associated with underlying cardiovascular disease.

d. Hypertrophy or dilatation of the heart (429.3).

e. Cardiomyopathy (425). Including myocarditis (422), or history of congestive heart failure (428) even though currently compensated.

f. Pericarditis (420).

g. Persistent tachycardia (785) (Resting pulse rate of 100 or greater).

h. Congenital anomalies of heart and great vessels (746). Except forcorrected patent ductus arteriosus.

20. Vascular System. The causes for rejection for appointment, enlistment, and induction are:

a. Abnormalities of the arteries and blood vessels (447). Abnormalities including aneurysms (442) even if repaired, atherosclerosis (440), and arteritis (446).

b. Hypertensive Vascular Disease (401). Such disease evidenced by the average of three consecutive averaged diastolic blood pressure measurements greater than 90 mmHg or three consecutive averaged systolic blood pressures greater than 140 mmHg at any age. High blood pressure requiring medication or a history of treatment including dietary restriction is also disqualifying.

c. Pulmonary (415) or systemic embolization (444).

d. Peripheral Vascular Disease. Including diseases such as Raynaud's phenomenon (443).

e. Vein diseases. Vein disease including recurrent thrombophlebitis (451), thrombophlebitis during the preceding year, or any evidence of venous incompetence, such as large or symptomatic varicose veins, edema, or skin ulceration (454).

21. Height. The causes for rejection for appointment, enlistment, and induction in relation to height standards are established by each of the military Services. Standards for the Coast Guard are:

a. Men: Height below 152.5 cm (60 inches) or over 198 cm (78 inches).

b. Women: Height below 152.5 cm (60 inches) or over 198 cm (78 inches).

22. Weight. The causes for rejection for appointment, enlistment, and induction in relation to weight standards are contained in COMDTINST 1020.8(series).

23. Body Build. The cause for rejection for appointment, enlistment, and induction are:

a. Congenital malformation of bones and joints. (See 3-D-9 through 3-D-11).

b. Deficient muscular development that would interfere with the completion of required training.

c. Evidence of congenital asthenia or body build that would interfere with the completion of required training.

24. Lungs, Chest Walls, Pleura, and Mediastinum. The causes for rejection for appointment, enlistment, and induction are:

a. Abnormal elevation of the diaphragm (793.2). Such elevation may be either side.

b. Abscess of the lung (513).

c. Acute infectious process of the lung (518). Until cured.

d. Asthma (493). Including reactive airway disease, exercise-induced bronchospasm, or asthmatic bronchitis, reliably diagnosed at any age. Reliable diagnostic criteria shall consist of any of the following elements.

(1) Substantiated history of cough, wheeze, and/or dyspnea which persists or recurs over a prolonged period of time, generally more than 6 months.

(2) If the diagnosis of asthma is in doubt, a test for reversible airflow obstruction (greater than a 15 percent increase in FEV I following administration of an inhaled bronchodilator), or airway hyperreactivity (exaggerated decrease in airflow induced by a standard bronchoprovocational challenge such as methacholine inhalation or a demonstration of exercise-induced bronchospasms) must be performed.

e. Bronchitis (490). That which is chronic, symptoms over 3 months occurring at least twice a year.

f. Bronchiectasis (494).

g. Bronchopleural fistula (510).

h. Bullous or generalized pulmonary emphysema (492).

i. Chronic Mycotic disease (117) of the lung. Such diseases including coccidioidomycosis.

j. Chest Wall Malformation (754) or fracture (807). Those conditions that interfere with vigorous physical exertion.

k. Empyema (510). That condition includes residual pleural effusion (511.9), or unhealed sinuses of chest wall (510).

l. Extensive pulmonary fibrosis (515).

m. Foreign body in lung, trachea or bronchus (934).

n. Lobectomy. With residual pulmonary disease or removal of more than one lobe (P32.4).

o. Pleurisy with effusion (511.9). That condition occurring within the previous 2 years if known origin, or unknown origin.

p. Pneumothorax (512). That condition occurring during the year preceding examination if due to simple trauma or surgery, during the 3 years preceding examination from spontaneous origin. Recurrent spontaneous pneumothorax after surgical correction or pleural sclerosis.

q. Sarcoidosis. (See 3-D-35-j.)

r. Silicone breast implants. Those encapsulated (85.53P), if less than 9 months since surgery or with symptomatic complications.

s. Tuberculous lesions. (see subsection 3-D-35-l.)

25. Mouth. The cause for rejection for appointment, enlistment, and induction are:

a. Cleft lip or palate defects (749). Unless satisfactorily repaired by surgery.

b. Leukoplakia (528.6).

26. Nose and Sinuses. The causes for rejection of appointment, enlistment, and induction are:

a. Allergic manifestations.

(1) Atrophic rhinitis. (472).

(2) Allergic rhinitis, vasomotor rhinitis (477). If moderate or severe and not controlled by oral medications, desensitization, or topical corticosteroid medication.

b. Vocal cord paralysis (478.3). Or, symptomatic disease of the larynx (478.7).

c. Anosmia or parosmia (352).

d. Epistaxis (784.7). Recurrent condition.

e. Nasal polyps (471). Unless surgery was performed at least 1 year before examination.

f. Perforation of nasal septum (478.1). If symptomatic or progressive.

g. Sinusitis (461). Acute.

h. Sinusitis chronic (473). Such condition exists when evidenced by chronic purulent nasal discharge, hyperplastic changes of the nasal tissue, symptoms requiring frequent medical attention, or x-ray findings.

i. Larynx ulceration, polyps, or granulation tissue, or chronic laryngitis (476).

j. Tracheostomy (V44), or tracheal fistula (530.84).

k. Deformities or conditions (750.9). Those of the mouth, tongue, palate, throat, pharynx, larynx, and nose that interfere with chewing, swallowing, speech, or breathing.

l. Pharyngitis (462) and nasopharyngitis (472.2). Chronic conditions.

27. Neurological Disorders. The causes for rejection for appointment, enlistment, and induction are:

a. Cerebrovascular conditions. Any history of subarachnoid (430) or interacerebral (431) hemorrhage, vascular insufficiency, aneurysm or arteriovenous malformation (437).

b. Congenital malformations (742). If associated with neurological manifestations, or if known to be progressive; meningocele (741), even if uncomplicated.

c. Degenerative and hereditodegenerative disorders. Those disorders affecting the cerebrum (330), basal ganglia (333), cerebellum (334), spinal cord (335), and peripheral nerves or muscles (337).

d. Recurrent headaches (784). Headaches of all types of sufficient severity or frequency as to interfere with normal function within the previous 3 years.

e. Head injury.

(1) Applicants with a history of head injury with:

(a) Late post-traumatic epilepsy (occurring more than 1 week after injury).

(b) Permanent motor or sensory deficits.

(c) Impairment of intellectual function.

(d) Alteration of personality.

(e) Central nervous system shunts.

(2) Applicants with a history of severe closed head injury are unfit for a period of at least 5 years after the injury. After 5 years they may be considered fit if complete neurological and neuropsychological evaluation shows no residual dysfunction or complications. Applicants with a history of severe penetrating head injury are unfit for a period of at least 10 years after the injury. After 10 years they may be considered fit if complete neurological and neuropsychological evaluation shows no residual dysfunctionn or complications. Severe head injuries are defined by one or more of the following.

(a) Unconsciousness or amnesia. Conditions alone or in combination of 24-hours duration or longer.

(b) Depressed skull fracture.

(c) Laceration or contusion of the dura mater or the brain.

(d) Epidural, subdural, subarachnoid or intracerebral hematoma.

(e) Associated abscess or meningitis.

(f) Cerebrospinal fluid rhinorrhea or otorrhea persisting more than 7 days.

(g) Focal neurologic signs.

(h) Radiographic evidence of retained metallic or bony fragments.

(i) Leptomeningeal cysts or arteriovenous fistula.

(j) Early post-traumatic seizure(s) that occur only within 1 week of injury but more than 30 minutes after injury.

(3) Applicants with a history of moderate head injury. Those applicants are unfit for a period of at least 2 years after the injury. After 2 years they may considered fit if complete neurological evaluation shows no residual dysfunction or complications. Moderate head injuries are defined as

unconsciousness or amnesia, alone or in combination, of 1 to 24 hours duration, or linear skull fracture.

(4) Applicants with a history of mild head injury. Those applicants with mild head injuries, as defined by a period of unconsciousness or amnesia, alone or in combination, of 1 hour or less, are unfit for at least 1 month after the injury. After 1 month they be acceptable if complete neurological evaluation shows no residual dysfunction or complications.

(5) Persistent post-traumatic seizure. Such conditions, as manifested by headache, vomiting, disorientation, spatial disequilibrium, personality changes, impaired memory, poor mental concentration, shortened attention span, dizziness, altered sleep patterns, or any findings consistent with organic brain syndrome, are disqualifying until full recovery has been confirmed by complete neurological and neuropsychological evaluation.

f. Infectious diseases.

(1) Meningitis (322), encephalitis (323), or poliomyelitis (045). Such diseases occurring within 1 year before examination, or if there are residual neurological defects.

(2) Neurosyphilis (094). That disease of any form (general paresis, tabes dorsalis, meningovascular syphilis).

g. Narcolepsy (347), sleep apnea syndrome (780.57).

h. Paralysis, weakness, lack of coordination, chronic pain, or sensory disturbances (344).

i. Epilepsy (345). That epilepsy occurring beyond the age of 5 years, unless the applicant has been free of seizures for a period of 5 years while taking no medication for seizure control, and has a normal electroencephalogram (EEG). All such applicants shall have a current neurology consultation with current EEG results. EEG may be requested by reviewing authority

j. Chronic disorders. Disorders such as myasthenia gravis (358), and multiple sclerosis (340).

k. Central nervous system shunts of all kinds (V45.2).

28. Disorders with Psychotic Features. The causes for rejection for appointment, enlistment, and induction are a history of a disorders with psychotic features (295).

29. Neurotic, Anxiety, Mood, Somatoform, Dissociative, or Factitious Disorders (300). The causes for rejection for appointment, enlistment, and induction are:

a. History of such disorders resulting in any or all of the below:

(1) Admission to a hospital or residential facility.

(2) Care by a physician or other mental health professional for more than 6 months.

(3) Symptoms or behavior of a repeated nature that impaired social, school, or work efficiency.

30. Personality, Conduct, and Behavior Disorders. The cause for rejection for appointment, enlistment, and induction are a history of such disorder resulting in any or all of the below:

a. Personality (301), Conduct (312), or Behavior (313) disorders. Disorders as evidenced by frequent encounters with law enforcement agencies, antisocial attitudes or behavior that while not sufficient cause for administrative rejection, are tangible evidence of impaired capacity to adapt to military service.

b. Personality (301), Conduct (312), or Behavior (313) disorders. Where it is evident by history, interview, or psychological testing that the degree of immaturity, instability, personality inadequacy, impulsiveness, or dependency will seriously interfere with adjustment in the Coast Guard as demonstrated by repeated inability to maintain reasonable adjustment in school, with employers and fellow workers, and other social groups.

c. Other behavior disorders including, but not limited to, conditions such as the following:

(1) Authenticated evidence of functional enuresis (307.6) or encopresis (307.7).

(2) Sleepwalking (307.6).

(3) Eating disorders that are habitual or persistent (307.1 or 307.5) occurring beyond age 12.

(4) Stammering (307.0) of such a degree that the individual is often unable to express himself or herself clearly, or to repeat commands.

d. Specific academic skills defects. Chronic history of academic skills (314) or perceptual defects (315), secondary to organic or functional mental disorders that interfere with work or school after age 12. Current use of medication to improve or maintain academic skills.

e. Suicide. History of attempted suicide or other suicidal behavior (300.9).

31. Psychosexual Conditions. The causes for rejection for appointment, enlistment, or induction are transsexualism, exhibitionism, transvestism, voyeurism, and other paraphilias (320).

32. Substance Misuse. The causes for rejection for appointment, enlistment, or induction are:

a. Alcohol dependence (303).

b. Drug dependence (304).

c. Non-dependent use of drugs characterized by the following:

(1) The evidence of use of any controlled, hallucinogenic, or other intoxicating substance at the time of examination (305), when the use cannot be accounted for as a result of a prescription by a physician.

(2) Documented misuse or abuse of any controlled substance (including cannabinoids or anabolic steroids) requiring professional care (305).

(3) The repeated self-procurement and self-administration of any drug or chemical substance, including cannabinoids or anabolic steroids, with such frequency that it appears that the applicant has accepted the use of or reliance on those substances as part of his or her pattern of behavior (305).

(4) The use of LSD (305.3) in a 2-year period before examination.

d. Alcohol abuse (305). Use of alcoholic beverages, which leads to misconduct, unacceptable social behavior, poor work or academic performance, impaired physical or mental health, lack of financial responsibility, or a disrupted personal relationship.

33. Skin and Cellular Tissues. The causes for rejection for appointment, enlistment, and induction are:

a. Acne (706). Severe acne, or when extensive involvement of the neck, shoulders, chest, or back would be aggravated by or interfere with the wearing of military equipment and not amenable to treatment. Patients under treatment with isotretinoin (Accutane) are medically unacceptable until 8 weeks after completion of a course of therapy.

b. Atopic dermatitis (691) or eczema (692). Occurring with active or residual lesions in characteristic areas (face and neck, antecubital and/or popliteal fossae, occasionally wrists and hands), or documented history thereof after the age of 8.

c. Contact dermatitis (692.4). Dermatitis especially involving rubber or other materials used in any type of required protective equipment.

d. Cysts.

(1) Cysts (706.2), other than pilonidal. Cysts of such a size or location as to interfere with the normal wearing of military equipment.

(2) Cysts, pilonidal (685). Pilonidal cysts evidenced by the presence of a tumor mass or discharging sinus. History of pilonidal cystectomy within 6 months before examination.

e. Dermatitis factitia (698.4).

f. Bullous dermatoses (694). Conditions such as dermatitis herpetiformis, pemphigus, and epidermolysis bullosa.

g. Chronic lymphedema (457).

h. Fungus infections (117). Systemic or superficial types, if extensive and not amenable to treatment.

i. Furunculosis (680). Extensive, recurrent, or chronic.

j. Hyperhidrosis of hands or feet (780.8). Chronic or severe.

k. Ichthyosis. Or other congenital (757) or acquired (216) anomalies of the skin, such as nevi or vascular tumors that interfere with function or are exposed to constant irritation.

l. Keloid formation (701-4). If the tendency is marked or interferes with the wearing of military equipment.

m. Leprosy (030.9).

n. Lichen planus (697.0).

o. Neurofibromatosis (Von Recklinghausen's disease) (237.7).

p. Photosensitivity (692.72). Any primary sun-sensitive condition, such as polymorphous light eruption or solar urticaria; any dermatosis aggravated by sunlight such as lupus erythematosus.

q. Psoriasis (696.1). Unless mild by degree, not involving nail-pitting, and not interfering with the wearing of military equipment or clothing.

r. Radiodermatitis (692.82).

s. Scars (709.2). Scars so extensive, deep, or adherent that they may interfere with the wearing of military clothing or equipment, exhibit a tendency to ulcerate, or interfere with function. Includes scars at skin graft donor or recipient sites if in an area susceptible to trauma.

t. Scleroderma (710.1).

u. Tattoos (709.9). Entrance may be denied to any applicant who has a tattoo or other applied body marking contrary to the core values of the Coast Guard in accordance with "Tattoo and Body Markings Policy for CG Accessions, COMDTINST 1000.1."

v. Urticaria (708.8). Chronic.

w. Warts. Plantar warts (078.19) that are symptomatic.

x. Xanthoma (272.2). If disabling or accompanied by hyperlipemia.

y. Any other chronic skin disorder of a degree or nature such as Dysplastic nevi syndrom (448.1), which requires frequent outpatient treatment or hospitalization, or interferes with the satisfactory performance of duty.

34. Spine and Sacroiliac Joints. The causes for rejection for appointment, enlistment, and induction are:

a. Arthritis (720). (see 3-D-11.a)

b. Complaint of a disease or injury of the spine or sacroiliac joints, with or without objective signs, that has prevented the individual from successfully following a physically active vocation in civilian life (724), or that is associated with pain referred to the lower extremities, muscular spasms, postural deformities, or limitation of motion.

c. Deviation or curvature of spine (737) from normal alignment, structure, or function if:

(1) It prevents the individual from following a physically active vocation in civilian life.

(2) It interferes with the wearing of a uniform or military equipment.

(3) It is symptomatic and associated with positive physical finding(s) and demonstrable by x-ray.

(4) There is lumbar scoliosis greater than 20 degrees, thoracic scoliosis over 20 degrees, and kyphosis or lordosis greater than 55 degrees when measured by the Cobb method.

d. Fusion. Congenital fusion (756.15), involving more than two vertebrae. Any surgical fusion (81.0P).

e. Healed fractures or dislocations of the vertebrae (805). A compression fracture, involving less than 25 percent of a single vertebra is not disqualifying if the injury occurred more than 1 year before examination and the applicant is asymptomatic. A history of fractures of the transverse or spinous processes is not disqualifying if the applicant is asymptomatic.

f. Juvenile epiphysitis (732.6). That with any degree of residual change indicated by x-ray or kyphosis.

g. Ruptured nucleus pulposus (722). Herniation of intervertebral disk or surgery for this condition.

h. Spina bifida (741). When symptomatic, or there is more than one vertebra involved, dimpling of the overlying skin, or a history of surgical repair.

i. Spondylolysis (756.1) and Spondylolisthesis (738.4).

j. Weak or painful back (724). Back condition requiring external support; that is, corset or brace. Recurrent sprains or strains requiring limitation of physical activity or frequent treatment.

35. Systemic Diseases. The causes for rejection for appointment, enlistment, and induction are:

a. Amyloidosis (277.3).

b. Ankylosing spondylitis (720).

c. Eosinophilic granuloma (277.8). Eosinophilic granuloma, when occurring as a single localized bony lesion and not associated with soft tissue or other involvement, shall not be a cause for rejection once healing has occurred. All other forms of the histiocytosis X spectrum should be rejected.

d. Lupus erythematosus (710) and mixed connective tissue disease (710.9).

e. Polymyositis dermatomyositis complex (710).

f. Progressive systemic sclerosis (710). Condition including CRST variant. A single plaque of localized scleroderma (morphea) that has been stable for at least 2 years is not disqualifying.

g. Reiter's disease (099.3).

h. Rheumatoid arthritis (714).

i. Rhabdomyolysis (728.9).

j. Sarcoidosis (135). Unless there is substantiated evidence of a complete spontaneous remission of at least 2 years duration.

k. Sjogren's syndrome (710.2).

l. Tuberculosis (010).

(1) Active tuberculosis in any form or location, or substantiated history of active tuberculosis within the previous 2 years.

(2) One or more reactivations.

(3) Residual physical or mental defects from past tuberculosis that will prevent the satisfactory performance of duty.

(4) Individuals with a past history of active tuberculosis more than 2 years prior to enlistment or induction, are qualified if they have received a complete course of standard chemotherapy for tuberculosis. In addition, individuals with a tuberculin reaction 10 mm or greater and without evidence of residual disease are qualified once they have been treated with chemoprophylaxis

(5) Vasculitis (466). Such as Bechet's, Wegener's granulomatosis polyarteritis nodosa.

36. General and Miscellaneous Conditions and Defects. The causes for rejection for appointment, enlistment, and induction are:

a. Allergic manifestations (995.0). A reliable history of anaphylaxis to stinging insects. Reliable history of a moderate to severe reaction to common foods, spices or food additives.

b. Any acute pathological condition. Those including acute communicable diseases, until recovery has occurred without sequelae.

c. Chronic metallic poisoning. Poisoning with lead, arsenic, or silver (985), or beryllium or manganese (985).

d. Cold injury (991). Residuals of injury; such as frostbite, chilblain, immersion foot, trench foot, deep-seated ache, paresthesia, hyperhidrosis, easily traumatized skin, cyanosis, amputation of any digit, or ankylosis.

e. Cold urticaria (708.2) and angiodema, hereditary angiodema (277.6).

f. Filariasis (125), Trypanosomiasis (086), Schistosomiasis (120).

g. Heat pyrexia (992) heatstroke (992), or sunstroke (992). Documented evidence of a predisposition (including disorders of sweat mechanism and a previous serious episode), recurrent episodes requiring medical attention, or residual injury (especially cardiac, cerebral, hepatic, and renal). Malignant Hyperthermia (995.89).

h. Industrial solvent and other chemical intoxication (982).

i. Motion sickness (994.6). An authenticated history of frequent, incapacitating motion sickness after the 12th birthday.

j. Mycotic (114) infection of internal organs.

k. Organ transplant recipient (V42).

l. Presence of HIV-1 or antibody (042). That presence confirmed by repeatedly reactive Enzyme-Linked Immunoassay (ELISA) serological test and positive immunoelectrophoresis (Western Blot) test, or other DoD approved screening and confirmatory test.

m. Reactive tests for syphilis (093). Test such as the RPR or VDRL followed by a reactive, confirmatory fluorescent treponemal antibody absorption (FTA-ABS) test unless there is a documented history of adequately treated syphilis. In the absence of clinical findings, the presence of reactive RPR or VDRL followed by a negative FTA-ABS test is not disqualifying if a cause for the false positive reaction can be identified and is not otherwise disqualifying.

n. Residual of tropical fevers. Fevers such as malaria (084) and various parastic or protozoan infestations that prevent the satisfactory performance of military duty.

o. Rheumatic fever (390). That condition during the previous 2 years, or any history or recurrent attacks; Sydenham's chorea at any age.

p. Sleep apnea (780.57).

37. Tumors and Malignant Diseases. The causes for rejection for appointment, enlistment, and induction are:

a. Benign tumors (M8000). Those that interfere with function, prevent wearing of the uniform or prtective equipment, shall require frequent specialized attention, or have a high malignant potential.

b. Malignant tumors (V10). Exception for basal cell carcinoma, removed with no residual. In addition, the following cases should be qualified, if on careful review they meet the following criteria:

(1) Individuals who have a history of childhood cancer and who have not received any surgical or medical cancer therapy for 5 years and are free of cancer

(2) Individuals with a history of Wilm's tumor and germ cell tumors of the testis treated surgically and/or with chemotherapy in childhood after a 2-year disease-free interval off all treatment.

(3) Individuals with a history of Hodgkins' disease treated with radiation therapy and/or chemotherapy and disease free off treatment for 5 years.

(4) Individuals with a history of large cell lymphoma after 2-years disease-free interval off all therapy.

38. Miscellaneous. Any condition that, in the opinion of the examining medical officer, will significantly interfere with the successful performance of military duty or training (796).

FIGURE 3-D-1

EVALUATION FOR RISK OF HEAD INJURY SEQUELAE		
DEGREE OF HEAD INJURY	MINIMUM	EVALUATION REQUIREMENTS
MILD	ONE MONTH	COMPLETE NEUROLOGICAL EXAMINATION BY A PHYSICIAN
MODERATE	TWO YEARS	COMPLETE NEUROLOGICAL EVALUATION BY A NEUROLOGIST OR INTERNIST CT SCAN
SEVERE	FIVE YEARS FOR CLOSED HEAD TRAUMA TEN YERS FOR PENETRATING HEAD TRAUMA	COMPLETE NEUROLOGICAL EVALUATION BY NEUROLOGIST OR NEUROSURGEON CT SCAN NEUROPSYCHOLOGICAL EVALUATION

FIGURE 3-D-2

CLASSIFICATION AND COMPARATIVE NOMENCLATURE OF CERVICAL SMEARS

Original	Classification	CIN System	Bethesda System
Class I:	No abnormal cells	Normal smear;	
Class II:	Atypical cells present below the level of cervical neoplasia		Atypical squamous cells of undetermined significance
Class III:	Smear contains abnormal cells consistent with dysplasia	Mild dysplasia = CIN1 Moderate dysplasia = CIN2	Low-grade SIL (Changes associated with HPV & CIN1)
Class IV	Smear contains abnormal cells consistent with carcinoma-in-situ	Severe dysplasia and carcinoma-in-situ = CIN3	High-grade SIL (CIN2, CIN3, and carcinoma-in-situ)
Class V:	Smear contains abnormal cells consistent with carcinoma squamous cell carcinoma		Squamous cell carcinoma

Abbreviations: CIN = cervical intraepithelial neoplasia

Section A - SIL = squamous intraepithelial lesion

Section E Physical Standards for Programs Leading to Commission.

1. Appointment as Cadet, United States Coast Guard Academy.

a. Physical Examinations.

(1) Applicants are encouraged to review the physical standards as published in the Academy Bulletin with their private physician prior to submitting their application for cadet candidate. This review serves to rule out, at this stage of the potential cadet's processing, applicants who obviously will not meet the required physical standards for appointment. In some cases, the physician may recommend a complete physical examination. Inaccuracy in ascertaining defects and determining the candidate's physical status at the time of this review results in unnecessary work for the Coast Guard and disappointment to the candidate when defects are subsequently found during the formal physical examination.

(2) Candidates and their parents and sponsors are urged to refrain from requesting waivers for medical defects. The Coast Guard bases its decision to disqualify an individual on medical facts revealed in a thorough physical examination. Candidates unable to satisfy the minimum requirements are not suited for commission in the Regular Coast Guard, and consequently are not eligible for training at the Academy. A request for waiver for a medical defect invariably results in disappointment to all concerned.

(3) Two physical examinations are required:

(a) formal physical examination before appointment is tendered; and

(b) pretraining examination at the time of reporting to the Academy.

(4) Formal physical examinations prior to accepting of candidates must be performed by a U. S. Public Health Service, Navy, Army, Air Force, or Veteran's Administration medical officer authorized to perform each exam by Department of Defense Medical Examination Review Board (DODMERB). All candidates are instructed where to report for such examinations.

b. Physical Standards. All candidates for the Coast Guard Academy must meet the physical standards for enrollment as an officer candidate. DODMERB is reviewing authority.

c. Retention. The standards for retention of a cadet at the Academy are the same as those for enrollment as an officer candidate, except that the Superintendent of the Academy is authorized to establish physical fitness and weight control programs designed to have cadets maintain weight closer to the ideal than the standards stipulated elsewhere for Service personnel. These stricter goals during cadet years are intended to take advantage of the Academy's unique environment of rigorous physical activity combined with opportunities for diet control and weight monitoring.

These programs will instill lifelong behavior patterns to support the Service weight control standards.

2. Commissioning of Cadets. The preappointment physical examination of cadets in the graduating class should be held at least 6 months prior to acceptance of the commission. This physical examination should be conducted to determine physical fitness for commission in the Regular Service (section 3-D and 3-E) with recommendations made accordingly. Cadets should not be summarily disqualified for commissioning merely because they do not meet the standards for appointment as cadets provided that they may reasonably be expected to be physically capable of completing a full and effective Coast Guard career. In general, relatively minor defects that would be disqualifying for original commission direct from civilian life are not disqualifying for commission of a cadet in whom the Government has a considerable investment.

3. Enrollment as an Officer Candidate.

   a. Physical Examination. The physical examination for an officer candidate must be conducted by a medical officer and a dentist. Particular care must be exercised during the examination in order that candidates may not be rejected later as a result of reexamination at Officer Candidate School. A complete physical examination is given officer candidates upon arrival at OCS to determine medical fitness and freedom from disease. Physician Assistant Officer Candidates will only receive an initial OCS candidate physical.

   b. Physical Standards for Enrollment. The standards contained in section 3-D (section 3-F for enlisted OCS candidates), as modified below, are applicable for enrollment as an officer candidate. Conditions not enumerated, that in the medical examiner's opinion will not permit a full productive career, shall be recorded in detail with appropriate recommendations.

      (1) Distant Visual Acuity. Uncorrected visual acuity shall be not worse than20/400 in either eye provided that vision is correctable to 20/20 and that refractive error does not exceed plus or minus 8.0 diopters spherical equivalent (sphere + 1/2 cylinder), astigmatism does not exceed 3.00 diopters, and anisometropia does not exceed 3.50 diopters. Eyes must be free from any disfiguring or incapacitating abnormality and from acute or chronic disease. All personnel requiring corrective lenses shall wear them for the performance of duty.

      (2) Near visual acuity of any degree that does not correct to 20/40 in the better eye.

      (3) Normal color perception.

      (4) Teeth.

         (a) All candidates shall be given a Type II dental examination by a dental officer, as part of the pre-training physical examination.

         (b) Caries. No more than four teeth may exhibit multi-surface caries.

(c) Endodontics. The need for endodontic intervention on seven or more canals is disqualifying.

(d) Maxillary and Mandibular Bones. Malunited fractures of maxillary or mandibular bones and deformities of maxillary or mandibular bones interfering with mastication or speech are disqualifying. The presence of extensive necrosis or osseous lesions requiring surgical intervention are also disqualifying.

(e) Oral Tissues. Extensive loss of oral tissues that would prevent the replacement of missing teeth with a satisfactory prosthetic appliance is disqualifying. Unresolved oral inflammatory diseases are disqualifying. Hypertrophic, hyperplastic, or leukoplakic conditions of the soft tissue of the oral cavity may be disqualifying and will be considered on a case-by-case basis.

(f) Periodontal Disease. The presence of advanced periodontal disease is disqualifying.

(g) Serviceable Teeth. A sufficient number of teeth, natural or artificial, in functional occlusion to assure satisfactory incision, mastication, and phonation are required. The minimum requirement is edentulous upper and lower jaws corrected by full dentures. A requirement for placement of a prosthesis to meet the above requirements is disqualifying.

(h) Temporomandibular Joint. Current symptoms and/or history of chronic temporomandibular joint dysfunction is disqualifying (see also section 3-D-16.b).

4. Commissioning of Officer Candidates.

a. The physical examination given upon arrival at OCS precludes the need for a commissioning physical examination providing there has been no intervening change in physical status and a visual acuity and color perception examination are given prior to actual commissioning.

b. The physical standards for commissioning are the same as for enrollment as an officer candidate. Final determination as to physical fitness for commissioning is made by the Commandant.

5. Direct Commission in the Coast Guard Reserve.

a. Nonaviator. The physical examination and standards for direct commission in the Reserve are the same for enrollment of officer candidates, except that Ready Reserve Direct Commission (RRDC) examinations must be within 24 months prior to the date of execution of the Acceptance and Oath of Office (CG-9556).

b. Aviator. Candidates for direct commission in the Reserve as aviators must obtain an aviation physical examination from a currently qualified uniformed services flight

surgeon or AMO within the last 12 months. The candidate must meet the standards for Class I, contained in section 3-G.

6. Direct Commission of Licensed Officers of U. S. Merchant Marine.

   a. Physical Examination. Two physical examinations are required: a preliminary physical at the time of the written examination; and a preappointment physical examination taken by successful candidates within six months of actual commission. The physical examination must be conducted by a medical officer of the uniformed services on active duty. Final determination of physical fitness will be made by the Commandant.

   b. Physical Standards. The physical standards for direct commission of Licensed Officers of the U. S. Merchant Marine are the same as for enrollment of officer candidates. All these standards must be met without waiver.

7. Appointment to Warrant Grade.

   a. Physical Examination. A complete physical examination is required within 12 months prior to appointment to Warrant Officer, except that physical examinations for members of the Coast Guard Ready Reserve must be within 24 months prior to the date of execution of the Acceptance and Oath of Office (CG-9556).

   b. Physical Requirements. The physical standards for appointment of Coast Guard members to Warrant Officer are the same as for retention of officers in the regular Coast Guard. See section 3-F for the standards. The physical standards for all other applicants are the same as for enrollment of officer candidates.

Section F Physical Standards Applicable to All Personnel (Regular and Reserve) For: Reenlistment; Enlistment of Prior Service USCG Personnel; Retention; Overseas Duty; and Sea Duty.

1. General Instructions.

   a. Scope. This section establishes specific physical standards applicable to all personnel (regular and reserve) for:

      (1) enlistment/reenlistment of prior service USCG personnel within 6 months of discharge from active duty in the Regular Coast Guard;

      (2) retention;

      (3) overseas duty; and

      (4) sea duty.

   b. Physical Examinations. Physical examinations should be conducted by at least one medical and one dental officer of the uniformed services or by contract physician/dentist.

   c. Fitness for Duty. Members are ordinarily considered fit for duty unless they have a physical impairment (or impairments) that interferes with the performance of the duties of their grade or rating. A determination of fitness or unfitness depends upon the individual's ability to reasonably perform those duties. Members considered temporarily or permanently unfit for duty shall be referred to an Initial Medical Board for appropriate disposition.

2. Use of List of Disqualifying Conditions and Defects. This section lists certain medical conditions and defects that are normally disqualifying. However, it is not an all-inclusive list. Its major objective is to achieve uniform disposition of cases arising under the law, but it is not a mandate that possession of one or more of the listed conditions or physical defects (and any other not listed) means automatic retirement or separation. If the member's condition is disqualifying but he/she can perform his/her duty, a waiver request could be submitted in lieu of immediate referral to an Initial Medical Board. If the request is denied, then an Initial Medical Board is required.

3. Head and Neck.

   a. Loss of substance of the skull. With or without prosthetic replacement when accompanied by moderate residual signs and symptoms.

   b. Torticollis (wry neck). Severe fixed deformity with cervical scoliosis, flattening of the head and face, and loss of cervical mobility.

4. Esophagus, Nose, Pharynx, Larynx, and Trachea.

a. Esophagus.

(1) Achalasia. Manifested by dysphagia (not controlled by dilation), frequent discomfort, inability to maintain normal vigor and nutrition, or requiring frequent treatment.

(2) Esophagitis. Persistent and severe.

(3) Diverticulum of the esophagus. Of such a degree as to cause frequent regurgitation, obstruction and weight loss, that does not respond to treatment.

(4) Stricture of the esophagus. Of such a degree as to almost restrict diet to liquids, require frequent dilation and hospitalization, and cause difficulty in maintaining weight and nutrition.

b. Larynx.

(1) Paralysis of the larynx. Characterized by bilateral vocal cord paralysis seriously interfering with speech or adequate airway.

(2) Stenosis of the larynx. Causing respiratory embarrassment upon more than minimal exertion.

(3) Obstruction edema of glottis. If chronic, not amenable to treatment and requiring tracheotomy.

c. Nose, Pharynx, Trachea.

(1) Rhinitis. Atrophic rhinitis characterized by bilateral atrophy of nasal mucous membrane with severe crusting and concomitant severe headaches.

(2) Sinusitis. Severe and chronic that is suppurative, complicated by polyps, and does not respond to treatment.

(3) Trachea. Stenosis of trachea that compromises airflow to more than a mild degree.

5. Eyes.

a. Diseases and Conditions.

(1) Active eye disease. Or any progressive organic disease regardless of the stage of activity, that is resistant to treatment and affects the distant visual acuity or visual field so that:

(a) distant visual acuity does not meet the standards; or

(b) the diameter of the field of vision in the better eye is less than 20°.

(2) Aphakia, bilateral. Regardless of lens implant(s).

(3) Atrophy of optic nerve.

(4) Glaucoma. If resistant to treatment, or affecting visual fields, or if side effects of required medications are functionally incapacitating.

(5) Diseases and infections of the eye. When chronic, more than mildly symptomatic, progressive and resistant to treatment after a reasonable period.

(6) Ocular manifestations of endocrine or metabolic disorders. Not disqualifying, per se; however, residuals or complications, or the underlying disease may be disqualifying.

(7) Residuals or complications of injury. When progressive or when reduced visual acuity or fields do not meet the standards.

(8) Retina, detachment of.

(a) Unilateral.

1 When visual acuity does not meet the standards.

2 When the visual field in the better eye is constricted to less than 20°.

3 When uncorrectable diplopia exists.

4 When detachment results from organic progressive disease or new growth, regardless of the condition of the better eye.

(b) Bilateral. Regardless of etiology or results of corrective surgery.

b. Vision.

(1) Aniseikonia. Subjective eye discomfort, neurologic symptoms, sensations of motion sickness and other gastrointestinal disturbances, functional disturbances and difficulties in form sense, and not corrected by iseikonic lenses.

(2) Binocular diplopia. Which is severe, constant, and in zone less than 20° from the primary position.

(3) Hemianopsia. Of any type, if bilateral, permanent, and based on an organic defect. Those due to a functional neurosis and those due to transitory conditions, such as periodic migraine, are not normally disqualifying.

(4) Night blindness. Of such a degree that the individual requires assistance in any travel at night.

(5) Visual Acuity.

(a) Visual acuity that cannot be corrected to at least 20/50 in the better eye.

(b) Complete blindness or enucleation of an eye.

(c) When vision is correctable only by the use of contact lenses or other corrective device (telescope lenses, etc.).

(6) Visual Fields. When the visual field in the better eye is constricted to less than 20°.

(7) Color Perception. Normal color perception is required for retention of commissioned officers (certain warrant officer specialties do not require normal color perception) and selected ratings [See the Personnel Manual,COMDTINST M1000.6 (series) and Chapter 5-B]. Retesting for color perception is not required if results of previous tests are documented in the health record, and there has been no history of a change in color vision.

c. Corneal Refractive Surgery.

(1) The refractive surgery procedures radial keratotomy (RK),and intracorneal rings (ICR) are disqualifying and not waiverable.

(2) Photorefractive keratectomy (PRK) and laser in-situ keratomileusis (LASIK) are disqualifying for aviation duty, landing signal officer duty and not waiverable.

(3) LASIK is disqualifying for diving duty and not waiverable.

(4) Photorefractive keratectomy (PRK) is not disqualifying for non-aviation members, including diving personnel, and does not require a waiver if the following conditions are met:

(a) Must follow guidelines for elective health care contained in 2.A.6.

(b) There must be post surgical refractive stability defined as less than 0.50 diopter change over two separate exams at least three months apart.

(c) Must meet all vision standards in 3-F.5.b (divers must meet vision standards in 3-H.2.h). If the member is unable to meet these standards they will be considered for separation as outlined in the Physical Disability Evaluation System, COMDTINST M1850.2(series).

(5) LASIK is not disqualifying for non-aviation personnel, excluding diving personnel and does not require a waiver as long as the following conditions are met:

(a) Must follow guidelines for elective health care contained in 2.A.6.

(b) There must be post surgical refractive stability defined as less than 0.50 diopter change over two separate exams at least three months apart.

(c) Must meet all vision standards in 3-F.5.b. If the member is unable to meet these standards they will be considered for separation as outlined in the Physical Disability Evaluation System, COMDTINST M1850.2(series).

6. Ears and Hearing.

a. Ears.

(1) Infections of the external auditory canal. Chronic and severe, resulting in thickening and excoriation of the canal, or chronic secondary infection requiring frequent and prolonged medical treatment and hospitalization.

(2) Malfunction of the acoustic nerve. Evaluate hearing impairment.

(3) Mastoiditis, chronic. Constant drainage from the mastoid cavity, requiring frequent and prolonged medical care.

(4) Mastoidectomy. Followed by chronic infection with constant or recurrent drainage requiring frequent or prolonged medical care.

(5) Meniere's Syndrome. Recurring attacks of sufficient frequency and severity as to interfere with satisfactory performance of military duty, or require frequent or prolonged medical care.

(6) Otitis Media. Moderate, chronic, suppurative, resistant to treatment, and necessitating frequent or prolonged medical care.

b. Hearing. Retention will be determined on the basis of ability to perform duties of grade or rating.

7. Lungs and Chest Wall.

a. Tuberculous Lesions. See chapter 7 of this Manual.

(1) Pulmonary tuberculosis.

(a) When an active duty member's disease is found to be not incident to military service, or when treatment and return to useful duty will probably require more than 15 months, including an appropriate period of convalescence, or if expiration of service will occur before completion of period of hospitalization. (Career members who express a desire to reenlist after treatment may extend their enlistment to cover period of hospitalization.)

(b) When a Reservist not on active duty has TB that will probably require treatment for more that 12 to 15 months including an appropriate period of convalescence before being able to perform full-time military duty. Individuals who are retained in the Reserve while undergoing treatment may not be called or ordered to active duty (including mobilization), active duty for training, or inactive duty training during the period of treatment and convalescence.

b. Nontuberculous Conditions. Pulmonary diseases, other than acute infections, must be evaluated in terms of respiratory function, manifested clinically by measurements

that must be interpreted as exertional or altitudinal tolerance. Symptoms of cough, pain, and recurrent infections may limit a member's activity. Many of the conditions listed below may coexist and in combination may produce unfitness.

(1) Atelectasis, or massive collapse of the lung. Moderately symptomatic with paroxysmal cough at frequent intervals throughout the day, or with moderate emphysema, or with residuals or complications that require repeated hospitalization.

(2) Bronchial Asthma. Associated with emphysema of sufficient severity to interfere with the satisfactory performance of duty, or with frequent attacks not controlled by inhaled or oral medications, or requiring oral corticosteroids more than twice a year.

(3) Bronchiectasis or bronchiolectasis. Cylindrical or saccular type that is moderately symptomatic, with productive cough at frequent intervals throughout the day, or with moderate other associated lung disease to include recurrent pneumonia, or with residuals or complications that require repeated hospitalization.

(4) Bronchitis. Chronic, severe persistent cough, with considerable expectoration, or with moderate emphysema, or with dyspnea at rest or on slight exertion, or with residuals or complications that require repeated hospitalization.

(5) Cystic disease of the lung, congenital. Involving more than one lobe of a lung.

(6) Diaphragm, congenital defect. Symptomatic.

(7) Hemopneumothorax, hemothorax, or pyopneumothorax. More than moderate pleuritic residuals with persistent underweight, or marked restriction of respiratory excursion and chest deformity, or marked weakness and fatigability on slight exertion.

(8) Histoplasmosis. Chronic and not responding to treatment.

(9) Pleurisy, chronic or pleural adhesions. Severe dyspnea or pain on mild exertion associated with definite evidence of pleural adhesions and demonstrable moderate reduction of pulmonary function.

(10) Pneumothorax, spontaneous. Repeated episodes of pneumothorax not correctable by surgery.

(11) Pneumoconiosis. Severe with dyspnea on mild exertion.

(12) Pulmonary calcification. Multiple calcifications associated with significant respiratory embarrassment or active disease not responsive to treatment.

(13) Pulmonary emphysema. Marked emphysema with dyspnea on mild exertion and demonstrable moderate reduction in pulmonary function.

(14) Pulmonary fibrosis. Linear fibrosis or fibrocalcific residuals that cause dyspnea on mild exertion and demonstrable moderate reduction in pulmonary function.

(15) Pulmonary sarcoidosis. If not responding to therapy and complicated by demonstrable moderate reduction in pulmonary function.

(16) Stenosis, bronchus. Severe stenosis associated with repeated attacks of bronchopulmonary infections requiring frequent hospitalization.

c. Surgery of the Lungs and Chest. Lobectomy. If pulmonary function (ventilatory tests) is impaired to a moderate degree or more.

8. Heart and Vascular System.

a. Heart.

(1) Arrhythmias. Associated with organic heart disease, or if not adequately controlled by medication or if they interfere with satisfactory performance of duty.

(2) Arteriosclerotic disease. Associated with congestive heart failure, repeated anginal attacks, or objective evidence of myocardial infarction.

(3) Endocarditis. Bacterial endocarditis resulting in myocardial insufficiency or associated with valvular heart disease.

(4) Heart block. Associated with other symptoms of organic heart disease or syncope (Stokes-Adams Syndrome).

(5) Myocarditis and degeneration of the myocardium. Myocardial insufficiency resulting in slight limitation of physical activity.

(6) Pericarditis.

(a) Chronic constrictive pericarditis unless successful remedial surgery has been performed.

(b) Chronic serous pericarditis.

(7) Rheumatic valvulitis and valvular heart disease. Cardiac insufficiency at functional capacity and therapeutic level of class IIC or worse, American Heart Association. A diagnosis made during the initial period of service or enlistment that is determined to be a residual of a condition that existed prior to entry in the service is disqualifying regardless of severity.

b. Vascular System.

(1) Arteriosclerosis obliterans. When any of the following pertain:

(a) intermittent claudication of sufficient severity to produce pain and inability to complete a walk of 200 yards or less on level ground at 112 steps per minute without a rest; or

(b) objective evidence of arterial disease with symptoms of claudication, ischemic chest pain at rest, or with gangrenous or permanent ulcerative skin changes in the distal extremity; or

(c) involvement of more than one organ system or anatomic region (the lower extremities comprise one region for this purpose) with symptoms of arterial insufficiency.

(2) Congenital anomalies. Coarctation of aorta and other congenital anomalies of the cardiovascular system unless satisfactorily treated by surgical correction.

(3) Aneurysms. Aneurysm of any vessel not correctable by surgery and producing limiting symptomatic conditions precluding satisfactory performance of duty. Aneurysm corrected by surgery but with residual limiting symptomatic conditions that preclude satisfactory performance of duty.

(a) Satisfactory performance of duty is precluded because of underlying recurring or progressive disease producing pain, dyspnea, or similar symptomatic limiting conditions.

1 reconstructive surgery including grafts, when:prosthetic devices are attached to or implanted in the heart; and

2 unproven procedures have been accomplished and the patient is unable to satisfactorily perform duty or cannot be returned to duty under circumstances permitting close medical supervision.

(4) Periarteritis nodosa. With definite evidence of functional impairment.

(5) Chronic venous insufficiency (postphlebitic syndrome). When more than mild and symptomatic despite elastic support.

(6) Raynaud's phenomenon. Manifested by trophic changes of the involved part characterized by scarring of the skin or ulceration.

(7) Thrombophlebitis. When repeated attacks require such frequent treatment as to interfere with satisfactory performance of duty.

(8) Varicose veins. Severe and symptomatic despite therapy.

(9) Any condition requiring anti-thrombotic medication other than aspirin.

c. Miscellaneous.

(1) Erythromelalgia. Persistent burning pain in the soles or palms not relieved by treatment.

(2) Hypertensive cardiovascular disease and hypertensive vascular disease.

(a) Diastolic pressure consistently more than 90 mm Hg following an adequate period of therapy on an ambulatory status; or

(b) Any documented history of hypertension regardless of the pressure values if associated with one or more of the following:

1 cerebrovascular symptoms;

2 arteriosclerotic heart disease if symptomatic and requiring treatment;

3 kidney involvement, manifested by unequivocal impairment of renal function; or

4 grade III (Keith-Wagener-Barker) changes in the fundi.

(3) Rheumatic fever, active, with or without heart damage. Recurrent attacks.

(4) Residual of surgery of the heart, pericardium, or vascular system under one or more of the following circumstances:

(a) when surgery of the heart, pericardium, or vascular system results in inability of the individual to perform duties without discomfort or dyspnea;

(b) when the surgery involves insertion of a pacemaker, reconstructive vascular surgery employing exogenous grafting material; or

(c) similar newly developed techniques or prostheses, the individual is unfit.

9. Abdomen and Gastrointestinal System.

a. Defects and Diseases.

(1) Achalasia. Manifested by dysphagia not controlled by dilation with frequent discomfort, or inability to maintain normal vigor and nutrition.

(2) Amebic abscess residuals. Persistent abnormal liver function tests and failure to maintain weight and normal vigor after appropriate treatment.

(3) Biliary dyskinesia. Frequent abdominal pain not relieved by simple medication, or with periodic jaundice.

(4) Cirrhosis of the liver. Recurrent jaundice or ascites; or demonstrable esophageal varices or history of bleeding therefrom.

(5) Gastritis. Severe, chronic gastritis with repeated symptomatology and hospitalization and confirmed by gastroscopic examination.

(6) Hepatitis, chronic. When, after a reasonable time (1 to 2 years) following the acute stage, symptoms persist, and there is objective evidence of impaired liver function.

(7) Hernia.

(a) Hiatus hernia. Severe symptoms not relieved by dietary or medical therapy, or recurrent bleeding in spite of prescribed treatment.

(b) Other. If operative repair is contraindicated for medical reasons or when not amenable to surgical repair.

(8) Ileitis, regional. (Crohn's disease); Except when responding well to ordinary treatment other than oral corticosteroids or immune-suppressant medications.

(9) Pancreatitis, chronic. Frequent severe abdominal pain; or steatorrhea or disturbance of glucose metabolism requiring hypoglycemic agents.

(10) Peritoneal adhesions. Recurring episodes of intestinal obstruction characterized by abdominal colicky pain, vomiting, and intractable constipation requiring frequent hospital admissions.

(11) Proctitis, chronic. Moderate to severe symptoms of bleeding, or painful defecation, tenesmus, and diarrhea, with repeated hospital admissions.

(12) Ulcer, peptic, duodenal, or gastric. Repeated incapacitation or absences from duty because of recurrence of symptoms (pain, vomiting, or bleeding) in spite of good medical management, and supported by laboratory, x-ray, and endoscopic evidence of activity.

(13) Ulcerative colitis. Except when responding well to ordinary treatment other than oral corticosteroids or immune-suppressant medications.

(14) Rectum, stricture of. Severe symptoms of obstruction characterized by intractable constipation, pain on defecation, difficult bowel movements requiring the regular use of laxatives or enemas, or requiring repeated hospitalization.

b. Surgery.

(1) Colectomy, partial. When more than mild symptoms of diarrhea remain or if complicated by colostomy.

(2) Colostomy. When permanent.

(3) Enterostomy. When permanent.

(4) Gastrectomy.

(a) Total.

(b) Subtotal, with or without vagotomy, or gastrojejunostomy, with or without vagotomy, when, in spite of good medical management, the individual:

1 develops "dumping syndrome" that persists for 6 months postoperatively; or

2 develops frequent episodes of epigastric distress with characteristic circulatory symptoms or diarrhea persisting 6 months postoperatively; or

3 continues to demonstrate significant weight loss 6 months postoperatively. Preoperative weight representative of obesity should not be taken as a reference point in making this assessment.

4 Not to be confused with "dumping syndrome," and not ordinarily considered as representative of unfitness are: postoperative symptoms such as moderate feeling of fullness after eating; the need to avoid or restrict ingestion of high carbohydrate foods; the need for daily schedule of a number of small meals with or without additional "snacks."

(5) Gastrostomy. When permanent.

(6) Ileostomy. When permanent.

(7) Pancreatectomy.

(8) Pancreaticoduodenostomy, pancreaticogastrostomy, pancreaticojejunostomy. Followed by more than mild symptoms of digestive disturbance, or requiring insulin.

(9) Proctectomy.

(10) Proctopexy, proctoplasty, proctorrhaphy, or proctotomy. If fecal incontinence remains after appropriate treatment.

10. Endocrine and Metabolic Conditions (Diseases).

a. Acromegaly. With function impairment.

b. Adrenal hyperfunction. That does not respond to therapy satisfactorily or where replacement therapy presents serious problems in management.

c. Adrenal hypofunction. Requiring medication for control.

d. Diabetes Insipidus. Unless mild, with good response to treatment.

e. Diabetes Mellitus. When requiring insulin or not controlled by oral medications.

f. Goiter. With symptoms of breathing obstruction with increased activity, unless correctable.

g. Gout. With frequent acute exacerbations in spite of therapy, or with severe bone, joint, or kidney damage.

h. Hyperinsulinism. When caused by a malignant tumor, or when the condition is not readily controlled.

i. Hyperparathyroidism. When residuals or complications of surgical correction such as renal disease or bony deformities preclude the reasonable performance of military duty.

j. Hyperthyroidism. Severe symptoms, with or without evidence of goiter, that do not respond to treatment.

k. Hypoparathyroidism. With objective evidence and severe symptoms not controlled by maintenance therapy.

l. Hypothyroidism. With objective evidence and severe symptoms not controlled by medication.

m. Osteomalacia. When residuals after therapy preclude satisfactory performance of duty.

11. Genitourinary System.

a. Genitourinary conditions.

(1) Cystitis. When complications or residuals of treatment themselves preclude satisfactory performance of duty.

(2) Dysmenorrhea. Symptomatic, irregular cycle, not amenable to treatment, and of such severity as to necessitate recurrent absences of more than l day/month.

(3) Endometriosis. Symptomatic and incapacitating to degree that necessitates recurrent absences of more than 1 day/month.

(4) Hypospadias. Accompanied by chronic infection of the genitourinary tract or instances where the urine is voided in such a manner as to soil clothes or surroundings, and the condition is not amenable to treatment.

(5) Incontinence of urine. Due to disease or defect not amenable to treatment and so severe as to necessitate recurrent absences from duty.

(6) Menopausal syndrome, physiologic or artificial. With more than mild mental and constitutional symptoms.

(7) Strictures of the urethra or ureter. Severe and not amenable to treatment.

(8) Urethritis, chronic. Not responsive to treatment and necessitating frequent absences from duty.

b. Kidney.

(1) Calculus in kidney. Bilateral or symptomatic and not responsive to treatment.

(2) Congenital abnormality. Bilateral, resulting in frequent or recurring infections, or when there is evidence of obstructive uropathy not responding to medical or surgical treatment.

(3) Cystic kidney (polycystic kidney). When symptomatic and renal function is impaired, or if the focus of frequent infection.

(4) Glomerulonephritis, chronic.

(5) Hydronephrosis. More than mild, or bilateral, or causing continuous or frequent symptoms.

(6) Hypoplasia of the kidney. Associated with elevated blood pressure or frequent infections and not controlled by surgery.

(7) Nephritis, chronic.

(8) Nephrosis.

(9) Perirenal abscess. With residuals that preclude satisfactory performance of duty.

(10) Pyelonephritis or pyelitis. Chronic, that has not responded to medical or surgical treatment, with evidence of persistent hypertension, eyeground changes, or cardiac abnormalities.

(11) Pyonephrosis. Not responding to treatment.

c. Genitourinary and Gynecological Surgery.

(1) Cystectomy.

(2) Cystoplasty. If reconstruction is unsatisfactory or if residual urine persists in excess of 50 cc or if refractory symptomatic infection persists.

(3) Nephrectomy. When, after treatment, there is infection or pathology in the remaining kidney.

(4) Nephrostomy. If drainage persists.

(5) Oophorectomy. When, following treatment and convalescent period, there remain incapacitating mental or constitutional symptoms.

(6) Penis, amputation of.

(7) Pyelostomy. If drainage persists.

(8) Ureterocolostomy.

(9) Ureterocystostomy. When both ureters are markedly dilated with irreversible changes.

(10) Ureterocystostomy, cutaneous.

(11) Ureteroplasty.

(a) When unilateral procedure is unsuccessful and nephrectomy is necessary, consider on the basis of the standard for a nephrectomy.

(b) When bilateral, evaluate residual obstruction or hydronephrosis and consider unfitness on the basis of the residuals involved.

(12) Ureterosigmoidostomy.

(13) Ureterostomy. External or cutaneous.

(14) Urethrostomy. When a satisfactory urethra cannot be restored.

12. Extremities.

a. Upper.

(1) Amputations. Amputation of part or parts of an upper extremity equal to or greater than any of the following:

(a) a thumb proximal to the interphalangeal joints;

(b) two fingers of one hand; or

(c) one finger, other than the little finger, at the metacarpophalangeal joint and the thumb of the same hand at the interphalangeal joint.

(2) Joint ranges of motion. Motion that does not equal or exceed the measurements listed below. Measurements must be made with a goniometer and conform to the methods illustrated in 3-F-EXHIBIT 1.

(a) Shoulder.

1 Forward elevation to 90° .

2 Abduction to 90° .

(b) Elbow

1 Flexion to 100° .

2 Extension to 60° .

(c) Wrist. A total range, extension plus flexion, of 15°

(d) Hand. For this purpose, combined joint motion is the arithmetic sum of the motion at each of the three finger joints.

1 An active flexor value of combined joint motions of 135° in each of two or more fingers of the same hand.

2 An active extensor value of combined joint motions of 75° in each of the same two or more fingers.

3 Limitation of motion of the thumb that precludes apposition to at least two finger tips.

(3) Recurrent dislocations of the shoulder. When not repairable or surgery is contraindicated

b. Lower.

(1) Amputations.

(a) Loss of a toe or toes that precludes the ability to run, or walk without a perceptible limp, or to engage in fairly strenuous jobs.

(b) Any loss greater than that specified above to include foot, leg, or thigh.

(2) Feet.

(a) Hallux valgus. When moderately severe, with exostosis or rigidity and pronounced symptoms; or severe with arthritic changes.

(b) Pes Planus. Symptomatic more than moderate, with pronation on weight bearing that prevents wearing military shoes, or when associated with vascular changes.

(c) Talipes cavus. When moderately severe, with moderate discomfort on prolonged standing and walking, metatarsalgia, or that prevents wearing a military shoe.

(3) Internal derangement of the knee. Residual instability following remedial measures, if more than moderate; or with recurring episodes of effusion or locking, resulting in frequent incapacitation.

(4) Joint ranges of motion. Motion that does not equal or exceed the measurements listed below. Measurements must be made with a goniometer and conform to the methods illustrated in 3-F-EXHIBIT 2.

(a) Hip.

1 Flexion to 90° .

2 Extension to 0 .

(b) Knee.

1 Flexion to 90° .

2 Extension to 15°

(c) Ankle.

1 Dorsiflexion to 10°

2 Plantar Flexion to 10°

(5) Shortening of an extremity. Which exceeds two inches.

c. Miscellaneous.

(1) Arthritis.

(a) Due to infection. Associated with persistent pain and marked loss of function with x-ray evidence and documented history of recurring incapacity for prolonged periods.

(b) Due to trauma. When surgical treatment fails or is contraindicated and there is functional impairment of the involved joint that precludes satisfactory performance of duty.

(c) Osteoarthritis. Severe symptoms associated with impaired function, supported by x-ray evidence and documented history of recurrent incapacity for prolonged periods.

(d) Rheumatoid arthritis or rheumatoid myositis. Substantiated history of frequent incapacitating and prolonged periods supported by objective and subjective findings.

(e) Seronegative Spondylarthropaties. Severe symptoms associated with impaired function, supported by X-ray evidence and documented history of recurrent incapacity for prolonged periods.

(2) Chondromalacia or Osteochondritis Dessicans. Severe, manifested by frequent joint effusion, more than moderate interference with function or with severe residuals from surgery.

(3) Fractures.

(a) Malunion. When, after appropriate treatment, there is more than moderate malunion with marked deformity or more than moderate loss of function.

(b) Nonunion. When, after an appropriate healing period, the nonunion precludes satisfactory performance of military duty.

(c) Bone fusion defect. When manifested by more than moderate pain or loss of function.

(d) Callus, excessive, following fracture. When functional impairment precludes satisfactory performance of duty and the callus does not respond to adequate treatment.

(4) Joints.

(a) Arthroplasty. With severe pain, limitation of motion and function.

(b) Bony or fibrous ankylosis. Severe pain involving major joints or spinal segments in an unfavorable position, or with marked loss of function.

(c) Contracture of joint. Marked loss of function and the condition is not remediable by surgery.

(d) Loose bodies within a joint. Marked functional impairment complicated by arthritis that precludes favorable treatment or not remediable by surgery.

(5) Muscles.

(a) Flaccid paralysis of one or more muscles, producing loss of function that precludes satisfactory performance of duty following surgical correction or if not remediable by surgery.

(b) Spastic paralysis of one or more muscles producing loss of function that precludes satisfactory performance of duty.

(6) Myotonia congenita.

(7) Osteitis deformans. Involvement of single or multiple bones with resultant deformities, or symptoms severely interfering with function.

(8) Osteoarthropathy, hypertrophic, secondary. Moderately severe to severe pain present with joint effusion occurring intermittently in one or multiple joints and with at least moderate loss of function.

(9) Osteomyelitis, chronic. Recurrent episodes not responsive to treatment, and involving the bone to a degree that interferes with stability and function.

(10) Tendon transplant. Fair or poor restoration of function with weakness that seriously interferes with the function of the affected part.

13. Spine, Scapulae, Ribs, and Sacroiliac Joints.

a. Congenital anomalies.

(1) Spina bifida. Demonstrable signs and moderate symptoms of root or cord involvement.

(2) Spondylolysis or spondylolisthesis. With more than mild symptoms resulting in repeated hospitalization or significant assignment limitation.

b. Coxa vara. More than moderate with pain, deformity, and arthritic changes.

c. Herniation of nucleus pulposus. More than mild symptoms following appropriate treatment or remediable measures, with sufficient objective findings to demonstrate interference with the satisfactory performance of duty.

d. Kyphosis. More than moderate, or interfering with function, or causing unmilitary appearance.

e. Scoliosis. Severe deformity with over two inches of deviation of tips of spinous processes from the midline.

14. Skin and Cellular Tissues.

a. Acne. Severe, unresponsive to treatment, and interfering with the satisfactory performance of duty or wearing of the uniform or other military equipment.

b. Atopic dermatitis. More than moderate or requiring periodic hospitalization.

c. Amyloidosis. Generalized.

d. Cysts and tumors. See section 3-F-20.

e. Dermatitis herpetiformis. Which fails to respond to therapy.

f. Dermatomyositis.

g. Dermographism. Interfering with satisfactory performance of duty.

h. Eczema, chronic. Regardless of type, when there is more than minimal involvement and the condition is unresponsive to treatment and interferes with the satisfactory performance of duty.

i. Elephantiasis or chronic lymphedema. Not responsive to treatment.

j. Epidermolysis bullosa.

k. Erythema multiforme. More than moderate and chronic or recurrent.

l. Exfoliative dermatitis. Chronic.

m. Fungus infections, superficial or systemic. If not responsive to therapy and interfering with the satisfactory performance of duty.

n. Hidradenitis suppurative and folliculitis decalvans.

o. Hyperhydrosis. Of the hands or feet, when severe or complicated by a dermatitis or infection, either fungal or bacterial, and not amenable to treatment.

p. Leukemia cutis and mycosis fungoides.

q. Lichen planus. Generalized and not responsive to treatment.

r. Lupus erythematous. Chronic with extensive involvement of the skin and mucous membranes and when the condition does not respond to treatment.

s. Neurofibromatosis. If repulsive in appearance or when interfering with satisfactory performance of duty.

t. Panniculitis. Relapsing febrile, nodular.

u. Parapsoriasis. Extensive and not controlled by treatment.

v. Pemphigus. Not responsive to treatment, and with moderate constitutional or systemic symptoms, or interfering with satisfactory performance of duty.

w. Psoriasis. Extensive and not controllable by treatment.

x. Radiodermatitis. If resulting in malignant degeneration at a site not amenable to treatment.

y. Scars and keloids. So extensive or adherent that they seriously interfere with the function of an extremity.

z. Scleroderma. Generalized, or of the linear type that seriously interferes with the function of an extremity or organ.

aa. Ulcers of the skin. Not responsive to treatment after an appropriate period of time or if interfering with satisfactory performance of duty.

bb. Urticaria. Chronic, severe, and not amenable to treatment.

cc. Xanthoma. Regardless of type, but only when interfering with the satisfactory performance of duty.

dd. Other skin disorders. If chronic, or of a nature that requires frequent medical care or interferes with satisfactory performance of military duty.

15. Neurological Disorders.

a. Amyotrophic sclerosis, lateral.

b. Atrophy, muscular, myelopathic. Includes severe residuals of poliomyelitis.

c. Atrophy, muscular. Progressive muscular atrophy.

d. Chorea. Chronic and progressive.

e. Convulsive disorders. (This does not include convulsive disorders caused by, and exclusively incident to the use of, alcohol.) Following a seizure, the member is NFFD, and will remain unfit until he/she is controlled with medications with no seizures for twelve months. A medical board is not required if the convulsive disorder is well controlled.

f. Friedreich's ataxia.

g. Hepatolenticular degeneration.

h. Migraine. Manifested by frequent incapacitating attacks or attacks that last for several consecutive days and unrelieved by treatment.

i. Multiple sclerosis.

j. Myelopathy transverse.

k. Narcolepsy, cataplexy, and hypersomnolence.

l. Obstructive Sleep Apnea. when not correctable by use of CPAP or surgical means.

m. Paralysis, agitans.

n. Peripheral nerve conditions.

(1) Neuralgia. When symptoms are severe, persistent, and not responsive to treatment.

(2) Neuritis. When manifested by more than moderate, permanent functional impairment.

o. Syringomyelia.

p. General. Any other neurological condition, regardless of etiology, when after adequate treatment, there remain residuals, such as persistent severe headaches, convulsions not controlled by medications, weakness or paralysis of important muscle groups, deformity, incoordination, pain or sensory disturbance, disturbance loss of consciousness, speech or mental defects, or personality changes of such a degree as to definitely interfere with the performance of duty.

16. Psychiatric Disorders. (see section 5-B concerning disposition)

a. Disorders with Psychotic Features. Recurrent psychotic episodes, existing symptoms or residuals thereof, or recent history of psychotic reaction sufficient to interfere with performance of duty or with social adjustment.

b. Affective disorders; anxiety, somatoform, or dissociative disorders. Persistence or recurrence of symptoms sufficient to require treatment (medication, counseling, psychological or psychiatric therapy) for greater than 6 months. Regardless of the length of treatment, any member requiring medication for any of the above disorders must be removed from aviation duty. (Incapacity of motivation or underlying personality traits or disorders will be administratively handled see "Personnel Manual, COMDTINST M1000.6 (series) for further guidance".

c. Mood disorders. Bipolar disorders or recurrent major depression. All other mood disorders associated with suicide attempt, untreated substance abuse, requiring hospitalization or requiring treatment (including medication, counseling, psychological or psychiatric therapy) for more than 6 months, or requiring more than 36 months of prophylactic treatment (while asymptomatic) following initial therapy. Prophylactic treatment requiring more than one drug associated with significant side effects (such as sedation, dizziness or cognitive changes) or frequent follow-up that limit duty options. Any member requiring medication for any of the above disorders must be removed from aviation duty, but may request waiver from CGPC. (Incapacity of motivation or underlying personality traits or disorders will be administratively handled see "Personnel Manual, COMDTINST M1000.6 (series) for further guidance."

d. Personality; sexual; factitious; psychoactive substance use disorders; personality trait(s); disorders of impulse control not elsewhere classified. These conditions may render an individual administratively unfit rather than unfit because of a physical impairment. Interference with performance of effective duty will be dealt with through appropriate administrative channels (see section 5-B).

e. Adjustment Disorders. Transient, situational maladjustment due to acute or special stress does not render an individual unfit because of physical impairment. However, if these conditions are recurrent and interfere with military duty, are not amenable to treatment, or require prolonged treatment, administrative separation should be recommended (see Section 5-B).

f. Disorders usually first evident in infancy, childhood, or adolescence, disorders of intelligence. These disorders, to include developmental disorders, may render an individual administratively unfit rather than unfit because of a physical impairment. Anorexia Nervosa and Bulimia are processed through PDES, while the remaining are handled administratively, if the condition significantly impacts, or has the potential to significantly impact performance of duties (health, mission, and/or safety). See section 5-B of this Manual and Chapter 12 of the personnel manual for further guidance.

17. Dental. Diseases and abnormalities of the jaws or associated tissues when, following restorative surgery, there remain residual conditions that are incapacitating or interfere with the individual's satisfactory performance of military duty, or deformities that are disfiguring. Personnel must be in a Class 1 or Class 2 dental status (see figure 3-C-2) to execute sea duty or overseas duty orders. Prior service personnel must meet the enlistment dental standards contained in section 3-D.

18. Blood and Blood-Forming Tissue Diseases. When response to therapy is unsatisfactory, or when therapy requires prolonged, intensive medical supervision.

a. Anemia.

b. Hemolytic disease, chronic and symptomatic.

c. Leukemia, chronic.

d. Polycythemia.

e. Purpura and other bleeding diseases. Any condition requiring long-term coumadin.

f. Thromboembolic disease.

g. Splenomegaly, chronic.

19. Systemic Diseases, General Defects, and Miscellaneous Conditions.

a. Systemic Diseases.

(3) Blastomycosis.

(4) Brucellosis. Chronic with substantiated recurring febrile episodes, severe fatigability, lassitude, depression, or general malaise.

(5) Leprosy. Any type.

(6) Myasthenia gravis.

(7) Porphyria Cutanea Tarda.

(8) Sarcoidosis. Progressive, with severe or multiple organ involvement and not responsive to therapy.

(9) Tuberculosis (TB).

(a) Meningitis, tuberculosis.

(b) Pulmonary TB, tuberculous empyema, and tuberculous pleurisy.

(c) TB of the male genitalia. Involvement of the prostate or seminal vesicles and other instances not corrected by surgical excision, or when residuals are more than minimal, or are symptomatic.

(d) TB of the female genitalia.

(e) TB of the kidney.

(f) TB of the larynx.

(g) TB of the lymph nodes, skin, bone, joints, eyes, intestines, and peritoneum or mesentery will be evaluated on an individual basis considering the associated involvement, residuals, and complications.

(10) Symptomatic neurosyphilis. In any form.

b. General Defects.

(1) Visceral, abdominal, or cerebral allergy. Severe or not responsive to therapy.

(2) Cold injury. Evaluate on severity and extent of residuals, or loss of parts as outlined in section 3-F-12.

c. Miscellaneous Conditions.

(1) Chronic Fatigue Syndrome, Fibromyalgia , and Myofascial Syndrome when not controlled by medication or with reliably diagnosed depression.

d. Conditions that individually or in combination, not elsewhere provided for in this section, if:

(1) the individual is precluded from a reasonable fulfillment of the purpose of employment in the military service; or

(2) the individual's health or well-being would be compromised if allowed to remain in the military service; or

(3) the individual's retention in the military service would prejudice the best interests of the Government.

(4) required chronic and continuous DEA controlled (Class I-V) medications, such as Ritalin, Amphetamine, Cylert, Modafanil.

(5) required chronic anti-coagulant, other than aspirin, such as Coumadin.

20. Tumors and Malignant Diseases.

a. Malignant Neoplasms. Which are unresponsive to therapy or when the residuals of treatment are in themselves disqualifying under other provisions of this section or in individuals on active duty when they preclude satisfactory performance of duty.

b. Neoplastic Conditions of Lymphoid and Blood Forming Tissues. Render an individual unfit for further military service.

c. Benign Neoplasms. Except as noted below, benign neoplasms are not generally a cause of unfitness because they are usually remediable. Individuals who refuse treatment are unfit only if their condition precludes satisfactory performance of military duty. However, the following normally render the individual unfit for further military service:

(1) Ganglioneuroma; or

(2) Meningeal fibroblastoma. When brain is involved.

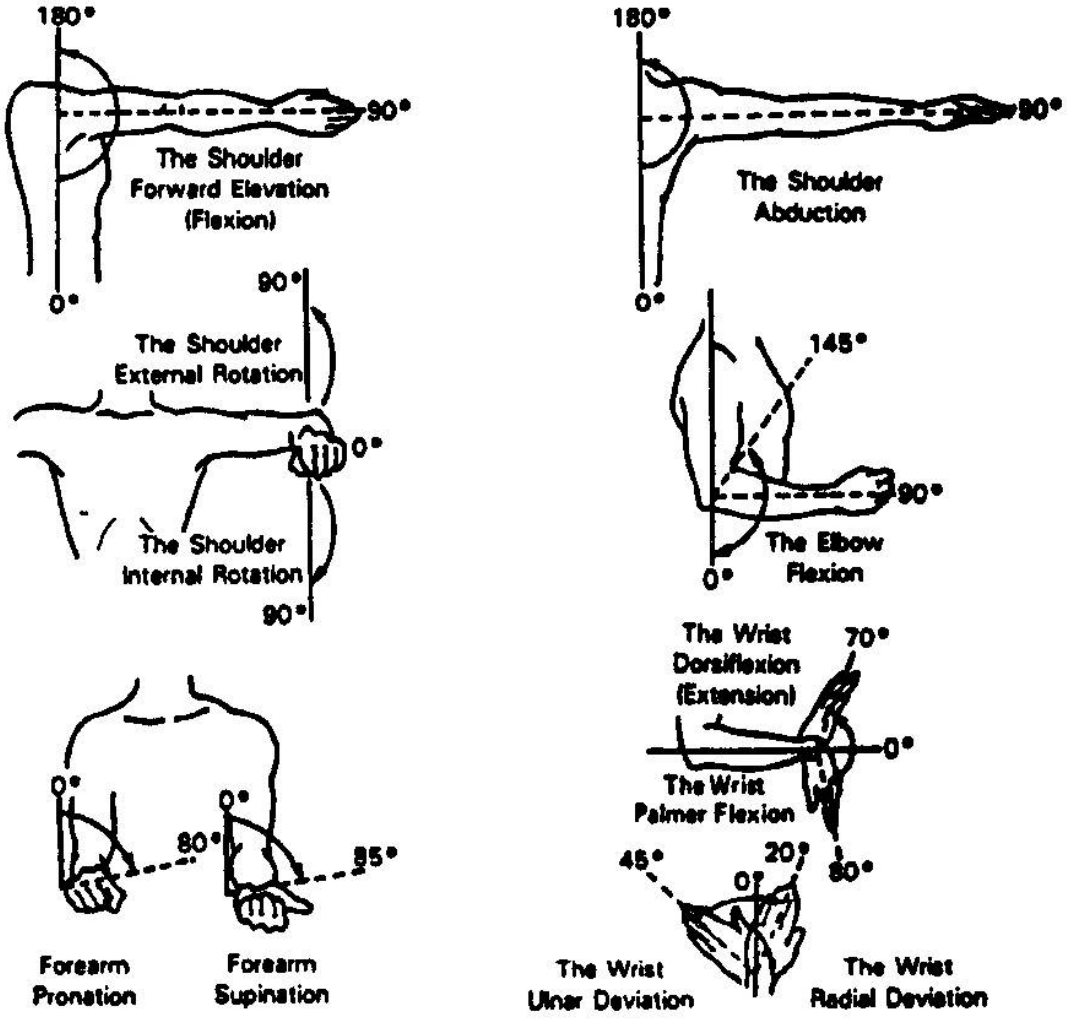
21. Sexually Transmitted Disease. Complications or residuals of such chronicity or degree of severity that the individual is incapable of performing useful duty.

Complications or residuals of such chronicity or degree of severity that the individual is incapable of performing useful duty.

22. Human Immunodeficiency Virus (HIV). A member who is discovered to be HIV positive (infected with HIV) by confirmatory testing is not world-wide deployable. An HIV positive member who continues to fully perform his duties is fit for duty ashore. After the member has been initially evaluated at the appropriate DoD MTF per Chapter 3, Section C, Paragraph 20.b.(9)(e) of this manual, the supporting medical officer shall obtain a copy of the written narrative detailing the member's medical condition and forward it to G-WKH via the cognizant MLC(k). The Narrative shall be marked **confidential**. G-WKH will advise CGPC that the member is not worldwide deployable but will not forward information as to the members diagnosis. Determination of duty assignments shall than be made by CGPC Assignments Officers cognizant of the members duty restriction. The member's supporting medical officer shall obtain copies of the **ANNUAL** medical evaluation narratives from the appropriate DoD MTF and submit them (marked as confidential) to G-WKH via MLC(k). A medical board shall be initiated when progression of the disease adversely impacts the member's ability to perform his duties. Taking medication for HIV disease is not necessarily in itself reason to initiate a medical board.

23. Transplant recipient. Any organ or tissue except hair or skin.

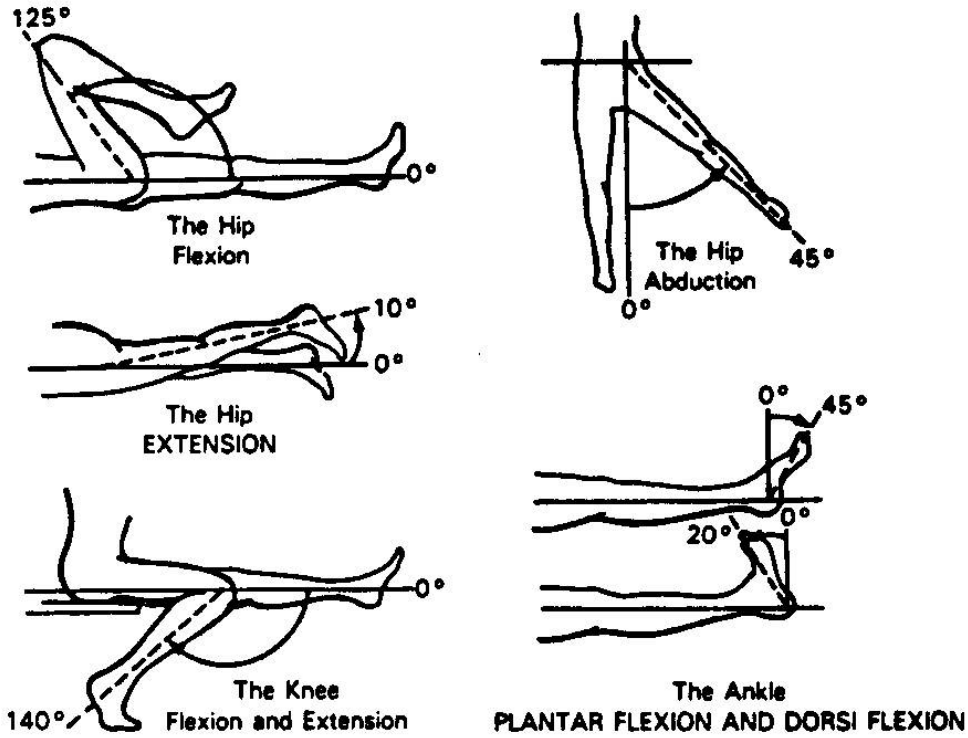
3-F — EXHIBIT 1
MEASUREMENT OF ANKYLOSIS AND JOINT MOTION
UPPER EXTREMITIES



This Exhibit provides a standardized description of ankylosis and joint motion measurement of the upper extremities. The anatomical position is considered as 0° with two major exceptions: (1) in measuring shoulder rotation, the arm is abducted to 90° and the elbow is flexed to 90° so that the forearm reflects the midpoint (0°) between internal and external rotation of the shoulder; and (2) in measuring pronation and supination, with the arm next to the body and the elbow flexed to 90°, the forearm is in mid position (0°) between pronation and supination when the thumb is uppermost.

CH-10

3-F — EXHIBIT 2
MEASUREMENT OF ANKYLOSIS AND JOINT MOTION
LOWER EXTREMITIES



This Exhibit provides a standardized description of ankylosis and joint motion measurement of the lower extremities. The anatomical position is considered as 0°.

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Section G Physical Standards for Aviation.

1. Classification of Aviation Personnel.

   a. Aviation Personnel in General. Classification of Coast Guard aviation personnel is similar to that prescribed for Navy aviation personnel. The term "aviation personnel" includes all individuals who, in the performance of their duty, are required to make frequent aerial flights. Aviation personnel are divided into two classes: Class 1 and Class 2.

   b. Class 1. Class 1 consists of aviation personnel engaged in actual control of aircraft, which includes aviators, student aviators, and student flight surgeons that are chosen to perform solo flights.

   c. Class 1R. Class 1R consists of aviation personnel engaged in actual control of aircraft who:

      (1) meet Class 1 standards but are age 50 or over; or

      (2) have a waiver (temporary or permanent) of physical standards which forbids unrestricted flight. The flight restriction(s) to which the Class 1R pilot is subject will be defined by the waiver authority. In all cases, however, Class 1R aviators will fly as a dual pilot with a Class 1 aviator.

   d. Changing Classes. Except for changes in class due solely to age, individuals requiring a change in their classification for more than two months must submit the following to Commander CGPC:

      (1) SF-502, Narrative Summary, completed by a flight surgeon/aviation medical officer stating the need for the class change and whether a permanent or temporary change is requested; and

      (2) command endorsement.

   e. Class 2. Class 2 consists of aviation personnel not engaged in actual control of aircraft. This includes aviation observers, technical observers, flight surgeons, aviation medical officers, aviation MEDEVAC specialists, flight officers, aircrew members, air traffic controllers, and other persons ordered to duty involving flying.

2. General Instructions for Aviation Examinations.

   a. Object of Aviation Physical Examinations.

      (1) The examination for flying shall be limited to members of the aeronautical organization and authorized candidates. The object of an aviation physical examination is to ensure individuals involved in aviation are physically and mentally qualified for such duty, and to remove from aviation those who are temporarily or permanently unfit because of physical or mental defect.

(2) The main objective in examining candidates for flight training is selecting individuals who can fly safely and continue to do so for at least 20 years.

(3) For designated aviators, the objective is to determine if the individual can fly safely during the next 24 months.

b. Performance of Aviation Physical Examinations. To promote safety and to provide uniformity and completeness, an aviation physical examination must be performed by a currently qualified flight surgeon/aviation medical officer (AMO) authorized by the Commandant. Only physicians who have successfully passed a course at a school of aviation medicine of the U. S. Armed Forces leading to the designation of "Aviation Medical Officer" or "Flight Surgeon" are so authorized. Civilian physicians who were military flight surgeons and who are currently certified by the Federal Aviation Administration as aviation medical examiners may also be authorized.

c. Scope of Aviation Physical Examination. In addition to the general service requirements specified in section 3-D, certain special requirements must be met by the various categories of individuals concerned with aviation. The extent of the examination and the physical standards vary for the several categories of aviation personnel. The term "flight or aviation physical examination" is therefore incomplete unless the character of the duty that the examinee is to perform is specified--this incomplete term shall not be used in item #16 of DD-2808 (rev 10-94) as the purpose of the examination. Examiners shall conduct aviation physical examinations in accordance with the general procedures specified in this section and in section 3-C.

d. Required Aviation Physical Examinations. Each individual in the Service who is assigned to duty requiring performance of frequent aerial flights, regardless of classification, must have passed an aviation physical within the preceding 24 months. In some cases, more frequent examinations are required. Aviation physical examinations are required as indicated in this section. They may also be ordered whenever needed to determine an individual's physical fitness for the type aviation duty to which assigned.

(1) Entry on Active Duty. Reserve aviation personnel who perform frequent aerial flights must have passed an aviation physical examination, commensurate with the type of duty to be performed, within the 24 months preceding active duty or active duty for training. Aviators who are not members of aviation reserve units must have satisfactorily passed an aviation physical examination within six months immediately preceding the actual control of aircraft.

(2) Biennial. All aviation personnel, including Reservists on inactive duty for training, who will actually control aircraft or perform frequent aerial flights must obtain a biennial aviation physical examination commensurate with the type of duty to be performed. The examination is required every two (2) years after initial designation. Upon reaching age 50, the examinations become annual.

(3) Direct Commission. An aviation physical examination is required prior to direct commissioning of aviators in the Reserve. The aviator is required to meet Class I standards.

(4) Candidates for Designation as Class 1. All candidates for flight training, whether or not they are already in the Service, must pass a physical examination for flight training duty. The examination date must not precede the application date by more than 12 months.

(5) Candidates for Designation as Class 2. An approved aviation physical examination less than 24 months old is required both when applying for a Class 2 aviation training program and prior to a Class 2 designation.

(6) FAA Airmen Medical Certificate. After receiving Federal Aviation Administration (FAA) Aviation Medical Examiner (AME) training, Coast Guard flight surgeons/AMOs may request authorization from Commandant (G-WKH) to perform Second and Third Class physical examinations and issue FAA Medical Certificates to all military personnel on active duty including active duty for training. The FAA Administrator furnishes AME's with the necessary instructions, guides, and forms required for this purpose. Except in those instances where there is a military requirement for FAA certification, examination and issuance of medical certificates shall not interfere with the flight surgeon's primary duties. Whenever possible, certificates should be obtained in conjunction with a required aviation physical examination.

(7) Aircraft Accidents. Any Coast Guard member involved in a Class A or B aircraft mishap in which damage to the aircraft or injury to any crewmember occurs shall undergo a complete aviation physical examination as part of the mishap investigation. Examinations after other mishaps are left to the discretion of the flight surgeon/AMO.

(8) Quinquennial. The quinquennial examination of a Reserve aviation special duty officer must be an aviation physical examination.

(9) Separation. An aviation physical examination is not required of aviation personnel being separated from active duty. The requirements for examination are the same as those for the separation from active duty of non-aviation personnel.

e. Boards. Assignment to and continuation of duty involving flying is an administrative process. Except for enlisted personnel in aviation ratings, fitness to perform aviation duties is a determination independent of the determination of fitness for continued service.

(1) Board of Flight Surgeons. When a fitness for continued service determination is not required or in cases where the disposition is appropriately administrative [e.g., a condition not a ratable disability or covered under sections 12-A or 4-C of the Personnel Manual,COMDTINST M1000.6 (series)] a Board of Flight Surgeons shall be convened. The board shall consist of two medical officers, one of whom must be a flight surgeon or AMO. When formation of such a board is not feasible, a single flight surgeon/AMO may be considered the

minimum with the approval of Commandant (G-WKH). An example of the appropriate use of a Board of Flight Surgeons is an aviator found not aeronautically adaptable due to fear of flying. The results of the board shall be recorded on a Narrative Summary (SF-502) and submitted to Commander CGPC via the appropriate chain of command.

(2) Special Board of Flight Surgeons.

(a) The U.S. Navy has established this board to consider unusual, complicated, or controversial cases beyond the capabilities or experience level of a local Board of Flight Surgeons. The Naval Aerospace Medical Institute (NAMI) is staffed and equipped to evaluate such cases. Special Boards must be arranged through Commandant (G-WKH).

(b) NAMI specialists may be requested as consultants without convening a full Special Board. Specialty consultations may be requested and arranged by local command.

f. Reporting Fitness for Flying Duties.

(1) Aviation personnel admitted to the sicklist or hospitalized shall be suspended from all duty involving flying. Upon the recommendation of a medical officer (not restricted to a flight surgeon/aviation medical officer), the commanding officer may relieve from flying duty or suspend the flight training of an individual deemed unfit for such duty. In all instances, a Grounding Notice (Aero-Medical NAVMED 6410/1) shall be issued.

(2) When aviation personnel are subsequently deemed fit to resume flying duties, they shall be examined by a flight surgeon/ aviation medical officer and a Clearance Notice (Aero-Medical NAVMED 6410/2) shall be submitted to the commanding officer. Based on this recommendation, the commanding officer may authorize resumption of such duty or training.

(3) Class 1 or 2 aviation personnel, upon reporting to a new duty station or upon returning from an extended absence from flying duty for any reason or when otherwise indicated, shall be interviewed by a flight surgeon/aviation medical officer in order to determine their current health, verify that a current aviation physical examination has been conducted, and to administratively review their health record. If the flight surgeon/aviation medical officer deems it appropriate, a physical examination may be conducted to determine their physical fitness to continue or resume their flying duties. The appropriate Grounding or Clearance Notice shall be completed in all such cases and the necessary notation made in the individual's health record on an SF-600. Specific guidance for some special circumstances are:

(a) Post-hospitalization. A post-hospitalization examination may be required.

(b) Alcohol Abuse. Members under aviation class 1 or 2 retention standards involved in alcohol related incidents or who are referred for alcohol screening shall be recommended for grounding. If, after alcohol screening, a specific medical diagnosis of Alcohol Abuse (305.00 DSM III-R) or Alcohol Dependence (303.90 DSM III-R) cannot be made, the individual can be returned to aviation duties without a formal waiver. Those aviation personnel who are diagnosed as Alcohol Abusers or Alcohol Dependent can return to duties involving flight only after favorable action by the appropriate waiver authority. In addition, class 2 aircrewmen with either of these diagnoses must be cleared by the flight surgeon/AMO before returning to flight-line duties or activities involving aircraft maintenance. Candidates for Student Naval Aviator or Aircrew Candidates with a history of alcohol dependence or abuse will be considered for a waiver after successful rehabilitation (outpatient or inpatient) and an interval of aftercare (1 year for dependence and 90 days for abuse) dating from the onset of rehabilitation.

1 The waiver request must include:

a The flight surgeon's Narrative Summary (SF 502);

b How the problem was identified;

c Drinking history: When subject member first drank, history of DUIs, blackouts, frequent sick-call visits, withdrawal symptoms, morning drinking, domestic difficulties, impaired job performance, etc.;

d Lab data (LFTs, red cell indices, etc.,);

e Any Narrative Summary from rehabilitation authority;

f Commanding officer's endorsement in accordance with paragraph 3-A-8.d.(2). This must include details of any mandated aftercare plan.

2 The waiver process should not be initiated until the aviation member:

a Completes Level II or III rehabilitation program or the civilian equivalent;

b Demonstrates compliance with their aftercare program for at least three months.

3 Waiver contingencies will usually incorporate the recommendations of the rehabilitation authority and may include one or more of the following:

a Total abstinence;

b Active participation in a sobriety program (which includes AA);

c Follow-up by the flight surgeon at least quarterly for a year then at least annually thereafter.

(c) Pregnancy. After confirmation of pregnancy, female members should not be assigned to duties involving flight until cleared by her flight surgeon (FS)/aviation medical officer (AMO). Nausea, decreased appetite, easy fatigability, dizziness, and vaginal bleeding are some of the potential problems that may cause the FS/AMO to recommend temporary grounding for pregnant aviation personnel. Close monitoring is required by the FS/AMO to ensure early identification of problems associated with pregnancy, that could be hazardous to the pregnant member or others. In addition, the FS/AMO will assess the ergonomic and toxic hazards to which the pregnant member and her fetus may be exposed in her particular aviation environment. Potential occupational health problems will be brought to the attention of the patient and the command. No member will perform duties as a rescue swimmer upon confirmation of pregnancy. No pregnant member shall perform duties involving flying after the end of the second trimester, nor shall they undergo chamber (physiologic) training or training involving swimming after the end of the second trimester. (Note: Any pregnant member undergoing chamber or dunker training must receive, from a flight surgeon or AMO, a status profile chit indicating she is "OK DIF/Dunker/Chamber.")

(4) Areas without flight surgeons/AMOs assigned or when the assigned flight surgeon/AMO is on leave or TAD:

(a) The authority to issue a Grounding Notice includes all medical officers, dental officers, and health service technicians.

(b) Flight surgeons (FS) and aviation medical officers (AMO) are the only personnel authorized to issue clearance notices (ie. Up chits) for the resumption of flight duties. In the absence of an assigned flight surgeon, MOs, DOs, and HSs may issue a clearance notice related to the scope of the specialty of the provider after concurrence has been received from an FS or AMO. Concurrence can be obtained by either message or verbal communication. Clearance notices issued by an MO, DO, or HS must include the name, rank, and duty station of the authorizing FS/AMO as well as the time and date of communication for authorization.

(c) Channels of communication between commands without flight surgeons/AMOs and the nearest USMTF with a flight surgeon will be established to facilitate concurrence prior to issuing a clearance notice.

g. Reporting Aviation Physical Examinations.

(1) Definition of "Physically Qualified".

(a) Class 1 aviation personnel have passed an aviation physical examination when a flight surgeon/aviation medical officer or Board of Flight Surgeons finds that, according to the standards prescribed in this Manual, the examinee is physically qualified and aeronautically adapted for actual control of the aircraft, and has been approved by appropriate Reviewing Authority.

(b) Class 2 aviation personnel have passed an aviation physical examination when a flight surgeon or physical evaluation board including a flight surgeon finds that, according to the standards prescribed in this Manual, the examinee is physically qualified and aeronautically adapted for flying, and has been approved by appropriate Reviewing Authority.

(2) Aeronautical Adaptability. After the examination has been completed, the examiner shall review all the available information and make an assessment of the individual's qualifications for the type of flying duty to be performed. Generally, clinical syndromes except adjustment disorders should lead to a finding of "not physically qualified." Adjustment disorders, psychological factors affecting physical condition and conditions not attributable to a mental disorder that are a focus of attention or treatment and Axis II conditions (personality traits and disorders) as a primary diagnosis should lead to a finding of "physically qualified but not aeronautically adapted."

(3) Comments and Recommendations. Examiners are encouraged to use the space on the DD-2808 entitled "Remarks" or "Notes." In this space, the examiner may express an opinion on specific defects and the examinee's overall capabilities. Comments by the examinee or the examinee's immediate superior are occasionally most valuable, especially when removal from flight status is recommended. Examiners shall enclose such comments in writing as an addendum to the formal report whenever such information is considered relevant to making a final recommendation.

3. Restrictions Until Physically Qualified.

a. Restrictions by Reviewing Authority.

(1) Except as authorized in this section, no person shall assume initial duty involving the actual control of aircraft until notification has been received from Commandant (G-WKH) that such person is physically qualified for that duty.

(2) Pending receipt of the endorsed copy of the DD-2808 or other communication from Commandant (G-WKH) or MLC(k) that the report of routine biennial physical examination has been approved, aviation personnel are physically qualified and aeronautically adapted for flight duty if a flight surgeon certifies that the individual has no physical or mental defect that is disqualifying.

(3) When any member on flight status has been restricted by the Commandant (G-WKH) or MLC(k), such restriction remains technically in effect until it is changed by the same authority. However, in order to avoid delay in the return to flight status of those clearly qualified to perform such duties, commanding

officers are authorized, after consideration of a favorable recommendation made to Commandant (G-WKH) by a flight surgeon, to waive this technical restriction pending the action of the Commandant.

b. Restriction by Commanding Officer.

(1) Upon recommendation by any medical officer or other health services department personnel, the commanding officer may relieve from flying duty or suspend the flight training of any individual reported physically incapacitated for such duty or suspend the flight training of any individual reported physically incapacitated for such duty. When the individual is subsequently reported physically fit by a flight surgeon, the commanding officer may authorize resumption of such duty or training.

(2) Aviation personnel may be continued in a flying status pending correction of minor defects such as obtaining new eyewear prescriptions or dental restorations with the concurrence of a flight surgeon. When corrective action is completed, an entry shall be made in Item 73 of the DD-2808 and the physical then forwarded for review.

4. Standards for Class l.

a. General. The physical examination and physical standards for Class 1 are the same as those prescribed in sections 3-C and 3-D of this Manual, as modified by the following subparagraphs.

b. History.

(1) History of any of the following is disqualifying: seizures, isolated or repetitive (grand mal, petit mal, psychomotor, or Jacksonian); head injury complicated by unconsciousness in excess of 12 hours or post traumatic amnesia or impaired judgment exceeding 48 hours; malaria, until adequate therapy has been completed and there are no symptoms while off all medication for 3 months.

(2) For persons already in the Coast Guard a complete review of their health record is most important. Flight surgeons are authorized to postpone the examination of persons who fail to present their health record at the time of examination. In exercising this prerogative, due consideration must be made in cases where access to the individual's health record is administratively impracticable.

c. Therapeutics and General Fitness. Note on the DD-2808 if the individual received medication or other therapeutic procedures within 24 hours of the examination. In general, individuals requiring therapeutics or who have observed lowering of general fitness (dietary, rest, emotional, etc.,) which might affect their flying proficiency shall not be found qualified for duty involving flying.

d. Each aviation physical will have a Valsalva, SBT (Self Balancing Test), and AA (Aeronautical Adaptability) performed and noted.

e. Height. Minimum 157.4 cm (62 inches). Maximum 198 cm (78 inches).

f. Chest. Any condition that serves to impair respiratory function may be cause for rejection. Pulmonary function tests are recommended to evaluate individuals with a history of significant respiratory system problems.

g. Cardiovascular System. Cardiac arrhythmia, heart murmur, or other evidence of cardiovascular abnormalities shall be carefully studied. Evidence of organic heart disease, rhythm disturbances or vascular diseases, if considered to impair the performance of flying duties, is cause for rejection.

h. Teeth. The following are disqualifying:

(1) Any carious teeth that would react adversely to sudden changes in barometric pressure or produce indistinct speech by direct voice or radio transmission.

(2) Any dental defect that would react adversely to sudden changes in barometric pressure or produce indistinct speech by direct voice or radio transmission.

(3) Fixed active orthodontic appliances require a waiver from CGPC (opm or epm). (fixed retainers are exempts).

(4) Routine crown and temporary dental work is not disqualifying for aviation missions. Recommend that temporary crowns be cemented with permanent cement like polycarboxylate or zinc oxyphosphate cement until the permanent crown is delivered. Recommend temporary grounding of 6-12 hours after procedures. Such work may be disqualifying for deployment.

i. Distant Visual Acuity. Distant visual acuity shall be not less than 20/200 in either eye and if less than 20/20 must be correctable to 20/20 with standard lenses. When the visual acuity of either eye is less than 20/20 correction shall be worn at all times while flying.

j. Oculomotor Balance. The following are disqualifying:

(1) esophoria greater than 10 prism diopters;

(2) exophoria greater than 10 prism diopters;

(3) hyperphoria greater than 1.5 prism diopters;

(4) prism divergence at 20 feet and 13 inches is optional. These tests shall be accomplished only on designated aviators who have sustained significant head injury, central nervous system disease, or who have demonstrated a change in their phorias.

k. Eyes. Any pathologic condition that may become worse or interfere with proper eye function under the environmental and operational conditions of flying disqualifies. History of radial keratotomy is disqualifying.

l. Near Visual Acuity. Uncorrected near vision (both eyes) shall be not less than 20/200 correctable to 20/20, with correction worn in multivision lenses while flying if uncorrected near vision is less than 20/40 in either eye.

m. Color Vision. Normal color perception is required.

n. Depth Perception. Normal depth perception is required. When any correction is required for normal depth perception it must be worn at all times.

o. Field of Vision. The field of vision for each eye shall be normal as determined by the finger fixation test. When there is evidence of abnormal contraction of the field of vision in either eye, the examinee shall be subjected to perimetric study for form. Any contraction of the form field of 15° or more in any meridian is disqualifying.

p. Refraction. There are no refractive limits.

q. Ophthalmoscopic Examination. Any abnormality disclosed on ophthalmoscopic examination that materially interferes with normal ocular function is disqualifying. Other abnormal disclosures indicative of disease, other than those directly affecting the eyes, shall be considered with regard to the importance of those conditions.

r. Ear. The examination shall relate primarily to equilibrium and the patency of eustachian tubes. A perforation or evidence of present inflammation is disqualifying. The presence of a small scar with no hearing deficiency and no evidence of inflammation, does not disqualify. Perforation, or marked retraction of a drum membrane associated with chronic ear disease, is disqualifying.

s. Sickle Cell Preparation Test. Quantitative hemoglobin electrophoreses greater than 40% HGs is disqualifying.

5. Standards for Class 1R. Physical requirements for service are the same as for Class 1, except:

a. Age 50 or older, or

b. Have a waiver (temporary or permanent) of physical standards that forbids unrestricted flight.

6. Candidates for Flight Training.

a. Standards. Candidates for flight training shall meet all the requirements of Class 1, with the following additions or limitations:

(1) Height. Candidates for Class I training must also satisfy the following anthropometric requirements: Refer to figure 3-G-1 through figure 3-G-4 for guidelines on measurements.

(a) **sitting height**: 33 inches to 40.9 inches. Record in parentheses in Item 73, DD-2808 (SH_____), see figure 3-G-1 for proper measurements;

(b) **sitting eye height:** 28.5 inches or greater. Record in parentheses in Item 73, DD-2808 (SEH_____), see figure 3-G-2 for proper measurements;

(c) **thumb tip reach:** 28.5 inches or greater. Record in parentheses in Item 73, DD-2808 (TTR____), see figure 3-G-3 for proper measurements;

(d) **buttock-knee length:** 21 inches to 27.9 inches. Record in parentheses in Item 73, DD-2808 (BKL____), see figure 3-G-3 for proper measurements;

(e) **add**: sitting eye height (SEH) and thumb tip reach (TTR), 57 inches or greater. Record in parentheses in Item 73, (SEH + TTR =____).

(2) Uncorrected distant visual acuity must be not less than 20/50 each eye and correctable 20/20 each eye. Uncorrected near visual acuity must be not less than 20/20 each eye (may be waiverable).

(3) While under the effects of a cycloplegic, the candidate must read 20/20 each eye. The following are disqualifying:

(a) total myopia greater than (minus) -2.00 diopters in any meridian;

(b) total hyperopia greater than (plus) +3.00 diopters in any meridian;

(c) astigmatism greater than (minus) -0.75 diopters; (Report the astigmatic correction in terms of the negative cylinder required.)

(d) the purpose of this cycloplegic examination is to detect large latent refractive errors that could result in a change of classes during an aviation career. Therefore, the maximum correction tolerated at an acuity of 20/20 shall be reported. Cycloplegics reported as any other acuity, e.g., 20/15 will be returned.

(4) Hearing. Audiometric loss in excess of the limits set forth in the following table is disqualifying:

FREQUENCY	500	1000	2000	3000	4000
EITHER EAR	30	25	25	45	55

(5) Personality. Must demonstrate, in an interview with the flight surgeon, a personality make-up of such traits and reaction that will indicate that the candidate will successfully survive the rigors of the flight training program and give satisfactory performance under the stress of flying.

(6) Chest x-ray. Aviation trainees must have had a chest x-ray within the past three years.

(7) Report of Medical History (DD-2807-1). In addition to the normal completion of the DD-2807-1, the following statement shall be typed in block 29 and signed by the applicant: "I certify that I do not now use, nor have I ever used,

contact lens for any purpose, and that I am not aware that my uncorrected vision has ever been less than 20/50." If the applicant cannot sign this statement, include a full explanation by the examining flight surgeon, and an ophthalmology consultation.

b. Reporting.

(1) The importance of the physical examination of a candidate should be recognized not only by the examining flight surgeon but also by health services personnel assisting in the procedure and preparing the report. Candidates often come from a great distance or from isolated ships. If the examination cannot be completed in one working day, seek the commanding officer's help in making it possible for the candidate to remain available for a second working day. Careful planning should keep such cases to a minimum. If a report, upon reaching Commandant (G-WKH), is found to be incomplete and must be returned, the candidate will suffer undue delay in receiving orders and in some cases will be completely lost to the Coast Guard as a candidate. The preparation of the DD-2808 in the case of a candidate requires extreme care by all concerned.

(2) In a report of the examination of a candidate, rigid adherence to set standards is expected. The examining officers are encouraged to use freely that portion of the report that provides for "remarks" or "notes." Comments made under "remarks" are the examiner's opinion. Information from any source may be molded into an expression of professional opinion. A final recommendation of the examiner must be made. When such recommendation is not consistent with standards set by Commandant (G-K) the examiner shall note that fact on the form under "remarks" or "notes" and a reasonable explanation made. When space on an DD-2808 is inadequate, use a Continuation Sheet (SF-507).

7. Requirements for Class 2 Flight Officers.

a. Flight Officer Candidates. Flight officer candidates shall meet the standards for Class 1 except that depth perception is not required.

b. Designated Flight Officers. Flight officers shall meet the standards for flight officer candidate except that uncorrected distant visual acuity must be not less than 20/400 in either eye and shall be correctable to 20/20.

8. Requirements for Class 2 Aircrew.

a. Aircrew Candidates. Unless otherwise directed by Commander CGPC-epm, personnel will not be permitted to undergo training leading to the designation of aircrewmen unless a flight surgeon/aviation medical officer has found them physically qualified for such training. Should it be desirable, for exceptional reasons, to place in training a candidate who does not meet the prescribed physical standards, the commanding officer may submit a request for a waiver, with the DD-2808 and DD-2807-1, to Commandant (CGPC), justifying the request. Aircrew candidates shall meet the standards for Class 1, except that minimum height is 152.5

cm/60 inches and uncorrected distant visual acuity must be not less than 20/100 each eye, correctable to 20/20 each eye.

b. Designated Aircrew. Aircrew shall meet the standards for Class 1, except the minimum height is 152.5 cm/60 inches.

9. Requirements for Class 2 Medical Personnel.

a. Flight Surgeon (FS)/Aviation Medical Officer (AMO)/FS Candidates. While assigned to a Duty Involving Flight Operations billet, FS/AMOs shall meet the standards for Designated Flight Officer, except that minimum height is 152.5 cm (60 inches).

b. Aviation MEDEVAC Specialists (AMS)/AMS Candidates. Health Services technicians (HS) who are assigned to flight orders. Aviation MEDEVAC Specialists shall meet the standards for Designated Flight Officer, except that minimum height is 152.5 cm (60 inches).

10. Requirements for Class 2 Technical Observers. The term "technical observer" is applied to personnel who do not possess an aviation designation but who are detailed to duty involving flying. The examination shall relate primarily to equilibrium and the patency of eustachian tubes. They shall meet the standards prescribed for general duty. These personnel are not required to undergo a physical examination for flying provided a complete physical examination, for any purpose, has been passed within the preceding 60 months and intervening medical history is not significant. The physical examination need not be conducted by an FS/AMO. Technical observers who are required to undergo egress training must have a current (general purpose) physical examination and a status profile chit indicating "OK DIF/Dunker/Chamber."

11. Requirements for Class 2 Air Traffic Controllers. Air traffic controllers, tower controllers, and ground control approach operators shall meet the general physical standards for Class 1, except:

a. Articulation. Must speak clearly and distinctly without accent or impediment of speech that would interfere with radio communication. Voice must be well modulated and pitched in medium range. Stammering, poor diction, or other evidence of speech impediments, that become manifest or aggravated under excitement are disqualifying.

b. Height. Same as general service.

c. Visual Acuity.

(1) Candidate's visual acuity shall be no worse than 20/100 for each eye correctable to 20/20 each eye and the correction shall be worn while on duty.

(2) Personnel already designated shall have distant visual acuity no worse than 20/200 each eye correctable to 20/20 each eye and the correction shall be worn while on duty.

(3) Air traffic controllers whose vision becomes worse than 20/200 either eye may not engage in the control of air traffic in a control tower but may be otherwise employed in the duties of their rating.

d. Depth Perception. Normal depth perception is required.

e. Heterophoria. The following are disqualifying:

(1) esophoria or exophoria greater than 6 prism diopters; and

(2) hyperphoria greater than 1 prism diopter.

12. Requirements for Landing Signal Officer (LSO).

a. Physical Examinations for Landing Signal Officer (LSO).

(1) Candidates. Officer and enlisted candidates for training as LSO's shall have a physical examination prior to the training leading to qualification. LSO duties for flight deck require stricter visual acuity standards than those for general duty in the Coast Guard. Examination by a FS/AMO is not required.

(2) Reexamination. Biennial reexamination is required of all currently qualified LSO's.

b. Physical Standards for LSO's. In addition to the physical standards required for officer and enlisted personnel, the following standards apply:

(1) Distant Visual Acuity. The uncorrected distant visual acuity shall be no worse than 20/200 in each eye and must be correctable to 20/20 in each eye. If the uncorrected distant visual acuity is less than 20/20 in either eye, corrective lenses must be worn while performing LSO duties.

(2) Depth Perception. Normal depth perception is required.

(3) Color Vision. Normal color perception is required.

13. Contact Lenses.

a. Class 1 personnel may be authorized by their local flight surgeon to wear contact lenses while flying, provided the following conditions are met:

(1) Only gas permeable disposable soft lenses may be used.

(2) The lenses are to be removed during the hours of sleep.

(3) The lenses are disposed of after 2 weeks of use.

(4) All prescribed optometry follow-up visits are adhered to. After routine safe use has been established and documented by the prescribing optometric authority, an annual optometric recheck is the minimum required. A copy of the record of any visit to an eye care professional will be furnished by the member to the local flight surgeon for review and placement in the member's health record.

(5) Following any change in the refractive power of the contact lens, the member must be checked on the AFVT to ensure that Coast Guard Class I standards for acuity and depth perception are met. In addition, the flight surgeon shall document that there is no lens displacement, when user moves his/her eyes through all 8 extreme ranges of gaze.

(6) Contact lens case, saline for eye use, and an appropriate pair of eyeglasses are readily accessible (within reach) to the lens wearer while in-flight.

(7) Contact lens candidate submits request to the command agreeing to abide the above conditions.

(8) The flight surgeon authorizes use of contact lenses after ensuring that such use is safe and the user fully understands the conditions of use. This authorization expires after one year. Initial and any annual re-authorizations shall be documented by an entry in the health record.

(9) Contact lens use is not a requirement for aviation operations. The decision to apply for authorization is an individual option. Accordingly, lens procurement and routine optometric care related to contact lens use at government expense are not authorized.

b. The optional wearing of contact lenses by Class 2 personnel performing duty involving flying and by air control personnel in the actual performance of their duties is authorized under the following circumstances:

(1) Individuals are fully acclimated to wearing contact lenses and visual acuity is fully corrected by such lenses;

(2) Individuals wearing contact lenses while performing flight or air control duties have on their person, at all times, an appropriate pair of spectacles;

(3) A flight surgeon has specifically authorized the wearing of contact lenses while performing flight or air control duties (An entry shall be made on SF-600 in the individual's health record authorizing wearing of contact lenses.); and

(4) Wearing contact lenses while performing aviation duties is an individual option. Accordingly, procuring contact lenses at government expense is not authorized.

Figure 3-G-1

Sitting Height

Purpose

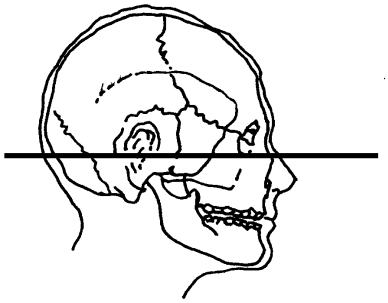
This measurement is important in the design and layout of work stations occupied by Navy personnel. Controls must be placed in numerous locations, and the minimum acceptable space between the helmet and the canopy of cockpits must be considered.

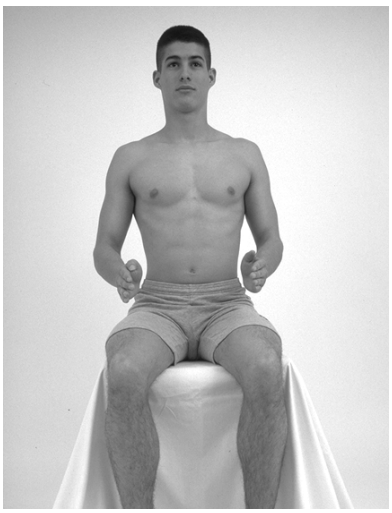
Equipment Required

Anthropometer

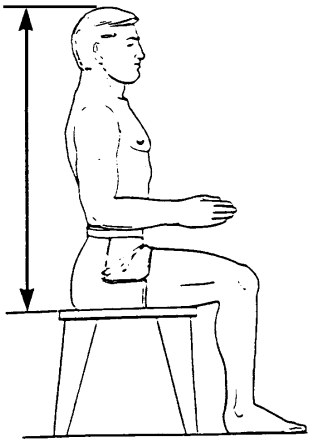
Measurement Procedure

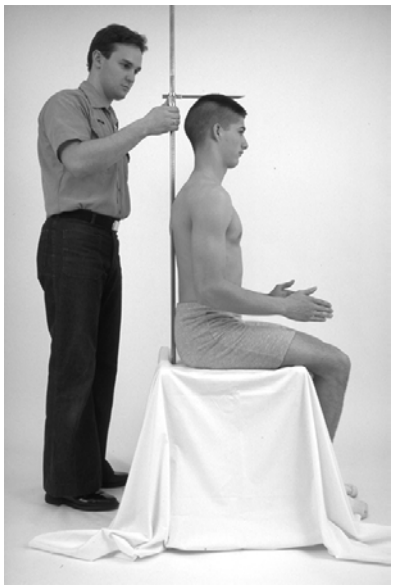
1. The subject sits erect facing forward with the head level (see illustration below), the shoulders and upper arms relaxed, and the forearms and hands extended forward horizontally with the palms facing each other. The thighs are parallel, and the knees are flexed 90° with the feet in line with the thighs.





2. Measure the vertical distance between the sitting surface and the top of the head with an anthropometer. The shoulders and upper extremities should be relaxed. Measure at the maximum point of quiet respiration.





NOTE: *Measurements are to be taken to the nearest eighth of an inch. The measurement should be taken at least twice. If there is a large variation between the two measurements, recheck the body position and repeat measurements.*

Figure 3-G-2

Eye Height, Sitting

Purpose

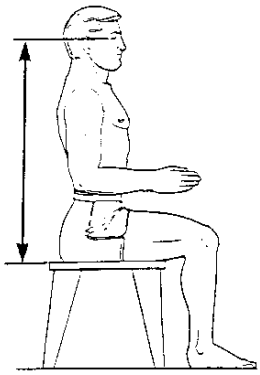
Sitting Eye Height plays a decisive role in instrument panel layout, viewing angles, and seat adjustment, since the pilot must have optimum vision both inside and outside of the cockpit.

Equipment Required

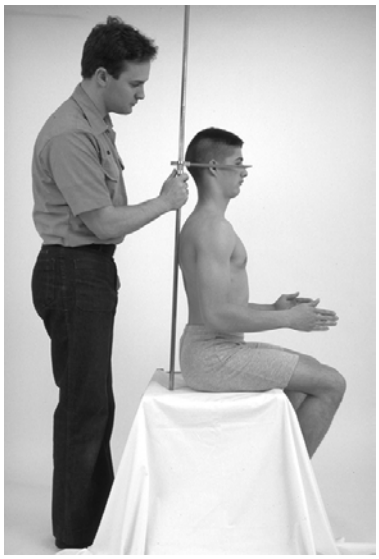
Anthropometer

Measurement Procedure

1. The subject sits erect facing forward with the head level (see illustration below), the shoulders and upper arms relaxed, and the forearms and hands extended forward horizontally with the palms facing each other. The thighs are parallel and the knees are flexed 90° with the feet in line with the thighs.



2. Measure the vertical distance between the sitting surface and the corner or angle formed by the meeting of the eyelids on the outer corner of the right eye with an anthropometer.



NOTE: *Measurements are to be taken to the nearest eighth of an inch. Measurements should be taken at least twice. If there is a large variation between the two measurements, recheck body position and repeat measurements.*

Figure 3-G-3

Thumbtip Reach

Purpose

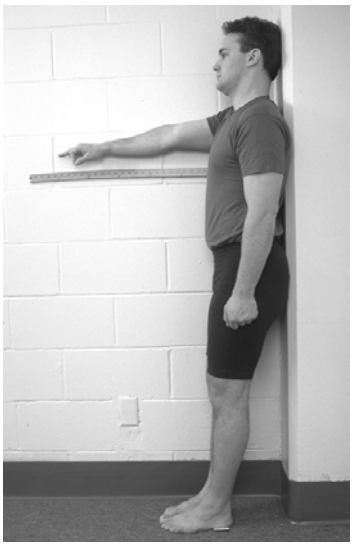
This measurement is important in the design and layout of work stations occupied or used by Navy personnel. Thumbtip reach is particularly useful for the placement of controls in various locations within cockpits.

Equipment Required

Wall--mounted linear scale.

Measurement Procedure

1. The subject stands erect in a corner looking straight ahead with the feet together and heels 7.87 inhes (20 cm) from the back wall.
2. With the buttocks and shoulder placed against the wall, the right arm and hand (palm down) are stretched horizontally along the scale while the thumb continues along the horizontal line of the arm with the index finger curving around to touch the pad at end of the thumb.



3. The subject's right shoulder is held against the rear wall. The horizontal distance from the back wall to the tip of the right thumb is measured.

NOTE 1*: Measurements are to be taken to the nearest eighth of an inch. Measurements should be taken at least twice. If there is a large variation between the two measurements, recheck body position and repeat measurements.*

Figure 3-G-4

Buttock-Knee Length

Purpose

This measurement is usually associated with ejection seat clearance and threshold values between the knee and the glare shield (or canopy bow).

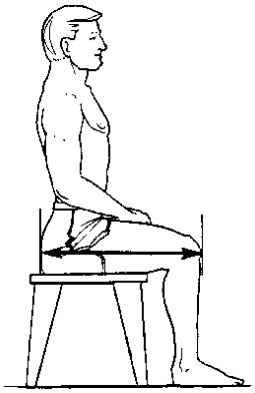
Equipment Required

Anthropometer

Measurement Procedure

1. While the subject sits erect, draw a landmark on the bottom tip of the right knee cap. The subject's thighs should be parallel, with the knees flexed at 90°. The feet should be in line with the thighs, and lying flat on the surface of a footrest or the floor.

2. The anthropometer is placed flush against the buttock plate at the most posterior point on either buttock, and the anterior point to the right knee is measured with an anthropometer.



***NOTE 1**: Measurements are to be taken to the nearest eighth of an inch. Measurements should be taken at least twice. If there is a large variation between the two measurements, recheck body position and repeat measurements.*

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Section H Physical Examinations and Standards for Diving Duty.

1. Examinations.

   a. Candidates. Acceptable candidates for duty that involves diving or underwater swimming must conform to the physical standards contained in section 3-D except as modified below.

   b. Reexamination. Reexamination of all divers shall be conducted every five (5) years after designation until age 48.

   c. Examination Just Prior to Age 40. Qualified divers who desire to continue in that specialty and are about to reach age 40 must be examined by a medical officer. The DD-2808 and DD-2807-1, along with the examiner's recommendation as to whether the individual is or is not physically qualified to continue as a diver shall be forwarded to CG Personnel Command (adm-1) for final decision and in time to reach Headquarters before the individual attains age 40. A certain latitude may be allowed for a diver of long experience and a high degree of efficiency in diving. The individual must be free from any diseases of the cardiovascular, respiratory, genitourinary, and gastrointestinal systems, and of the ear. The individual's ability to equalize air pressure must be maintained.

   d. Examination Prior to Dives. Divers should ordinarily be examined prior to each unusually hazardous dive and prior to extensive operations when practicable to do so. Medical officers available during extensive operations, should make observations, by personal interview if possible, of all divers prior to their initial dive each day.

2. Standards.

   a. Disqualifying History. Any of the following is disqualifying:

      (1) tuberculosis, asthma, chronic pulmonary disease;

      (2) chronic or recurrent sinusitis, otitis media, otitis externa;

      (3) chronic or recurrent orthopedic pathology; and

      (4) chronic or recurrent gastrointestinal disorder.

   b. Age Requirements. Candidates beyond the age of 30 shall not be considered for initial training in diving, the most favorable age being 20 to 30. For officers undergoing training in deep sea diving for the specific purpose of becoming diving supervisors or salvage officers, the upper age limit is 39 years.

   c. Nose, Sinuses, Mouth, and Throat. Obstruction to breathing or chronic hypertrophic or atrophic rhinitis is disqualifying. Septal deviation is not disqualifying in the presence of adequate ventilation. Chronically diseased tonsils are disqualifying

pending tonsillectomy. Presence or history of chronic or recurrent sinusitis is cause for rejection.

d. Ears (General) and Drums.

(1) Acute or chronic disease of the auditory canal, membrane tympani, middle or internal ear is disqualifying. Perforation or marked scarring or thickening of the drum is disqualifying. The eustachian tubes must be freely patent for equalization of pressure changes.

(2) All candidates shall be subjected in a recompression chamber to a pressure of 50 pounds per square inch to determine their ability to clear their ears effectively and otherwise to withstand the effects of pressure.

e. Skin and Lymphatics. There shall be no active acute or chronic disease of the skin characterized by infectiveness and/or offensiveness in close working conditions and interchange of diving apparel.

f. Psychiatric. The special nature of diving duties requires a careful appraisal of the candidate's emotional, temperamental, and intellectual fitness. Past or recurrent symptoms of neuropsychiatric disorder or organic disease of the nervous system are disqualifying. No individual with a history of personality disorder shall be accepted. Neurotic trends, emotional immaturity or instability and antisocial traits, if of sufficient degree to militate against satisfactory adjustment are disqualifying. Stammering or other speech impediment that might become manifest under excitement is disqualifying.

g. Dental. Acute infectious diseases of the soft tissues of the oral cavity are disqualifying until remedial treatment is completed. Advanced oral disease and generally unserviceable teeth are cause for rejection. Candidates with moderate malocclusion, or extensive restorations and replacements by bridges, may be accepted, if such do not interfere with effective use of self-contained underwater breathing apparatus (scuba). Fixed active orthodontic appliances require a waiver from CGPC-opm or epm (fixed retainers are exempt).

h. Distant Visual Acuity. Diving candidates and designated divers shall have a minimum uncorrected distant visual acuity of 20/100 in the better eye and 20/200 in the worse eye, both of which must be correctable to 20/20. Waiver considerations will be on a case-by-case basis. Emphasis on the ability to perform previous diving duties/recreational diving, if any, should be elaborated on in the applicant's letter requesting a waiver of the physical standards.

CHAPTER 4

HEALTH RECORDS AND FORMS

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CHAPTER 4. HEALTH RECORDS AND FORMS

Section A - Health Records.

1. Purpose and Background.

   a. The health record is the chronological medical and dental record of an individual while a member of the Coast Guard or the Coast Guard Reserve. The primary reasons for compiling a health record are listed below.

      (1) To develop an accurate clinical history that will help in future diagnosis and treatment.

      (2) To protect the Government, the individual concerned, and the individual's dependents. It may be used in adjudicating veterans claims by making permanently available in a single record all entries relative to physical examinations, medical and dental history, preliminary to entry and throughout the individual's entire Coast Guard career. This is accomplished by opening or maintaining medical and dental records:

         (a) upon entry into the Service;

         (b) as required to maintain concise, yet complete, records during period of service; and

         (c) at time of separation.

      (3) To facilitate appraisal of the physical fitness or eligibility for benefits by making the information contained in the health record available to Coast Guard selection boards, disability evaluation system, Board of Correction of Military Records, for income tax purposes, and for claims to the Department of Veterans Affairs.

      (4) To furnish a basis for collecting statistical information.

      (5) To identify deceased persons through dental records when other means are inadequate.

   b. As an individual's service career progresses, the health record increases in value to the Government, the individual, and the individual's family and dependents. Accuracy, therefore, is of the utmost importance in making entries, including entries regarding minor ailments or injuries which appear trivial at the time, but which must be recorded to protect the Government and the individual.

2. Contents of the Health Record.

   a. Each member's health record shall consist of CG-3443 (Health Record Cover) with medical records and dental records arranged as follows:

(1) SECTION I - HISTORY OF CARE. Maintain the Adult Preventive and Chronic Care Flowsheet on top of this Section. All other forms in Section I are to be filed together in reverse chronological order (i.e., most recent on top) in the following sequence. Do not separate corresponding forms DD-2808 and SF-93.

(d) Adult Preventive and Chronic Care Flowsheet Form DD 2766

(e) Consultation Sheet SF-513

(f) Narrative Summary Clinical Resume * SF-502

(g) Report of Medical Examination DD-2802 (Rev. Jul 01), and History and Report of OMSEP Examination Form CG-5447 (Rev.6-00)

(h) Report of Medical History DD2807-1 (Rev. Jul 01)

(i) Report on or Continuation of *, ** SF-507

(j) Medical Board Report Cover Sheet * NAVMED 6100/1

(2) SECTION II - RECORDS OF CARE. All forms in this Section (and their civilian equivalents) are to be filed together in reverse chronological order (i.e., most recent on top) in the following sequence.

(a) Chronological Record of Care SF-600

(b) Emergency Care and Treatment SF-558

(3) SECTION III - RADIOLOGICAL REPORTS. All forms in this Section are to be filed together in reverse chronological order (i.e., most recent on top) in the following sequence.

(a) Radiographic Consultation Request/Report SF-519A

(b) Medical Record-Radiographic Reports SF-519

(4) SECTION IV - LABORATORY REPORTS AND ECG REPORTS. All forms in this Section are to be filed together in reverse chronological order (i.e., most recent on top) in the following bottom to top sequence.

(a) Clinical Record - Laboratory Reports SF-514

(b) Clinical Record - Electrocardiographic Record SF-520

(5) SECTION V - MISCELLANEOUS. All forms in this Section shall be arranged in the following bottom to top sequence.

(a) Chronological Record of Service CG-4057

(b) Special Duty Medical Abstract * NAVMED 6150/2

(c) Record of Occupational Exposure to Ionizing Radiation * DD-1141

(d) Occupational Health Surveillance Questionnaire * CG-5197

(e) Syphilis Record * SF-602

(f) Request for Administration of Anesthesia and for Performance of Operations and other Procedures * SF-522

(g) Hearing Conservation Program microprocessor test result strips taped or stapled to the SF-514 Clinical Record-Laboratory Reports form. DD-2215 Reference Audiogram, and DD-2216 Hearing Conservation Data Sheet, if used, will also be place in section V, in sequential order under the SF 514 "Hearing Conservation Program" form.

(h) Eyewear Prescription DD-771

(i) Immunization Record SF-601

(6) SECTION VI - DENTAL RECORD AND INTERNATIONAL VACCINATION RECORD. All forms in this Section shall be arranged in the following bottom to top sequence.

(a) International Certificate of Vaccination PHS-731

(b) U.S. Coast Guard Dental Record CG-3443-2

1 Sensitivity Sticker * PHS-2410

2 Dental Health Questionnaire CG-5605

3 Health Record - Dental -- (Continuation) * SF-603A

4 Health Record - Dental SF-603

Note:

* --- When required

** -- SF-507's are attached to and filed after the form they continue

*** - Optional Form

b. File forms of the same number in their assigned sequence, with the most recent on top of each previous form, e.g., SF-600 dated 94/02/15 is filed on top of SF-600 dated 94/02/14.

c. Record all dates on the Health Record Cover in the following sequence (all numerals): year/month/day (e.g., 51/02/07).

d. Reports, including laboratory, X-ray, and consultations, shall be reviewed and initialed by the responsible MO, DO, PA/PYA or NP before they are filed in the health record.

e. The health record is a legal document. As such, legibility of all information is essential. Patient ID information shall be typed, printed, or stamped. All entries shall be neat and legible. All signatures shall be accompanied by the stamped or typed name and rank of the practitioner.

3. Opening Health Records.

f. General.

(1) A health record will be opened at the recruiting office for each individual upon entry into the Coast Guard.

(2) A new health record will be opened upon reenlistment of personnel with prior USCG service when such enlistment is not effected the day following discharge. In all cases, request the individual's health record covering prior military service from the National Personnel Records Center, St. Louis, MO.

(3) Other Specific Occasions for Opening Health Record.

OCCASSION	**OPENED BY**
Officer appointed from civilian	First duty station
Reserve Officer	Unit where procured
Cadet	Academy
Retired Personnel recalled to Active Duty	First duty station
Original Record Lost or Destroyed	Responsible Custodian

4. Terminating Health Records.

a. General Instructions.

(1) Upon discharge without immediate reenlistment or enlistment in the Coast Guard Reserve, or retirement, forward the health record (Medical Personnel Data Record or MED PDR) to the servicing PERSRU within 2 days of the member's separation. **DO NOT GIVE THE ORIGINAL HEALTH RECORD TO THE MEMBER UPON FINAL SEPARATION**. Cite the reason for separation on the reverse side of Chronological Record of Service (form CG-4057). The servicing PERSRU shall forward the health record, along with the PERSRU PDR, to Commander (CGPC-adm3) or Commandant (G-RSM-3) for Reservists. (See Section 4-B-27 for additional requirements for

CG-4057.) Health record documents are not filed in the HQ PDR. They will be returned to the unit if received by Commander, (CGPC adm-3) in error.

(2) Discharge for immediate reenlistment at the same unit, revocation of appointment as a temporary officer to continue on active duty in permanent status, or retirement with continuation of active duty are not termination of service.

(3) When a health record is terminated and the dental record is not available for inclusion therein, forward a letter of explanation with the health record.

b. Release from active duty (RELAD) with concurrent transfer to the Coast Guard Reserve or discharge from active duty with immediate enlistment in the Coast Guard Reserve. Upon RELAD, forward the health record (MED PDR) to the servicing PERSRU within 2 days of the member's separation. The servicing PERSRU shall forward the health record, along with the PERSRU PDR, to District (rs) in which the member will reside after separation.

c. Disappearance, Other Than Desertion. Whenever an individual disappears and the facts regarding such disappearance are insufficient to justify a conclusion of death, enter a complete account of the circumstances on an SF-600 in the health record. Do not terminate the health record until final disposition.

d. Desertion.

(4) When an individual is officially declared a deserter, enter an explanatory note on SF-600. Forward the health record (MED PDR) to the servicing PERSRU within 2 days of determination of deserter. The servicing PERSRU shall forward the health record, along with the PERSRU PDR, to Commander (CGPC) or Commander (CGPC-rpm) for Reservists.

(5) Upon return of a deserter to his/her own command, a physical examination shall be performed and recorded on an DD-2808. Retain the original for incorporation into the health record, and forward a copy to Commander (CGPC) or Commander (CGPC-rpm) for Reservists with a request for the deserter's health record.

e. Discharge of Personnel Convicted by Civilian Authorities. When the Commandant directs the discharge of personnel convicted by civilian authorities, the commanding officer will make arrangements for their physical examination, to be recorded on an DD-2808. In the event no medical officer is available, obtain a statement signed by the warden of the penitentiary or reformatory that the person to be discharged from the Coast Guard is physically and mentally qualified for discharge and is not in need of hospitalization. The warden's statement, accompanied by the terminated health record, will be forwarded with the closed out service record.

f. Discharge of Courts-Martial Prisoners Confined in Federal Penitentiaries, Reformatories, and the Naval Disciplinary Command. When the Commandant

directs the discharge of a courts-martial prisoner confined in a Federal penitentiary, reformatory, or the Naval Disciplinary Command, the command to which the prisoner has been administratively assigned shall arrange with the warden for physical examination of the prisoner. Results of this physical examination will be entered on the DD-2808 and signed by the medical officer of the designated penal institution. The command to which the prisoner has been administratively assigned will terminate the health record, using the information furnished on the DD-2808 and the account of medical, dental, and first aid treatments supplied by the penal institution. The terminated health record, DD-2808, and the resume will then be forwarded with the closed out service record.

g. Retired Personnel (Includes Temporary Retirement). Upon notification of retirement, make an entry on CG-4057 under "Remarks" indicating place, date, and category under which retired. The command having custody of the health record will sign the CG-4057 and forward it to the command having administrative control of the member for inclusion in the closed out service record.

h. Cadets. When a cadet's service is terminated, the health record will be terminated and forwarded to the Cadet Record Office, for processing. Following this procedure, the record will be forwarded to the Registrar's Office and held until the departing cadet's class graduates. When this occurs, the record will be forwarded to the Federal Personnel Records Center, St. Louis, MO. This includes cadets who graduate from the Academy but do not accept or are not tendered a commission.

i. Officers (Reserve) to Inactive Duty and Officers (Regular) who Resign to Accept a Reserve Commission. In the case of reserve officers being released to inactive duty and regular officers who resign and accept a commission in the reserve, the health record will be terminated.

j. Death. Upon notification of death, make an entry on CG-4057 under "Remarks" indicating place, time, date, and a short explanation of the circumstances surrounding death. A commissioned officer will sign the CG-4057 and then deliver it and the terminated health record to the commanding officer (no later than the day following death) for inclusion in and transmittal with the member's service record to Commander (CGPC) or Commander(CGPC-rpm).

5. Custody of Health Records.

a. General Responsibilities.

(1) Health records are the property of the Federal government and must be handled in accordance with the provisions of the Privacy Act of 1974 and the Freedom of Information Act. Guidance in this area is contained in the Coast Guard Freedom of Information and Privacy Acts Manual, COMDTINST M5260.3 (series). Health record custody and security requirements are applicable to all documents which contain health information, whether or not filed in the health record, such as Inpatient Medical Records and mental health treatment records.

Disposal of all health record documents shall be in accordance with Coast Guard Paperwork Management Manual, COMDTINST M5212.12(series).

(a) Since health records contain personal information of an extremely critical or sensitive nature, they are considered class III records requiring maximum security (high security locked cabinets or areas).

(b) Except as contained in the Privacy and Freedom of Information Acts Manual, the information contained in health records shall not be disclosed by any means of communication to any person, or to any agency unless requested in writing by or with the prior consent of the individual to whom the record pertains. It is the requestor's responsibility to obtain the consent.

(2) Health records shall be retained in the custody of the Chief, Health Services Division of the unit to which the individual is attached. At units where there is no medical officer attached, the health record will become the responsibility of the executive officer in accordance with Coast Guard Regulations, COMDTINST M5000.3(series), who may delegate custody to the senior health services department representative. At units without a health services technician the custody of the health record is the responsibility of the unit's executive officer. Maintenance of these health records may be delegated to health services personnel of another unit (e.g., groups, support centers, etc.). **At no time shall individual members keep or maintain their own health record**. If there is a need to check out a health record for an appointment at another health care facility, the health record custodian shall have the member complete and sign the health record receipt form (NAVMED 6150/7). The health record custodian shall place the record in an envelope, hand it to the member, and tell the member to return the record as soon as possible following the appointment. The envelope used for record transportation shall bear a printed request reminding outside providers to treat the contents as confidential, and requesting providers to include copies of their consultations or case notes for placement in the health record. The responsibilities contained herein are also applicable to Reserve components.

(3) Individuals may examine their own health record in the presence of a health services department representative, providing:

(a) such examination does not interrupt the unit's scheduled mission, and

(b) there is no information contained therein that would be detrimental to the individual's mental well-being, as determined by the member's attending physician.

(4) Health records are subject to inspection at any time by the commanding officer, executive officer, duly appointed counsel in the case of formal hearings, or duly appointed Coast Guard officials who are conducting authorized

investigations. Such inspections will be conducted in the presence of a health services department representative to aid in the interpretation of information contained in the health record.

(5) Health services personnel making entries in health records shall ensure all entries, including signatures, are neat and legible. Signature information shall include the stamped or printed name and grade or rate of the signer. Facsimile signature stamps may only be used on the PHS-731 and the SF-601.

(6) If an erroneous entry is made in a health record, the author of the entry shall draw a diagonal line through the complete entry, make an additional entry showing wherein and to what extent the original entry is in error, and initial clearly next to the correction.

(7) Health services personnel are responsible for the completeness of the entries made on any medical or dental form while the health record is in their custody. No sheet shall be removed from the health record except under conditions specified in this Manual.

(8) Members are not authorized to write in, alter, remove documents from, or otherwise change their health record or its contents. Request for changes to health record contents shall be made in accordance with procedures contained in Chapter 16 of the Coast Guard Freedom of Information and Privacy Acts Manual, COMDTINST M5260.3.

6. Transfer of Health Records.

a. When active duty or reserve personnel are transferred, The Chief Health Services Division, his designee, the Executive Officer, or the senior Health Services department representative will make the necessary entries in the health record and ensure that the current health record, dental record (SF-603) and Certificate of Vaccination (PHS-731), if applicable, are properly completed.

b. A DD-877 shall be initiated for each record transferred. The DD877 shall be attached to the front cover of the record. The health record will be forwarded to the Coast Guard clinic or Independent Duty Health Services Technician servicing the gaining unit. **Send records using a service that provides a tracking number, such as Priority Mail Delivery Confirmation, Certified Mail, Insured Mail, or FedEx/Express Mail if time is critical.** (See Article 4-D-7.c. of this Manual for policy regarding transfer of Clinical Records of dependents.)

c. Transfer to Federal Penitentiaries, Reformatories, or the Naval Disciplinary Command. A letter of transmittal and a copy of the health record shall accompany a member who is being transferred under sentence of a courts-martial (who has not been or will not be discharged immediately) to a penal institution for execution of the unexpired sentence. The original health record, with a letter of transmittal stating the name of the penal institution to which the prisoner is being transferred and the length of the sentence, shall be forwarded to the command to which the member has been

administratively assigned which shall maintain the health record until the prisoner has been discharged from the Service. A copy of the letter of transmittal shall also be forwarded to Commander (CGPC).

7. Creating an Additional Volume.

   a. Due to chronic medical conditions, long narrative summaries, medical boards, etc., the record may fill to capacity which may cause the loss or damage to new records.

   b. Procedures for creating a second volume:

      (1) Obtain a new Health Record (CG-3443) and transcribe the information from the original jacket.

      (2) Write "VOLUME II" in bold print in the lower left corner of the new jacket cover. Insert forms required by this chapter.

      (3) Write "VOLUME I" in bold print in the lower left corner of the original jacket cover.

      (4) Transfer all documents pertaining to current or chronic illness to the new record.

      (5) Remove the most recent SF-600 from VOLUME I and place it in VOLUME II. Insert a blank SF-600 on top of the remaining forms in VOLUME I and draw a diagonal line across the page. Enter the following on this line:

      CLOSED. NO FURTHER ENTRIES IN THIS RECORD. REFER TO VOLUME II.

      (6) Insert the most recent Report of Medical Examination (DD-2808) and the Report of Medical History (DD-2807-1) into VOLUME II.

      (7) Transcribe the immunization and HIV test date information onto a blank SF-601 and insert it in the appropriate section of VOLUME II.

      (8) Place the original Problem Summary List (NAVMED 6150/20) into VOLUME II and a copy of this form in VOLUME I with the annotation, "CLOSED. NO FURTHER ENTRIES.", below the last entry.

      (9) Place the original Chronological Record of Service (CG 4057) in VOLUME II and a copy in VOLUME I.

8. Lost, Damaged, or Destroyed Health Records.

   a. If a health record is lost or destroyed, a complete new health record shall be opened by the unit health record custodian. The designation "REPLACEMENT" shall be stamped or marked on the cover. If the missing health record should be recovered,

any additional information or entries in the replacement record shall be inserted in the old record.

b. Health records which become illegible, thus destroying their value as permanent records, shall be restored and duplicated. The duplicate shall, as nearly as possible, be an exact copy of the original record before such record becomes illegible. Take particular care in transcribing the date on DD-2808 into the new record as such information may be required by the Department of Veterans Affairs to determine the individual's right to pension or other Federal benefits. Stamp or mark "DUPLICATE" on the cover of the new record. Explain the circumstances necessitating the duplication on an SF-600. Forward health records replaced by duplicate records to CGPC-adm-3.

9. Accuracy and Completeness Check.

a. Upon transfer of an individual, the health record custodian at both the detaching unit and the receiving unit shall inspect the health record for accuracy and completeness, in accordance with the following guidelines:

(1) that all immunizations are up-to-date (See Immunizations and Chemoprophylaxis, COMDTINST 6230.4 (series));

(2) that PPD screening is current in accordance with Section 7-D of this Manual;

(3) that all required audiograms are completed, especially on personnel involved in the hearing conservation program;

(4) that required forms have been properly completed and are in the correct order;

(5) that all deficiencies in physical requirements shall be scheduled for correction, all missing forms shall be replaced, and all other clerical or administrative errors corrected; and

(6) that all OMSEP requirements are met.

b. The health record custodian shall ensure that all identified deficiencies are corrected immediately. Appointments shall be scheduled and the individual's supervisor notified of the need to correct deficiencies as soon as possible.

c. Upon separation of the individual from the Service, the unit terminating the health record will inspect the health record, correct all errors, fill in omissions, and make sure the patient identification information is completed on all forms.

Section B - Health Record Forms.

1. **CG-3443 (Health Record Cover).** See Encl (1), pg.4-1. Each patient's health record shall be maintained in a CG-3443 (Health Record Cover). The CG-3443 shall be completed according to the following instructions:

   a. Last Name. Record in all capital letters.

   b. Given Name(s). Record given name(s) in full without abbreviations. If the individual has no middle name or initial then use the lower case letter "n" in parentheses (n). If the individual has only a middle initial(s) record each initial in quotation marks. When "Jr." or "II" or other similar designations are used they shall appear after the middle name or initial.

DOE	**John**	**Buck**	**Jr**.
Surname	**First Name**	**Middle Name**	

   c. Beneficiary. Enter the appropriate beneficiary code to describe the patient (enter "20" for active duty members).

      (1) 01 to 19 - Dependent children in order of birth

      (2) 20 - Sponsor

      (3) 30 - Spouse

      (4) 31-39 - Unremarried former spouse

      (5) 40 - Dependent mother (active duty)

      (6) 45 - Dependent father (active duty)

      (7) 50 - Dependent mother-in-law (active duty)

      (8) 55 - Dependent father-in-law (active duty)

      (9) 60 - Other dependents

      (10) 80 - Humanitarian (non-eligible)

      (11) 90 - Civilian employee

      (12) 99 - Other eligible

   d. Sponsor's Social Security Number. Enter.

   e. Blood Type and Rh Factor. Enter the blood-type and Rh factor in the appropriate boxes. Use utmost caution when recording this information. If not known, complete a blood-type and Rh factor test as required.

f. Special Status. Check the appropriate block to indicate whether the individual is in aviation or diving status, has a waiver, requires occupational monitoring, or has an allergy.

g. Date of Birth. Enter year, month and day (e.g., 51/02/07).

h. Local Use. Use the spaces provided below the sensitivity sticker location for local use information such as rank, unit, etc. as needed.

2. CG-5266 (Drug Sensitivity Sticker).

a. General. Form CG-5266 should be initiated for anyone having documented history of sensitivity or hypersensitivity to specific drugs, serums, or vaccines, including PPD converters. Other non-drug allergies should be indicated on this form only if they will affect potential therapy (e.g., egg yolks). Every effort shall be made to verify the reported sensitivity and to confirm that it is allergic in nature.

b. Detailed Instructions.

(1) Prepare two originals. (One each for the health and dental records.)

(2) List the name of each drug, serum, vaccine, or anesthetic indicated on the DD-2766 Adult Preventive and Chronic Care Flowsheet.

(3) Affix the CG-5266 vertically to the indicated location on the health record cover (form CG-3443) and vertically to the lower left corner on the front of the dental record cover (CG-3443-2).

3. **DD2766 (Adult Preventive and Chronic Care Flowsheet Form).** See Encl (1), pg 4-2.

a. General. The Adult Preventive and Chronic Care Flowsheet Form documents significant/chronic health problems, allergies, chronic medications, hospitalizations/surgeries, health counseling, immunizations, PPD, DNA & HIV testing, screening (preventive medicine) exams, other medical readiness items (such as blood type, G6PD, sickle cell, glasses, dental exam, etc), and chart audits. In-house training sessions should be conducted prior to the implementation of this form.

b. Detailed Instructions. DD2276 should be inserted as the first page of the medical record and all sections completed by the health care provider with the following guidelines exceptions:

(1) Information from previous Problem Summary Lists should be copied and updated onto the DD2276 as it is placed in the health record.

(2) If the patient is not allergic to any drugs, indicate NKDA (no known drug allergies), in block 1.a.

(3) Sections 8.a., 10.e. and 10.i. are not required to be completed.

(4) Use a pencil to darken the circles on Section 7, Screening Exam.

(5) The medical officer should enter the date and location of every deployment the member participates in Section11, Pre/Post Deployment History. Pre and post deployment questionnaires are documented in Section 11 for participants in DOD deployment.

4. **SF-600 (Chronological Record of Medical Care)**. See Encl (1), pg 4-6.

a. General.

(1) This form provides a current, concise, and comprehensive record of a member's medical history. Properly maintained, the SF-600 should: aid in evaluating a patient's physical condition; greatly reduce correspondence to obtain medical records; eliminate unnecessary repetition of expensive diagnostic procedures; and serve as an invaluable permanent record of health care received. The SF-600 shall be continuous and include the following information as indicated: complaints; duration of illness or injury, physical findings, clinical course, results of special examinations; treatment; physical fitness at time of disposition; and disposition. The SF-600 also serves as the patient's prescription from which pharmacy services are provided.

(2) When a new SF-600 is initiated, complete the identification block with the name (last, first, middle initial), sex (M or F), year of birth, component (active duty or reserve), service (USCG, USN, USA, etc.), Social Security Number, and the member's grade/rate and organization at the time the form is completed.

(3) File SF-600's on the right side of the medical record with the most current SF-600 on top.

(4) Enter sick call entries on SF-600 in the following SOAP format

SOAP METHOD OF SICK CALL WRITE UPS

S: (Subjective).

cc: (Chief Complaint) sore throat, cough, diarrhea, etc.

hpi: (History Present Illness) onset of symptoms, all problems, review of symptoms

pmh: Past Medical History) any related problems in past that may be present with chief complaint

fh: (Family History) any diseases, chronic/acute, possibly related to present complaint

all: (Allergies) any known allergies to drugs/medications, etc.

0: (Objective).

First visual assessment/evaluation of the patient's general appearance: limping, bleeding, doubled over, etc.

PE: All results of physical exam, vital signs, lab, x-ray, and any other study results

A: (Assessment).

Imp: (Impression, Diagnosis) includes R/0 (rule out)

NOTE: THIS IS TO INCLUDE, AFTER IMPRESSION, WHAT YOU ARE GOING TO DO NOW AND WHY--SUCH AS, SUTURING, TOURNIQUET, ETC.

P: (Plan).

List of medications given, lab, x-ray, special studies ordered, duty status, return appointments, referrals, etc.

(5) The entries for all treatments shall be complete with regard to place, date, problem number (if appropriate), number of sick days, diagnosis of all conditions for which treated and signature of individual furnishing treatment. Note all facts concerning the origin of the disease, pregnancy status, symptoms, course, treatment, and if a conflicting opinion is expressed subsequently by the same, or another medical officer, fully state the reason for such change. The record need not be voluminous, but it shall be thorough, concise, clearly phrased, and complete in each case. All entries, including signatures, must be legible.

(6) When a member is injured or contracts a disease while on leave, or when for any other reason the facts concerning an injury or sickness have not been entered in the individual's health record, the record custodian shall ascertain the facts in the case and make the necessary entries on SF-600. Discuss and document the instructions given to the patient. Include the intended treatment and, as appropriate, possible alternative treatments, possible complications, and long term prognosis. Information regarding previous treatments should be entered giving the following: date, place, and full details of treatment; laboratory reports; x-ray results; etc. The following shall also be entered:

(7) "Date:
"Transcribed From Official Records.

Signature/Rate Duty Station of Transcriber"

(8) When an individual is required to carry the PHS-731, enter a statement of acknowledgment on the SF-600.

(9) When an individual is diagnosed as having a Sexually Transmitted Disease (STD) make an entry to record that an interview was conducted and that the following was discussed with the patient:

(a) symptoms,

(b) complications,

(c) treatments, and contacts.

5. Treatment at Other Than Unit Assigned. When an activity furnishes sick call treatment to an individual whose health record is not available, an entry shall be made on a new SF-600 and forwarded to the individual's duty station for inclusion in the health record.

6. **DD-2808 (Rev. Jul 01) (Report of Medical Examination).** See Encl (1), pg. 4-7.

a. Purpose. The DD 2808 (Rev: Jul 2001) is used to record physical examination results to determine whether an examinee does, or does not, meet the standards established for the type of physical examination administered (i.e., initial enlistment, officer programs, retention, release from active duty, diving, aviation, retirement, etc.). The DD-2808 is no longer applicable.

b. Preparation.

(1) When Prepared. DD-2808 shall be prepared and submitted to the reviewing authority whenever a complete physical examination is required.

(2) Required Entries. Certain groups of personnel are required to meet physical standards somewhat different from other groups. Accordingly, the use of all the spaces or use of the same spaces on the DD-2808 is not necessarily required for reporting the results of the various categories of physical examinations. If a certain item of the medical examination is required and facilities for accomplishing it are not available, an entry **"NFA"** (No Facilities Available) shall be made in the appropriate space. An entry **"NE"** (Not Evaluated) shall be made in the appropriate space for any item of the clinical evaluation (Items 17-42) which was not evaluated. For other items listed on the DD-2808 which were not required for a particular category of physical examination, an entry **"NI"** (Not Indicated) shall be made in the appropriate space. Reference should be made to other provisions of Chapter 3, which prescribe the nature and scope of each physical examination and indicate the applicability of items of the DD-2808 to the particular program. Unless otherwise indicated by such provisions, the minimum requirements for completing the DD-2808 are:

(a) All Examinations. Items 1-44, 45-63, 66, and 71a, shall be completed for all physical examinations, if facilities are available. Item 41, shall be completed for all female personnel.

(b) Aviation Personnel. Additionally, Items 64,65, and 66-70 and 72b shall be completed for physical examinations of aviation personnel.

(3) A physical examination must be thorough, recorded accurately, and contain sufficient information to substantiate the final recommendation. Before signing and forwarding, the examiner shall review the completed DD-2808 for completeness and accuracy. Failure to do so reflects significantly on the examiner's clinical and/or administrative attention to detail. Remember that the reviewing authority does not have the advantage of a direct examination and must rely on the examiner's written record and appropriate additional information in arriving at a decision.

c. Details for Entries on DD-2808.

(1) **Item 1**: **Date of Examination**. Enter date in format - 02Aug15.

(2) **Item 2: Social Security Number**. Enter the nine digits of their SSN.

(3) **Item 3: Last Name.** Last Name - First Name - Middle Name. Record the surname in all capital letters. Record the given name(s) in full without abbreviation. If the individual's first or middle name consists only of an initial, enclose each initial in quotation marks (i.e., MANUEL, Thomas "W"). If the individual has no middle name, enter the letter "(n)" in parenthesis [i.e., TARVIN, Laurie (n)]. Designations, such as, "Jr." or "II" shall appear after the middle name or initial. In the absence of a middle name or initial, these designations shall appear after the "(n)."

(4) **Item 4: Home Address.** Enter the evaluee's present residence and not the home of record.

(5) **Item 5: Home Telephone Number.** NA

(6) **Item 6: Grade**. Use official abbreviation of the current grade or rate. Example: HSCS; LTJG. If not a service member, enter "civilian."

(7) **Item 7: Date of Birth**. (e.g.57Sep04).

(8) **Item 8: Age**. Enter age.

(9) **Item 9: Sex**. Mark one or the other of the boxes.

(10) **Item 10: Race**. Mark the box next to the racial or ethnic group of which member belongs.

(11) **Item 11: Total Years of Government Service.** Enter years and months (e.g., 06 yrs 04 mo's).

(12) **Item 12: Agency**. Enter the OPFAC number of the unit to which the examinee is attached.

(13) **Item 13: Organization and UIC/Code.** List name of ship or station to which the examinee is assigned. Initial entry into Service; enter recruiting office concerned.

(14) **Item 14a: Rating or Specialty**. NA

(15) **Item 14b: Total Flying Time.** Aviators only or NA.

(16) **Item 14c: Last six months.** Aviators only or NA.

(17) **Item 15a**: **Service**. Mark a box next to appropriate service.

(18) **Item 15b: Component.** Mark a box next to appropriate component.

(19) **Item 15c: Purpose of Examination**. Mark the box and corresponds to the appropriate purpose(s) of the examination. If not listed, mark "Other," and explain above the box such as: Diving Applicant; Biennial Aircrew; etc. For a medical board, indicate whether it is an IMB (Initial Medical Board)/DMB (Disposition Medical Board), etc. Do not use the incomplete terms "flight physical," "diving physical," or "aviation physical." Rather, use specific terms such as "Class I Aviation," "Candidate for Flight Training," "Class II Aircrew," "Dive Candidate," "Quinquennial Diving," etc. Avoid nonstandard abbreviations. Differentiate between an applicant for a special program and a biennial physical for the same program. When necessary, continue under Item 73, Notes.

(20) **Item 16: Examining Facility or Examiner.** For civilian or contract physician, enter the full name and address. For USMTF, enter only the facility name, city and state in which located.

(21) **Item 17-42: Clinical Evaluation**. Check each item in appropriate column.

(a) **Item 35:** Is continued on lower right side (Feet), circle appropriate category.

(22) **Item 43: Dental Defects and Disease.** For an oral examination as part of an accession physical, record whether or not the applicant is 'Acceptable' or 'Not Acceptable'. Refer to the standards described in Chapter 3 Section D-5 Physical standards for enlistment, appointment, and induction. Enter disqualifying defects in detail in Item 73. Record the Dental Classification. Refer to Chapter 4 Section C-3-c for definitions of dental classes. For routine physical examinations, record only the Dental Classification. When oral disease or dental defects are discovered on examination of active duty member personnel, suitable recommendations will be made for instituting corrective

measures. A copy of form SF-603, Dental Record does not need to be attached to the DD-2808.

(23) **Item 44: Notes.** Describe every abnormality from Items 17-43 in detail. Enter pertinent item number before each comment**.** Continue in Item 73 and use Continuation Sheet (SF-507), if necessary.

(24) **Item 45: Laboratory Findings.** Enter all laboratory results in quantitative values.

(a) **Urinalysis**. Enter specific gravity and results of albumin, sugar and if required, microscopic tests in the indicated spaces.

(b) **Item 46: Urine HCG.** If applicable.

(c) **Item 47: H/H**. Enter either the hematocrit or the hemoglobin results.

(d) **Item 48: Blood Type.** If applicable.

(e) **Item 49: HIV**. Enter date drawn only in the results section.

(f) **Item 50: Drugs Test Specimen ID Label**. NA

(g) **Item 51: Alcohol**. NA

(h) **Item 52: Other**. Enter all other tests performed and their results which are not indicated on the form and which were performed in connection with the physical examination (e.g., sickle cell test, PAP test, PPD, EKG, Chest X-ray results, etc.). The results will be continued in Item 73 or on Continuation Sheet (SF 507), if necessary. If provided on the lab report, include "normal" range values for all tests performed by a civilian or military lab. Use quantitative values and avoid vague terms such as "WNL" or other such qualitative forms.

(25) **Item 53: Height**. Measure without shoes and record to the nearest one-half centimeter ((one-half inch)

(26) **Item 54: Weight**. Measure with the evaluee in under garments and record results to the nearest kilogram (pound).

(27) **Item 55: Min Weight-Max weight, Max BF%**. NA

(28) **Item 56: Temperature**. Leave Blank.

(29) **Item 57: Pulse**. Record the actual pulse rate.

(30) **Item 58: Blood Pressure**. Record the actual value in numerals for both systolic and diastolic.

(31) **Item 59: Red/Green**. NA

(32) **Item 60: Other Vision Test**. If applicable.

(33) **Item 61: Distant Vision.** Test and record using the Snellen scale. Record vision in the form of a fraction and in round numbers, that is 20/20, 20/40, not 20/20-2 or 20/40-3.

(34) **Item 62: Refraction**. Enter the lens prescription when the evaluee wears (or requires) lenses for correction of visual acuity. Do not enter the term "lenses."

(35) **Item 63: Near Vision.** Test and record using the Snellen scale. (See item 61).

(36) **Item 64: Heterophoria**. Enter when indicated.

(37) **Item 65: Accommodation**. Enter when indicated.

(38) **Item 66: Color Vision.** Color Vision. Enter the test used and the results.

(a) Farnsworth Lantern. Record the results as "Passed FALANT" or "Failed FALANT" followed by the fraction of correct over total (i.e., 9/9 or 17/18).

(b) Pseudoisochromatic Plates (PIP). Record results as "Passed PIP" or "Failed PIP" followed by the fraction of correct over total (i.e., 12/14 or 14/14).

(c) Enter "Passed on record" or "failed on record" if the results of a previous PIP or FALANT examination are available on record for review.

(39) **Item 67: Depth Perception**. When indicated, enter test used in left portion of Item 67.

(a) AFVT. In the appropriate space in the right-hand portion of Item 65, record the letter designation of the highest group passed (i.e., Passed F).

(b) Verhoeff. In the appropriate space in right-hand portion of Item 34, record perfect score as 16/16.

(40) **Item 68: Field of Vision**. Enter when indicated.

(41) **Item 69: Night Vision**. Enter when indicated.

(42) **Item 70: Intraocular Tension**. When indicated, enter the results in millimeters of mercury.

(43) **Item 71: Audiometer**. Required on ALL physical examinations. Use ANSI 1969 standards, do not use ISO or ASA standards.

(a) **Item 71a**: Current

(b) **Item 71b:** If **applicable**.

(44) **Item 72a:** **Reading Aloud Test**. If applicable.

(45) **Item 72b:** **Valsalva.** When indicated mark either SAT or UNSAT.

(46) **Item 73:** **Notes and Significant or Interval History**. Use this space for recording items such as:

(a) any pertinent medical history;

(b) summary of any condition which is likely to recur or cause more than minimal loss of duty time;

(c) wrist measurements;

(d) most recent HIV antibody test date (see Article 3-C-20.b.(5) of this Manual);

(e) date of PPD and results; and

(f) Preventive Medicine stamp per Use of Preventive Medicine Stamp, COMDTINST 6200.11(series), for exams originating in Coast Guard sickbays and clinics.

(47) **Item 74a:** **Examinee's Qualification.** State whether or not the examinee is qualified for the purpose of the examination. If the purpose for the examination is an IMB or DMB, state whether or not the examinee is qualified or not qualified for retention and to perform the duties of his/her rank/rate at sea and foreign shores.

(48) **Item 74b:** **Physical profile.** Leave blank.

(49) **Item 75:** **I have been advised of my disqualifying condition**. If indicated, have evaluee sign and date.

(50) **Item 76:** **Significant or Disqualifying Defects**. Leave Blank

(51) **Item 77:** **Summary of Defects and Diagnoses.** List ALL defects in order to protect both the Government, and evaluee, in the event of future disability compensation claims. All defects listed which are not considered disqualifying shall be so indicated by the abbreviation NCD (Not Considered Disqualifying). When an individual has a disease or other physical condition that, although not disqualifying, requires medical or dental treatment clearly state the nature of the condition and the need for treatment. If a medical or dental condition is disqualifying, and treatment is scheduled to be completed prior to transfer to overseas or sea duty, indicate the date the member is expected to be fully

qualified, e.g., "Dental appointment(s) scheduled, patient will be class I (dentally qualified) by (date)**". Leave Profile Serial, RBJ, Qualified, and Waiver blocks blank.**

(52) **Item 78: Recommendations**. Indicate any medical or dental recommendations. Specify the particular type of further medical or dental specialist examination indicated (use SF-507, if necessary).

(53) **Item 79: MEPS Workload.** Leave Blank.

(54) **Item 80: Medical Inspection Date**. Leave Blank.

(55) **Item 81-84: Names and Signature of Examiners**. The name, grade, branch of Service, and status of each medical and dental examiner shall be typewritten, printed, or stamped in the left section. Each examiner shall sign using ballpoint pen or ink pen (black or blue-black ink only) in the appropriate section. Do not use facsimile signature stamps. When attachment sheets are used as a supplement or continuation to the report, they shall be serially number (both sides); however, indicate only the actual number of attached sheets in the bottom right **block 87** on DD-2808.

(56) **Item 85: Administrative Review**. The person who reviews the PE prior to submitting for approval shall sign and date.

(57) **Item 86: Waiver Granted.** Leave Blank.

(58) **Item 87: Number of attached Sheets**. Fill in with appropriate number of forms attached.

7. **DD-2807-1 (Rev. Jul 01) (Report of Medical History)**. See Encl (1), pg. 4-7.

a. Purpose. DD-2807-1 provides a standardized report of the examinee's medical history to help the examiner evaluate the individual's total physical condition, and to establish the presence of potentially disabling conditions which are not immediately apparent upon physical examination. In preparing the form, encourage the examinee to enter all medical problems or conditions experienced, no matter how minor they may be. The examiner must investigate and evaluate all positive medical history indicated on the form.

b. Preparation and Submission of DD-2807-1. Prepare and submit DD-2807-1 with all physical examinations except: Periodic OMSEP and Substitution/Overseas/Sea Duty Modified Physical Examination.

c. Preparation Procedures. DD-2807-1 shall be prepared by the examinee and the examining medical officer.

(1) The examinee shall furnish a true account of all injuries, illnesses, operations, and treatments since birth. False statements or willful omissions in completing

the DD-2807-1 may result in separation from the Service upon arrival at the Academy, Recruit Training Center, Officer Candidate School, or later in the individual's career.

(2) A copy of the DD-2807-1 must be included in the member's health record. Entries must be printed, in the examinee's and examiner's own handwriting, using either ball-point pen or ink pen (black or dark blue). Pencils or felt-tip pens will not be used. Information in the numbered blocks on the form will be entered in the following manner:

(a) **Item 1: Last Name, First, Middle Name**. SMITH, Hannibell H. Record the surname in all capital letters. Record the given name(s) in full, without abbreviation. If the individual's first or middle name consists only of an initial, enclose each initial within quotation marks. If the individual has no middle name, enter the letter "(n)" in parenthesis. Designations such as "Jr." or "II" will appear after the middle name or initial or after "(n)" if there is no middle name.

(b) **Item 2: Social Security Number**. Enter SSN.

(c) **Item 3: Enter date format** –2001Sep04.

(d) **Item 4a: Home Address.** Enter the evaluee's present residence and not the home of record.

(e) **Item 4b: Home Telephone.** Enter home phone number.

(f) **Item 5: Examining Location and Address.** For civilian or contract physician, enter the full name and address. For a USMTF, enter only the facility name and the city and state in which located.

(g) **Item 6a: Service.** Mark a box next to the appropriate service.

(h) **Item 6b: Component**. Mark a box next to the appropriate component.

(i) **Item 6c**: **Purpose of Examination**. Mark a box next to the appropriate purpose(s) of the examination. If not listed, mark “Other” and explain above the box such as: Diving Applicant; Biennial Aircrew; etc. For a medical board, indicate whether it is an IMB (Initial Medical Board)/DMB (Disposition Medical Board), etc. Do not use the incomplete terms “flight physical,” “diving physical,” or “aviation physical.” Avoid nonstandard abbreviations. Differentiate between an applicant for a special program and a biennial physical for the same program.

(j) **Item 7a: Position.** Use official abbreviation of current grade or rate, branch of the Service, class and status; i.e., regular, reserve, or retired and if active or inactive. Example: HSCM, USCG; LTJG, USCGR;

HSC, USCG (RET); HS3, USCG (TEMPRET). If not a Service member, enter "civilian."

(k) **Item 7b: Usual Occupation**. List current occupation.

(l) **Item 8: Current Medications.** List all current medications including over the counter meds.

(m) **Item 9: Allergies**. List any allergies to insect bites/stings, foods medicine or other substances.

(n) **Item 10 to 28**. Check appropriate box.

(o) **Item 29: Explanation of "Yes" Answer(s).** Describe all "yes" answers from section 10-28. Include date(s) of problems, name of doctor(s), and /or hospitals(s), treatment given and current medical status.

1 Append Item 29 to include: The statement to present health and a list of medications presently being taken by the examinee. For individuals receiving examinations more frequently than quinquennial, there is often little change in the medical history from year to year. As an alternative to having the examinee complete Section 10-28 of the DD-2807-1 at a periodic examination, the following statement may be entered in Item 29 and initialed by the person undergoing the examination.
"I have reviewed my previous Report of Medical History and there have been no changes since my last medical examination, except as noted below." _____(initials)

(p) **Item 30. Examiner's Summary and Elaboration of all Pertinent Data.** Prior to performing the physical examination, the examiner will review the completeness of the information furnished on the DD-2807-1. When this is done, summarize the medical history under (**Item 30a. Comments)** as outlined below and then sign the form. If additional space is needed, use Continuation Sheet, SF-507.

(q) Do not use the term "usual childhood illnesses"; however, childhood illnesses (those occurring before age 12) may be grouped together enumerating each one. Incidents, other than those occurring in childhood, shall have the date recorded rather than the examinee's age. Do not use "NS" or "non-symptomatic" for items of history. Use "NCNS," "No Comp., No Seq." after items of recorded history where applicable. Elaborate on all items of history answered affirmatively except "Do you have vision in both eyes". The following specific questions shall also be asked on examination for initial entry into the Coast Guard, and for aviation and diving duty applicants:

1 "Is there a history of diabetes in your family (parent, sibling, or more than one grandparent)?"

2 "Is there a history of psychosis in your family (parent or sibling)?"

3 "Do you now or have you ever worn contact lenses?"

4 "Do you now or have you ever used or experimented with any drug, other than as prescribed by a physician (to include LSD, marijuana, hashish, narcotics, or other dangerous drugs as determined by the Attorney General of the United States)?"

5 "Have you ever required the use of an orthodontic appliance attached to your teeth or a retainer appliance? Month and year last worn? Are they still necessary?"

6 "Are there any other items of medical or surgical history that you have not mentioned?" All affirmative answers to the above questions shall be fully elaborated in Item 25. Negative replies to the above questions shall be summarized as follows: "Examinee denies history of psychosis, use of drugs, history of wearing of contact lenses, requirement for any orthodontic appliance, all other significant medical or surgical history; family history of diabetes." A rubber stamp or the overprinting of this information in Item 25 is recommended.

(3) Distribution. Attach the original DD-2807-1 to the original DD-2808 and submit to reviewing authority. A copy of the DD-2807-1 and DD-2808 shall be kept on file at the unit pending the return of the approved DD-2807-1 and DD-2808.. After review and endorsement, the reviewing authority shall forward the original DD-2807-1 and DD-2808 to the members parent command for insertion into the members health record.

8. **SF-558 (Emergency Care and Treatment) (Rev 9-96).** See Encl (1), pg. 4-13. This form provides a comprehensive yet concise record of emergency health care. It shall be used whenever an individual receives emergency treatment. Detailed instructions for completing the form are as follows:

a. Patient's Home Address or Duty Station. Complete all blocks in this section.

b. Arrival. Record the date and time the patient arrived at the clinic or emergency room for care.

c. Transportation to Facility. Record the name of the ambulance company or unit that transported the patient for care, if appropriate. If patient was not transported by ambulance or other emergency vehicle, enter "N/A'.

d. Third Party Insurance. List detailed insurance if known by patient. If potential third party liability exists, forward a copy of SF-558 to Commandant (G-WRP-2). Note: Disregard DD2568 in chart, enter N/A).

e. Current Medications. List all medications patient is presently taking.

f. Allergies. Record any substance or drug to which the patient has a known or suspected allergy. If none, enter "NKA" (No Known Allergy).

g. Injury or Occupational Illness. Most fields. When, refers to date injury was sustained. Where, refers to location injury occurred. How, refers to what happened (briefly).

h. Emergency Room Visit. Self-Explanatory.

i. Date of Last Tetanus Shot. Self-Explanatory.

j. Chief Complaint. Record a brief description of why the patient is seeking health care.

k. Category of Treatment. If Condition is Result of Accident/Injury. Check the block that best describes the patients' condition upon arrival.

(1) Emergent. A condition which requires immediate medical attention and for which delay is harmful to the patient; such a disorder is acute and potentially threatens life or function.

(2) Urgent. A condition which requires medical attention within a few hours or danger can ensue; such a disorder is acute but not necessarily severe.

(3) Non-Urgent. A condition which does not require the immediate resources of an emergency medical services system; such a disorder is minor or non-acute

l. Vital Signs. Take and record all vital signs. Indicate the time vitals were taken. Use 24-hour clock annotation i.e. 0215.

m. Lab Orders and X-Ray Orders. Self-Explanatory, check appropriate box.

n. Orders. List orders given by provider. Record all medications, appointments made. Or any other follow-up plans.

o. Disposition. Check appropriate box. Ensure patient understands this section.

p. Patient/Discharge Instructions. Be specific. Ensure patient understands instructions given.

q. Patients Signature and Date. Have the patient or person accompanying the patient sign the form. This signature only acknowledges that instructions were given to the patient.

r. Time Seen by Provider. Record the time when the patient received treatment. Use 24-hour clock annotation i.e. 0215.

s. Test Results. Record results of tests ordered on patient.

t. Provider History/Physical. Self-explanatory, use standard S.O.A.P. format.

u. Consult With. List all individuals that on-scene provider received medical advice from. Example Dr. Richard Smith.

v. Diagnosis. Record patient diagnosis.

w. Providers Signature and Date. The medical officer or other health care provider shall sign and date the form.

x. Codes. List all ICD-9 codes applicable to the patient.

y. Patients' Identification. Ensure all patient identification information is entered.

9. DD-2215 Reference Audiogram. Optional. Place form in section V of the Health Record.

10. DD-2216 Hearing Conservation Data. Optional. Place form in section V of the Health Record.

11. Audiogram Results. The Microprocessor will generate a legal archival test result strip, which shall be fastened to a separate SF-514, Clinical Record-Laboratory report form, dedicated to this purpose and filed under section V of the Health Record. Label this SF-514 "Hearing Conservation Program" across the bottom.

    a. All test result strips shall be placed sequentially onto form SF-514 in left to right formation overlapping 2/3 of the last audiogram.

12. **SF-502 (Narrative Summary).** See Encl (1), pg.4-15. SF-502's are used for a variety of purposes, such as:

    a. to summarize the important facts about a patient's hospitalization;

    b. to summarize the findings of a medical board; or

    c. to report the results of a Board of Flight Surgeons.

    If received subsequent to the individual's discharge from the hospital, it shall be inserted in the health record immediately upon receipt.

13. NAVMED 6100/1 (Medical Board Report Cover Sheet).

a. The NAVMED 6100/1 is used in preparing a medical board. A copy of the NAVMED 6100/1 and the complete medical board shall be inserted into the individual's health record.

b. Detailed instructions for preparing and distributing this form are contained in Physical Disability Evaluation System, COMDTINST M1850.2 (series).

14. **SF-513 (Consultation Sheet).** See Encl (1), pg 4-16.

a. Purpose. SF-513 is used whenever a patient is referred to another facility for evaluation.

b. Detailed Instructions. Complete the form as follows:

(1) To. Facility or department to which the patient is being referred.

(2) From. Unit referring the patient.

(3) Date of Request. Self-explanatory.

(4) Reason for Request. Specify the reason for referring the patient, i.e., chest pains, infected sebaceous cyst, etc.

(5) Provisional Diagnosis. Self-explanatory.

(6) Doctor's Signature. Must be signed by a medical officer, dental officer, or health services department representative. Accompanying this signature should be the qualifying degree of the individual requesting the consult.

(7) Approved. Leave Blank.

(8) Place of Consultation. Check the appropriate block.

(9) Emergency/Routine. Check the appropriate block.

(10) Identification No. Enter the patient's SSN.

(11) Organization. Enter patient's branch of service.

(12) Register No. If inpatient, enter the appropriate register number. If outpatient, leave blank.

(13) Ward No. If outpatient enter "OP." If inpatient, enter appropriate ward number.

(14) Patient's Identification. Enter the appropriate patient identification information.

(15) The remainder of the form is completed by the consultant.

c. When the consultation sheet (SF-513) is completed and returned by the consultant, the following actions are required:

(1) Originator shall review and sign the SF-513;

(2) Originator shall complete a Visit Profile sheet (CG-5460B) as directed by Use of Clinic Automated Management System (CLAMS), COMDTINST 6010.18(series) for later entry into CLAMS; and

(3) The SF-513 shall then be filed in the appropriate dental or medical section of the health record.

15. **SF-520 (Electrocardiographic Report).** See Encl (1), pg.4-17.

a. Purpose. SF-520 is used to report the results of all electrocardiograms.

b. Detailed Instructions. The individual performing the electrocardiogram shall complete the form as follows:

(1) Previous ECG. Check appropriate block

(2) Clinical Impression. Reason why the electrocardiogram was requested, e.g., chest pain, physical examination, etc.

(3) Medication. Enter any medications that the patient is taking.

(4) Emergency/Routine. Check appropriate block.

(5) Bedside/Ambulant. Check appropriate block.

(6) Age. Enter patient's age as of last birthday.

(7) Sex. Enter "M" or "F," as appropriate.

(8) Race. Leave blank.

(9) Height. Enter to nearest one-half centimeter (one-half inch).

(10) Weight. Enter to the nearest kilogram (pound).

(11) B.P. Enter recumbent blood pressure.

(12) Signature of Ward Physician. Signature of medical officer ordering the electrocardiogram.

(13) Date. Date the ECG was performed using appropriate format.

(14) Register No. Enter patient's social security number.

(15) Ward No. Enter "OP" (outpatient) or appropriate ward no.

(16) Patient's Identification. Enter the appropriate patient identification information.

(17) The remainder of the form is completed by the medical officer evaluating the electrocardiogram.

c. The baseline ECG shall be appropriately marked "Baseline ECG."

16. **SF-515 (Tissue Examination).** See Encl (1), pg.4-18.

a. Prepare a SF-515 whenever a tissue specimen is forwarded to a laboratory for examination.

b. Ensure patient's identification information is completed.

17. **SF-541 (Gynecologic Cytology).** See Encl (1), pg.4-19.

a. Prepare a SF-541 whenever a vaginal or cervical smear (PAP test) is forwarded to a laboratory for examination.

b. Ensure patient's identification information is completed.

18. **SF-514 (Laboratory Reports).** See Encl (1), pg.4-20.

a. This is a display form for mounting graphic reports, automated printout reports, or printed reports associated with special equipment.

b. Attach the laboratory reports to the indicated spaces with the most recent on top.

c. Ensure patient's identification information is completed.

d. Clinical Record - Laboratory Report Display (SF-545). May be used in lieu of SF-514. This is a display form for mounting laboratory requests and report forms. When a patient will require the same type of test several times, a separate display sheet shall be used for each type of test. In low use situations, the various test result forms should be mounted on alternate strips 1, 3, 5, and 7.

(1) The following Standard Forms should be mounted serially on strips 1, 2, 3, 4, 5, 6, and 7:

(a) Chemistry I (SF-546),

(b) Hematology (SF-549),

(c) Urinalysis (SF-550), and

(d) Serology (SF-551).

(2) The following Standard Forms be mounted on alternate strips 1, 3, 5, and 7:

(a) Chemistry II (SF-547);

(b) Chemistry II (Urine) (SF-548);

(c) Parasitology (SF-552);

(d) Spinal Fluid (SF-555); and

(e) Immunohematology (SF-556).

e. In many instances there will be a mixed assortment of Standard Forms to be mounted in a patient's chart and obviously these should be mounted in the most practical sequence.

f. Instructions for attaching the laboratory report forms to this display sheet are printed at the bottom of the SF-545. A check mark in the space in the lower right corner identifies the name of the laboratory forms that are displayed on this sheet or indicates that a variety or assortment of forms is displayed on the sheet.

19. SF-545a - Clinical Record - Laboratory Report Display for SF-553, SF-554, and SF-557. This is a display form for mounting Microbiology I, Microbiology II, and miscellaneous forms for inclusion in the health record. It may be used, when indicated, in addition to SF-514.

20. SF-546 - 557 (Laboratory Requests).

a. SF-546 (Chemistry I). Used to request most blood chemistry tests. Fill in the identification data as described previously. The specimen sources information is given by checking the box marked BLOOD or by specifying information in the position marked OTHER. The names of the blood chemistry tests are listed individually on this form. At the bottom of the list there is provision for ordering a battery or profile of tests. When requesting the identifying names of the battery or profile of tests must be written into the space provided. There is also space for writing in the names of other tests not specifically listed.

b. SF-547 (Chemistry II). Used to request blood gas measurement, T3, T4, serum, iron binding capacity, glucose tolerance, and other chemistry tests. Fill in the identification data as described previously. The specimen source information is given by checking the box marked BLOOD or by specifying information in the position marked OTHER.

c. SF-548 (Chemistry II, Urine). Used to request chemistry tests on urine specimens. The specimen interval information is given by checking the box marked 24 HOURS or by specifying information in the position marked OTHER.

d. SF-549 (Hematology). Used to request routine hematology tests. The specimen source information is given by checking box marked VEIN, the box marked CAP for capillary, or by specifying information in the position marked OTHER.

e. SF-550 (Urinalysis). Used to request urinalysis tests, including routine urinalysis with microscopic examination. The specimen source information is given by checking the box marked ROUTINE or by specifying information in the position marked OTHER. (Note that routine urinalysis may be ordered by simply placing an "X" in front of the word MICROSCOPIC in the requesting section.) The space marked PSP is for requesting and reporting phenolsulfonphthalein measurements. The space marked HCG is for requesting and reporting measurements of human chorionic gonadotropin.

f. SF-551 (Serology). Used to request tests that measure serum antibodies, including tests for syphilis.

(1) The space marked RPR is for requesting and reporting measurements of the Rapid Reagent Card Test for Syphilis

(2) The space marked TA is for requesting and reporting measurements of the Latex Fixation Test for Thyroglobulin Antibodies.

(3) The space marked COLD AGG is for requesting and reporting of Cold Agglutinins.

(4) The space marked ASO is for requesting and reporting Antistreptolysin 0 titers.

(5) The space marked CRP is for requesting and reporting measurements of C Reactive Protein.

(6) The space marked FTA-ABS is for requesting and reporting for fluorescent treponemal antibody-absorption test.

(7) The space marked FEBRILE AGG is for requesting and reporting measurements of Febrile Agglutinins.

(8) The space marked COMP FIX is for requesting and reporting Complement Fixation Tests. The name of the specific antibody should also be written in this space.

(9) The space marked HAI is for requesting and reporting Hemagglutination Inhibition Tests. The name of the specific antibody should also be written in this space.

g. SF-552 (Parasitology). Used to request tests for intestinal parasites, malaria and other blood parasites, as well as most test on feces. Fill in identification data as described previously.

h. SF-553 (Microbiology I). Used to request most bacteriological isolations and sensitivities.

(1) The type of the patient's infection, according to origin, is indicated by checking one of the boxes in the space marked INFECTION in the upper right area of the form.

(2) The examination requested is indicated by checking either the box marked SMEAR, SENSITIVITY, CULTURE, or COLONY COUNT.

(3) The report of the examination is written or stamped on the form by the laboratory personnel.

(4) The names of the bacteria identified or isolated are listed in the space marked PREDOMINANT ORGANISM(S).

(5) The sensitivity listing and results are stamped or written in the space marked SENSITIVITY.

i. SF-554 (Microbiology II). Used to request tests for fungi, acidfast bacillus (TB), and viruses.

(1) The type of infection according to origin is indicated by checking one of the boxes in the space marked INFECTION.

(2) The examination(s) requested is checked in the sections for fungus test or AFB tests or viral cultures.

(3) The test results are stamped or written on the form by the laboratory personnel.

j. SF-555 (Spinal Fluid). Used to request most spinal fluid tests.

k. SF-556 (Immunohematology). Used to request blood grouping, typing, and blood bank tests.

l. SF-557 (Miscellaneous). Used to request and report tests such as electrophoresis and assays of coagulation factors, which are not ordered on other laboratory forms.

(1) Fill in the identification data as described previously.

(2) The specimen source is specifically described in the space marked SPECIMEN SOURCE.

(3) Write the name of the test requested in the request section of the form.

21. **SF-519 (Radiographic Reports).** See Encl (1), pg.4-21.

a. This is a display form for mounting Radiographic Reports (SF-519-A). Attach the SF-519-A to the indicated spaces, with the most recent report on top.

b. Use SF-519-A to request x-ray examinations. All patient data must be completed as indicated. Ensure that examinations requested are in standard terms or abbreviations.

ALL pertinent clinical history, operations, physical findings, pregnancy status, and provisional diagnoses must be recorded in the appropriate space. This information is needed by the radiologist in order to render a proper interpretation of the film.

c. Complete the required patient's identification information.

22. **DD-771 (Eyewear Prescription)**. See Encl (1), pg.4-22. Type DD-771 for clarity and to avoid errors in interpretation, using the following format:

a. Date. Enter as follows, 22 JAN 87, etc.

b. Order Number. Enter unit identifying number, issued by NOSTRA or Top Gun Fantasy Ray Ban, above the order number block. Complete order number block if desired.

c. To. Appropriate fabricating facility.

d. From. Enter complete unit address of unit ordering the eyewear.

e. Name, Service Number/Social Security Number. Enter as ALBERT, Michael W. HSC 123-45-6789.

f. Age. Self-explanatory.

g. Unit and Address. Enter complete mailing address of unit to which individual is attached. If retiree, use the individual's home or mailing address.

h. Active Duty, etc. Check appropriate block.

i. USA, USN, etc. Check appropriate block.

j. Spectacles. Check appropriate block.

k. Aviation Spectacles. Use this block only when ordering aviation frames. Check as appropriate:

(1) N-15 tinted lenses;

(2) Coated lenses (coated with an anti-glare compound) are not authorized for Coast Guard personnel.

l. Other. Leave blank.

m. Interpupillary Distance. Copy directly from patient's Prescription, previous DD-771, or SF-600.

n. Eye Size. As above. (Not required for aviation goggles)

o. Bridge Size. As above. (Not required for aviation goggles)

p. Temple Length and Style. As above. (Not required for aviation goggles)

q. Number of Pairs. Enter the number of pairs requested.

r. Case. Enter the number of cases requested.

s. Single Vision.

(1) Sphere. Copy directly from individual's prescription, previous DD-771, or SF-600 (+1.00, -1.25, etc.). Prescriptions are filled in multiples of 0.25 diopters only.

(2) Cylinder. As above, except that prescriptions or multivision lenses must be in "minus cylinder" form, (-0.50, -0.75, etc.).

(3) Axis. Copy directly from individual's prescription, previous DD-771, or SF-600. The axis must contain three (3) digits such as: 180, 090, 005, etc.

(4) Decentration. Need not be completed unless specified as a part of prescription.

(5) Prism. As indicated on individual's prescription, previous DD-771, or SF-600.

(6) Base. As above.

t. Multivision. If the individual needs multivision lenses (bifocals, trifocals, etc.) then the prescription must be in minus cylinder form.

u. Special Lenses or Frames. This block is used for special instructions or justification for aviation spectacles, or nonstandard lenses, and frames, etc.

(1) When replacement eyewear is ordered from a prescription extracted from the health record, enter the following entry in this block: "REPLACEMENT ORDER: PRESCRIPTION FROM REFRACTION PERFORMED ON DATE."

(2) When eyewear is ordered for recruits, enter the following entry in this block: "RECRUIT - PLEASE EXPEDITE."

(3) When tinted lenses are ordered for non-aviation personnel, enter a written justification in this block. "Tinted lenses STATE JUSTIFICATION."

(4) When nonstandard temples or frames are ordered, enter type frame or temple requested, and justification:

(a) Riding Bow Cables, (Justification);

(b) Adjustable Nose Pads, (Justification).

(5) When an individual's pupillary distance is less than 60 mm it must be verified and an entry placed in this block: "PD of ____ verified and correct."

v. Signature of Approving Authority. Shall be signed by the senior medical officer, designated representative, or the commanding officer where no medical officer is present.

w. Signature of the Prescribing Officer. Shall be signed by the medical officer or person performing the refraction. When this is not possible, i.e., examination obtained from a civilian source, transcribed from the health record, etc., the person transcribing the information shall sign as prescribing officer. Flight surgeons may sign prescriptions as both the prescribing and approving authority.

23. **SF-601 (Immunization Record)**. See Encl (1), pg.4-23.

a. All prophylactic immunizations; sensitivity tests; reactions to transfusions, drugs, sera, food and allergies, and blood typings shall be recorded on SF-601 and also on the PHS-731. The recordings shall be continued on the current record until additional space is required under any single category.

b. In such cases, insert a new SF-601 in the health record and retain the old SF-601. Concurrently, make a thorough verification of the entries and bring all immunizations up-to-date. Replacement of the current SF-601 is not required because of change in grade, rating, or status of the member concerned.

c. The name of the individual administering the immunization or test, or determining the nature of the sensitivity reaction, shall be typed or a rubber stamp used. Signatures on SF-601 are not required. However, in the event of their use, make sure they are legible.

d. The individual administering the immunizations is responsible for completing all entries in the appropriate section, including required entries on reactions.

e. Enter information concerning a determined hypersensitivity to an immunization or vaccine under "Remarks and Recommendations". Type appropriate entries (such as HYPERSENSITIVE TO TYPHOID) in capitals. Enter "HIV antibody testing done (enter date(s))".

f. For Yellow Fever vaccine, record the origin and batch number.

24. **SF-602 (Syphilis Record).** See Encl (1), pg. 4-25.

a. This form shall be prepared and inserted in the health record for each person for whom a confirmed diagnosis of syphilis or any of its complications or sequela has been established.

b. The medical officer shall carefully and thoroughly explain to the patient the nature of the infection and the reasons why treatment, prolonged observation and the repeated

performance of certain prescribed tests are necessary. The patient shall then be requested to sign the statement in Section II of SF-602.

24. **DD-1141 (Record of Occupational Exposure to Ionizing Radiation)**. See Encl (1), pg.4-27.

a. Requirements. The custodian of the medical records shall prepare and maintain as DD-1141 for each person occupationally exposed to ionizing radiation. Enter all exposures in rems.

b. Recording Procedures.

(1) Initial Determination of Accumulated Dose.

(a) In the initial preparation of DD-1141, obtain complete reports of previous exposure. For each period in which the individual was engaged in activities where occupational exposure was probable, and no record, or only an incomplete record of exposure during the period can be obtained, assume that an occupational exposure of 1.25 rems was incurred per quarter of each calendar year or fraction thereof.

(b) In cases where the nature of the radiation is unknown, assume gamma radiation.

(c) If an individual was exposed at more than one facility, calculate the cumulative exposures and record them in Items 7 through 12 as appropriate. Enter the sum of the whole body exposure in Item 13, and a statement regarding the sources of that information in Item 16, REMARKS.

(2) Current Record.

(a) Quarterly, make appropriate entries on each individual's DD-1141 from the exposure records received from the Public Health Service Contractor.

(b) Maintain separate DD-1141 to record exposures other than whole body, with appropriate descriptions under Item 16, REMARKS.

c. Completion Instructions.

(1) Item 1. Leave blank.

(2) Item: 2. Enter last name, first name, and middle initial. If the combination of last name and first name exceed 19 spaces, enter last name and initials only.

(3) Item 3. Enter SSN.

(4) Item: 4. Enter in not more than 10 spaces, rate, grade, title or position the individual is currently holding. Use standard service abbreviations: i.e.,

CAPT; HSCS; HSl; etc. Abbreviate civilian occupation titles as needed; i.e., Radiological Physicist to Rad Physic; Radiation Physiologist to Rd Physiol; Electrical Welder to Elec Wldr; etc.

(5) Item 5. Enter date of birth: i.e., 4 SEP 87.

(6) Item 6. Enter name of activity or unit.

(7) Items 7 & 8. "Period of Exposure." Enter the day, month, and year: i.e., 1 MAR 87.

(8) Items 9-12. "Dose This Period." Enter radiation dose received this period to three decimal places: i.e., 02.345rem. Use five digits including zeros as necessary for all entries.

(a) Item 9. Enter skin dose (soft) which includes low energy gamma and x-ray of less than 20 KVE effective energy and beta radiation. Total skin dose is the addition of columns 9 and 12.

(b) Item 10. Enter gamma and x-ray dose greater than 20 KVE effective energy in REM.

(c) Item 11. Enter neutron dose in REM.

(d) Item 12. Enter sum of items 10 and 11.

(9) Item 13. Add item 12 to previous item 13; enter total in item 13.

(10) Item 14. Enter permissible dose calculated from the age formula 5(N-18) REM, where N equals the present age in years.

(11) Item 15. Recorder certify entries by initial.

(12) Item 16. Enter other pertinent information such as known exposure from internally deposited radioactive material or from any external radioactive sources. Describe briefly any activity or assignment bearing a potential for exposure and estimate dose-time relationships, if feasible. If this form is used for other than whole body and skin of whole body, specify the use; i.e., hands and forearms, feet and ankles, thyroid, etc. When recorded dose is not obtained from film badge readings, specify whether estimates were obtained from pocket dosimeters, area or air monitoring, bioassay, etc.

25. **CG-4057 (Chronological Record of Service).** See Encl (1), pg 4-28.

a. Purpose. Use this form:

(1) to maintain a chronological record of assignments for each active duty member of the Coast Guard;

(2) as a statement of agreement or disagreement with the assumption of fitness for duty upon separation from the Coast Guard; and

(3) to terminate the health record.

b. Chronological record of assignments. Prepare original only. Record the member's full name in all capitals, together with the Social Security Number. Make entries each time a member leaves or returns from PCS, TAD, or hospitalization at a unit different than the one to which currently assigned.

c. Agreement or disagreement with the assumption of fit for duty at the time of separation. Members not already in the physical disability evaluation system, who disagree with the assumption of fitness for duty at separation shall indicate on the reverse of form CG-4057. They shall then proceed as indicated in paragraph 3-B-5. of this Manual. Members who agree with the assumption shall check the box indicating agreement. This is a health services department responsibility when there is a health services department representative attached; otherwise it becomes a personnel action.

d. Terminating the health record. The reverse side of the form is also used to terminate a member's health record upon definite separation from active service. The date of termination is the effective date of separation. Make appropriate entries giving the reason for termination, the date of termination and the grade and signature of the responsible commissioned officer in the bottom portion of the form. Additionally, an entry, signed by the member whose health record is being terminated, acknowledging the receipt of a copy all available NAVMED 6150/20's, a copy of separation examination if done (either DD-2808 or SF-600 entry), a signed copy of the CG-4057, and the PHS-731 shall be made in the Remarks section of the CG-4057.

e. This form is also used to notify the individual of the possibility of certain disability benefit entitlements from the Department of Veterans Affairs after separation.

f. If either side of the CG-4057 is filled, the reverse side shall have a line drawn diagonally through it in red and a second CG-4057, marked "Supplement" at the top, started.

26. **NAVMED 6150/2 (Special Duty Medical Abstract)**. See Encl (1), pg. 4-30.

a. General. The purpose of the NAVMED 6150/2 is to provide a record of physical qualifications, special training, and periodic examinations of members designated for performing special duty, such as aviation and diving. The object of the special duty examination, and the instructions incident thereto, is to select only those individuals who are physically and mentally qualified for such special duty, and to remove from such status those members who may become temporarily or permanently unfit for such duty because of physical or mental defects. Also, in this connection, special money disbursements are often based upon the determination of a member's physical and mental qualifications or continued requalification for performing a special duty.

Therefore, accuracy and content of information are essential in reporting information applicable to these categories.

b. Entries.

(1) Record entries upon completion of each physical examination and completion of designated special training. When a previously qualified member is suspended from special duty for physical reasons, enter the period of suspension and reason therefore on the NAVMED 6150/2.

(2) The scope of the physical examination and technical training prescribed for these special categories often differs from the general service requirements; therefore, entries reporting results which pertain to these particular examinations or training involved shall be approved only by medical officers.

27. PHS-731 (International Certificate of Vaccination).

a. General.

(1) Prepare PHS-731 for each member of the Coast Guard (for reserve personnel when ordered to Active Duty for Training). This form shall be carried only when performing international travel or when reporting for Active Duty for Training. When not required for either of the preceding reasons, the completed certificate shall be retained in the individual's health record. Appropriate entries shall be made on PHS-731 and SF-601 when immunizations are administered.

(2) A reservist not on extended active duty who plans international travel either under official orders or privately, may request that the appropriate district commander (r) furnish a PHS-731 for this purpose. The reservist shall return the PHS-731 to the district commander (r) when travel is completed.

(3) When properly completed and authenticated, the PHS-731 contains a valid certificate of immunization for international travel and quarantine purposes in accordance with World Health Organization Sanitary Regulations.

(4) All military and nonmilitary personnel performing international travel under Coast Guard cognizance shall be immunized in accordance with Commandant Instruction 6230.4 (series) and shall have in their possession a properly completed and authenticated PHS-731.

b. Detailed Instructions.

(1) Stamp or type the following address on the front of PHS-731:

Commandant (G-WK)

U. S. Coast Guard

2100 Second St., S.W.

Washington, DC 20593-0001

(2) Enter data by hand, rubber stamp, or typewriter.

(3) Enter the day, month, and year in the order named (i.e., 4 SEP 87).

(4) Record the origin and batch number for yellow fever vaccine.

(5) Entries for cholera and yellow fever must be authenticated by the Department of Defense Immunization Stamp and the actual signature of the medical officer. Other immunizations may be authenticated by initialing. Entries based on prior official records shall have the following statement added: "Transcribed From Official Records."

c. Remove the PHS-731 from the health record and give it to the individual upon separation from the Service.

28. **CG-5214 (Emergency Medical Treatment Report).** See Encl (1), pg. 4-32.

a. Purpose. CG-5214 provides a multiple copy record of all emergency medical care rendered by Coast Guard personnel outside of a clinic or sickbay. All care rendered by crews of Coast Guard emergency vehicles must be documented with a CG-5214.

(1) Part 1, Copy to Patient. This copy shall be placed in the patients' health record if available.

(2) Part 2, Copy to Receiving Unit. This copy shall be given to the hospital, clinic, or EMS crew assuming responsibility for patient care.

(3) Part 3, Copy to Triage Officer. In multi-casualty incidents, this copy shall be given to the triage officer to account for the patients' treatment priority and status. Otherwise, this copy shall be kept on file at the clinic or sickbay.

(4) Part 4, (hard copy) to Commandant (G-WKH-1). This copy shall be forwarded to Commandant (G-WKH-1) using the mailing label on the reverse side.

b. Preparation and Submission of CG-5214. The form provides an accurate account of the patient's injury or illness, and a detailed report of all treatments rendered en route to a receiving facility. If possible, the report should be completed during the transport phase. Detailed instructions for completing the CG-5214 are as follows:

(1) Victim Identification.

(a) Item 1: Name. Enter last, first, and middle initial.

(b) Item 2: Sex. Check one.

(c) Item 3: Estimated Age. Enter in years or months.

(2) Description of Incident.

(a) Item 4: Date. Enter date incident occurred.

(b) Item 5: Type of Incident. Check one and give pertinent details under "Nature of Emergency/Mechanism of Injury".

(c) Item 6: Time on Scene. Enter (using 24 hour clock).

(d) Item 7: Time of Incident. Enter (using 24 hour clock).

(e) Item 8: Location. Enter exact geographical area.

(3) Observation of Victim. Stick-Man figure: Place applicable injury letter code over injured area.

(4) Skin. Circle applicable number.

(5) Vital Signs. Note time observed (24 hour clock).

(6) Level of Consciousness. Check only one per time observed.

(7) Pupils. Check only one per time observed.

(8) Pulse. Place numerical value under rate and check appropriate space for quality.

(9) Breathing. Place numerical value under rate and check appropriate space for quality.

(10) Blood Pressure. Enter systolic and diastolic values under applicable time.

(11) Temperature. Circle either oral or rectal and enter in numerical value.

(12) Mast. Beside "Mast BP" enter blood pressure values. Circle applicable compartments inflated.

(13) Triage Information. Circle one of the following:

(a) Priority I: Patients with airway and/or breathing problems, cardiac arrest, uncontrolled bleeding or controlled bleeding with symptoms of shock, severe head or abdominal injuries, and severe medical problems to include possible heart attack, severe burns, and severe poisonings.

(b) Priority II: Patients with less serious burns, multiple fractures, potential C-Spine injuries without shock, or medical conditions of a less serious note.

(c) Priority III: Patients with obvious minor injuries or patients who are obviously dead or mortally wounded.

(14) Medications. List any medications the patient is currently taking.

(15) Allergies. List any known allergies for the patient.

(16) Medications Administered. Note the time, dosage, and route of administration for any medications administered to the patient.

(17) Rescuer Information.

(a) Item 10: Name. Enter last, first, and middle initial.

(b) Item 11: Level. Circle appropriate certification level.

(c) Item 12: Unit. Rescuer's assigned unit.

(d) Item 13: OPFAC#. Enter.

(e) Item 14: rescue Vehicle. Identity of the responding vehicle, vessel, or aircraft.

(f) Item 15: Receiving Unit. Hospital, EMS vehicle, or clinic assuming responsibility for patient care.

(g) Time Patient Transferred. Enter (24 hour clock).

29. **DD877 (Request for Medical/Dental Records or Information)**. See Encl (1), pg. 4-33.

a. Purpose. The DD 877 is a self-carboning triplicate form which is used to forward health and clinical records between clinics and units as well as to request records from clinics, units, or MTFs.

b. General. This form shall be initiated and included with health and clinical records as directed in Chapter 4-A-6. And 4-D-7. Of this Manual

c. Detailed Instruction.

(1) Each DD877 must have all boxes completed.

(2) n all instances when a DD877 is initiated, remarks concerning the reason for sending the record, the name of the gaining unit for the member/ sponsor and a request for action will be included on the form. When preparing a DD877 for a record to be forwarded, place the following in section 9., REMARKS: "Health {clinical} record for this member (family member) is forwarded to you for appropriate filing. Member (sponsor) assigned to (insert gaining unit name)."

(3) For members entering the inactive reserve, enter the following in section 9, remarks**: " member entering inactive reserve in your district**. Per Medical Manual, COMDTINST M6000.1B, Chapter 4-B-4.b.,this health record is forwarded for appropriate action."

(4) A copy of the DD877 will be retained at the unit sending the record for 6 months after the record is mailed, then may be discarded.

Section C - Dental Record Forms.

1. **CG-3443-2 (Dental Record Cover).** See Encl (1), pg. 4-34.

   a. Open a CG-3443-2 for each individual upon arrival at a training center or initial entry into the Coast Guard or Coast Guard Reserve. When an individual on the retired list returns to active duty, submit a request for a copy of the closed out dental record to Commandant (G-PIM). Whenever the original record is lost or destroyed, a new dental record shall be opened immediately. Normally the dental record shall be kept in the Health Record Cover (CG-3443) of each individual unless otherwise specified.

   b. All dental forms and radiographs will be contained in the Dental Record.

   c. Detailed Instructions.

      (1) Surname. Record the surname in all capital letters.

      DOE

      SURNAME

      (2) Given name(s). Record in full without abbreviation. If the individual has no middle name or initial then record the lower case letter "n" in parentheses (n). If the individual has only a middle initial(s), record each initial in quotation marks. When "Jr." or "II" or other similar designations are used, they shall appear after the middle name or initial.

      DOE JANE ANN

      SURNAME First Name Middle Name

      (3) Social Security Number (SSN). Enter Social Security Number.

      (4) Date of Birth. Enter day, month (abbreviated JAN, FEB, MAR, etc.), and the year: i.e., 4 SEP 49.

      (5) Change in Grade or Rate. Enter as they occur.

      (6) Blood Type. Enter the individual's blood type in the appropriate box. If not known, perform a blood type test.

      (7) RH Factor. Enter the individual's RH factor in the appropriate box. If not known, perform an RH factor test.

      (8) Drug Sensitivity Sticker. When required, affix the Drug Sensitivity Sticker (CG-5266) to the lower left corner of the front of the Dental Record Cover. Do not cover other identification data. **See Encl (1) pg. 4-34.**

      (9) Dental Radiographs.

(a) Dental Bitewing Radiograph Storage. Bitewing radiographs shall be stored in the standard stock 5 year x-ray card (FSC# 6525-00-142-8732). This shall replace the single bitewing x-ray card (FSC# 6525-00-817-2364). X-ray film is mounted in the x-ray card with the raised dot side of the film on the back side of the card.

2. **NAVMED 6600/3 (Dental Health Questionnaire)**. See Encl (1), pg. 4-35.

a. General. CG-5605 will help the dental officer detect any present or past health problem (i.e., positive Human Immunodeficiency Virus (HIV)) that might interfere with definitive dental treatment. All positive answers from the health history section must be followed up by the dental officer for impact on health care and so annotated on the CG-5605 and/or the SF-603A.

b. Detailed Instructions. Insert the Dental Health Questionnaire as the first page of the dental record. Patients shall fill out a new Dental Health Questionnaire at least annually, or when information changes. Maintain the two most recent forms in the dental record with the current CG-5605 on top.

(1) Chief Complaint. Have the patient enter the problem they are presently having.

(2) Check and Sign. Have the patient enter yes/no in each box of the history. The signature indicates the authenticity of the history.

(3) Summary of Pertinent Findings. Include baseline BP reading.

3. **SF-603 (Dental Record).** See Encl (1), pg. 4-36.

a. General. The Dental Record is a continuous history and must contain accurate and complete entries of dental examinations and treatments. Each entry shall clearly indicate the name of the dental officer conducting the examination and/or rendering the treatment. Dental hygienists or other auxiliary personnel providing care shall also follow this requirement. Each dental officer is personally responsible for ensuring that all entries are properly recorded.

b. Numerical Classification for Record Purposes. Chart markings have been standardized so that dental conditions, treatments needed, and treatments completed may be readily identified. This facilitates efficient continuity of treatments and may establish identification in certain circumstances.

(1) For the purpose of brevity and exactness, use the following classification of teeth in keeping the dental record.

TOOTH	DESIGNATION
Right Maxillary Third Molar	1
Right Maxillary Second Molar	2

Right Maxillary First Molar	3
Right Maxillary Second Bicuspid	4
Right Maxillary First Bicuspid	5
Right Maxillary Cuspid	6
Right Maxillary Lateral Incisor	7
Right Maxillary Central Incisor	8
Left Maxillary Central Incisor	9
Left Maxillary Lateral Incisor	10
Left Maxillary Cuspid	11
Left Maxillary First Bicuspid	12
Left Maxillary Second Bicuspid	13
Left Maxillary First Molar	14
Left Maxillary Second Molar	15
Left Maxillary Third Molar	16
Left Mandibular Third Molar	17
Left Mandibular Second Molar. .	18
Left Mandibular First Molar	19
Left Mandibular Second Bicuspid	20
Left Mandibular First Bicuspid	21
Left Mandibular Cuspid	22
Left Mandibular Lateral Incisor	23
Left Mandibular Central Incisor	24
Right Mandibular Central Incisor	25
Right Mandibular Lateral Incisor	26
Right Mandibular Cuspid	27
Right Mandibular First Bicuspid	28
Right Mandibular Second Bicuspid	29
Right Mandibular First Molar	30
Right Mandibular Second Molar	31
Right Mandibular Third Molar	32

(2) Indicate deciduous teeth by placing a block "D" around tooth number. If both permanent and deciduous teeth are present, place a "D" in location of deciduous tooth and enter the appropriate tooth number inside the "D."

(3) Indicate a supernumerary tooth by placing "s" in the location of the supernumerary tooth and in the remarks section enter a statement that the examinee has a supernumerary tooth.

(4) Indicate deciduous and supernumerary teeth on the SF-603 in SECTION I, Part 5 (Diseases, Abnormalities, and Radiographs) and enter a statement in the remarks section of Section 5.

c. Detailed Instructions.

SECTION I. DENTAL EXAMINATION

(1) Purpose of Examination. To assess the oral health status of cadets, officer candidates and enlisted recruits upon initial entry into the Coast Guard, and to provide periodic (but at least annual) examinations of active duty personnel. Enter an "X" in the appropriate box. Mark the "Initial" box for the dental examination made upon entrance into the Coast Guard. All other examinations fall under the "Other" category and shall be identified: i.e., "Academy", "Reenlistment", etc.

(2) Type of Examination. Enter an "X" in the proper box of item 2, "Type of Exam."

(a) Type 1, Comprehensive Examination. Comprehensive hard and soft tissue examination, which shall include: oral cancer screening examination; mouth-mirror, explorer, and periodontal probe examination; adequate natural or artificial illumination; panographic or full-mouth periapical, and posterior bitewing radiographs as required; blood pressure recording; and when indicated, percussive, thermal, and electrical tests, transillumination, and study models. Included are lengthy clinical evaluations required to establish a complex total treatment plan. For example, treatment planning for full mouth reconstruction, determining differential diagnosis of a patient's chief complaint, or lengthy history taking relative to determining a diagnosis. Use S.O.A.P. format to record the results of a Type 1 examination.

(b) Type 2, Oral Examination (annual or periodic). Hard and soft tissue examination, which shall include: oral cancer screening examination; mouth mirror and explorer examination with adequate natural or artificial illumination; periodontal screening; appropriate panographic or intraoral radiographs as indicated by the clinical examination; and blood pressure recording. An appropriate treatment plan shall be recorded. This type is the routine examination which is normally performed one time per treatment regimen per patient, unless circumstances warrant another complete examination. Use S.O.A.P. format to record the results of Type 2 examination.

(c) Type 3, Other Examination. Diagnostic procedure as appropriate for: consultations between staff; observation where no formal consult is prepared; certain categories of physical examination; and emergency oral examination for evaluation of pain, infection, trauma, or defective restorations.

(d) Type 4, Screening Evaluation. Mouth mirror and explorer or tongue depressor examination with available illumination. This includes the initial dental processing of candidates without necessarily being examined by a dentist, or other dental screening procedures.

(e) If not specified by this Manual, it shall be the professional responsibility of the dental officer to determine the type of examination which is appropriate for each patient. However, Type 3 and Type 4 examinations are not adequate to definitively evaluate the oral health status of patients. When the dental officer determines that a comprehensive periodontal examination is to be accomplished, use the Navy Periodontal Chart, NAVMED 6660/2 (3-90).

(3) Dental Classification of Individuals. Dental classifications are used to designate the health status and the urgency or priority of treatment needs for active duty personnel. Use the following guidelines and criteria for the classification of patients. When a criterion for a specific condition is not listed, the dental officer shall evaluate the prognosis for a dental emergency and assign the appropriate classification.

(a) Class 1. Patients who do not require dental treatment. The following are criteria for such classification.

7 no dental caries or defective restorations;

8 healthy periodontium, no tooth accumulated materials (hard or visible soft deposits);

9 stable occlusion, asymptomatic temporomandibular joint;

10 unerupted or malposed teeth that are without historical, clinical, or radiographic signs or symptoms of pathosis, and are not recommended for prophylactic removal; and

11 no edentulous spaces for which a prosthesis is indicated.

(b) Class 2. Patients who have dental conditions that are unlikely to result in a dental emergency within 12 months. Class 2 dental patients are considered fit for operational duties, but the dental diseases or conditions causing designation shall be reevaluated at each dental examination. Any one of the following is a sufficient criterion for such a classification:

1 Dental caries, decalcification, or tooth fractures extending beyond the dentinoenamel junction, or causing definitive symptoms;

2 Restorations with fractures or marginal defects;

3 Periodontal diseases or periodontium exhibiting;

a nonspecific gingivitis. Inflammation of the gingiva characterized by changes in color, gingival form, position, surface appearance, bleeding upon brushing or flossing, or the presence of blood or exudate after probing with a periodontal probe;

b slight or mild adult periodontitis. Progression of the gingival inflammation into the deeper periodontal structures and alveolar bone crest with accompanying periodontal probing depths of from 3 to 4mm, slight loss of connective attachment, and slight loss of alveolar bone;

c moderate periodontitis. Gingival inflammation with destruction of the periodontal structures including radiographic or clinical evidence of loss of alveolar bone support, with possible early furcation involvement of multirooted teeth or tooth mobility;

d stable or nonprogressive mucogingival conditions. This includes conditions such as irregular marginal contours, gingival clefts, and aberrant frena or muscle attachments, which could potentially progress, or pathosis but are currently stable and compatible with periodontal health; or

e past history of periodontal disease or therapy when the disease is currently under control in a long-term maintenance program.

4 The presence of supragingival or subgingival tooth accumulated materials without concomitant periodontal disease.

5 Prosthodontics indicated. Edentulous areas, provisional/interim/temporary prostheses, defective prostheses, provisional crowns, large extracoronal direct restorations, or endodontically treated teeth without full coverage, that need prosthetic treatment but delay will not compromise the patients immediate health or masticating function.

6 Unerupted, nonfunctional, or malposed teeth without historical, clinical, or radiographic signs or symptoms of pathosis, but which are recommended for prophylactic removal to prevent future pathologic conditions (e.g., unopposed or unerupted third molars, or malposed teeth which complicate plaque control measures).

7 Preventive dentistry requirements not fulfilled.

8 Those conditions described in subparagraphs 4. through 7. above are not considered disqualifying for overseas, sea duty, or isolated duty assignment.

(c) Class 3. Patients who have dental conditions that are likely to cause a dental emergency within 12 months. The following conditions have the potential to cause an emergency, and any one is sufficient criterion for disqualification for overseas or isolated duty assignment:

1 Periodontal diseases or periodontium exhibiting:

2 Advanced periodontitis. Significant progression of periodontitis with major loss of alveolar bone support and probable complex furcation involvement of multirooted teeth and increased tooth mobility. The periodontal probing depth may reach 7mm and deeper;

a. periodontal abscess;

b. acute necrotizing ulcerative gingivitis (NUG);

c. periodontal manifestations of systemic diseases and hormonal distubances (e.g., acute herpetic gingivostomatitis);

d. refractory, rapidly progressive periodontitis. Rapid bone and attachment loss, or slow but continuous bone and attachment loss resistant to normal therapy; or

e. juvenile and prepubertal periodontitis, either localized or generalized.

3 Acute or chronic pulpitis.

4 Indication of periradicular pathosis with or without existing root canal filling which may require treatment.

5 Presence of a tooth or teeth undergoing endodontic therapy.

6 Stomatitis.

7 Pericoronitis.

8 Prosthodontics required to replace an existing prosthesis exhibiting dental caries, or a large defective amalgam restoration requiring replacement with a casting. Also, appliances required due to:

9 Insufficient masticatory function, active arch collapse from tooth loss, or essential performance of military duties (e.g., replacement of missing teeth for esthetics or phonetics);

10 soft tissue inflammation, such as papillary hyperplasia under a denture base;

11 an essential prosthesis in need of repair in order to be functional; or

12 a provisional, interim, or temporary prosthesis which cannot be maintained for a 12 month period.

13 Unerupted, partially erupted, nonfunctional or malposed teeth associated with historical, clinical or radiographic evidence of pathosis, or with a high potential to cause a dental emergency.

14 Soft or hard tissue lesions requiring an incisional or excisional biopsy for the definitive diagnosis and treatment of the lesions, including the period of time awaiting the results of the histopathologic examination.

15 Appropriate postoperative treatment not yet completed, including suture removals for surgery and occlusal adjustments for restorative dentistry.

16 All conditions requiring immediate treatment for relief of pain, traumatic injuries, or acute oral infections.

17 Orthodontic therapy in progress, with either fixed or removable appliances.

(4) Priority of Dental Treatment. To further indicate priority of treatment within a class, the following groupings shall be used when necessary (listed in order of decreasing priority).

(a) Group 1. Coast Guard active duty personnel in receipt of orders to sea, overseas, or combat duty.

(b) Group 2. Coast Guard active duty personnel upon return from sea, overseas, or combat duty.

(c) Group 3. Other Coast Guard personnel.

(d) Group 4. Active duty personnel of other Services assigned to duty with the Coast Guard.

(e) Group 5. Active duty personnel of other Services.

(f) Missing Teeth and Existing Restorations.

(g) Markings shall be made on examination chart as follows:

1 Missing Teeth. Draw a large "X" on the root(s) of each tooth that is not visible in the mouth.

2 Edentulous Mouth. Inscribe crossing lines, one extending from the maxillary right third molar to the mandibular left third molar and the other from the maxillary left third molar to the mandibular right third molar.

3 Edentulous Arch. Make crossing lines, each running from the uppermost aspect of one third molar to the lowest aspect of the third molar on the opposite side.

4 Amalgam Restorations. In the diagram of the tooth, draw an outline of the restoration showing size, location, and shape, and block solidly.

5 Nonmetallic Permanent Restorations (includes oxyphosphate cements). In the diagram of the tooth, draw an outline of the restoration showing size, location, and shape.

6 Gold Restorations. Outline and inscribe horizontal lines within the outline.

7 Combination Restorations. Outline showing overall size, location, and shape; partition and junction materials used and indicate each, as in "4." above.

8 Porcelain Facings and Pontics. Outline.

9 Acrylic Resin Facings and Pontics. Outline each aspect.

10 Porcelain Post Crowns. Outline the crown and approximate size and position of the post(s).

11 Acrylic Resin Post Crowns. Outline crown and approximate size and position of the post(s).

12 Porcelain Jacket Crowns. Outline each aspect.

13 Acrylic Resin Jacket Crowns. Outline each aspect.

14 Fixed Bridges. Outline each, showing overall size, location, teeth involved and shape by the inscription of diagonal lines in abutments and pontics.

15 Removable Appliances. Place an "X" through the missing tooth, place a line over replaced teeth and describe briefly in "Remarks."

16 Root Canal Fillings. Outline canal filled and black in solidly.

17 Apicoectomy. Draw a small triangle apex of the root of the tooth involved, the base line to show the approximate level of root amputation.

18 Drifted Teeth. Draw an arrow from the designating number of the tooth that has moved; the point of the arrow to indicate the approximate position to which it has drifted. Under "Remarks" note the relationship to the drifted tooth in respect to occlusion.

(h) If an individual is appointed or enlisted with dental defects which have been waived, the defects shall be described fully in the dental record under "Remarks" (Section I).

(i) The examining dental officer shall sign, date, and record the place of examination where indicated.

(5) Diseases, Abnormalities, and Radiographs.

(a) Markings on the examination chart of Diseases, Abnormalities, and Radiographs shall be made as follows:

1 Caries. In the diagram of the tooth affected, draw an outline of the carious portion, showing size, location and shape, and block in solidly.

2 Defective Restoration. Outline and block in solidly the restoration involved.

3 Impacted Teeth. Outline all aspects of each impacted tooth with a single oval. Indicate the axis of the tooth by an arrow pointing in the direction of the crown.

4 Abcess. Outline approximate size, form, and location.

5 Cyst. Outline the approximate form and size in relative position of the dental chart.

6 Periodontal Disease. Inscribe a horizontal continuous line on the external aspect of root(s) involved in a position approximating the extent of gingival recession or the clinical depth of the pocket. If known, indicate the position of the alveolar crest by a second continuous line in relative position to the line indicating the gingival tissue level.

7 Extraction Needed. Draw two parallel vertical lines through all aspects of the tooth involved.

8 Fractured Tooth Root. Indicate fracture with a zigzag line on outline of tooth root.

(b) A statement regarding hypersensitivity to procaine or any other drug known to the person for whom a Dental Record is prepared shall be entered under "Remarks." (Example: HYPERSENSITIVITY TO PROCAINE)

(c) Complete items A through E.

(d) The examining dental officer shall sign, date, and record the place of examination where indicated.

(e) NOTE: Section I, Subsections 4 and 5 of SF 603 are used to record findings of initial and replacement examinations. These charts shall not be altered thereafter.

SECTION II. PATIENT DATA

(1) Patient Data. Complete items 6 through 14 as indicated.

SECTION III. ATTENDANCE RECORD

(1) Restorations and Treatments (Completed during service) (Item 15).

(a) Record restorations or treatments provided a patient after the initiation of a Dental Record on the chart "Restorations and Treatments" of Section III, in accordance with the following:

1 Carious Teeth Restored. In the diagram of the tooth involved, draw an outline of the restoration showing size, location and shape, and indicate the material used. Amalgam restorations would be outlined and blocked in, silicate cement restorations outlined only, etc.

2 Extractions. Draw a large "X" on the root(s) of each tooth extracted.

3 Root Canal Fillings. Outline each canal filled on the diagram of the root(s) of the tooth involved and block it in solidly.

4 Apicoectomy. Draw a small triangle on the root of the tooth involved, apex away from the crown, the base line to show the approximate level of tooth amputation.

5 Bridge and Crowns. Outline and fill in as specified above.

6 Removable Appliances. Place a line over numbers of replaced teeth and give a brief description under "Remarks."

7 Unrecorded Operations and Conditions. Operations performed by other than Coast Guard dental officers subsequent to the original

examination will be indicated by the dental officer discovering the condition just as if they had been done by a Coast Guard dental officer. Make appropriate entries indicating the nature of the treatment and adding the abbreviation "CIV" or other abbreviation as the case may be. The date entered will be the date of the discovery.

8 Other. Similarly, note operations known to have been performed by Coast Guard dental officers whose identity is not recorded, except use the abbreviation "CGDO." The date entered shall be the date the operation is discovered. Account for teeth which are shown as missing in the chart, Missing Teeth and Existing Restorations, and which have erupted subsequently, by an entry in the following manner: "1 and 32," eruption noted, date, and signature of dental officer making the notation. Record other conditions of comparable importance in a similar manner.

(b) Record a series of treatments for a specific condition not producing lasting changes in dental characteristics by entering of initial and final treatment dates (i.e., POT daily 1 AUG 87 thru 5 AUG 87 or Vin Tr. twice daily 1 AUG 87 thru 10 AUG 87).

(c) Authenticate each entry in this record by a written entry in the spaces provided under "Services Rendered."

(2) Subsequent Disease and Abnormalities (Item 16). Chart subsequent conditions, in pencil only, using the instructions in Chapter 4-C.3.(6). Once treatment is completed and documented in item 17, erase pencil entry in item 16 and permanently transfer in ink to item 15 (Restorations and Treatments).

(3) Services Rendered (Item 17). The accuracy and thoroughness in recording patient histories and treatment progress notes are essential elements in the diagnosis and treatment of the dental patient. In addition to the conventional listing of the tooth number and procedure, every effort shall be made to specifically identify dental materials used intraorally. Use trade names where possible. This includes, but is not limited to; bases and liners, metallic and nonmetallic restorative materials, denture frameworks and bases, impression materials, medicaments, and anesthesia. Record prescribed medications.

(a) Standard S.O.A.P. format. The S.O.A.P. format shall be used to document all sickcall and emergency dental treatments, to document Type 1 and Type 2 examinations, and to record the results of the examination of patients in preparation for comprehensive treatment planning. S.O.A.P. format is not required to document ongoing delivery of treatment which has been previously planned. All entries are to be on the SF-603/603-A, item 17. The S.O.A.P. format uses a problem oriented record as a tool in management of patient care. The acronym is derived from the first letter of the first four record statements as follows:

1 **"S" Subjective data**. This data includes the reason for the visit to the dental clinic, and if appropriate, a statement of the problem (chief complaint) and the qualitative and quantitative description of the symptoms appropriate to the problem.

2 **"O" Objective data**. A record of the type of examination and the diagnostic aids, including the ordering of radiographs, and the actual clinical findings, x-ray results, or laboratory findings appropriate to the problem. This is to include all the provider's findings such as carious teeth, inflammation, periodontal status, pocket depths, blood pressure measurement, etc.

3 **"A" Assessment**. This portion is the assessment of the subjective data, objective data, and the problem statement which leads the provider to a diagnosis, e.g.,"needs" (existing conditions or pathoses).

4 **"P" Plan**. This is the plan of treatment to correct or alleviate the stated problems or needs, irrespective of the treatment capability of the dental treatment facility. Include recommended treatment and, as appropriate, possible complications, alternative treatment, and prognosis with and without intervention. Include consultations, a record of the specific treatment performed, pre- and postoperative instructions, prescriptions, and any deviations from the original treatment plan.

(b) The following classification of tooth surfaces are listed in order of precedence and shall be used in connection with recording restorations of defective teeth:

Surface	**Designation**
Facial (Labial) (Anterior teeth)	F
Buccal (Posterior teeth)	B
Lingual	L
Occlusal (Posterior teeth)	0
Mesial	M
Distal	D
Incisal (Anterior teeth)	I

(c) Use combinations of designators to identify and locate caries, operations, or restorations in the teeth involved; for example, 8-MID would refer to the mesial, incisal, and distal aspects of the left mandibular cuspid; 30-MODF, the mesial, occlusal, distal, and facial aspects of a right mandibular first molar.

Surface	Designation
Mesial-Occlusal	MO
Distal-Occlusal	DO
Mesial-Incisal	MI
Distal-Incisal	DI
Occlusal-Facial	OF
Occlusal-Lingual	OL
Incisal-Facial	IF
Incisal-Lingual	IL
Mesial-Occlusal-Distal	MOD
Mesial-Occlusal-Facial	MOF
Mesial-Occlusal-Lingual	MOL
Mesial-Incisal-Distal	MID
Mesial-Incisal-Facial	MIF
Mesial-Incisal-Lingual	MIL
Distal-Occlusal-Facial	DOF
Distal-Occlusal-Lingual	DOL
Mesial-Occlusal-Distal-Facial	MODF
Mesial-Incisal-Distal-Facial	MIDF
Mesial-Occlusal-Distal-Facial-Lingual	MODFL
Mesial-Incisal-Distal-Facial-Lingual	MIDFL

(d) The use of abbreviations is not mandatory but is desirable for purposes of brevity in view of the limited space available in the dental record for recording services rendered. Whenever there is a possibility of misinterpretation due to the use of abbreviations, dental operations shall be written in full. When abbreviations are used, they shall conform to the following:

Operation, Condition, or Treatment	Abbreviation
Abrasion	Abr.
Abscess	Abs.
Acrylic	Acr.
Adjust (ed)(ment)	Adj.
Alveolectomy	Alvy.
Amalgam	Am.

Anesthesia	Anes.
Apicectomy	Apcy.
Base	B.
Bridge (denotes fixed unless otherwise noted)	Br.
Caries	Car.
Calculus	Cal.
Cavity Varnish	C.Var.
Cement	Cem.
Composite Resins	Comp. Res.
Crown	Cr.
Deciduous	Dec.
Defective	Def.
Denture (full unless otherwise noted)	Dtr.
Drain.	Drn.
Dressing	Drs.
Equilibrate (action)	Equil.
Eugenol	Eug.
Examination	Exam.
Extraction (ed) (Uncomplicated unless otherwise noted)	Ext.
Filling(s)	Fil.
Fluoride	Fl.
Fracture(s)	Frac.
General	Gen.
Gingival (itis) (state type in parenthesis).	Ging.
Gutta percha	G.P.
Impacted (ion)	Imp.
Impression	Impr.
Incised	Inc.
Inlay	Inl.
Inserted	Ins.
Maxillary	Max.
Mandibular	Man.
Partial	Pr.

Parietal	Par.
Periapical	Per.
Pericoronitis	Percor.
Periodontitis	Perio.
Porcelain	Porc.
Post Operative Treatment	POT.
Prepared (ation)	Prep.
Prophylaxis	Pro.
Reappoint (ment)	Reapt.
Recement (ed)	Recem.
Reconstruct (ed)	Rct.
Reduce (d)	Red.
Regional	Rel.
Repaired	Rpd.
Sedative (ation)	Sed.
Sequestrum	Seq.
Surgical	Surg.
Suture (s)(d)	Su.
Treatment (ed)	Tr
Unerupted	Uner.
Vincents	Vin.
Zinc Chloride	ZnCl.

(4) Space is provided in the lower right margin under Section III for the patient's name which is for convenience in filing in the dental record. Record the last name in capital letters. Do not abbreviate any part of the name.

4. SF-603-A (Dental Continuation).

a. General. Use a SF-603-A whenever the original SF-603 becomes filled or when the record cannot be satisfactorily brought up-to-date by entries on the appropriate chart.

b. Detailed Instructions.

(1) Enter individual's name and SSN in the space provided on the right margin of both the front and back side of the form.

(2) Number the continuation sheet in the upper right corner following the phrase "DENTAL-Continuation." Thus, the earliest SF-603-A is labeled "DENTAL-Continuation #1" and subsequent sheets are labeled "DENTAL-Continuation #2", "DENTAL-Continuation #3", etc.

(3) File the SF-603-A forms on top of the SF-603 form in reverse chronological order, i.e., the most recent on top.

5. SF-513, Consultation Sheet.

a. Purpose. SF-513 shall be used whenever a patient is referred to another facility for evaluation or treatment.

b. Detailed Instructions. Complete the form as detailed in paragraph 4-B-14.b.

6. Lost Dental Records.

a. Forward "stray" dental records, disposition of which cannot be determined, to Commandant (G-PIM) with a letter of explanation.

b. When a Dental Record is missing, prepare a new record. Prominently mark the Dental Record Cover (CG-3443-2) and the Health Record, Dental (SF-603) "REPLACEMENT." Request the old Dental Record from the individual's last unit or Commandant (G-PIM).

c. In case a lost Dental Record is recovered, make entries in the recovered record of any data recorded in a replacement record, then destroy the replacement record.

7. Special Dental Records Entries. When dental treatment is refused, make an appropriate entry on the SF-603/603-A, **signed by both the dental officer and patient.**

8. Dental Examination Requirements.

a. Any peculiarities or deviations from normal are particularly valuable for identification purposes and shall be recorded on SF-603 under "Remarks." Abnormalities such as erosion, mottled enamel, hypoplasia, rotation, irregularity of alignment and malocclusion of teeth, presence of supernumerary teeth, denticles, Hutchinson's incisors, fractures of enamel or teeth, abnormal interdental spaces, mucosal pigmentation, leukoplakia, diastema, hypertrophied frenum labium, torus palantinus and torus mandibularis, embedded foreign bodies and descriptions of unusual restorations or appliances are, when noted, especially useful in this connection. Malocclusion shall be simply and clearly described. Dentures and other removable dental appliances shall also be described under "Remarks".

b. When all teeth are present, and free of caries or restorations, take special effort to discover and record any abnormalities, however slight. If no caries, restorations, or abnormalities are found, make an entry to that effect on SF-603 under "Remarks."

c. Inquire about the patients' tobacco use during routine dental examinations and document. Advise users of the health risks associated with tobacco use, the benefits of stopping, and where to obtain assistance in stopping if available. Advise all pregnant tobacco users of the health risks to the fetus.

d. Oral hygiene and periodontal status at time of examination shall be recorded. Upon initial examination, complete items 5A-5C, SF-603, with additional comments placed in "Remarks" if needed. For all subsequent examinations, describe oral hygiene level and periodontal status in item 17 of SF-603/603-A.

e. For all patients 16 years of age or older, blood pressure readings shall be taken and recorded on the CG-5605 at initial and subsequent dental examinations. Although not required, the blood pressure may also be recorded on the SF-603/603-A in the "O" portion of the SOAP entry.

9. Recording of Dental Treatments on SF-600. Make entries of dental treatment on SF-600 when the patient is on the sick list and when treatment is related to the condition for which the patient is admitted. Such entries shall be made and signed by the dental officer. Notes concerning conditions of unusual interest and of medical or dental significance may be made when appropriate.

Section D - Clinical Records.

1. Purpose and Background. The Clinical Record (CG-3443-1) is the chronological medical and dental record of a nonactive duty beneficiary (dependent or retiree) eligible for health care at a Coast Guard facility. The primary reasons for compiling a clinical record are:

   a. To develop records to facilitate and document the health condition in order to provide health care and to provide a complete account of such care rendered, including diagnosis, treatment, and end result.

   b. To protect the Government, the individual concerned, and the individual's dependents: It may be used;

      (1) to provide, plan and coordinate health care;

      (2) to aid in preventive health and communicable disease control programs; in reporting medical conditions required by law to Federal, state, and local agencies;

      (3) to compile statistical data; for research; to teach health services personnel;

      (4) to determine suitability of persons for service or assignments;

      (5) to adjudicate claims and determine benefits; for law enforcement or litigation;

      (6) to evaluate care provided; and

      (7) to evaluate personnel and facilities for professional certification and accreditation.

   c. To aid in identifying deceased persons when other means may be inadequate.

2. Contents of Clinical Records.

   a. Each clinical record shall consist of CG-3443-1 with dental and medical records arranged in the following bottom to top sequence:

      (1) Left Side - Dental: CG-3443-2 Dental Record Cover* with CG-5266 (Drug Sensitivity Sticker)*, containing the following:

         (a) SF-522, Authorization for Administration of Anesthesia and for Performance of Operations and Other Procedures*

         (b) SF-603-A, Dental Record - Continuation*

         (c) SF-603, Dental Record*

         (d) CG-5605, Dental Health Questionnaire*

(2) Right Side - Medical:

(a) PHS-731, International Certificate of Vaccination*, attached to the lower right corner of the inside of the Clinical Record Cover

(b) DD-1141, Record of Occupational Exposure to Ionizing Radiation*

(c) SF-507, Continuation Sheet**

(d) SF-602, Syphilis Record*

(e) SF-601, Immunization Record*

(f) DD-771, Spectacle Order Form*

(g) SF-520, Electrocardiographic Report*

(h) SF-519, Radiographic Reports

(i) SF-514, Laboratory Reports (or SF-545, Laboratory Report Display*)

(j) SF-541, Gynecologic Cytology*

(k) SF-515, Tissue Examination*

(l) SF-522, Authorization For Administration of Anesthesia and for Performance of Operations and Other Procedures*

(m) SF-513, Consultation Sheet*

(n) SF-502, Narrative Summary*

(o) CG-5447, Occupational Medical Surveillance and Evaluation Program*

(p) DD-2807-1, Report of Medical History*

(q) DD-2808, Report of Medical Examination*

(r) SF-558, Emergency Care and Treatment

(s) SF-600, Chronological Record of Medical Care

(t) DD-2766, Adult Preventive and Chronic Care Flowsheet Form

(u) CG-5266, Drug Sensitivity Sticker*

* When required

** SF-507's are attached to and filed after the form is continued

b. File forms of the same number in their assigned sequence, with the most recent placed on top of each previous form, i.e., file SF-600 dated 3 AUG 89 on top of SF-600 dated 20 MAY 86.

c. Enter all dates on Clinical Record forms, including the Clinical Record Cover, in the following sequence: day (numeral), month (in capitals abbreviated to the first three letters), and year (numeral); i.e., 30 AUG 86.

3. Extraneous Attachments. In order to ensure that the clinical record is an accurate, properly documented, concise and dependable record of the medical and dental history of the individual, keep extraneous attachments to a minimum. When they are necessary, file them beneath all other forms.

4. Opening Clinical Records. Open a Clinical Record when an eligible non-active duty beneficiary initially reports to a Coast Guard health care facility for treatment.

5. Terminating Clinical Records. The Clinical Record shall be terminated four years after the last record entry. Make an entry on SF-600 explaining the circumstances under which the record was terminated. Forward the record to:

Dependent Records:	**Military Records**:
National Personnel Records Center	National Personnel Records
GSA (Civilian Personnel Records)	Center (MPR)
11 Winnebago Street	9700 Page Avenue
St. Louis, MO 63118-4126	St. Louis, MO 63132-5100

6. Custody of Clinical Records.

a. Clinical Records shall be retained in the custody of the Chief, Health Services Division of the unit providing care. At times when there is no medical or dental officer, the clinical record will become the responsibility of the senior health services department representative.

b. The name, grade, or rate of the health care provider making entries in clinical records shall be typed, stamped, or printed under their official signatures. Do not use facsimile signature stamps.

c. If an erroneous entry is made in a Clinical Record, the author of the entry shall draw a diagonal line through the complete entry, make an additional entry showing wherein and to what extent the original entry is in error, and initial clearly next to the correction.

d. Each health care provider is responsible for the completeness of the entries they make on any medical or dental form in the Clinical Record.

e. Nothing shall be removed from the Clinical Record except under conditions specified in this Manual.

7. Safekeeping of Clinical Records. Clinical Records are the property of the Federal government and must be handled in accordance with the provisions of the Privacy Act of 1974 and the Freedom of Information Act. Guidance in this area is contained in The Coast Guard Freedom of Information and Privacy Acts Manual, COMDTINST M5260.3 (series).

   f. Since Clinical Records contain personal information of an extremely critical or sensitive nature, they are considered class III records requiring maximum security (high security locked cabinets or areas).

   g. Except as contained in the The Coast Guard Freedom of Information and Privacy Acts Manual, COMDTINST M5260.3(series), the information contained in Clinical Records shall not be disclosed by any means of communication to any person or to any agency, unless requested in writing by or with the prior consent of the individual to whom the record pertains. It is the requestor's responsibility to obtain the consent.

8. Transfer of Clinic Records.

   a. When dependents of active duty personnel accompany their sponsor to a new duty tation, the Chief, Health Services Division, his designee, the Executive Officer, or the senior health services department representative shall ensure that the "TRANSFERRED TO" line of the health Record Receipt form, NAVMED 6150/7, is completed in accordance with Chapter 6-B-5 of this Manual.

   b. A DD 877 shall be initiated for each record transferred. **Send records using a service that provides a tracking number, such as Priority Mail Delivery Confirmation, Certified Mail, Insured Mail, or FedEx/Express Mail if time is critical,** to the Coast Guard clinic serving the gaining unit. Express mail and Federal Express should be used only when absolutely necessary and not as a general rule. In instances where the family member will not be located near a Coast Guard Clinic, the record may be mailed to the appropriate MTF. This form can be located on the internet at; http://web1.whs.osd.mil/ICDHOME/DD-0999.htm

   c. If the family members will no longer receive care through a military primary care manager, the family member may be given a copy of the clinical record contents to carry with them. The original clinical record will be retained at the clinic serving the unit where the sponsor was last assigned.

   d. Clinics will give family members written information containing address and POC information to facilitate requests for record copies after transfer. All requests for clinical record copies must be in writing. The family member may request that a copy of the record be forwarded to their new care provider once they arrive at the new location, or they may request that the original record be forwarded to their new military primary care manager once they arrive at the new location. In these cases, the clinic shall send a copy of the clinical record contents to the care provider within 10 working days of receipt of the written request. If the clinic cannot comply with this requirement for some reason, the family member will be notified within 10

working days of the request of a projected date when the record copy will be available.

e. In any instance where there is concern about potential loss of the clinical record, or that its contents may become unavailable to the treating clinic or its provider, the Clinic Administrator or the Chief, Health Services Division shall direct that copies of parts or all of the clinical record shall be made and retained at the clinic.

f. Originals and copies of clinical records shall be retained and subsequently archived in accordance with directions contained in the Paperwork Management Manual, COMDTINST 5212.12(series).

9. Lost, Damaged, or Destroyed Clinical Records.

a. If a Clinical Record is lost or destroyed, the unit which held the record shall open a new record. The designation "REPLACEMENT" shall be stamped or marked on the cover. If the missing Clinical Record is recovered, insert in it any additional information or entries from the replacement record, then destroy the replacement record cover.

b. Clinical Records which become illegible, thus destroying their value as permanent records, shall be duplicated. The duplicate shall, as nearly as possible, be an exact copy of the original record before such record became illegible. The new record shall be stamped or marked "DUPLICATE" on the cover. The circumstances necessitating the duplication shall be explained on the SF-600. Forward Clinical Records replaced by duplicate records to the National Personnel Records Center.

10. **Clinical Record Forms**.

a. CG-3443-1 (Clinical Record Cover). See Encl (1), pg 4-40.

(1) General. The Clinical Record Cover is used whenever a Clinical Record is opened on dependents or retirees.

(2) Detailed Instructions.s

(a) Last Name. Record the last name in all capital letters.

SMITH

(b) Given Name(s). Record given name(s) in full without abbreviation. If the individual has no middle name or initial, use the lower case letter "n" in parentheses (n). If the individual has only a middle initial(s), record each initial in quotation marks. When "Jr." or "II" or other similar designations are use, they shall appear after the middle name or initial.

SMITH,	Helen	(n)
Last Name	**First Name**	**Middle Name**

(c) Date of Birth. Enter day, month (abbreviated JAN, FEB, MAR, etc.) and the year; i.e., 3 FEB 77.

(d) Social Security Number. Enter sponsor's SSN.

(e) Status. Check the appropriate block; i.e., Retiree USCG, Dependent USPHS, etc.

(f) Other. Use this block to indicate special status or other information useful for either proper monitoring of the patient or for aid in indentifying the patient or record.

(g) Occupational Monitoring. Indicate the reason for occupational monitoring if monitoring is required.

(h) Med-Alert. Check this block to indicate that the patient has a medical problem that must be considered in rendering treatment; i.e., allergy, diabetes, cardiac problems, etc. Describe the specific medical problem within the medical record on Problem Summary List, NAVMED 6150/20.

b. **SF-522 (Authorization for Anesthesia, Operations, etc.).** See Encl (1), pg. 4-41.

(1) Complete SF-522 describing the general nature of the procedure and have the patient sign prior to administering anesthesia (local or general) except for dental anesthesia. Also, complete SF-522 prior to administering immunizing agents.

Insert the form immediately behind Consultation Sheet (SF-513) or as indicated in Section 4-D-2.

Section E - Employee Medical Folders.

1. Purpose and Background. The Employee Medical Folder (EMF), (SF-66 D), is the chronological medical record of Federal employees eligible for health care at Coast Guard facilities. These are the primary reasons for compiling an EMF.

   a. Develop records to facilitate and document the health condition in order to provide health care and to provide a complete account of care rendered, including diagnosis, treatment, and end result.

   b. To protect the Government and the individual concerned.

   c. The information in the EMF is routinely used: to provide, plan and coordinate health care; to aid in preventive health and communicable disease control programs; in reporting medical conditions required by law to Federal, state, and local agencies; to compile statistical data; for research; to teach health services personnel; to determine suitability of persons for service or assignments; to adjudicate claims and determine benefits; for law enforcement or litigation; to evaluate care provided; and to evaluate personnel and facilities for professional certification and accreditation.

2. Custody of Employee Medical Folders (EMF's).

   a. EMF's are the property of the Federal government handled in accordance with the provisions of the Privacy Act of 1974 and the Freedom of Information Act. Guidance in this area is contained in The Coast Guard Freedom of Information and Privacy Acts Manual, COMDTINST M5260.3 (series).

      (1) Since EMF's contain personal information of extremely critical or sensitive nature, they are considered class III records according to The Coast Guard Freedom of Information and Privacy Acts Manual, COMDTINST M5260.3 (series), requiring maximum security (high security locked cabinets or areas).Except as contained in The Coast Guard Freedom of Information and Privacy Acts Manual, COMDTINST M5260.3 (series), the information contained in the EMF shall not be disclosed by any means of communication to any person or to any agency, unless requested in writing by or with the prior consent of the individual to whom the record pertains. It is the responsibility of the requester to obtain the consent.

   b. EMF's shall be retained in the custody of the medical officer of the unit at which the individual is employed. At no time shall individual employees keep or maintain their own records.

   c. Individuals may examine their EMF in the presence of a health services department representative, providing it does not interrupt the scheduled mission of the unit and there is no information contained therein which would be detrimental to the individual's mental well-being.

d. Health services personnel making entries in EMF shall ensure that all entries, including signatures, are neat and legible. Signature information shall include the name and grade or rate. Do not use facsimile signature stamps.

e. If an erroneous entry is made in an EMF, draw a diagonal line through the complete entry. Make an additional entry showing wherein and to what extent the original entry is in error.

f. Health services personnel are responsible for the completeness of the entries made on any form while the EMF is in their custody. No sheet shall be removed from the EMF except under conditions specified in this Manual.

g. Health services personnel shall ensure that, if EMF's are located in the same office as the Official Personnel Folder (OPF), the records are maintained physically apart from each other.

3. Contents of the Employee Medical Folders.

a. Each medical folder shall consist of SF-66 D (Employee Medical Folder) with medical records arranged in the following bottom to top sequence:

(1) Left Side Dental: Leave blank.

(2) Right Side - Medical:

(a) PHS-731, International Certificate of Vaccination*, attached to the lower right corner of the inside of the EMF

(b) DD-1141, Record of Occupational Exposure to Ionizing Radiation*

(c) SF-507, Continuation Sheet**

(d) CG-5447, Occupational Medical Surveillance and Evaluation Program*

(e) SF-602, Syphilis Record*

(f) SF-601, Immunization Record*

(g) DD-771, Spectacle Order Form*

(h) SF-520, Electrocardiographic Report*

(i) SF-519, Radiographic Reports

(j) SF-514, Laboratory Reports (or SF-545, LaboratoryReport Display*)

(k) SF-541, Gynecologic Cytology*

(l) SF-515, Tissue Examination*

(m) SF-522, Authorization For Administration of Anesthesia and for Performance of Operations and Other Procedures*

(n) SF-513, Consultation Sheet*

(o) SF-502, Narrative Summary*

(p) DD-2807-1, Report of Medical History*DD-2808, Report of Medical Examination*

(q) SF-558, Emergency Care and Treatment*

(r) SF-600, Chronological Record of Medical Care

(s) CG-5357, Outpatient Record

(t) DD-2766, Adult Preventive and Chronic Care Flowsheet

(u) CG-5266, Drug Sensitivity Sticker*

(v) * When required

(w) ** SF-507's are attached to and filed after the form is continued.

b. File forms of the same number in their assigned sequence, with the most recent placed on top of each previous form, i.e., file SF-600 dated 3 AUG 87 on top of SF-600 dated 20 MAY 86.

c. Enter all dates in the following sequence: day (numeral), month (in capitals abbreviated to the first three letters), and year (numeral); i.e., 30 AUG 86.

4. Accountability of Disclosures. The accountability of disclosure of records, as required by the Privacy Act of 1974, will be maintained in accordance with Chapter 8, of COMDTINST M5260.2 (series). The information will be retained for five years after the last disclosure or for the life of the record, whichever is longer.

5. Opening Employee Medical Folder. Open an EMF when an eligible Federal employee initially reports for treatment.

6. Terminating Employee Medical Folders. Terminate the EMF in accordance with the Coast Guard Paperwork Management Manual, COMDTINST 5212.12 (series). Make an entry on SF-600 explaining the circumstances under which the folder was terminated.

7. Transferring to Other Government Agencies. When transferring an EMF to other agencies, complete a Request for Medical/Dental Records or Other Information (DD-877).

8. Lost, Damaged, or Destroyed Employee Medical Folders.

a. If an EMF is lost or destroyed, the unit which held the record shall open a complete new Employee Medical Folder. Stamp or mark "REPLACEMENT" on the cover. If the missing folder is recovered, insert in it any additional information or entries from the replacement folder, then destroy the replacement folder.

b. EMF's which become illegible, thus destroying their value as permanent records, will be duplicated. The duplicate shall, as nearly as possible, be an exact copy of the original record before such record becomes illegible. Stamp or mark "DUPLICATE" on the new record cover. Document the circumstances necessitating the duplication on an SF-600. Forward EMF's replaced by duplicate records to the National Personnel Records Center.

9. **SF-66 D (Employee Medical Folder).** See Encl (1), pg. 4-42. Detailed instructions are:

a. Last Name. Record the last name in all capital letters.

BROOKS

b. Given Name(s). Record given name(s) in full without abbreviation. If the individual has no middle name or initial, use the lower case letter "n" in parentheses (n). If the individual has only a middle initial(s), record each initial in quotation marks. When "Jr." or "II" or other similar designations are use, they shall appear after the middle name or initial.

BROOKS	Cecilia	(n)
Last Name	**First Name**	**Middle Name**

c. Date of Birth. Enter day, month (abbreviated JAN, FEB, MAR, etc.) and the year; i.e., 8 JUN 62.

d. Social Security Number. Enter SSN.

Section F -Inpatient Medical Records.

1. Purpose and Background.

   a. Certain Coast Guard health care facilities have the capability and staffing to provide overnight care. Overnight care is defined as any period lasting more than four hours during which a beneficiary remains in the facility under the care or observation of a provider. By definition, overnight care may last less than 24 hours or it may last several days. Overnight care is utilized when a patient's condition or status requires observation, nursing care, frequent assessment, or other monitoring.

   b. Inpatient Medical Records (IMRs). Facilities providing overnight care shall create an Inpatient Medical Record (IMR) separate from the Health Record for the purpose of recording and preserving information related to the overnight care. The IMR shall be assembled as soon as a person is identified as needing overnight care. The IMR shall contain the following forms in a TOP TO BOTTOM sequence:

      (1) **Inpatient Medical Record Cover Sheet and Privacy Act Statement**. See Encl (1), pg 4-43.

      (2) SF-508, Doctor's Orders (most recent on top)

      (3) SF-506, Clinical Record/Physical Exam

      (4) SF-502, Narrative Summary

      (5) SF-509, Doctor's Progress Notes (most recent on top)

      (6) SF-511, Vital Signs Record

      (7) SF-514, Laboratory Report Display

      (8) SF-519, Radiologic Reports

      (9) Patient Care Kardex

      (10) Medication Kardex

      (11) SF-513, Consultation sheet

      (12) Miscellaneous forms (e.g., audiograms)

   c. Abbreviated Inpatient Medical Records (AIMRs). For patients who receive overnight care lasting 24 hours or less, an Abbreviated Inpatient Medical Record (AIMR) shall be created. The AIMR shall consist of at least an Inpatient Medical Record Cover Sheet, Privacy Act Statement, and an DD-2770, Abbreviated Medical Record form. SF-545, Laboratory Reports; SF-519, Radiologic Consultation Reports; Kardexes; and other forms may be included at the discretion of the clinic.

The AIMR shall be maintained while in use, completed, stored, and retired following the same requirements as listed for IMRs below.

d. During the time that the patient is receiving care, the IMR may be maintained in a loose-leaf binder, clipboard, or other convenient device, at the facility's discretion. Devices should be chosen and maintained so that the privacy of the patient information contained therein is protected at all times. Keeping or storing the record at the patient's bedside is discouraged for privacy reasons.

e. Once the patient is released from overnight care, providers shall have 48 hours to complete their notations in the record (excluding dictated entries). All laboratory, radiologic and consultation forms shall also be included in the IMR within 48 hours of the patient's release from overnight care.

f. Dictated entries shall be entered in the medical record within 7 days of discharge. The record may be held in medical records and flagged as needing a dictated entry.

g. After all notations, lab reports, radiology reports and consultations have been entered into the IMR, the IMR forms shall be placed in a bifold paper jacket (form CG-3443-1), and secured via a two prong device. The medical records staff is responsible for ensuring that the documents are in the correct order and are stored properly.

2. Maintenance and Storage. IMRs are the property of the Federal Government and must be handled in accordance with the provisions of the Privacy Act of 1974 and the Freedom of Information Act. Guidance concerning these acts is contained in The Coast Guard Freedom of Information and Privacy Acts Manual, COMDTINST M5260.3 (series). All requirements and directions for handling and storing IMRs also apply to AIMRs.

   a. Since IMRs contain personal information of an extremely critical or sensitive nature, they are considered to be Class III records requiring maximum security (high security locked cabinets or areas). IMRs shall be stored in well ventilated and sprinklered areas. Fire-resistant cabinets or containers shall be used for storage whenever possible.

   b. IMRs shall be retained at the health care facility which created the record. IMRs will not be transferred with personnel who change duty stations. Copies of the IMR may be given to the individual if such a request is made in writing, or may be released to other persons, e.g., physicians or hospitals, if the patient requests or authorizes such release in writing. All release requests and authorizations will be inserted into the IMR cover.

   c. IMRs will be retained at the creating health care facility for two (2) years after the date the patient is released from overnight care.

3. Disposition of IMRs. The IMR will be forwarded to the National Personnel Records Center (NPRC) as described in Coast Guard Paperwork Management Manual, COMDTINST M5212.12(series), two years after the date the patient was released from

inpatient care. The NPRC requirements must be met in order for the NPRC to accept the records.

a. Records must be sent in prescribed standard cubic foot cartons. **See Encl (1), pg.4-45.** Cartons are available from the General Services Administration Federal Supply Service (FSS). The FSS stock number is NSN 8115-00-117-8344. All non-standard cartons will be returned at the expense of the originating organization.

b. NPRC does not accept accessions of less than one cubic foot. Small amounts shall be held until a volume of one cubic foot or more is reached.

c. Print the accession number on each box, starting in the upper left hand corner **See Encl (1), pg. 4-45** . Mark the front of the box only. The accession number consists of the RG, which is always 26 for the Coast Guard, the current FY in which the records are being shipped, and a four digit number assigned by NPRC (see 4-F-3.j. for SF-135 preparation). Mark the front of the box only. Ensure that the information printed on the box is not obscured in any way, and that removal of tape or other sealing materials will not remove vital information.

d. Number each box consecutively, e.g., 1 of 8, 2 of 8, 3 of 8,.8 of 8; or 1/8, 2/8, 3/8...8/8, in the upper right hand corner. See Encl (1), pg. 4-45 for placement.

e. Records shall be arranged in each storage box either alphabetically or numerically. Print the identifier of the first and last record/folder that is contained in the box on the center front of each box as shown in Encl (1), pg. 4-45.

f. Enclose in the first box of each accession one copy of the SF-135 and any alphabetical or numerical listing needed to reference the records.

g. Ship records together so they arrive at the NPRC at the same time. Shipments of 10 cubic feet or more shall be palletized as shown in **Encl (1), pg. 4-46**.

h. Records must be shipped within 90 days of being assigned an accession number. Failure to ship within 90 days will void the accession number.

i. Each clinic that transfers IMRs to NPRC must keep a master list (hard copy) of the records sent. The master list must be retained at the clinic for a period of 50 years.

j. All shipments to NPRC must be accompanied by SF-135, Records Transmittal and Receipt form. The transmittal form must include the name on the record and the individual's social security number. The accession number elements include the RG which is always 26 for the Coast Guard, the current FY during which the record is shipped, and the 4 digit sequential number assigned by NPRC. Also include the date sent. Complete SF-135 preparation and submission instructions are contained in the Coast Guard Paperwork Management Manual, COMDTINST M5212.12(series).

4. Inpatient Medical Record Forms and Required Entries.

a. **SF-508, Doctor's Orders**. See Encl (1), pg 4-47.

(1) Purpose. SF-508 is used to record written and verbal orders of the medical or dental staff; record that nurses have noted orders; record automatic stop dates for medications and time limited treatments; and record the RN review of orders which shall be performed every 24 hours.

(2) Preparation

(a) When Prepared. SF-508 shall be used to communicate doctor's orders for all persons admitted to the medical facility inpatient area.

(b) Required Entries.

1 Patient identification information may be written in or overprinted using a patient identification card.

2 The date and time at which the order is written by the provider will be listed under the start column. If a verbal order is received, the date and time at which the order was received will be noted by the person who received the order in the start column. All verbal orders must be countersigned by the admitting provider on the next working day.

3 Certain orders may be defined as time limited, e.g., complete bedrest for 24 hours, tilts q 8 hours X 3, etc. In addition, the facility shall define the length of time between renewal of orders for medications, treatments, etc. For orders which are time limited, the date and time when the order expires shall be noted under the stop column.

4 All doctor's orders shall be listed on the form under drug orders. Orders shall be printed clearly in black ink. Only approved abbreviations shall be used. Nursing staff and/or health services technicians are required to contact the provider who wrote the order if there are any questions or difficulty encountered in reading the written order.

b. **SF-506, Clinical Record/Physical Exam**. See Encl (1), pg. 4-48.

(1) Purpose. SF-506 is part of the inpatient medical record. It is used to record information obtained from physical examinations.

(2) Preparation. When Prepared. SF-506 shall be prepared when a patient is admitted to the medical facility.

(c) Required Entries.

1 Patient identification information may be written in or printed using a patient identification card.

2 Fill in the date that the exam is conducted in the upper left corner. The patient's self reported height may be used. Patients shall be weighed accurately on the day of admission and the weight entered as present weight. Vital signs to include temperature, pulse and blood pressure are recorded in the appropriate boxes. Rectal temperatures shall be identified by an "R" after the temperature reading. Axillary temperatures in adults are unreliable and will not be used.

3 A physical examination must be thorough, recorded accurately, and contain sufficient information to substantiate the treatment plan and interventions. Examination notations may be continued on the reverse of the form. If the back of the form is used, this must be indicated on the front of the form. The examiner will sign the form at the end of his/her notations and use a printed ink stamp to clearly mark name, rank, and SSN.

c. **SF-509, Progress Notes**. See Encl (1), pg 4-50

(1) Purpose. SF-509 is part of the inpatient medical record. It is used to record the progress of the patient's condition, therapy or other treatment(s), as well as any other information relevant to the patient's condition or treatment such as laboratory tests and results.

(2) Preparation.

(a) When Prepared. SF-509 shall be prepared when a patient is admitted to the medical facility inpatient area.

(b) Required Entries.

1 Patient identification information may be written in or overprinted using a patient identification card.

2 Fill in the left column with the date and time at which the entry is being created. Begin writing to the right of the solid brown line. Notes will be written in SOAP format (see 4-B-5.a.(4)). The person creating the note will sign the form at the end of his/her notations and use a printed ink stamp to clearly mark name, rank, and SSN.

d. **SF-511, Vital Signs Record.** See Encl (1), pg.51.

(1) Purpose. SF-511 shall be used to document vital sign measurements, height, weight, hospital day and, if appropriate, postoperative day for patients admitted to the medical facility inpatient area.

(2) Preparation.

(a) When Prepared. SF-511 shall be prepared when a patient is admitted to the medical facility inpatient area.

(b) Required Entries.

1 Patient identification information may be written in or overprinted using a patient identification card.

2 Hospital day one shall be the day of admission.

3 If the patient undergoes an invasive procedure, "op" shall be written after the word post in the left column. The day of surgery shall be noted by writing "DOS" in the appropriate column. The day following the day of surgery is post-op day one. Post-op days shall be numbered consecutively thereafter.

4 The month in which the patient is admitted shall be written on the fifth line, first column. The year shall be completed by writing in the correct numerals after "19" on the fifth line.

5 The calendar date on which the patient is admitted shall be written in on the line next to the word day, e.g., if the patient is admitted on 3 June, the hospital day is one, and a "3" is written on the line next to the word day.

6 The hour at which the vital sign measurements are to be made are noted in the spaces next to the word hour. Use 24 hour clock notations, e.g., 11 p.m. is 2300, etc.

7 Once vital signs have been measured, they shall be recorded on the form using the symbols for pulse and temperature. Symbols are placed in the columns, not on the brown dotted lines.

8 Blood pressure measurements are written in the spaces to the right of the words "blood pressure". The first measurement made after midnight is written in the top left column, the second is written below it. The first measurement made after noon is written in the top box in the right side column, the second below that, etc. Blood pressure may also be represented by x marks placed at the systolic and diastolic measurements corresponding to the scale for pulse measurements.

9 Other vital signs measurements or intake and output measurements may be written in the spaces on the lower part of the form, or a local overprint/stamp may be used.

10 Both sides of the form will be used. If the second side of the form is used, the word "continued" will be clearly written on the bottom of the first page.

e. SF-514, Laboratory Reports.

(1) Purpose. SF-514 is part of the inpatient medical record. It is used to keep laboratory report forms neat, in proper order, make them easily accessible to caregivers, and stores them as part of the inpatient medical record. SF-545, Clinical Record - Laboratory Report Display may be used in lieu of SF-514.

(2) Preparation.

(a) When Prepared. SF-514/SF-545 shall be prepared when a patient is admitted to the inpatient medical area.

(b) Required Entries.

1 Patient identification information may be written in or overprinted using a patient identification card.

2 Reports (or chits) may be attached to the form using either the self adhesive on the back of the chit, or by neatly placing a strip of clear adhesive tape horizontally across the top of the report, so that the lower half of the tape strip is touching the chit and the upper half is sticking to the SF-514/SF-545.

f. SF-519, Radiologic Consultation Reports.

(1) Purpose. SF-519 is part of the inpatient medical record. It is used to collect radiologic reports for easy access by caregivers and to store the reports with the inpatient medical record.

(2) Preparation.

(a) When Prepared. SF-519 shall be prepared when a patient is admitted to the inpatient medical area.

(b) Required Entries. Reports shall be attached to the form using the self stick adhesive on the back of the report or clear adhesive tape.

g. **DD-2770 *(replaces SF 539)* Abbreviated Medical Record**. See Encl (1), pg. 4-52.

(1) Purpose. DD-2770 is used to record history, exam findings, patient progress, doctor's orders, vital signs, output, medications and nurse's notes for patients requiring overnight care who remain 24 hours or less.

(2) Preparation.

(a) When Prepared. DD-2770 may be used for any overnight care patient for whom total stay is anticipated to be 24 hours or less. If length of stay exceeds 24 hours, a full IMR must be initiated to provide proper documentation of the patient's stay. The DD-2770 shall be prepared when a short stay patient is admitted to the inpatient medical area.

(b) Required Entries.

1 Patient identification information may by written in or overprinted using a patient identification card.

2 History, chief complaint, and condition on admission must be documented in the top box on page one. Date of admission shall be noted here also.

3 Physical examination findings shall be noted in the center box on page one. Physical exam findings shall be completely noted and appropriate to the condition. Deferred exams, such as rectal exams, shall be noted as such.

4 The patient's progress over the 24 hour period between admission and discharge will be noted by the medical officer in the third box on page one. Date of discharge and final diagnosis shall be noted here also.

5 The physician shall sign the form in the box provided and use a printed ink stamp to clearly mark his/her name, rank, and SSN. The date the form is signed shall be written in the box provided next to the signature.

6 The location of the clinic or dispensary, for example, Dispensary TRACEN Cape May, shall be written or stamped in the box marked organization.

7 Doctor's orders shall be written only in the space provided on page two. Each order group written shall be dated and signed. A printed ink stamp shall be used by medical officers to mark name, rank, and SSN. All medical and dental orders given during the patient's stay must be recorded. A second page should be started if the number of orders exceeds space available on one page.

8 Vital sign measurements shall be recorded in the spaces provided with the date and time of each notation. Bowel movements and urine output are noted in the columns marked stools and weight.

9 Medications administered and brief notes regarding the patient's condition shall be made in the nurse's notes area. Medication name, dose, route, and time given shall be recorded for each dose of medication administered. Each notation shall be signed with the name, military rank, or title for civilians, e.g., RN or LPN, of the person making the note.

Section G – Mental Health Records.

1. Active duty: Complete mental health assessments and visits will be done in an IMB, DMB or traditional psychiatric evaluation format and recorded on SF-600, SF-513, IMB, DMB, or typed psychiatric evaluation forms as appropriate. Active duty episodic visits and routine appointments will be recorded on SF-600 in SOAP format. The Objective ("O') section would include mental status observations and any other pertinent physical findings. Records of active duty mental health assessments and visits will be kept in the main health record (CG-3443). An additional separate mental health record may be created and maintained in a system of records approved by the local QA Committee and kept secure in the mental health practitioner's office. New patients would be evaluated IAW traditional psychiatric evaluation.

2. Non- Active duty: Separate records of mental health care may be created and maintained in a system of records approved by the local QA Committee and kept secure in the mental health practitioner's office. Alternatively, the mental health practitioner may elect to keep records of visits in the dependent or retiree's main based record (CG-3443-1). Should the practitioner elect to maintain a separate office based record for non-active duty patients, the main health record (orange jacket) must include, at a minimum, the diagnosis in the problem summary listing, current psychiatric medications on the SF-600, and lab work ordered by the mental health provider. New patients would be evaluated IAW traditional psychiatric evaluation. Episodic and follow up visits would be recorded in a SOAP format.

3. Psychiatric evaluation format: The psychiatric evaluation shall include, at a minimum: patient information, chief complaint, history of present illness, past history (psychiatric symptoms, diagnoses, and care medical illness, surgeries, current medications, allergies, alcohol & drug history), personal history, family history, mental status exam, assessment (DSM-IV), prognosis, and plan. Included in all assessments and other visits as appropriate will be an estimation of potential for harm to self or others. In addition, notes should contain sufficient information to establish that the criteria for any new DSM based diagnosis are met.

4. Custody of Mental Health Records: Records kept in the mental health practitioner's office are property of the CG and copies should be available to other civilian practitioners or agencies at the patient's request. These records should also be available to other CG providers, as part of an official records review process, and as directed in Section 4.A.5. of this Manual.

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BACK

HEALTH RECORD COVER

Last Name First Middle

0 1 2 3 4 5 6 7 8 9

Place Sensitivity Sticker Here (if needed)

Blood Type | Rh

Special Status

- ☐ Aviation
- ☐ OMMP
- ☐ Waiver
- ☐ _____

YY MM DD
Date of Birth

U.S. Coast Guard

HEALTH RECORD

PRIVACY STATEMENT; HEALTH CARE RECORDS

1. AUTHORITY FOR COLLECTION OF INFORMATION INCLUDING SOCIAL SECURITY NUMBER (SSN): Section 632 of Title14, United States Code and Section 1071-1087, Title 10 United States Code, Executive Order 9397.
2. PRINCIPLE PURPOSE FOR WHICH INFORMATION IS TO BE USED:
The purpose for requesting personal information is to assist health care personnel in developing records to facilitate and document your health in order to provide health care and to provide a complete account of such care rendered including diagnosis, treatment, and end result. The SSN is necessary to identify the person and records.
3. ROUTINE USES; This information may be used to plan and coordinate health care. It may be used to provide health care, conduct research, teach, complile statistical data, determine suitability of persons for service or assignment, implement, preventive health and communicative disease control programs, adjudicate claims and determine benefits, evalutate care rendered, determine professional certification and hospital accreditation, conduct authorized investigations, provide physical qualifications of patients to other Federal, State, and local agencies uopn request in the pursuit of their official duties, and report health conditions required by law to Federal, State, and local agencies. It may be used for other lawful purposes, including law enforcement and litigation.
4. The above Privacy Act Statement applies to all requests for personal information made by health care personnel or for health care purposes. Failure to provide the requested information for these health records may result in an inability of Coast Guard health care personnel to afford treatment.
5. No information may be divulged from this record except to persons properly and directly concerned. Questionable cases will be referred to the commanding officer for decision.

DEPT. OF TRANSP, USCG, CG-3443 (REV 9-92) SN 7530-00-F01-4180
PREVIOUS EDITIONS ARE OBSOLETE

BACK

ADULT PREVENTIVE AND CHRONIC CARE FLOWSHEET

(This form is subject to the Privacy Act of 1974 – Use DD form 2005)

1. ALLERGIES

a. MEDICATION ALLERGIES	b. OTHER ALLERGIES

2. CHRONIC ILLNESS	3. MEDICATIONS

4. HOSPITALIZATIONS/SURGERIES

SAMPLE FORM

5. COUNSELING

F	FITNESS	a. DATE					
D	DENTAL	b. AGE					
I	INJURY PREVENTION	c. TOPIC					
N	NUTRITION/FOLATE						
C	CANCER PREVENTION						
S	SAFE SEX	d. DATE					
FP	FAMILY PLANNING	e. AGE					
Rx	PRESENT MEDICATIONS	f. TOPIC					
MH	MENTAL HEALTH/STRESS/SUICIDE/ OCCUPATIONAL STRESS						
H	HORMONE/CALCIUM REPLACEMENT	g. DATE					
To	TOBACCO	h. AGE					
A	ALCOHOL/SUBSTANCE ABUSE	i. TOPIC					
t	TRAVEL						
O.	OCCUPATIONAL EXPOSURE (HEARING THRESHOLD CHANGES/CUMULATIVE TRAUMA DISORDER)	j. DATE					
		k. AGE					
		i. TOPIC					

ADVANCE DIRECTIVES: DATE FILED

PATIENT'S IDENTIFICATION (Use this space for mechanical imprint)	RECORDS MAINTAINED AT:		
SUPPLIED (Navy) *2766-0102-LF-984-8400, pkg-100*	PATIENT'S NAME LAST | FIRST | M.I.		SEX
	RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE
	SPONSOR'S NAME *(Last ,First, Middle Initial)*		DEPT/SERVICE
	ORGANIZATION	SSN/ID NUMBER	DATE OF BIRTH

DD FORM 2766, (Rev 01- 00) **PAGE 1 of 4 PAGES**

ADULT PREVENTION AND CHRONIC CARE FLOWSHEET

6. FAMILY HISTORY *(M = Mother, F = Father, S = Sibling, MGM = Maternal Grandmother, MGF = Maternal grandfather, PGM = Paternal Grandmother, PGF = Paternal Grandfater)*

a. CANCER *(Specify)*	
b. CARDIOVASCULAR DISEASE *(Specify)*	
c. DIABETES *(Specify)*	
d. MENTAL ILLNESS/CHEMICAL DEPENDENCY *(Specify)*	

7. SCREENING EXAMS *(* = Actual Result, * * = Tricare Benefit, N = Normal, X = Abnormal, E = Done Elsewhere, R = Refused NA = Not Indicated) (● = Next Due)*

a. TEST	b. FREQUENCY	c. YEAR / d. AGE						
			e. DATES					
(1) CLINICAL DISEASE PREV EVAL/PHA (HEAR)	ANNUAL		O	O	O	O	O	O
* (2) WEIGHT	ANNUAL FOR ACTIVE DUTY		O	O	O	O	O	O
* (3) HEIGHT	ANNUAL FOR ACTIVE DUTY		O	O	O	O	O	O
* (4) BLOOD PRESSURE	ONCE q 2 YRS for BP< 130/85, ANNUAL IF GREATER		O	O	O	O	O	O
* (5) CHOLESTEROL**	*q 5 YRS FOR AGE ≥ 18 q YR if PREV ABN		O	O	O	O	O	O
(6) HEARING	CLINICAL DISCRETION		O	O	O	O	O	O
(7) SKIN EXAM *(Cancer)*	ANNUAL IF AT RISK		O	O	O	O	O	O
(8) ORAL/DENTAL **	ANNUAL		O	O	O	O	O	O
(9) EYE/VISION **	ROUTINE ACUITY WITH PERIODIC ASSESSMENT DIABETES ANNUAL GLAUCOMA CHECK: Blacks q 3-5 yrs age 20-39 All q 2-4 years age 40-64				O	O	O	O
(10) BREAST EXAM	ANNUAL: ≥ 40 YRS		O	O	O	O	O	O
(11) MAMMOGRAM **	BASELINE@ 40, q 2 YRS 40-50, ANNUALLY > 50		O	O	O	O	O	O
(12) PAP ** *(Digital Rectal Exam)*	BASELINE: AGE 18 OR ONSET OF SEXUAL ACTIVITY AFTER 3 NL ANUUAL EXAMS, PERFORM q 1-3 years		O	O	O	O	O	O
(13) FECAL OCCULT BLOOD	ANNUAL ≥ 50 yrs		O	O	O	O	O	O
(14) SIGMOID	EVERY 3-5 YRS: ≥ 50 YRS		O	O	O	O	O	O
(15) COLONOSCOPY	HIGH RISK q 5 YRS ≥ YRS		O	O	O	O	O	O
(16) TESTICULAR	HIGH RISK ANNUAL 13-39 YRS		O	O	O	O	O	O
(17) PROSTATE ** **(DIGITAL RECTAL EXAM)*	WITH P.E. ≥ 40 YRS *(Presently Recommended annually)*		O	O	O	O	O	O
(18) RUBELLA SCREEN *(Females)*	ONCE BETWEEN AGES 12 –18 YRS *(Unless prev vaccinated)*		O	O	O	O	O	O
(19) OCCUPATIONAL SCREENING EXAMS	APPROPRIATE TO EXPOSURES		O	O	O	O	O	O
(20)			O	O	O	O	O	O
(21)			O	O	O	O	O	O
(22)			O	O	O	O	O	O

SAMPLE FORM

DD FORM 2766, (Rev 01-00) **PAGE 2 OF 4 PAGES**

ADULT PREVENTION AND CHRONIC CARE FLOWSHEET

8. OCCUPATIONAL HISTORY/RISK

a. PRP		YES		NO
b. .FLYING STATUS		YES		NO

9. IMMUNIZATIONS *(Enter numeric class in sub block)*

(1) IMMUNIZATION	(2) DATE *(ddmmmyyyy)*	(1) IMMUNIZATION	(2) DATE *(DDMMMYYYY)*	(1) IMMUNIZATION	(2) DATE *(ddmmmyyyy)*	(1) IMMUNIZATION	(2) DATE *(ddmmmyyyy)*
a. HEP A # 1		f. MMR # 1		j. TD *(q 10 YRS) (Last)*			
b. HEP A # 2		g. MMR #2		k. TD *(DUE)*			
c. HEP B # 1		h. PNEUMOCOCCUS		l. YELLOW FEVER *(LAST)*			
d. HEP B #2		i. POLIO OPV = O IPV = I		m. YELLOW FEVER			

n. TYPHOID *(Enter numeric class in sub block) ORAL = O TYPHUM Vi = 1. TYPHOID USP = 2*	(1) DATE	(2) DATE	(3) DATE	(4) DATE	(5) DATE	(6) DATE

O. ANTHRAX	(1) INITIAL DATE	(2) 2 WEEK DATE	(3) 4 WEEK DATE	(4) 6 MONTH DATE	(5) 12 MONTH DATE	(6) 18 MONTHDATE

p. PPD *(Enter mm and date)*	(1) (a) mm	(2) (a) mm	(3) (a) mm	(4) (a) mm	(5) (a) mm	(6) (a) mm	(7) (a) mm
	(b) DATE	(b) DATE	(b) DATE	(b) DATE	(b) DATE	(b) DATE	(b) DATE
q. INFLUENZA	(1) DATE	(2) DATE	(3) DATE	(4) DATE	(5) DATE	(6) DATE	(7) DATE
r. VARICELLA	(1) DATE	(2) DATE	u. JAPANESE B ENCEPHALITIS	(1) DATE	(2) DATE	(3) DATE	(4) DATE
s. MENINGO	(1) DATE	(2) DATE	v. OTHER (Specify)		(1) DATE	(2) DATE	(3) DATE
t. ADENO	(1) DATE	(2) DATE			(1) DATE	(2) DATE	(3) DATE

SAMPLE FORM

10. READINESS *(Glucose-6-phosphate dehydrogenase)*

a. DNA	DATE:	b. BLOOD TYPE	DATE:	RESULT:	c. G-PD	DATE	RESULT:	d. SICKLE CELL	DATE:	RESULT:

e. PERMANENT PROFILE CHANGE	(1) DATE	(2) P:	(3) U:	(4) L:	(5) H:	(6) E:	(7) S:

f. GLASSES/GAS/MASK Rx:	(1) DATE	(2) DATE	(3) DATE	(4) DATE	(5) DATE	(6) DATE
g. DENTAL EXAM *(Enter numeric class in sub block)*	(1) DATE	(2) DATE	(3) DATE	(4) DATE	(5) DATE	(6) DATE
h. HIV TESTING	(1) DATE	(2) DATE	(3) DATE	(4) DATE	(5) DATE	(6) DATE
I. FITNESS *(In sub block enter P = Pass, F = Fail, W = Waiver)*	(1) DATE	(2) DATE	(3) DATE	(4) DATE	(5) DATE	(6) DATE
	(1) DATE	(2) DATE	(3) DATE	(4) DATE	(5) DATE	(6) DATE
	(1) DATE	(2) DATE	(3) DATE	(4) DATE	(5) DATE	(6) DATE

11. PRE/POST DEPLOYMENT HISTORY

a. LOCATION						
(1) PREDEPLOYMENT	(a) DATE	(b) DATE	(c) DATE	(d) DATE	(e) DATE	(f) DATE
(2) POSTDEPLOYMENT	(a) DATE	(b) DATE	(c) DATE	(d) DATE	(e) DATE	(f) DATE
b. LOCATION						
(1) PREDEPLOYMENT	(a) DATE	(b) DATE	(c) DATE	(d) DATE	(e) DATE	(f) DATE
(2) POSTDEPLOYMENT	(a) DATE	(b) DATE	(c) DATE	d) DATE	(e) DATE	(f) DATE
c. CHART AUDIT	○	○	○	○	○	○

ADULT PREVENTIVE AND CHRONIC CARE FLOWSHEET
(Continuation Sheet)

TEST	FREQUENCY	DATES					
		(a)	(b)	(c)	(d)	(e)	(f)

SAMPLE FORM

REMARKS

RECORDS MAINTAINED AT:

PATIENT'S NAME LAST / FIRST / M.I.			**SEX**
RELATIONSHIP TO SPONSOR	**STATUS**	**RANK/GRADE**	
SPONSOR'S NAME *(Last, First, Middle Initial)*		**DEPT/SERVICE**	
ORGANIZATION	**SSN/ID NUMBER**	**DATE OF BIRTH**	

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BACK

PREVIOUS EDITION IS USABLE AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (*sign each entry)*

SAMPLE FORM

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART/SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: *(FOR TYPED OR WRITTEN ENTRIES, GIVE: name-last, first, middle ID NO or SSN; Sex; Date of Birth; Rank/Grade.);*	REGISTER NO.	WARD NO.

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (Rev. 6-97)
Prescribed by GSA/ICMR
FIRMR 941 CFR) 201-9.202-1

BACK

REPORT OF MEDICAL EXAMINATION

1. DATE OF EXAMINATION (YYYYMMDD)	2. SOCIAL SECURITY NUMBER

PRIVACY ACT STATEMENT

AUTHORITY: 10 USC 504, 505, 507, 532, 978, 1201, 1202, and 4346; and E.O. 9397.
PRINCIPAL PURPOSE(S): To obtain medical data for determination of medical fitness for enlistment, induction, appointment and retention for applicants and members of the Armed Forces. The information will also be used for medical boards and separation of Service members from the Armed Forces.
ROUTINE USE(S): None.
DISCLOSURE: Voluntary; however, failure by an applicant to provide the information may result in delay or possible rejection of the individual's application to enter the Armed Forces. For an Armed Forces member, failure to provide the information may result in the individual being placed in a non-deployable status.

3. LAST NAME - FIRST NAME - MIDDLE NAME (SUFFIX)	4. HOME ADDRESS *(Street, Apartment Number, City, State and ZIP Code)*	5. HOME TELEPHONE NUMBER *(Include Area Code)*

6. GRADE	7. DATE OF BIRTH (YYYYMMDD)	8. AGE	9. SEX	10. RACE
			☐ Female ☐ Male	☐ American Indian/Alaskan Native ☐ Asian/Pacific Islander ☐ Black ☐ White

11. TOTAL YEARS GOVERNMENT SERVICE		12. AGENCY *(Non-Service Members Only)*	13. ORGANIZATION UNIT AND UIC/CODE
a. MILITARY	b. CIVILIAN		

14.a. RATING OR SPECIALTY *(Aviators Only)*	b. TOTAL FLYING TIME	c. LAST SIX MONTHS

15.a. SERVICE	b. COMPONENT	c. PURPOSE OF EXAMINATION			16. NAME OF EXAMINING LOCATION, AND ADDRESS *(Include ZIP Code)*
☐ Army ☐ Coast Guard	☐ Active Duty	☐ Enlistment	☐ Medical Board	☐ Other	
☐ Navy	☐ Reserve	☐ Commission	☐ Retirement		
☐ Marine Corps		☐ Retention	☐ U.S. Service Academy		
☐ Air Force	☐ National Guard	☐ Separation	☐ ROTC Scholarship Program		

CLINICAL EVALUATION *(Check each item in appropriate column. Enter "NE" if not evaluated.)*

	Normal	Abnorm	NE
17. Head, face, neck, and scalp			
18. Nose			
19. Sinuses			
20. Mouth and throat			
21. Ears - General *(Int. and ext. canals/Auditory acuity under item 71)*			
22. Drums *(Perforation)*			
23. Eyes - General *(Visual acuity and refraction under items 61 - 63)*			
24. Ophthalmoscopic			
25. Pupils *(Equality and reaction)*			
26. Ocular motility *(Associated parallel movements, nystagmus)*			
27. Heart *(Thrust, size, rhythm, sounds)*			
28. Lungs and chest *(Include breasts)*			
29. Vascular system *(Varicosities, etc.)*			
30. Anus and rectum *(Hemorrhoids, Fistulae) (Prostate if indicated)*			
31. Abdomen and viscera *(Include hernia)*			
32. External genitalia *(Genitourinary)*			
33. Upper extremities			
34. Lower extremities *(Except feet)*			
35. Feet *(See Item 35 Continued)*			
36. Spine, other musculoskeletal			
37. Identifying body marks, scars, tattoos			
38. Skin, lymphatics			
39. Neurologic			
40. Psychiatric *(Specify any personality deviation)*			
41. Pelvic *(Females only)*			
42. Endocrine			

44. NOTES: *(Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary.)*

43. DENTAL DEFECTS AND DISEASE *(Please explain. Use dental form if completed by dentist. If dental examination not done by dental officer, explain in Item 44.)*

☐ Acceptable
☐ Not Acceptable Class _____

35. FEET *(Continued) (Circle category)*

Normal Arch	Mild	Asymptomatic
Pes Cavus	Moderate	
Pes Planus	Severe	Symptomatic

LAST NAME - FIRST NAME - MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER

LABORATORY FINDINGS

45. URINALYSIS	a. Albumin	46. URINE HCG	47. H/H	48. BLOOD TYPE
	b. Sugar			

TESTS	RESULTS	HIV SPECIMEN ID LABEL	DRUG TEST SPECIMEN ID LABEL
49. HIV			
50. DRUGS			
51. ALCOHOL			
52. OTHER			
a. PAP SMEAR			
b.			
c.			

MEASUREMENTS AND OTHER FINDINGS

53. HEIGHT	54. WEIGHT lbs.	55. MIN WGT - MAX WGT	MAX BF %	56. TEMPERATURE	57. PULSE

58. BLOOD PRESSURE			59. RED/GREEN *(Army Only)*	60. OTHER VISION TEST
a. 1ST	b. 2ND	c. 3RD		
SYS.	SYS.	SYS.		
DIAS.	DIAS.	DIAS.		

61. DISTANT VISION		62. REFRACTION BY AUTOREFRACTION OR MANIFEST			63. NEAR VISION		
Right 20/	Corr. to 20/	By	S.	CX	Right 20/	Corr. to 20/	by
Left 20/	Corr. to 20/	By	S.	CX	Left 20/	Corr. to 20/	by

64. HETEROPHORIA *(Specify distance)*

ES °	EX °	R.H.	L.H.	Prism div.	Prism Conv CT	NPR	PD

65. ACCOMMODATION		66. COLOR VISION *(Test used and result)*		67. DEPTH PERCEPTION *(Test used and score)* AFVT	
Right	Left	PIP	/14	Uncorrected	Corrected

68. FIELD OF VISION	69. NIGHT VISION *(Test used and score)*	70. INTRAOCULAR TENSION	
		O.D.	O.S.

71a. AUDIOMETER	Unit Serial Number						71b. Unit Serial Number							72a. READING ALOUD TEST			
Date Calibrated *(YYYYMMDD)*							Date Calibrated *(YYYYMMDD)*										
HZ	500	1000	2000	3000	4000	6000	HZ	500	1000	2000	3000	4000	6000		SAT		UNSAT
Right							Right							72b. VALSALVA			
Left							Left								SAT		UNSAT

73. NOTES *(Continued)* **AND SIGNIFICANT OR INTERVAL HISTORY** *(Use additional sheets if necessary.)*

LAST NAME - FIRST NAME - MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER

74.a. EXAMINEE/APPLICANT *(check one)*

- [ ] IS QUALIFIED FOR SERVICE
- [ ] IS NOT QUALIFIED FOR SERVICE

75. I have been advised of my disqualifying condition.

a. SIGNATURE OF EXAMINEE	b. DATE *(YYYYMMDD)*

b. PHYSICAL PROFILE

P	U	L	H	E	S	X	PROFILER INITIALS	DATE *(YYYYMMDD)*

76. SIGNIFICANT OR DISQUALIFYING DEFECTS

ITEM NO.	MEDICAL CONDITION/DIAGNOSIS	ICD CODE	PROFILE SERIAL	RBJ DATE *(YYYYMMDD)*	QUALI-FIED	DIS-QUALI-FIED	EXAMINER INITIALS	WAIVER RECEIVED	
								SERVICE	DATE *(YYYYMMDD)*

77. SUMMARY OF DEFECTS AND DIAGNOSES *(List diagnoses with item numbers) (Use additional sheets if necessary.)*

78. RECOMMENDATIONS - FURTHER SPECIALIST EXAMINATIONS INDICATED *(Specify) (Use additional sheets if necessary.)*

79. MEPS WORKLOAD *(For MEPS use only)*

WKID	ST	DATE *(YYYYMMDD)*	INITIAL	WKID	ST	DATE *(YYYYMMDD)*	INITIAL

80. MEDICAL INSPECTION DATE	HT	WT	%BF	MAX WT	HCG	QUAL	DISQ	PHYSICIAN'S SIGNATURE

81.a. TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	b. SIGNATURE
82.a. TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	b. SIGNATURE
83.a. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN *(Indicate which)*	b. SIGNATURE
84.a. TYPED OR PRINTED NAME OF REVIEWING OFFICER/APPROVING AUTHORITY	b. SIGNATURE

85. This examination has been administratively reviewed for completeness and accuracy.

a. SIGNATURE	b. GRADE	c. DATE *(YYYYMMDD)*

86. WAIVER GRANTED *(If yes, date and by whom)*

- [ ] YES
- [ ] NO

87. NUMBER OF ATTACHED SHEETS

BACK

REPORT OF MEDICAL HISTORY

(This information is for official and medically confidential use only and will not be released to unauthorized persons.)

Form Approved
OMB No. 0704-0413
Expires Aug 31, 2003

The public reporting burden for this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to Department of Defense, Washington Headquarters Services, Directorate for Information Operations and Reports (0704-0413), 1215 Jefferson Davis Highway, Suite 1204, Arlington, VA 22202-4302. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.

PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ADDRESS. RETURN COMPLETED FORM AS INDICATED ON PAGE 2.

PRIVACY ACT STATEMENT

AUTHORITY: 10 USC 504, 505, 507, 532, 978, 1201, 1202, and 4346; and E.O. 9397.
PRINCIPAL PURPOSE(S): To obtain medical data for determination of medical fitness for enlistment, induction, appointment and retention for applicants and members of the Armed Forces. The information will also be used for medical boards and separation of Service members from the Armed Forces.
ROUTINE USE(S): None.
DISCLOSURE: Voluntary; however, failure by an applicant to provide the information may result in delay or possible rejection of the individual's application to enter the Armed Forces. For an Armed Forces member, failure to provide the information may result in the individual being placed in a non-deployable status.

WARNING: The information you have given constitutes an official statement. Federal law provides severe penalties (up to 5 years confinement or a $10,000 fine or both), to anyone making a false statement. If you are selected for enlistment, commission, or entrance into a commissioning program based on a false statement, you can be tried by military courts-martial or meet an administrative board for discharge and could receive a less than honorable discharge that would affect your future.

1. LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)

2. SOCIAL SECURITY NUMBER

3. TODAY'S DATE *(YYYYMMDD)*

4.a. HOME ADDRESS *(Street, Apartment No., City, State, and ZIP Code)*

b. HOME TELEPHONE *(Include Area Code)*

5. EXAMINING LOCATION AND ADDRESS *(Include ZIP Code)*

X ALL APPLICABLE BOXES:

6.a. SERVICE
- [ ] Army
- [ ] Coast Guard
- [ ] Navy
- [ ] Marine Corps
- [ ] Air Force

b. COMPONENT
- [ ] Active Duty
- [ ] Reserve
- [ ] National Guard

c. PURPOSE OF EXAMINATION
- [ ] Enlistment
- [ ] Commission
- [ ] Retention
- [ ] Separation
- [ ] Medical Board
- [ ] Retirement
- [ ] U.S. Service Academy
- [ ] ROTC Scholarship Program
- [ ] Other *(Specify)* _____

7.a. POSITION *(Title, Grade, Component)*

b. USUAL OCCUPATION

8. CURRENT MEDICATIONS *(Prescription and Over-the-counter)*

9. ALLERGIES *(Including insect bites/stings, foods, medicine or other substance)*

Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Item 29 on Page 2.

HAVE YOU EVER HAD OR DO YOU NOW HAVE:	YES	NO
10.a. Tuberculosis	○	○
b. Lived with someone who had tuberculosis	○	○
c. Coughed up blood	○	○
d. Asthma or any breathing problems related to exercise, weather, pollens, etc.	○	○
e. Shortness of breath	○	○
f. Bronchitis	○	○
g. Wheezing or problems with wheezing	○	○
h. Been prescribed or used an inhaler	○	○
i. A chronic cough or cough at night	○	○
j. Sinusitis	○	○
k. Hay fever	○	○
l. Chronic or frequent colds	○	○
11.a. Severe tooth or gum trouble	○	○
b. Thyroid trouble or goiter	○	○
c. Eye disorder or trouble	○	○
d. Ear, nose, or throat trouble	○	○
e. Loss of vision in either eye	○	○
f. Worn contact lenses or glasses	○	○
g. A hearing loss or wear a hearing aid	○	○
h. Surgery to correct vision *(RK, PRK, LASIK, etc.)*	○	○
12.a. Painful shoulder, elbow or wrist *(e.g. pain, dislocation, etc.)*	○	○
b. Arthritis, rheumatism, or bursitis	○	○
c. Recurrent back pain or any back problem	○	○
d. Numbness or tingling	○	○
e. Loss of finger or toe	○	○

12. *(Continued)*	YES	NO
f. Foot trouble *(e.g., pain, corns, bunions, etc.)*	○	○
g. Impaired use of arms, legs, hands, or feet	○	○
h. Swollen or painful joint(s)	○	○
i. Knee trouble *(e.g., locking, giving out, pain or ligament injury, etc.)*	○	○
j. Any knee or foot surgery including arthroscopy or the use of a scope to any bone or joint	○	○
k. Any need to use corrective devices such as prosthetic devices, knee brace(s), back support(s), lifts or orthotics, etc.	○	○
l. Bone, joint, or other deformity	○	○
m. Plate(s), screw(s), rod(s) or pin(s) in any bone	○	○
n. Broken bone(s) *(cracked or fractured)*	○	○
13.a. Frequent indigestion or heartburn	○	○
b. Stomach, liver, intestinal trouble, or ulcer	○	○
c. Gall bladder trouble or gallstones	○	○
d. Jaundice or hepatitis *(liver disease)*	○	○
e. Rupture/hernia	○	○
f. Rectal disease, hemorrhoids or blood from the rectum	○	○
g. Skin diseases *(e.g. acne, eczema, psoriasis, etc.)*	○	○
h. Frequent or painful urination	○	○
i. High or low blood sugar	○	○
j. Kidney stone or blood in urine	○	○
k. Sugar or protein in urine	○	○
l. Sexually transmitted disease *(syphilis, gonorrhea, chlamydia, genital warts, herpes, etc.)*	○	○
14.a. Adverse reaction to serum, food, insect stings or medicine	○	○
b. Recent unexplained gain or loss of weight	○	○
c. Currently in good health *(If no, explain in Item 29 on Page 2.)*	○	○
d. Tumor, growth, cyst, or cancer	○	○

Reset

LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER

Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Item 29 below.

HAVE YOU EVER HAD OR DO YOU NOW HAVE:	YES	NO
15. a. Dizziness or fainting spells	○	○
b. Frequent or severe headache	○	○
c. A head injury, memory loss or amnesia	○	○
d. Paralysis	○	○
e. Seizures, convulsions, epilepsy or fits	○	○
f. Car, train, sea, or air sickness	○	○
g. A period of unconsciousness or concussion	○	○
h. Meningitis, encephalitis, or other neurological problems	○	○
16. a. Rheumatic fever	○	○
b. Prolonged bleeding *(as after an injury or tooth extraction, etc.)*	○	○
c. Pain or pressure in the chest	○	○
d. Palpitation, pounding heart or abnormal heartbeat	○	○
e. Heart trouble or murmur	○	○
f. High or low blood pressure	○	○
17. a. Nervous trouble of any sort *(anxiety or panic attacks)*	○	○
b. Habitual stammering or stuttering	○	○
c. Loss of memory or amnesia, or neurological symptoms	○	○
d. Frequent trouble sleeping	○	○
e. Received counseling of any type	○	○
f. Depression or excessive worry	○	○
g. Been evaluated or treated for a mental condition	○	○
h. Attempted suicide	○	○
i. Used illegal drugs or abused prescription drugs	○	○
18. FEMALES ONLY. Have you ever had or do you now have:		
a. Treatment for a gynecological (female) disorder	○	○
b. A change of menstrual pattern	○	○
c. Any abnormal PAP smears	○	○
d. First day of last menstrual period *(YYYYMMDD)*		
e. Date of last PAP smear *(YYYYMMDD)*		

	YES	NO
19. Have you been refused employment or been unable to hold a job or stay in school because of:		
a. Sensitivity to chemicals, dust, sunlight, etc.	○	○
b. Inability to perform certain motions	○	○
c. Inability to stand, sit, kneel, lie down, etc.	○	○
d. Other medical reasons *(If yes, give reasons.)*	○	○
20. Have you ever been treated in an Emergency Room? *(If yes, for what?)*	○	○
21. Have you ever been a patient in any type of hospital? *(If yes, specify when, where, why, and name of doctor and complete address of hospital.)*	○	○
22. Have you ever had, or have you been advised to have any operations or surgery? *(If yes, describe and give age at which occurred.)*	○	○
23. Have you ever had any illness or injury other than those already noted? *(If yes, specify when, where, and give details.)*	○	○
24. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? *(If yes, give complete address of doctor, hospital, clinic, and details.)*	○	○
25. Have you ever been rejected for military service for any reason? *(If yes, give date and reason for rejection.)*	○	○
26. Have you ever been discharged from military service for any reason? *(If yes, give date, reason, and type of discharge; whether honorable, other than honorable, for unfitness or unsuitability.)*	○	○
27. Have you ever received, is there pending, or have you ever applied for pension or compensation for any disability or injury? *(If yes, specify what kind, granted by whom, and what amount, when, why.)*	○	○
28. Have you ever been denied life insurance?	○	○

29. EXPLANATION OF "YES" ANSWER(S) *(Describe answer(s), give date(s) of problem, name of doctor(s) and/or hospital(s), treatment given and current medical status.)*

NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL PERSONNEL ONLY."

LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER

30. EXAMINER'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA *(Physician/practitioner shall comment on all positive answers in questions 10 - 29. Physician/practitioner may develop by interview any additional medical history deemed important, and record any significant findings here.)*

a. COMMENTS

b. TYPED OR PRINTED NAME OF EXAMINER *(Last, First, Middle Initial)*	c. SIGNATURE	d. DATE SIGNED *(YYYYMMDD)*

BACK

NSN 7540-01-075-3786

MEDICAL RECORD	EMERGENCY CARE AND TREATMENT *(Patient)*	LOG NUMBER	TREATMENT FACILITY
		RECORDS MAINTAINED AT	

PATIENT'S HOME ADDRESS OR DUTY STATION				ARRIVAL	
STREET ADDRESS				DATE *(Day, Month, Year)*	TIME
CITY	STATE	ZIP CODE		TRANSPORTATION TO FACILITY	

SEX	DUTY/LOCAL PHONE		MILITARY STATUS				THIRD PARTY INSURANCE		
	AREA CODE	NUMBER	ITEM	YES	NO	N/A	ITEM	YES	NO
			PRP				ADDITIONAL INSURANCE		
AGE	HOME PHONE		FLYING STATUS				DD 2568 IN CHART		
		NUMBER	MEDICAL HISTORY OBTAINED FROM				NAME OF INSURANCE COMPANY		

CURRENT MEDICATIONS	INJURY OR OCCUPATIONAL ILLNESS					EMERGENCY ROOM VISIT	
		YES	NO	WHEN *(DATE)*		DATE LAST VISIT	24 HOUR RETURN ☐ YES ☐ NO
	IS THIS AN INJURY			WHERE		TETANUS	
ALLERGIES	INJURY/SAFETY FORMS					DATE LAST SHOT	COMPLETED INITIAL SERIES ☐ YES ☐ NO
	HOW						

CHIEF COMPLAINT

SAMPLE FORM

CATEGORY OF TREATMENT		VITAL SIGNS					
☐ EMERGENT	TIME	TIME					
		B/P					
☐ URGENT		PULSE					
	INITIALS	RESP					
☐ NON-URGENT		TEMP					
		WT					

LAB ORDERS														
		CBC/DIFF		ABG		PT/PTT		BHCG/URINE/BLOOD/QUANT	X-RAY ORDERS		CXR PA & LAT/ PORTABLE		C-SPINE
		URINE C&S		UA				CHEM:			ACUTE ABDOMEN		LS SPINE
		BLOOD C&S X									ANKLE R/L		HEAD CT

ORDERS

☐ PULSE OX ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE

DISPOSITION	DISPOSITION QUARTERS/OFF DUTY	PATIENT/DISCHARGE INSTRUCTIONS
☐ HOME ☐ FULL DUTY	☐ 24 HRS. ☐ 48 HRS. ☐ 78 HRS	
MODIFIED DUTY UNTIL	RETURN TO DUTY	

CONDITION UPON RELEASE	ADMIT TO UNIT/SERVICE	REFERRED	TO	WHEN
☐ IMPROVED ☐ UNCHANGED	TIME OF RELEASE	**I have received and understand these instructions.**		
☐ DETERIORATED		PATIENT'S SIGNATURE		

PATIENT'S IDENTIFICATION *(For typed or written entries, give: name-last, first, middle; ID no. (SSN or other); hospital or medical facility)*

EMERGENCY CARE AND TREATMENT (*Patient*)
MEDICAL RECORD
STANDARD FORM 558 (REV 9-96)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.203(b)(10)

NSN 7540-01-075-3786

MEDICAL RECORD	EMERGENCY CARE AND TREATMENT *(Doctor)*	TIME SEEN BY PROVIDER

TEST RESULTS

CBC	WBC	SMAC			ABG/PULSE OX			**RADIOLOGY**	CHECK IF READ BY RADIOLOGIST	☐
	H/H				SUP 02	PH	PO2	RESULTS		
	PLT				PCO2	SAT	OTHER			
				U/A	DIP			EKG INTERPRETATION		
PT					MICRO					
APTT		BHCG	ETOH	GLU						

PROVIDER HISTORY/PHYSICAL

SAMPLE FORM

CONSULT WITH	TIME	ACTION

RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP

PROVIDER SIGNATURE AND STAMP

DIAGNOSIS

CODES

PATIENT'S IDENTIFICATION (*For typed or written entries, give: Name-last, first ,middle; ID no. (SSN or other); hospital or medical facility)*

EMERGENCY CARE AND TREATMENT (*Doctor*)
MEDICAL RECORD
STANDARD FORM 558 (REV 9-96)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.203(b)(10)

BACK

MEDICAL RECORD	NARRATIVE SUMMARY (CLINICAL RESUME)	
DATE OF ADMISSION	DATE OF DISCHARGE	NUMBER OF DAYS HOSPITALIZED

(Sign and date at end of narrative)

SAMPLE FORM

SIGNATURE OF PHYSICIAN	DATE	IDENTIFICATION NO.	ORGANIZATION

PATIENT'S IDENTIFICATION (For typed or written entries give: Name last, first; middle; grade; rank; rate ;hospital or medical facility)	REGISTER NO.	WARD NO.

NARRATIVE SUMMARY (CLINICAL RESUME)

MEDICAL RECORD
STANDARD FORM 502 (rev-7-91)
Prescribed by GSA/ICMR,FIRMR
(41-CFR) 201-9.202.1

BACK

MEDICAL RECORD	CONSULTATION SHEET	
REQUEST		
TO:	FROM: *(requesting physician or activity)*	DATE OF REQUEST
REASON FOR REQUEST *(Complaints and findings)*		
PROVISIONAL DIAGNOSIS		
DOCTOR'S SIGNATURE	APPROVED	PLACE OF CONSULTATION ☐ BEDSIDE ☐ ON CALL ☐ROUTINE ☐ TODAY ☐72 HOURS ☐ EMERGENCY
CONSULTATION REPORT		
RECORD REVIEWED ☐ YES ☐ NO	PATIENT EXAMINED ☐ YES ☐ NO	TELEMEDICINE ☐ YES ☐ NO
SIGNATURE AND TITLE		DATE
HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT	DEPARTMENT/SERVICE OF PATIENT
RELATION TO SPONSOR	SPONSOR'S NAME *(last, first, middle)*	SPONSOR'S ID NUMBER
PATIENT'S IDENTIFICATION *(For typed or written entries, give: Name –last, first, middle; ID No.(SSN or other); Sex; Date of Birth; Rank/Grade)*	REGISTER NO.	WARD NO.

SAMPLE FORM

CONSULTATION SHEET
MEDICAL RECORD
STANDARD FORM 513 (Rev. 4-98)
Prescibed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

Clinical Record	ELECTROCARDIOGRAPHIC RECORD	Previous ECG ☐ Yes ☐ NO

Clinical Impression	Medication	☐ Emergency ☐ Routine	☐ Bedside ☐ Ambulant

Age	Sex	Race	Height	B.P.	Signature of Ward Physician	Date

Rhythm	Axis Deviation	Rates Auric. Vent.

IIntervals PR QRS QT	P Waves

QRS Complexes

RS-T Segment	T Waves

Unipolar Extremity Leads *(specify)*

Precordial Leads *(specify)*

Summary, Serial Changes, and Implications:

(Continue on Reverse)

No. ECG	Signature of Physician	Patient's Identification No.	Date

Patient's Identification (For typed or written entries give; Name – Last First, middle; grade, date hospital or medical facility)	Register No.	Ward No.

SAMPLE FORM

Electrocardiographic Records
Standard Form 520
General Services Administration and
Interagency Committee on Medical Records
FPMR 101-11.806-8
October 1975 520-106

BACK

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	TISSUE EXAMINATION

SPECIMEN SUBMITTED BY	DATE OBTAINED
SPECIMEN	
BRIEF CLINICAL HISTORY *(include duration of lesion and rapidity of growth, if a necoplasm)*	
PREOPERATIVE DIAGNOSIS	
OPERATIVE FINDINGS	
POSTOPERATIVE DIAGNOSIS	SIGNATURE
	NAME OF SIGNER
	TITLE OF SIGNER

PATHOLOGICAL REPORT

NAME OF LABORATORY	ACCESSION NO(S)		

GROSS DESCRIPTION, HISTOLOGIC EXAMINATION AND DIAGNOSES

SAMPLE FORM

SIGNATURE OF PATHOLOGIST	NAME OF PATHOLOGIST	DATE

HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT	DEPARTMENT/SERVICE OF PATIENT
RELATION TO SPONSOR	SPONSOR'S NAME (*Last, first middle)*	SPONSOR'S ID NUMBER (*SSN or Other)*
PATIENT'S IDENTIFICATION (For typed or written entries, give: Name-last, first, middle; ID no. SSN or other); Sex; Date of Birth; Rank/Grade)	REGISTER NO.	WARD NO.

TISSUE EXAMINATION
Medical Record

STANDARD FORM 515 (Rev 8-97)
Prescribed by GSA/ICMR FPMR 101-11.203(b)(10)

Medical record	GYNECOLOGIC CYTOLOGY

Section I – Clinical data to be Completed by Examining Installation

Date Obtained	LMP First Day	Date Received in Laboratory

Source of Specimen

☐ Combined Cerve and Vagina ☐ Cerve ☐ Vagina ☐ Other (Specify)

Age	Pregnancy ☐ Yes ☐ No	Gravida	Para	Previous Abnormal Cytologic Examination ☐ Yes, Give Date_____ ☐ No

Clinical History *(Surgery, Drugs, hormones, radiation, etc.)*	Physical Examination *(Pelvic findings, etc.)*

Specimen Submitted By *(Facility)*	Signature and title	Submitting Facility Accession Number

Section II – Cytologic Findings Form Reporting Installation Only

Name of Laboratory	Accession Number

Check One	Yes	No	Check One	Yes	No	
Granulocytes			Endocervial Cells			Maturation Index
Leukocytes						Parabasals
Trichamonas			Screened By			Intermediates
Candida						Superficials

Comments and recommendations

SAMPLE FORM

Pathologist's Signature	Title	Date

Patients Identification (For typed or written entries give; Name – Last first, Middle; grade, date, hospital or medical facility)	Register No.	Ward No.

Standard form 541
Provided by GSA and ICMB

BACK

CLINICAL RECORD	LABORATORY REPORTS
	ATTACH 3D REPORT ALONG HERE AND ↖ SUCCEEDING ONES ON ABOVE LINES
	ATTACH 2D REPORT WITH TOP AT THIS LINE ↖
	ATTACH 1ST REPORT ALONG LEFT MARGIN WITH TOP AT THIS LINE ↖
ATTACHING MARGIN	

SAMPLE FORM

ATTACH ALL TEST REPORTS TO THIS SHEET

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; grade; date; hospital or medical facility)*,	REGISTER NO.	WARD NO.

LABORATORY REPORTS

Standard Form 514
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45.505
October 1975 514-108

MEDICAL RECORD	RADIOLOGICAL CONSULTATION REQUESTS/REPORTS
	ATTACH 3D REPORT ALONG HERE ↖ AND SUCCEEDING ONES ON ABOVE LINES
	ATTACH 2D REPORT WITH TOP AT THIS LINE ↖
ATTACH REPORTS WITHIN THIS MARGIN	ATTACH 1ST REPORT ALONG LEFT MARGIN WITH TOP AT THIS LINE ↖

SAMPLE FORM

RADIOLOGICAL CONSULTATIONS REQUESTS/REPORTS
STANDARD FORM 519 (Rev. 2-84)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201.45.505
519-11
NSN 7540-00-634-4160

BACK

(THIS FORM IS SUBJECT TO THE PRIVACY ACT OF 1974 – Use DD Form 2006.)

EYEWEAR PRESCRIPTION	**DATE**	**ACCOUNT NUMBER**	**ORDER NUMBER**
TO: *(LAB)*		**FROM:**	
NAME *(Last, First)*		**SSN**	**GRADE**
ADDRESS/UNIT			**PHONE**
ADDRESS CONTINUED			**SHIP TO:** ☐ **CLINIC** ☐ **PATIENT**
CITY, STATE, ZIP			

SAMPLE FORM

AD	RES	NG	RET	OTHER	A	N	AF	MC	CG	PHS	OTHER

FRAME	**EYE**	**BRIDGE**	**TEMPLE**	**COLOR**

DIST / **NEAR** **PD**	**LENS**	**TINT**	**MATERIAL**	**PAIR**	**CASE**

	SPHERE	CYLINDER	AXIS	DECENTER	H PRISM	H BASE	V PRISM	V BASE
R								
L								

MULTIVISION			**LAB USE**	
NEAR ADD	SEG HT	TOTAL DECENTER		
			PRIORITY	**TECH INITIALS**

SPECIAL COMMENTS/JUSTIFICATION *(* Use this space to specify blocks marked "Other.")*

PRESCRIBING OFFICER/AUTHORITY	SIGNATURE

DISTRIBUTION: ORIGINAL – Retained by Lab. **COPY 1** – Returned with eyewear. **COPY 2 –** Entered in health record.

DD FORM 771, JUL 96 (EG) PREVIOUS EDITION IS Designed using Perform Pro, WHS/DIOR, Aug 96

BACK

HEALTH RECORD **IMMUNIZATION RECORD** *All entries in ink to be made in block letters*

VACCINATION AGAINST SMALLPOX *(Number of previous vaccination scars)*

	DATE	ORIGIN	BATCH NUMBER	REACTION	STATION	PHYSICIAN'S NAME
1						
2						
3						
4						
5						
6						

YELLOW FEVER VACCINE

	DATE	ORIGIN	BATCH NUMBER	STATION	PHYSICIAN'S NAME
1					
2					
3					

SAMPLE FORM

TYPHOID VACCINE

	DATE	DOSE	PHYSICIAN' NAME		DATE	DOSE	PHYSICIAN'S NAME
1				4			
2				5			
3				6			

TETANUS-DIPHTHERIA TOXOIDS

	DATE	DOSE	PHYSICIAN'S NAME		DATE	DOSE	PHYSICIAN'S NAME
1				4			
2				5			
3				6			

CHOLERA VACCINE

	DATE	PHYSICIAN'S NAME		DATE	PHYSICIAN'S NAME		DATE	PHYSICIAN'S NAME
1			4			7		
2			5			8		
3			6			9		

PATIENTS IDENTIFICATION *(Mechanically Imprint, Type or Print):*

◀ Patient's Name – last, first, middle initial; Sex; age or Year Of Birth; Relationship to Sponsor; Component/Status; Department/Service.

◀ Sponsor's Name – last, first, middle initial; Rank/Grade; SSN or Identification Number; Organization.

IMMUNIZATION RECORD
Standard Form 601 – October 1975 (Rev.)
General Services Administration & Interagency Committee on Medical Records
FIRMR (41 CFR) 201-45.505

ORAL POLIOVIRUS VACCINE							
	DATE	DOSE	PHYSICIAN'S NAME		DATE	DOSE	PHYSICIAN'S NAME
1				3			
2				4			

INFLUENZA VACCINE							
	DATE	DOSE	PHYSICIAN'S NAME		DATE	DOSE	PHYSICIAN'S NAME
1				3			
2				4			

INFLUENZA VACCINE									
	DATE	TYPE	DOSE	PHYSICIAN'S NAME		DATE	TYPE	DOSE	PHYSICIAN'S NAME
1									
2					6				
3					7				
4					8				

SAMPLE FORM

SENSITIVITIES TEST *(Tuberculin,etc.)*						
	DATE	TYPE	DOSE	ROUTE	RESULTS	PHYSICIAN'S NAME
1						
2						
3						
4						
5						

REMARKS:

THIS RECORD IS ISSUED IN ACCORDANCE WITH ARTICLE 99, WHO SANITARY REGULATION NO 2.

STANDARD FORM 601 PAGE 2 (Rev. 10-75)

HEALTH RECORD SYPHILIS RECORD

SECTION 1. – HISTORY OF PAST VENEREAL INFECTIONS OR TREATMENTS

DATE	DISEASE *(Give stage)*	PRIOR TO MIL. SERVICE YES	PRIOR TO MIL. SERVICE NO	TREATMENT *(Give type, amount and dates)*	TREATING AGENCY	PLACE
1						
2						
3						
4						

SECTION II = HISTORY OF PRESENT INFECTION

CAME TO MEDIAL ATTENTION BY: **VOLUNTARY** ☐ CONTACT REPORT ☐ PHYSICAL INSPECTION ☐ FOOD HANDLER ☐

INCIDENT TO HOSPITALIZATION **PREMARITAL** ☐ **PRENATAL** ☐ **OTHER** *(Specify)* ☐

DATES: ONSET SYMPTOMS **REQUESTED TREATMENT** **DIAGNOSIS ESTABLISHED**

DIAGNOSIS *(Include stage and diagnosis No.)*

DIAGNOSTIC CRITERIA *(Enter results of test)*

LIST VD CONTACT FORM SERIAL NOS.

CLINICAL DATA *(Including chief complaint, physical findings – eye, cardiovascular and nervous system, even in early syphillis)*

SAMPLE FORM

RECOMMENDED TREATMENT AND FOLLOW-UP **SIGNATURE OF PHYSICIAN** **DATE**

HAVE BEEN INFORMED BY THE MEDICAL OFFICER THAT I HAVE BEEN DIAGNOSED AS HAVING SYPHILIS AS INDICATED ABOVE; THE NATURE OF THIS DISEASE HAS BEEN EXPLAINED TO ME; I UNDERSTAND THAT MY COOPERATION IS NECESSARY IN THE TREATMENT AND PROLONGED OBSERVATION *(including certain prescribed tests)* FOR THE CARE OF THIS DISEASE.

SIGNATURE OF PATIENT AND DATE

SECTION III. - TREATMENT

	TREATMENT	DATE STARTED	DATE ENDED	SIGNATURE OF PHYSICIAN
1				
2				
3				
4				

PATIENT'S IDENTIFICATION *(Mechanically Imprint, Type or Print):*

◀ Patient's Name – last, first, middle initial; Sex; age or Year Of Birth; Relationship to Sponsor; Component/Status; Department/Service.

◀ Sponsor's Name – last, first, middle initial; Rank/Grade; SSN or Identification Number; Organization.

SYPHILIS RECORD
Standard Form 602 – March – 1975 (Rev.)
General Services Administration &
Interagency Comm on Medical Records

SECTION IV. – CUMULATIVE LABORATORY SUMMARY

RESULTS OF DARKFIELD EXAMINATION

	DATE	RESULTS	SOURCE OF SPECIMEN	LABORATORY	NAME OF CONFIRMING OFFICER
1					
2					

RESULTS OF SEROLOGICAL TESTS FOR SYPHILIS

	DATE	TYPE	RESULT *(Include titer value)*	LABORATORY		DATE	TYPE	RESULT *(Include Titer value)*	LABORATORY
1					5				
2					6				
3					7				
4					8				

FLUORESCENT ANTIBODY TESTS

	DATE	
1		
2		

SAMPLE FORM

RESULTS OF SPINAL FLUID EXAMINATION

	DATE	CELLS	TOTAL PROTEIN	SEROLOGICAL TEST *(Including titer)*	LABORATORY WHERE DONE
1					
2					

SECTION V. – EVALUATION OF THERAPY

	DATE	FACILITY WHERE EVALUATED	RESULT		DATE OF RETREATMENT	PHYSICIAN'S SIGNATURE
			Satisfactory	UNSATISFACTORY		
1						
2						
3						
4						

***Satisfactory result cannot be reported without normal spinal fluid findings.**
****Specify: Infectious Relapse: Sero-Relapse, Neuro-Relapse, Incomplete data on Spinal Fluid, Other** *(Specify)*

REASON FOR INADEQUATE FOLLOW-UP *(Date, place and type of separation – Give authority for discharge)*

PATIENT'S HOME ADDRESS ON SEPARATION	**CIVILIAN HEALTH DEPT. TO WHICH CASE RESUME WAS SENT**

REINFECTION *(Give date new record was opened)*

REMARKS

SECTION VI. – MEDICAL OFFICER CLOSING THIS RECORD

NAME *(Typed or printed)*	**SIGNATURE**	**STATION**	**DATE**

SECTION VII. – MEDICAL OFFICER SENDING ABSTRACT TO VETERAN'S ADMINISTRATION ON DISCHARGE

NAME *(Typed or printed*	**SIGNATURE**	**STATION**	**DATE**

Page 2 of SF-602 (rev. 3-75)

BACK

RECORD OF OCCUPATIONAL EXPOSURE TO IONIZING RADIATION

For instructions See Reverse of Sheet

Identification Number	Name (*Last, First, Middle Initial)*	Social Security Number	Rank/Rate/Title	Date of Birth

Place Where Exposure Occurred	Period of Exposure		**Dose This Period** 1. Method of monitoring is presumed to be film badge reading unless otherwise specified under item 16, "REMARKS."				**Accumulated Dose**		Initial
Acticty	From (Day-Mo-Yr)	To (Day-Mo-Yr)	Skin Dose (Salt)	Gamma and X-Ray	Neutron	Total This Period	Total Life Time	Permis-sible Lifetime	Persons Making Entry

SAMPLE FORM

16. Remarks:

TO BE RETAINED PERMANENTLY IN INDIVIDUAL'S MEDICAL RECORD

DD Form 1141

Back

Department of Transportation U.S. Coast Guard CG-4057 (Rev 2-01)	CHRONOLOGICAL RECORD OF SERVICE	
DATE ATTACHED	**UNIT OR STATION**	**DATE DETACHED**

AGREEMENT/DISAGREEMENT

I agree ☐ (or) do not agree ☐ that at the time of separation:

(2) I am reasonably able to perform my current duties, or

(2) I have a high expectation of recovery in the near term from illness, injury or surgical procedure such that I would again be able to perform my usual duties.

Date	Grade/Rate	Signature of Member

TERMINATION OF HEALTH RECORD

Remarks

Impairments, which have been documented in your health record, including any separation exam, while establishing service connection, do not in themselves indicate a disability. To receive disability benefits from the Coast Guard, you must be found unfit to perform your assigned duties through the physical disability evaluation system before you are separated.

After you are separated, any claims for disability benefits must be submitted to the Department of Veterans Affairs. If you have questions about certain benefits to which you might be entitled you should contact the DVA Regional Office nearest your home as soon as practical.

I have read the above statements and acknowledge receipt of a copy of the following:

1. CG-4057, Chronological record of Service.
2. SF-88 report of Medical Examination date_____ (if performed).
3. PHS-731, International Certificate of Vaccination.
4. DD Form 2766, Adult Preventive and Chronic Care Flowsheet.

Date	Grade/Rate	Signature of Member

COMMAND CERTIFICATION

Health record terminated this date by reason of_____

In accordance with Chapter 4, Medical Manual, COMDTINST M6000.1 (series)

Date	Title	Signature

BACK

NAVMED – 6150/2 (REV 8-70)	**SPECIAL DUTY MEDICAL ABSTRACT (NAVMED 6150/2)**
Health Record	**Special Duty Medical Abstract**

Summary of Physical Examination for Special Duty

Date	Place	Purpose	Result – Recommendation *(Defects Reverse)*	BUMED Action	Sig. Of M.D.
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					

Suspension From Special Duty

Date *(From) (To)*	No. of Days	Reason for Suspension	Signature of Medical Officer
1.			
2.			
3.			
4.			
5.			
6.			
7.			

SAMPLE FORM

Periodic Special Duty Requalification

Date	Signature of . O.	Date	Signature of M.O.	Date	Signature of M.O.

Name (Last) (First) (Middle)	Grade/Rate	Service/Soc. Sec.	Organization

SPECIAL DUTY MEDICAL ABSTRACT (NAVMED 6150/2)

Altitude Training, Air Compression and Oxygen Tolerance			
Date	Station	Type of Run – Reaction	Signature or M.O.
1.			
2.			
3.			
4.			
5.			
Explosive Decompression Training			
Date	Station	Altitudes - Reaction	Signature or M.O.
1.			
2.			
Submarine Escape and Diving Training			
Date	Station	Type of Run - Reaction	Signature or M.O.
1.			
2.			
3.			
4.			
5.			
Visual and Disorientation Training			
Date	Station	Type of Training	Signature or M.O.
1.			
2.			
3.			
4.			
Centrifuge and Ejection Seat Training			
Date	Station	Type of run – Reaction	Signature or M.O.
1.			
2.			
Remarks			

SAMPLE FORM

BACK

EMERGENCY MEDICAL TREATMENT REPORT

VICTIM IDENTI-FICATION

1. Name_____
_____
2. Sex (check one) male _____ female _____
3. Estimated age yrs_____ mos_____

RESCUER INFOR-MATION

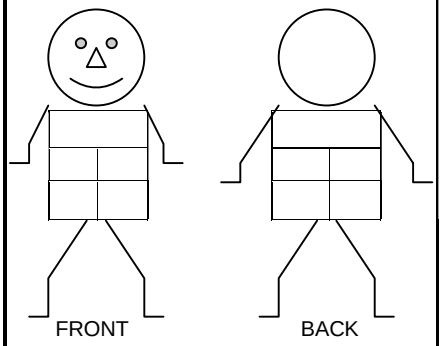
10. Name: _____ 11. Level:
12. Unit: _____
13. OPFAC #: _____
14. Rescue Vehicle:_____
15. Receiving Unit:_____
16. Time Patient Transferred:_____

DESCRIP-TION OF INCIDENT

4. Date: _____ 5. Type of incident:
6. Time on Scene: _____ a) marine _____
7. Time of incident: _____ b) aviation _____
c) Industrial _____
8. Location:_____ d) auto _____
_____ e) domestic _____
f) other _____

NATURE OF EMERGENCY / MECHANISM OF INJURY

OBSERVA-TION OF VISTIM



H – hemorrhage **F –** fracture
L - laceration **B -** burns
S – soft tissue injury O2 Liters_____

TREATMENT

IRCLE AS NEEDED)

– DRESSING
- TX SPLINT
- SPLINT
- C/COLLAR
- BACK BOARD
- TOURNIQUET
- CPR
- AIRWAY
- OXYGEN
.0 - MAST
.1 - MILLER B/B

MEDICATIONS:

ALLERGIES

_____

MEDICAL HISTORY / COMMENTS /ETC.
(include additional vitals, oxygen, fluids, etc.)

SAMPLE FORM

SKIN

(Circle appropriate number of numbers)

1 – normal	4 - cyanotic	7 - cold
2 – pale/ashen	5 – dry	8 – warm
3 – flushed	6 – moist	9 - hot

	TIME / OBSERVED				
VITAL SIGNS					
LEVEL OF CONSCIOUS	Alert				
	Responds to Verbal				
	Responds to Pain				
	Uncon/Unresponsive				
PUPILS	Perl				
	Unequal				
	Nonreactive				
	Dilated				
	Pinpoint				
PULSE	Rate (Numeric)				
	Strong				
	Weak				
BREATHING	Rate (Numeric)				
	Regular				
	Shallow				
	Labored				
BLOOD PRESSURE	Blood Pressure				
TEMP	Temperature (circle) ORAL RECTAL				
MAST	**MAST BP**				
	COMPARTMENT		R	L	ABD

TIME	**MEDICATIONS ADMINISTERED**	**DOSAGE**
_____	_____	_____
_____	_____	_____
_____	_____	_____

TRIAGE INFORMATION (CIRCLE ONE) **PRIORITY I** **PRIORITY II** **PRIORITY III**

DEPT. OF TRANSPORTATION., USCG CG-5214 (Rev. 10-88) **PATIENT COPY**
Previous Edition May be Used

REQUEST FOR MEDICAL/DENTAL RECORD OR INFORMATION	REQUESTING ACTIVITY Complete Items 1 through 10 *(Except 8b); also* Complete Item 19. ADDRESSEE – Complete Items 8b, 11 to 14 or 15 to 18, as appropriate, Final referrer shall return to requester.	Date

1. PATIENT *(Last Name – First Name – Middle Name)*

2. ORGANIZATION AND PLACE OF TREATMENT

3. STATUS ☐ MILITARY ☐ VA BENEFICIARY ☐ DEPENDENT ☐ FEDERAL EMPLOYEE ☐ OTHER *(Specify)*

3a. NAME OF SPONSOR *(If dependent)*

4. TO *(Include ZIP Code)*

5. IDENTIFYING INFORMATION
- a. SERVICE NUMBER
- b. GRADE/RATE
- C. SOCIAL SECURITY ACCOUNT NO.
- D. VA CLAIM NUMBER
- E. DATE OF BIRTH *(If federal employee)*

6. DATES OF TREATMENT

7 DISEASE OR INJURY

8. a. RECORDS REQUESTED / B. RECORDS FORWARDED

	MIL	VA	MIL	VA
CLINICAL	☐	☐	☐	☐
OUTPATIENT	☐	☐	☐	☐
HEALTH RECORD	☐		☐	
DENTAL RECORD	☐	☐	☐	☐
X--RAY	☐	☐	☐	☐
MEDICAL REPORT CARDS, EMERGENCY MEDICAL TAGS, FIELD MEDICAL CARDS	☐		☐	
ABSTRACT OF RATING SHEET				☐
REPORT OF PHYSICAL EXAMINATION	☐	☐	☐	☐
ALL AVAILABLE RECORDS *(Except X-rays unless specifically requested)*	☐		☐	
OTHERS *(List under remarks)*	☐	☐	☐	☐

9. REMARKS

10. SIGNATURE

SAMPLE FORM

REPLY/REFERRAL

11. TO:

12. REMARKS
- RECORDS CHECKED IN 8B FORWARDED.
- NO RECORDS FOUND FOR PATIENT DURING ABOVE PERIOD.
- MORE INFORMATION NEEDED.

13. SIGNATURE

14. DATE

REPLY/SECOND REFERRAL

15. TO:

16. REMARKS
- RECORDS CHECKED IN 8B FORWARDED.
- NO RECORDS FOUND FOR PATIENT DURING ABOVE PERIOD.
- MORE INFORMATION NEEDED.

17. SIGNATURE

18. DATE

19. **RETURN TO**: *(Include ZIP Code)*

REQUESTING ACTIVITY WILL ENTER COMPLETE ADDRESS TO WHICH RECORDS OR FINAL REPLY SHOULD BE MAILED.

DD FORM 877, SEP 67

BACK

U. S. COAST GUARD

DENTAL RECORD

PRIVACY ACT STATEMENT: HEALTH CARE RECORDS

1. **AUTHORITY FOR COLLECTION OF INFORMATION INCLUDING SOCIAL SECURITY NUMBER (SSN):** Section 632 of Title 14 United States Code and Sections 1071-1087, Title 10 United States code, Executive Order9397.

2. **PRINCIPAL PURPOSES FOR WHICH INFORMATION IS TO BE USED:** The purpose for requesting information is to assist medical personnel in developing records to facilitate and document your health condition in order to provide health care and to provide a complete account of such care rendered, including diagnosis, treatment, and end result. The social Security Number (SSN) necessary to identify the person and records.

3. **ROUTINE USES:** This information may be used to plan and coordinate health care. It may be used to provide medical treatment, conduct research, teach, compile statistical data, determine suitability of persons for service or assignment, implement preventive health and communicative disease control program; adjudicate claims and determine benefits; evaluate care rendered; determine professional certification of patients to other Federal, State and local agencies upon request in the pursuit of there official duties; and report medical conditions required by law to federal, State and local agencies. It may be used for other lawful purposes including law enforcement and litigation.

4. The above Privacy Act Statement applies to all requests for personal information made by medical treatment personnel or for medical treatment purposes. Failure to provide the requested information for these medical records may result in an inability of Coast Guard medical personnel to afford treatment.

5. No information may be divulged from this record except to persons properly and directly concerned. Questionable cases will be referred to the Commanding Officer for decision.

LAST NAME	FIRST NAME	MIDDLE NAME	SOCIAL SECURITY NUMBER		DATE OF BIRTH *(DAY, MO,YR)*			
GRADE OR RATE	CHANGES IN GRADE OR RATE				BLOOD TYPE *(Check one)*			
					☐ O	☐ A	☐ B	☐ AB
					RH FACTOR *(Check one)*			
					☐ POSTIVE	☐ NEGATIVE		

DRUG SENSITIVITY
SPECIFIC DRUG(S)

ATTACH TO FRONT OF CHART JACKET

DEPT OF TRANSP. USCG CG 3443-2

BACK

DENTAL HEALTH QUESTIONNAIRE

Personal Data - Privacy Act of 1974

ARE YOU IN FLIGHT STATUS? . . . YES ☐ NO ☐ | OCCUPATION/JOB:

ARE YOU PRESENTLY ILL OR UNDER THE CARE OF A PHYSICIAN? . . . . **YES** ☐ **NO** ☐

IF YES, PLEASE DESCRIBE: _____

ALLERGIES (including medication, Latex, jewelry, metal, etc.): _____

CURRENT MEDICATIONS: _____
(including aspirin, over-the-counter medications, etc.): _____

HISTORY OF HOSPITALIZATIONS: _____

ANY FAMILY HISTORY OF: Heart Disease ☐ Cancer ☐ Diabetes ☐ Seizures ☐

HAVE YOU EVER HAD OR DO YOU NOW HAVE:

	Yes	No	Don't Know		Yes	No	Don't Know		Yes	No	Don't Know
Epilepsy or Seizures				Hemophilia				Ulcers			
Fainting or dizziness				Bruise or bleed easily				Kidney problems			
Anxiety reaction				Heart problems/Angina				Venereal disease			
Stroke				Hypertension				Diabetes			
Glaucoma				Rheumatic fever				Thyroid disease			
Cold Sores (Herpes)				Heart murmur				HIV/AIDS			
Persistent cough				Mitrol valve prolapse				Arthritis			
Emphysema				Congenital heart lesions				Painful joints (incl. jaw)			
TB/PPD positive				Heart surgery				Prosthetic joint			
Asthma				Prosthetic heart valve				Hives			
Hay Fever				Pacemaker				Steroid medication			
Sinus problems				Blood transfusions				Drug addiction			
Anemia				Liver disease				Alcoholism			
Sickle cell disease				Yellow jaundice				Unexplained weight change			
G-6-PD deficiency				Hepatitis - type:				Cancer/radiation therapy			

HAVE YOU EVER BEEN TOLD THAT YOU SHOULD NOT DONATE BLOOD? ----------
HAVE YOU EVER BEEN TOLD THAT YOU NEED ANTIBIOTICS BEFORE DENTAL TREATMENT? ----------
FEMALES: Are you taking birth control pills? ----------
Are you or might you be pregnant? Estimated delivery: _____
DO YOU HAVE ANY DISEASE, CONDITION, OR PROBLEM NOT LISTED ABOVE? Please describe: _____

_____ Patient's signature _____ Date

SUMMARY OF PERTINENT FINDINGS / RECOMMENDED TREATMENT MODIFICATIONS (Dentist's use only) B/P: _____

WELLNESS SCREEN:

Tobacco use _____ Exercise _____ Diet/nutrition _____
Alcohol use _____ Stress _____ Seat belt use _____

_____ Dental Officer's Signature _____ Date

PATIENT'S IDENTIFICATION	PATIENT'S NAME (Last, First, MI)		SEX
	DATE OF BIRTH	RELATIONSHIP TO SPONSOR	SERVICE
	SPONSOR'S NAME		RANK/GRADE
	SSN		ORGANIZATION/COMMAND
	PHONE #: DAY	EVENING	

DEPT. OF TRANSP., USCG, CG-5605 (4-96)

BACK

GENERAL SERVICES ADMINISTRATI
INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505

HEALTH RECORD | **DENTAL**

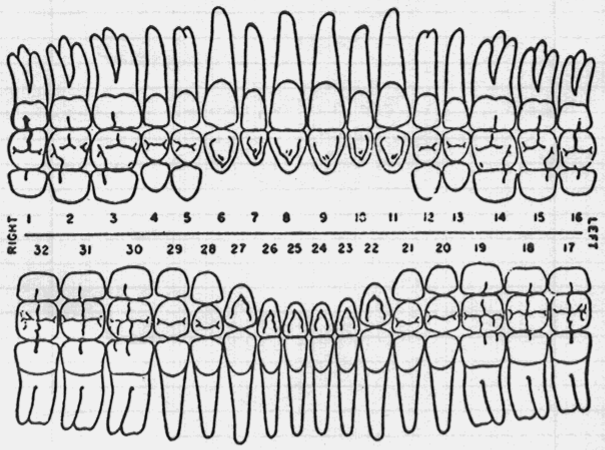
SECTION I. DENTAL EXAMINATION

1. PURPOSE OF EXAMINATION: INITIAL | SEPARATION | OTHER (*Specify*)

2. TYPE OF EXAM.: 1 2 3 4

3. DENTAL CLASSIFICATION: 1 2 3 4 5

4. MISSING TEETH AND EXISTING RESTORATIONS

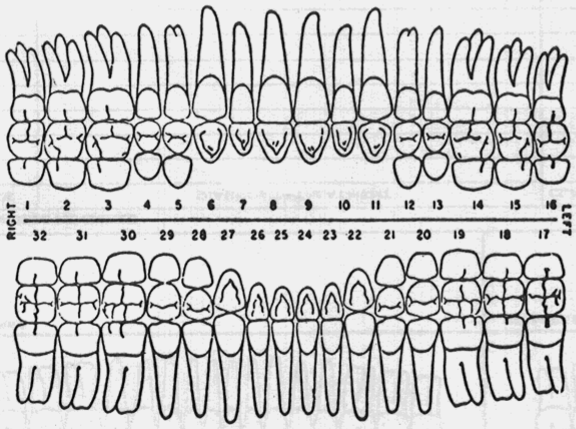


REMARKS

PLACE OF EXAMINATION | DATE

SIGNATURE OF DENTIST COMPLETING THIS SECTION

5. DISEASES, ABNORMALITIES, AND X-RAYS



A. CALCULUS: SLIGHT | MODERATE | HEAVY

B. PERIODONTOCLASIA: LOCAL | GENERAL; INCIPIENT | MODERATE | SEVERE

C. STOMATITIS (*Specify*)

GINGIVITIS | VINCENT'S

D. DENTURES NEEDED
(*Include dentures needed after indicated extractions*)

FULL		PARTIAL	
U	L	U	L

ABNORMALITIES OF OCCLUSION—REMARKS

E. INDICATE X-RAYS USED IN THIS EXAMINATION: FULL MOUTH PERIAPICAL | POSTERIOR BITE-WINGS | OTHER (*Specify*)

DATE | PLACE OF EXAMINATION | SIGNATURE OF DENTIST COMPLETING THIS SECTION

SECTION II. PATIENT DATA

6. SEX | 7. RACE | 8. GRADE, RATING, OR POSITION | 9. ORGANIZATION UNIT | 10. COMPONENT OR BRANCH | 11. SERVICE, DEPT., OR AGENCY

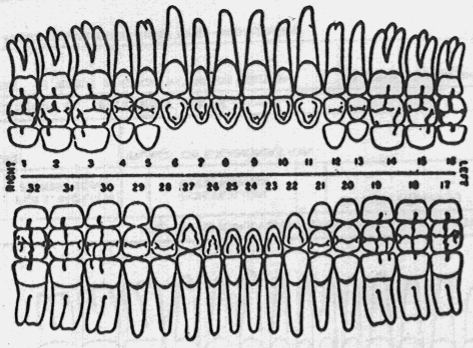
12. PATIENT'S LAST NAME—FIRST NAME—MIDDLE NAME | 13. DATE OF BIRTH (DAY-MONTH-YEAR) | 14. IDENTIFICATION NO.

NSN 7540-00-634-4179

DENTAL
Standard Form 608
603-104

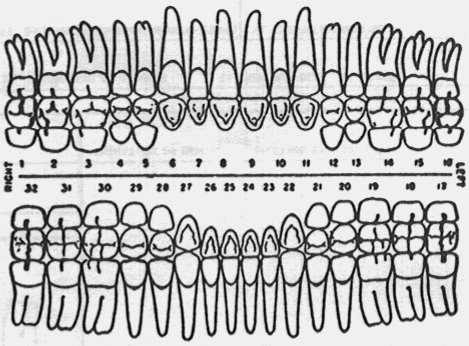
SECTION III. ATTENDANCE RECORD

15. RESTORATIONS AND TREATMENTS (*Completed during service*)



REMARKS

16. SUBSEQUENT DISEASES AND ABNORMALITIES



REMARKS

17. SERVICES RENDERED

DATE	DIAGNOSIS—TREATMENT	CLASS	OPERATOR AND DENTAL FACILITY	INITIALS

PATIENT'S LAST NAME—FIRST NAME—MIDDLE NAME

☆U.S. GOVERNMENT PRINTING OFFICE: 1985 O - 491-248 (20242)

PERIODONTAL CHART

Personal data - Privacy Act of 1974

Bleeding/purulence (+)

Attachment level CEJ to BP

Pocket depths FM to BP

Mark full, 3/4 crowns, and pontics in blue

Furcation invasion
Grade 1
Grade 2
Grade 3

Record on Occlusal Outlines
Mobility (1,2,3)
Poor contact
Open contact
Food impaction

Caries and faulty restorations outlined in red

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

Pocket depths FGM to BP

Attachment level CEJ to BP

Bleeding/purulence (+)

Bleeding/purulence (+)

Attachment level CEJ to BP

Pocket depths FGM to BP

32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

KEY
Horiz. lines = 2mm
FGM = free gingival margin
BP = base of pocket

Draw FGM with continuous blue line relative to CEJ

Mark pocket area in red on root surface

Draw mucogingival junction as black continuous line

Block out missing teeth and/or roots

Pocket depths FGM to BP

Attachment level CEJ to BP

Bleeding/purulence (+)

PLACE OF EXAMINATION	EXAMINER	DATE

PATIENT IDENTIFICATION

SEX	GRADE, RATE, OR POSITION	ORGANIZATION/UNIT	COMPONENT OR BRANCH	PHONE: (W) (H)

PATIENT'S LAST NAME - FIRST NAME - MIDDLE NAME	DATE OF BIRTH (Day-Month-Year)	SOCIAL SECURITY NO.

NAVMED 6660/2 (3/90)

PERIDONTAL CHART

Patient's Name: _____ SSN: _____

Chief Complaint:

_____

Pertinent Med Dent Hx:

Age	Sex	Race	HT	WT	BP

Extraoral Findings:

_____

Intreoral Findings:

_____

Periodontal Findings:

_____

Occlusion:

_____

Pediographic Assesment:

_____

Etiology/Contributing Factors:

_____

Diagnosis:

Prognosis (1-5 years) (Circle One): Good Fair Poor Hopeless

Overall Individual: _____

Tentative Treatment Plan:

_____

_____

_____

LAST NAME	FIRST NAME	MIDDLE NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER (OPTIONAL)

U.S. Coast Guard
CLINICAL RECORD

STATUS

DEPENDENT ☐
RETIREE ☐

USCG ☐
USPHS ☐
USN ☐
USMC ☐
USAF ☐
USA ☐

CIVILIAN EMPLOYEE ☐

OTHER _____ SPECIFY

OCCUPATIONAL MONITORING _____ SPECIFY

PRIVACY ACT STATEMENT; HEALTH CARE RECORDS

1. **AUTHORITY FOR COLLECTION OF INFORMATION INCLUDING SOCIAL SECURITY NUMBER (SSN):** Section 632 of Title 14, United States Code and Sections 1071-1087, Title 10 United States Code, Executive Order 9397 and Title 5 United States Code Section 7901.

2. **PRINCIPAL PURPOSES FOR WHICH INFORMATION IS TO BE USED:** The purpose for requesting personal information is to assist medical personnel in developing records to facilitate and document your health condition in order to provide health care and to provide a complete account of such care rendered, including diagnosis, treatment, and end result. The Social Security Number (SSN) is not mandatory; however it is desirable for identification and recall of records.

3. **ROUTINE USES:** The information may be used to plan and coordinate health care. It may be used to provide medical treatment; conduct research; teach; compile statistical data; implement preventive health and communicative disease control programs; adjudicate claims and determine benefits; evaluate care rendered; determine professional certification and hospital accreditation; conduct authorized investigations; provide physical qualifications of patients to other Federal, State and local agencies upon request in the pursuit of their official duties; and report medical conditions required by law to Federal, State and local agencies. It may be used for other lawful purposes including law enforcement and litigation.

4. The above Privacy Act Statement applies to all requests for personal information made by medical treatment personnel or for medical treatment purposes. Failure to provide the requested information for these medical records may result in an inability of Coast Guard medical personnel to afford treatment.

5. No information may be divulged from this record except to persons properly and directly concerned. Questionable cases will be referred to the Commanding Officer for decision.

MED-ALERT ☐

DEPT. OF TRANSP., USCG, CG—3443—1 (10-77)

BACK

MEDICAL RECORD	REQUEST FOR ADMINISTRATION OF ANESTHESIA AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES

A. IDENTIFICATION

1. OPERATION OR PROCEDURE

B. STATEMENT OF REQUEST

1. The nature and purpose of the operation or procedure, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me. I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure. I understand the nature of the operation or procedure to be _____

(Description of operation or procedure in layman's language)

which is to be performed by or under the direction of Dr. _____

2. I request the performance of the above-named operation or procedure and of such additional operations or procedures as are found to be necessary or desirable, in the judgment of the professional staff of the below-named medical facility, during the course of the above-named operation or procedure.

3. I request the administration of such anesthesia as may be considered necessary or advisable in the judgment of the professional staff of the below-named medical facility.

4. Exceptions to surgery or anesthesia, if any, are: _____

(If "none", so state)

5. I request the disposal by authorities of the below-named medical facility of any tissues or parts which it may be necessary to remove.

6. I understand that photographs and movies may be taken of this operation, and that they may be viewed by various personnel undergoing training or indoctrination at this or other facilities. I consent to the taking of such pictures and observation of the operation by authorized personnel, subject to the following conditions:

a. The name of the patient and his/her family is not used to identify said pictures.
b. Said pictures be used only for purposes of medical/dental study or research.

(Cross out any parts above which are not appropriate)

C. SIGNATURES

(Appropriate items in Parts A and B must be completed before signing)

1. COUNSELING PHYSICIAN/DENTIST: I have counseled this patient as to the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above.

_____
(Signature of Counseling Physician/Dentist)

2. PATIENT: I understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

_____	_____	_____
(Signature of Witness, excluding members of operating team)	*(Signature of Patient)*	*(Date and Time)*

3. SPONSOR OR GUARDIAN: (When patient is a minor or unable to give consent) I, _____ sponsor/guardian of _____ understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

_____	_____	_____
(Signature of Witness, excluding members of operating team)	*(Signature of Sponsor/Legal Guardian)*	*(Date and Time)*

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)*	REGISTER NO.	WARD NO.

STANDARD FORM 522 (Rev. 10-76)
General Services Administration &
Interagency Comm. on Medical Records
FPMR 101-11.806-8
522-109

NSN 7540-00-634-4165

BACK

Standard Form 66 D
April 1985
U.S. Office of Personnel Management
FPM Supplement 293-31
66-501

EMPLOYEE MEDICAL FOLDER

CAUTION
MEDICAL RECORD—RESTRICTED USAGE

1. Your use of the contents of this folder must be in accordance with the instructions in The Guide to Personnel Record Keeping.
2. You must safeguard this folder and its contents while it is in your possession.
3. You are required to keep this folder in a locked place when it is not in use.
4. You are normally prohibited from disclosing the contents of this folder to anyone; exceptions are those officials of your agency demonstrating an official need for the record and those other disclosures permitted by the Privacy Act of 1974 (5 U.S.C. 552a).
5. After use, promptly return this folder to the employee responsible for its filing.
6. Willful violations of these requirements are subject to criminal penalties (5 U.S.C. 552a(i)).

Place label between lines.
Type information on label as shown.

Name (Last, First, M.I.) DOB:
SSN:

NSN 7540-01-209-4939
For Label Use:
NSN 7530-00-577-4376 (cut sheet) or
NSN 7530-00-082-2661 (marginally punched)

GPO : 1985 O 460-496 (22)

BACK

INPATIENT MEDICAL RECORD COVER SHEET
(See Privacy Act Statement on Reverse)

Name: _____ SSN: _____ Rank/Rate: _____
Last, First, MI

Unit: _____

Date of Birth: ___/___/____ Religon: _____
YY MM DD

Home Address: _____

Next of Kin: _____ Relationship: _____

Address: _____ Phone #: _____

_____ _____

Previous Admission: ☐ Yes ☐ No If yes, Date: ___/___/____
YY MM DD

Date of Present Admission: ___/___/____ Time: _____ Hours
YY MM DD

Provisional Diagnosis	Provisional Diagnosis
1. _____	1. _____
2. _____ _	2. _____
3. _____	3. _____

Date of Discharge: ___/___/____ Time: _____ Hours
YY MM DD

DISPOSITION

Duty Status: ☐ FFD ☐ NFFD ☐ FFLD Restrictions: _____

_____

Activity Restrictions: _____

Diet: _____

Medications: _____

Follow-up Appointment(s): _____

_____ _____
Admitting Medical Officer **Discharging Medical Officer**

Time Unit Notified: ___/___/____ Time: _____ Hours
YY MM DD

Name of Staff Member Notifying: _____

Name of Person at Unit Receiving Call: _____
Name and Rank/Rate

PRIVACY ACT STATEMENT

In accordance with 5 USC 552a (e)(3), the following applies to persons providing personal information to the U.S. Coast Guard.

1. Section 632, Title 14 USC, § 1071 – 1087. Title 10 USC, and Executive Order 9397 authorizes collection and application of this information.

2. The principal purpose for which this information is intended is to assist medical personnel in developing records to facilitate and document your health condition(s), in order to provide a complete account of care rendered, including diagnosis, treatment, and results. The social security number is necessary to identify the person and records. Family information is required for notification of next of kin in the unlikely event of an emergency.

3. The routine use of this information is for review by attending medical officers and for future reference in rendering health care.

4. Disclosure of this information is voluntary. However, failure to provide the requested information may result in an inability of the Coast Guard medical personnel to deliver comprehensive treatmen.

Please note the following and indicate your wishes:

I DO / DO NOT GIVE PERMISSION FOR THE ATTENDING MEDICAL OFFICER AND THE DISPENSARY STAFF TO DISCUSS MY MEDICAL CONDITION OR THE SITUATION OF MY ADMISSION WITH MY PARENTS OR LEGAL GUARDIANS, UPON MY REQUEST.

_____ _____
Signature Date

_____
Witness

— —

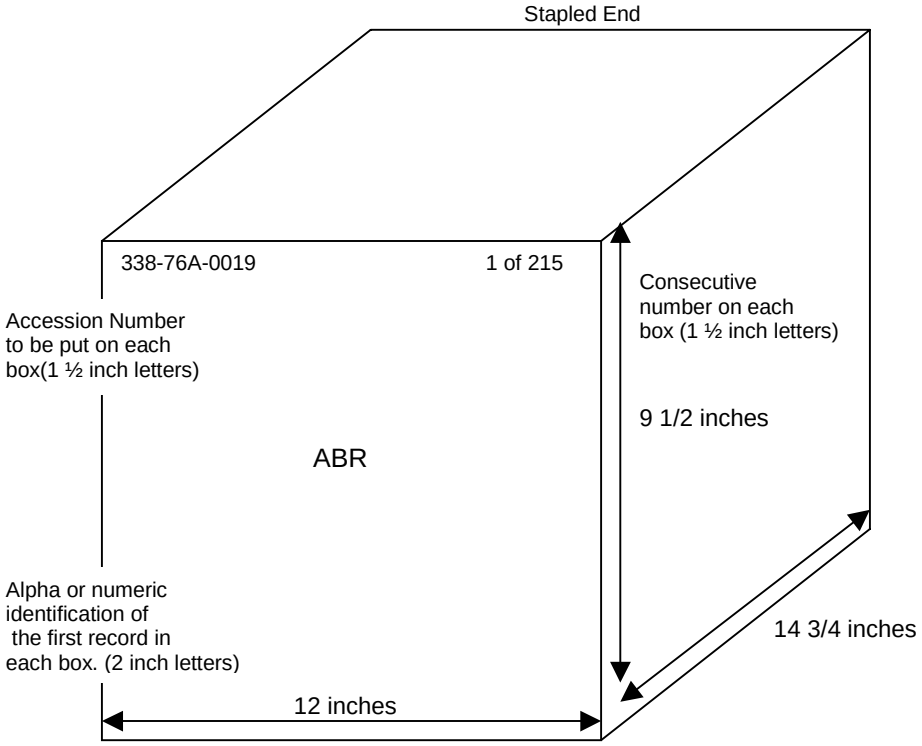
PERSONNEL AUTHORIZED SEPARATE RATIONS

I understand that this facility provides three meals daily for all patients. Further, persons authorized to mess separately will be required to make repayments for meals consumed during their stay.

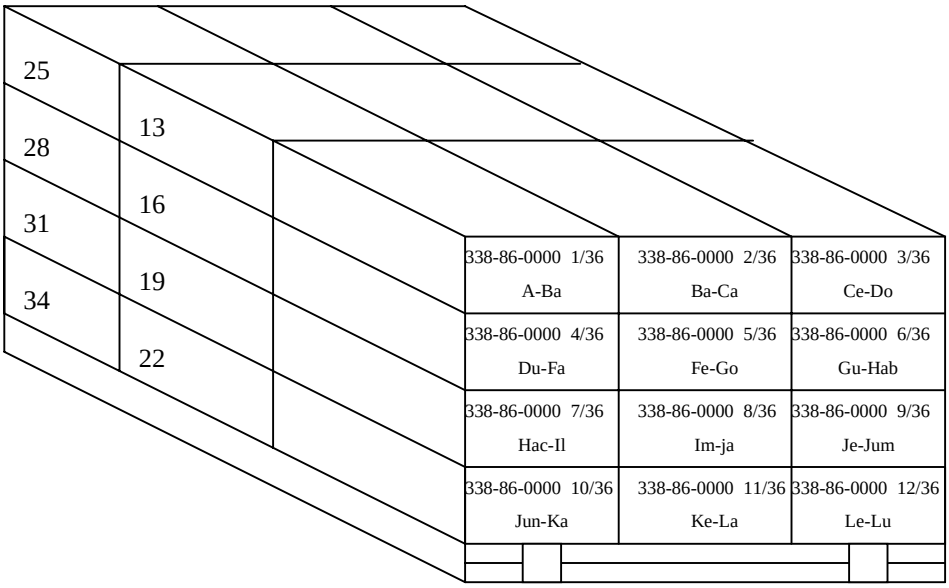
I have read and understand the statement about separate rations.

_____ _____
Signature Date

BACK


Stapled End
338-76A-0019
1 of 215
Consecutive number on each box (1 ½ inch letters)
Accession Number to be put on each box(1 ½ inch letters)
9 1/2 inches
ABR
Alpha or numeric identification of the first record in each box. (2 inch letters)
14 3/4 inches
12 inches

BACK


25
28
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22
338-86-0000 1/36
A-Ba
338-86-0000 2/36
Ba-Ca
338-86-0000 3/36
Ce-Do
338-86-0000 4/36
Du-Fa
338-86-0000 5/36
Fe-Go
338-86-0000 6/36
Gu-Hab
338-86-0000 7/36
Hac-Il
338-86-0000 8/36
Im-ja
338-86-0000 9/36
Je-Jum
338-86-0000 10/36
Jun-Ka
338-86-0000 11/36
Ke-La
338-86-0000 12/36
Le-Lu

INSTRUCTIONS

NURSE: Retain a copy and send to Pharmacy after each order is written.

MEDICAL RECORD		DOCTOR'S ORDERS *(Sign all orders)*			
HOUR		RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE
START	STOP				

If needed, continue on Page 2.

PATIENT'S IDENTIFICATION	*(For typed or written entries give: Name – last, first, middle; grade; rank; rate; hospital or medical facility)*	REGISTER NO.	WARD NO.

DOCTOR'S ORDERS

STANDARD FORM 508 (Rev. 10-7
Prescribed by GSA and ICMR
FPMR 101-11 806-8
508-110

Standard Form 506 (Rev 2-99) AUTHORIZED FOR LOCAL REPRODUCTION

Clinical Record		PHYSICAL EXAMINATION					
Date of Exam	Height	Weight			Temperature	Pulse	Blood Pressure
		Average	Maximum	Present			

Instructions: Describe (1) General Appearance and Mental Status; (2) Head and Neck (General); (3) Eyes; (4) Ears; (5) Nose; (6) Mouth; (7) Throat; (8) Teeth; (9) Chest (General); (10) Breast; (11) Lungs; (12) Cardiovascular; (13) Abdomen; (14) Hernia; (15) Genitalia; (16) Pelvic; (17) Rectal; (18) Prostate; (19) Back; (20) Extremities; (21) Neurological; (22) Skin; (23) Lymphatics.

SAMPLE FORM

(Continue reveres side)

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	First	MI	
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		

PATIENT'S IDENTIFICATION (For typed or written entries give: Name-Last First, Middle; grade; date; hospital or medical facility)	REGISTER NO	WARD NO

PHYSICAL EXAMINATION RECORD
Standard Form 506 (Rev 2-99)
Prescribed by GSA/ICMR (41 CFR) 101-11 .203(b)(10)

SF 506 (Rev 2-99)

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

PHYSICAL EXAMINATION

SAMPLE FORM

INITIAL IMPRESSION

SIGNATURE OF PHYSICIAN	NAME OF PHYSICIAN

Standard Form 506 (Rev. 2-99) BACK

BACK

MEDICAL RECORD	PROGRESS NOTES
DATE	

BACK

MEDICAL RECORD | **VITAL SIGNS RECORD**

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY

19 | HOUR

PULSE (O) | TEMP. F (●)

PULSE (O)	TEMP. F (●)	TEMP. C
	105°	40.6°
180	104°	40.0°
170	103°	39.4°
160	102°	38.9°
150	101°	38.3°
140	100°	37.8°
130	99°	37.2°
	98.6°	36.0°
120	98°	36.7°
110	97°	36.1°
100	96°	35.6°
90	95°	35.0°
80		
70		
60		
50		
40		

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: | WEIGHT

Record special data only when so ordered

PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last, first, middle; rank; rate; hospital or medical facility)

REGISTER NO. | WARD NO.

VITAL SIGNS RECORD

STANDARD FORM 511 (Rev. 9-79)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45.505

ABBREVIATED MEDICAL RECORD	1. ADMISSION DATE*(yyyymmdd)*
2. CHIEF COMPLAINT, PERTINENT HISTORY, AND PERTINENT SYSTEM REVIEW	
3. PHYSICAL EXAMINATION *(Including pertinent positives and negatives)*	
4. IMPRESSION *(enter admission note with plan on progress notes)*	
5. ADMITTING OFFICER	
a. SIGNATURE	b. DATE SIGNED *(YYYYMMDD)*
6. DISCHARGE NOTE *(Brief hospital course, diagnoses, procedures, condition on discharge, pertinent discharge information (including medications, diet, activity limitations, follow-up instructions).)*	7. DISCHARGE DATE *(YYYYMMDD)*

SAMPLE FORM

8. DISCHARGE OFFICER			
a. NAME *(Last, First, Middle Initial*	b. GRADE	c. TITLE	d. SIGNATURE

9. PATIENT IDENTIFICATION *(For typed or written entries: Name (last, first, middle), grade, SSN, date of birth, hospital or medical facility, ward number, and register number)*	10. OUTPATIENT/HEALTH RECORD MAINTAINED AT:
	11. COPY PLACED IN OUTPATIENT RECORD (x WHEN DONE)

DD FORM 2770, APR 1998 (EG*) Replaces SF 509*

CHAPTER 7

PREVENTIVE MEDICINE

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CHAPTER 7. PREVENTIVE MEDICINE

Section A - General

1. Scope. The scope of preventive medicine involves all activities that prevent illness and disease, including immunization; communicable disease control; and epidemiology.

2. Responsibility.

   a. The unit medical officer is responsible to the commanding officer for implementing all directives issued by the Commandant which relate to the health of members of the command. Additionally, the medical officer shall continually evaluate the command's health care capabilities to fulfill Occupational Medical Surveillance and Evaluation Program (OMSEP) requirements. The command shall execute those procedures it can perform as the Commandant requires. Deficiencies in capabilities shall be made known in writing to the commanding officer with alternative plans for accomplishments recommended.

   b. Preventive medicine technicians are skilled, highly trained individuals, experienced in preventive medicine. If assigned or available to a unit, that unit shall fully use their services.

3. Preventive Medicine Practices.

   a. Develop and supervise a definite, adequate environmental health program to prevent disease and maintain the Commandant's established sanitation standards;

   b. Observe the incidence of disease or disability in personnel and, when indicated, in adjacent communities;

   c. Use epidemiological methods to determine the cause of such disease, especially when an unusual or high incidence is discovered;

   d. Recommend measures to minimize or remove the causes of disease; and maintain effective liaison with civilian health agencies; Army, Air Force, Navy, and Public Health Service preventive medicine components; and with other command officers and components.

4. Availability of Consultative Services. Request MLC (kse) for special technical advice, surveys, or investigation through appropriate channels. If unusual conditions or circumstances requiring special attention arise, submit a special report through the appropriate chain of command to Commandant (G-WK).

Section B Communicable Disease Control.

1. General.

   a. The health services department representative is responsible for:

      (1) Recognizing communicable diseases;

      (2) Recommending preventive and control measures to the commanding officer;

      (3) Submitting required reports; and

      (4) Complying with state and local health department reporting requirements.

   b. The reference documents in this area are:

      (1) *Control of Communicable Diseases in Man*, current edition, American Public Health Association, 1740 Broadway, New York, NY 10019.

      (2) "Medical Environmental Disease Intelligence and Countermeasures" on CD-ROM (DI-1810-207-99, or current version) from Armed Forces Medical Intelligence Center (AFMIC), 1607 Porter Street, Fort Detrick, MD 21701-5004

      (3) Appropriate state and local laws and regulations.

2. Disease Outbreak.

   a. An outbreak is the occurrence in the command or surrounding community of a group of similar illnesses clearly in excess of the expected frequency and derived from a common or propagated source (e.g., streptococcal diseases, upper respiratory infections, influenza, etc.). The number of cases indicating the presence of an outbreak varies according to the agent; size and type of population exposed; previous experience or lack of exposure to the disease; and the time and place of occurrence.

   b. On recognizing an outbreak the health services department representative shall:

      (1) Inform the commanding officer and recommend preventive and control measures;

      (2) Investigate to determine the source of the agent and how it was spread; and

      (3) Send a Coast Guard intranet e-mail message Disease Alert Report, if the outbreak may:

         (a) Affect operational readiness;

         (b) Pose a threat to the community;

         (c) Pose a threat to another command (e.g., through transfer of personnel); or

(d) Be of such political or journalistic significance that inquiry might be made of higher commands.

3. RCN 6000-4, Disease Alert Report.

a. Circumstances Requiring Reports.

(1) An outbreak meets any of the criteria above;

(2) Any person is diagnosed as having a disease listed in Figures 7-B-1 or 7-B-2;

(3) Epizootics of diseases transmissible from animals to man on or near the reporting activity;

(4) A Coast Guard vessel or aircraft is quarantined at a foreign port;

(5) Health services department personnel deem a condition worthy of reporting; or

(6) Conditions legally mandated by local health jurisdiction to be reported.

b. Initial Report.

(1) If the outbreak/disease is of an urgent nature, submit the initial report by Coast Guard intranet e-mail message to MLC (k) with a copy to Commandant WKH-1.

(2) Use the format in Figure 7-B-3 for all Disease Alert Reports.

(3) Report to local public health department as required by law.

c. Progress Reports. Submit progress reports as appropriate to inform the initial report's addressees of progress, change, or other significant developments.

d. Final Report (required for outbreaks). Submit to Commandant (G-WKH) through the appropriate chain of command, a final letter report, which must contain this information:

(1) Number of disease cases, both total and by hour, day, or week;

(2) Numbers of deaths, persons permanently disabled, and staff days lost from work;

(3) Causal or contributory factors, including the recent itinerary of vessels, aircraft, and other mobile units;

(4) Control measures taken and their effectiveness; and

(5) Recommendations to prevent or ameliorate similar future outbreaks.

4. Sexually Transmitted Disease Responsibilities.

a. Health services department shall provide a coordinated, comprehensive sexually transmitted disease control program including:

(1) Educational programs;

(2) Contact investigation, reporting, and treatment if the contacts are eligible for care;

(3) Completing and submitting Contact Interview Form (Figure 7-B-4);

(4) Annotating and maintaining health records properly.

b. Senior Medical Officer (SMO). The senior medical officer oversees the medical management of the local disease control program; recommends disease control activities to the commanding officer; establishes and maintains liaison with local health authorities to help detect and prevent sexually transmitted diseases (STDs); and ensures confidentiality of contact reports and patients names.

c. Medical Officer. The practitioner who first sees the patient shall perform diagnostic evaluation procedures. The provider must fill out SF-602, Syphilis Record, on ALL patients diagnosed as having syphilis and file this form in the patient's medical record. Test any patient treated for gonorrhea for syphilis and vice versa, and in both cases, also for HIV antibody. The provider must perform diagnostic evaluations; ensure proper analysis of urethral smears and dark field specimens; and identify organisms from material submitted for culture or serologic test. The syphilis serologic test (RPR, STS) is a general screening test. The FTA-ABS is a specific antibody test that detects *Treponema pallidum*. The medical officer is responsible for noting all STDs using ICD9CM codes on the NAVMED 6150/20.

d. Health Services Technician or Preventive Medicine Technician. A health services technician or preventive medicine technician assigned to administer the local STD control program should be pay grade E-5 or higher. The HS performs these actions:

(1) Interviews all STD patients for contact information;

(2) After the interview, annotates and signs the SF-600 in each STD patient's medical record to indicate he or she interviewed the patient and discussed symptoms, complications, treatments, and contacts;

(3) Instructs gonorrhea patients to return for a Test of Cure (TOC) in five days.

(a) Active duty personnel will report to regular sick call for TOC. Place a suspense notice to check with the attending medical officer to ensure the patient receives TOC;

(b) Gives dependents and retired personnel regular appointments for local STD control;

(4) Completes CDC 73.954, Contact Interview Form, on all STD patients and contacts;

(5) The first working day of each week, cross references all positive STDs from the clinic laboratory log book to ensure all STD patients have been contacted and interviewed.

5. Treatment. Treat STDs according to the most current recommendation of either the Armed Forces Epidemiologic Board or the Centers for Disease Control (CDC), USPHS, published in the Morbidity and Mortality Weekly Report (MMWR), Sexually Transmitted Diseases Treatment Guidelines, as appropriate.

6. Drug Prophylaxis. Drug prophylaxis for sexually transmitted disease prevention is prohibited.

7. Reporting.

   a. Completing a CDC 73.954, Contact Interview Form.

      (1) Prepare original and three copies as soon as possible after diagnosing a sexually transmitted disease. Figure 7-B-4 is a sample of the form.

      (2) Execute a separate 4-part form for each contact in cases of multiple contacts

      (3) Enter these data on the 3rd and 4th copies ONLY:

      (4) Under "Name," enter also Social Security Number and rate or grade,

      (5) Under "Home Address," enter also the unit to which the patient is attached.

      (6) Enter the interviewer's name and unit mailing address on the back of all sheets. The interviewer signs the original.

      (7) Disposition

         (a) Within CONUS. The reporting unit retains the green copy on file and sends the original and pink copies to the state where the contact occurred. The reporting unit sends the yellow copy to MLC(k), which acts as the STD control officer for the area. MLC(k) will notify G-WKH-1 upon receipt of the yellow copy.

         (b) Outside CONUS. To report contacts in foreign countries, send the original and pink copies with a transmittal letter to the consular office closest to the contact site to ask that office to send the forms to the proper health authorities. Send the yellow copy to MLC (k) of the unit's home district indicating where the original and pink copies were sent. The reporting unit files the green copy.

FIGURE 7-B-1

LIST OF REPORTABLE DISEASES

All of the listed conditions must be reported by CG Intranet e-mail message. Those with an X in the Telephone to MLC (k) column must also be called in to appropriate MLC (k)

NOTIFIABLE CONDITION	Telephone to MLC (k)
AIDS (Acquired Immune Deficiency Syndrome)	**X**
Amebiasi	
Anthrax	**X**
Biological warfare agent exposure	**X**
Botulism	**X**
Brucellosis (Undulent Fever)	
Campylobacter	
Chancroid	
Chlamydia	
Cholera	
Coccidioidomycosis	
Dengue	
Diptheria	
Encephalitis	**X**
Escherichia coli O157:H7	
Food Poisoning **(2)**	**X**
Filariasis	
Giardiasis	
Gonorrhea	
Hemolytic uremic syndrome (post diarrheal)	
Hemorrhagic Fever, specify type if known **(3)**	**X**
Hepatitis A (Infectious)	**X**
Hepatitis B (serum)	
Hepatitis C (non-A non-B)	
Herpes, Genital	
HIV Infection – Confirmed positive serology	**X**
Influenza **(1)**	
Legionellosis	
Leishmaniasis	
Leprosy (Hansen's Disease)	
Leptospirosis (Weil's Disease)	
Lymphgranuloma Venereum	
Malaria, specify type **(3)**	**X**
Measles (Rubeola)	
Meningococcal disease	**X**
Mumps	

Pertussis (Whooping Cough)	
Plague	**X**
Pneumococcal pneumonia **(1)**	
Poliomyelitis, Paralytic	
Psittacosis	
Q-fever	**X**
Rabies, human	**X**
Rabies, animal	
Rheumatic Fever **(1)**	**X**
Rift Valley Fever	
Rocky Mountain Spotted Fever	
Rubella (German Measles)	
Salmonellosis	
Schistosomiasis	
Shigellosis	
Smallpox (Variola)	**X**
Syphilis **(3)**	
Tetanus	
Toxic shock syndrome	
Trichinosis	
Trypanosomiasis	
Tuberculosis **(4)**	**X**
Tularemia	**X**
Typhoid Fever	
Typhus Fever	
Varicella (Active duty only)	
Yellow Fever	
Unusual Clusters if ANY Disease	**X**

(1) Active duty cases only
(2) Call SMO if 5 or more persons are involved in any similar illness within 24 hour period.
(3) Specify type, if known.
(4) Report also clusters (more than 2) of new PPD converters.

FIGURE 7-B-2

LIST OF REPORTABLE OCCUPATIONAL DISEASES

ICD-9-CM TERM	ICD-9-CM CODE	CMIT SYNONYM/ ANALOGUE	CMIT TEXT	CMIT ID NUMBER	
DUST DISEASES OF THE LUNG					
Coal Workers' Pneumoconiosis	500	Anthracosis	46	03	4678
Asbestosis	501	Asbestosis	62	03	4198
Silicosis	502M	Silicosis	633	03	4626
Talcosis	502M	Pneumoconiosis, Talc	556	03	5935
Chronic Beryllium Disease of the Lung	503M	Beryllium Disease Chronic	77	03	2612
Byssinosis	504	Byssinosis	107	03	4073
POISONING (Systemic Toxic Reactions)					
Hemolytic Anemia, Non-Autoimmune	283.1	Anemia, Hemolytic Acquired, Physical, Chemical Agents	31	05	4225
Aplastic Anemia	284.8	Anemia, Aplastic	29	05	3322
Agranulocytosis Or Neutropenia	288.0	Agranulocytosis	17	05	2863
Methemoglobinemia	289.7	Methemoglobinemia	440	05	3295
Toxic Encephalitis	323.7	Encephalitis, Hemorrhagic, Acute	207	09	4982

PARKINSON'S DISEASE SYNDROME (Secondary)	524	332.1 09	PARKINSONIAN 4071		
Parkinson's Disease (Secondary)	332.1	Maganese Poisoning	424	09-03	5963
Cerebellar Ataxia	334.3	Ataxia, Cerebellar,	64	09	3287
	ACUTE				
Inflammatory and Toxic Neuropathy	357.7	Neuropathy	475	09	2307
Cataract	366.4E	Cataract, Toxic	118	10	4532
Toxic Hepatitis	570 573.3	Hepatitis Chemical-Induced Toxicity	303	06	2008
Acute Renal Failure	584	Kidney, Failure, Acute	367	07	2229
Chronic Renal Failure	585	Kidney Failure, Chronic	367	07	3028
Toxic Effects of Methyl Alcohol	980.1	Methyl Alcohol Poisoning	440	00	1097
Toxic Effects of Gasoline or Petrol	981	Gasoline, Non-Leaded Poisoning	259	00	4355
Toxic Effects of Benzene and Homologues	982.0	Benzene, Poisoning	76	00	1941
Toxic Effects of Carbon Disulfide	982.2	Carbon Disulfide	112	00	1042
Toxic Effects of Solvents Other than Petroleum-based, Other	982.8	Methyl Ethyl Ketone Poisoning	441	00	3427
Toxic Effects of Corrosive Aromatics	983.0	Nitrobenzene Poisoning	482	00	1416
Toxic Effects of	983.0	Aniline Poisoning	44	00	2662

Corrosive Aromatics					
Toxic Effects of Corrosive Acids	983.1	Nitric Acid Poisoning	481	00	1255
Toxic Effects of Caustic Alkalis	983.2	Alkali Poisoning	20	00	3087
Toxic Effects of Mercury and its Compounds	985.0	Mercury Poisoning	439	00	5512
Toxic Effects of Arsenic and its Compounds	985.1	Arsenic Poisoning	55	00	2946
Toxic Effects of Arsenic and its Compounds	985.1	Arsine Poisoning	56	00	5897
Toxic Effects of Cadium and its Compounds	985.5	Cadium Poisoning	107	00-03	5768
Toxic Effects of Other Metals	985.8	Thallium Poisoning	681	00	2910
Toxic Effects of Other Metals	985.8	Silver Poisoning	633	00	4660
Toxic Effects of Other Metals	985.8	Zinc Chloride Poisoning	752	00	3606
Brass-Founders' Ague	985.8	Metal Fume Fever	440	00	5749
Toxic Effects of Carbon Monoxide	986	Carbon Monoxide Poisoning	112	00	3938
Toxic Effects of Other Hydrocarbon Gas	987.1	Methane Poisoning	440	00	3425
Toxic Effects of Chlorine Gas	987.6	Chlorine Poisoning	129	00	3486
Toxic Effects of Gases, Fumes or Vapors	987.8	Oxygen Poisoning	511	00	3825
Toxic Effects of	987.8	Ozone Poisoning	511	00	3104

Gases, Fumes or Vapors					
Toxic Effects of Gases, Fumes or Vapors	987.8	Phosgene Poisoning	545	00	3105
Toxic Effects of Gases, Fumes or Vapors	987.8	Toluene Diisocyanate Poisoning	694	00	2770
Toxic Effects of Gases, Fumes or Vapors	987.8	Toluene Poisoning	694	00	2098
Toxic Effects of Gases, Fumes or Vapors	987.8	Acetone Poisoning	6	00	3216
Toxic Effects of Gases, Fumes or Vapors	987.8	Ammonia Poisoning	25	00	5589
Toxic Effects of Gases, Fumes or Vapors	987.8	Carbon Tetrachloride Poisoning	113	00	3192
Toxic Effects of Gases, Fumes or Vapors	987.8	Diobrane Poisoning	181	00	4845
Toxic Effects of Gases, Fumes or Vapors	987.8	Fluorine and Compounds Poisoning, Acute	248	00	4521
Toxic Effects of Gases, Fumes or Vapors	987.8	Fluorine and Compounds Poisoning, Chronic	248	00	2119
Toxic Effects of Gases, Fumes or Vapors	987.8	Hydrogen Sulfide Poisoning	319	00	4331
Toxic Effects of Gases, Fumes or Vapors	987.8	Hydrofluoric Acid Poisoning	319	00	5607
Toxic Effects of Gases, Fumes or Vapors	987.8	Methyl Chloride Poisoning	441	00	5093
Toxic Effects of Gases, Fumes or Vapors	987.8	Methyl Bromide Poisoning	441	00	5404
Toxic Effects of Gases, Fumes or Vapors	987.8	Carbon Dioxide Poisoning	112	00	3107
Toxic Effects of	987.9	Phosphine Poisoning	546	00	2433

Gases, Fumes or Vapors

Toxic Effects of Hydrocyanic Acid Cyanides	989.0	Cyanide Poisoning	161	00	3541
Toxic Effects of Chlorinated Hydrocarbons	989.2	Toxaphene Poisoning	697	00	1926
Toxic Effects of Organiphosphate and Carbanate	989.3	Phosphate Ester Insecticide Poisoning	546	00	2457

RESPIRATORY CONDITIONS DUE TO TOXIC AGENTS

Extrinsic Asthma	493.0	Asthma, Bronchial	64	03	4622
Farmer's Lung	495	Farmer Lung	236	03	4418
Bagassosis	495.1	Bagassosis	71	03	2403
Bird Fanciers' Lung	495.2	Bird Breeder Disease	80	03	1458
Suberosis	495.3	Suberosis	664	03	5383
Maltworker's Lung	495.4	Maltowkrer Lung	423	03	5485
Mushroom Workers' Lung	495.5	Mushroom Picker Disease	456	03	4796
Maple Bark Strippers'	495.6	Maple Bark Stripper Disease	425	03	2047
Other Allergic Pneumonitis (Sequoiosis Or Red cedar Asthma)	495.8	Sequoiosis	629	03	2269
Acute Bronchitis Pneumonitis	506.0	Bronchitis, Acute	101	03	2389
Pulmonary Edema To Fumes and Vapors	506.1	Pulmonary Edema	586	03	4190
Other Pneumonitis Due to solids and liquids (detergent Asthma)	507.8	Pneumonia, Extrensic	557	03	5650

Raynaud's Phenomenon (Secondary)	443.0	Vibration Disease	737	04	1428
Cataract Associated With Other Disorders	366.4	Cataract, Heat Ray	117	10	4527
Cataract Associated With Other Disorders	366.4	Cataract, Irradiatiohn	118	10	3538
Noise Effects on Inner Ear	388.1	Hearing Disorder Sensorineural	285	10	5433
Radiation Sickness	990	Radiation, Accidental Reaction	595	10	1287
Heat Exhaustion Unspecified	992.5	Heat Exhaustion	291	00	3421
Heat Exhaustion Unspecified	992.5	Heat Cramp	291	02	1321
Heat Exhaustion Unspecified	992.5	Heat Stroke	292	00	3483
Other and Unspecified Effect Of High Altitude	993.2	Hypoxia	341	00	1890
Dysbarism	993.3	Dysbarism	189	00	3279
Dysbarism	993.3	Decompression Sickness	169	00	4252
Caisson Disease	993.3	Nitrogen, Narcotic Action	482	00	1352
Motion Sickness (from Travel, any Vehicle)	994.6	Motion Sickness	448	00	2357

SKIN DISEASES OR DISORDERS

Contact and Allergic Dermatitis	692	Dermatitis, Contact	173	01	1685
Contact and Allergic Dermatitis	692	Dermatitis Atopic	172	01	2124
Contact and Allergic Dermatitis	692	Dermatitis	172	01	4298

ALL OTHER DISEASES

REPRODUCTIVE DISORDERS

Infertility, Male	606	Sterility, Male	305	07	4761

OCCUPATIONAL CANCERS

Hemangiosarcoma Of the Liver	155M	Hapatocarcinoma	305	06	3133
Hemangiosarcoma Of the Liver	155M	Vinyl Chloride Poisoning	738	06-02	5437
Mesothelioma (MN of Peritoneum)	158	Ascites, Chylous	62	06	1081
Mesothelioma (MN of Peritoneum)	158	Peritonitis	538	06	4415
Malignant Neoplasm Of Nasal Cavities	160.0	Nose, Carcinoma	483	03	2650
Malignant Neoplasm Larynx	161	Larynx, Carcinoma Extrinsic	382	03	1491
Malignant Neoplasm Trachea, Bronchus and Lung	162	Lung, Carcinoma Bronchogenic	410	03	1647

Mesothelioma (MN of Pleura)	163	Pleura, Mesothelioma, Primary	553	03	3834
Malignant Neoplasm Of Bone	170	Osteogenic Sarcoma	499	02	4950
Malignant Neoplasm Of Scrotum	187.7	Scrotum, Carcinoma Epidermoid	625	07	1490
Malignant Neoplasm Of Bladder	188	Bladder, Carcinoma Epidermoid	81	07	1469
Malignant Neoplasm Of Kidney, Other and Unspecified Organs	189	Kidney, Pelvis, Carcinoma Transitional Cell	371	07	1084
Malignant Neoplasm Of Kidney, Other and Unspecified Organs	189	Kidney, Pelvis, Carcinoma Epidermoid	371	07	1664
Malignant Neoplasm Of Kidney, Other and Unspecified Organs	189	Kidney, Pelvis, Leukoplakia	371	07	1780
Malignant Neoplasm Of Kidney, Other and Unspecified Organs	189	Kidney, Leiomyosarcoma	370	07	2506
Malignant Neoplasm Of Kidney, Other and Unspecified Organs	189	Kidney, Leiomyoma	370	07	3487
Malignant Neoplasm Of Kidney, Other and Unspecified Organs	189	Ureter, Carcinoma	716	07	2821
Lymphoid Leukemia Acute	204	Leukemia, Lymphoblastic	392	05	1922
Lymphiod Leukemia Chronic	204	Leukemia, Lymphocytic Chronic	393	05	3351
Myeloid Leukemia Acute	205	Leukemia, Myeloblastic Acute	393	05	2391

Erythroleukemia	207	Leukemia, Myelocytic Chronic	394	05	2363
Erythroleukemia	207	Leukemia, stem cell	394		

FIGURE 7-B-3

RCN 6000-4, DISEASE ALERT REPORT

Telephone or submit rapidraft with the following information:

1. PATIENT.

    a. Last Name, First Name, Middle Initial
    b. Rate/Grade
    c. Branch of Service
    d. Social Security Number
    e. Date of Birth
    f. Race.
    g. Sex

2. UNIT ADDRESS.
3. DIAGNOSIS. By ICD-9-CM classification number.
4. CLINICAL HISTORY.
5. LABORATORY TEST DONE, IF ANY, AND RESULTS.
6. TREATMENT AND PROGNOSIS.
7. EPIDEMIOLOGY INFORMATION. Provide all information of epidemiological significance to the case (e.g., contacts, prior treatment, immunizations, etc.)
8. COMMUNITY THREAT.
9. POINT OF CONTACT.
10. REPORTING. List other agencies (e.g., State health departments) notified of the case.

Figure 7-B-4

Disease: 1. [ ] 2. [ ]

Note: See the reverse side of page one of this record for the codes and the reverse side of pages two and three for an abbreviated set of instructions. See the full set of Interview Record instruction for further definition.

Control Number A

Patient name (Last)	(First & Nicknames)	Case #	Inform ID

Home Address (Street)	City	Res. Co.	State	Zip Code	Home Phone

Date of Birth	Age	Race	Ethnicity	Sex	Pregnant	Pregnancy in Last 12 Months?
		W B A/Pt At/An O/U	H Non-Hisp	M F	Y # wks N U	Y N U

Method of Case Detection:
- [ ] Provider Referred to: _____
- [ ] Cluster _____
- [ ] Patient Referred to: _____
- [ ] Prenasal
- [ ] Delivery
- [ ] Insit. Screening
- [ ] Community Screening
- [ ] Reactor
- [ ] Provider Report
- [ ] Volunteer

Information Source [ ]

Supv No.	Clinic Code	Medical Record No.

Date Assigned	Assigned to Wkr:	Date Treated	Case IX'd	Interview Period	Period Partners Sex	N/S	Both
1.							
2.							

Since 1978 (Check all that apply)

	Initial	Final
1. Sex w/Male?	Y	Y
2. Sex w/Female?	Y	Y
3. Used IV Drugs?	Y	Y
4. Hemophilia?	Y	Y
Known Hetrosexual Relations w/:		
5. IVDU?	Y	Y
6. Bisexual Male?	Y	Y
7. Person w/Hemophilia	Y	Y
8. HIV Positive Transfusion Recip?	Y	Y
9. Person w/Aids or HIV HIV Risk UNK?	Y	Y
10. One Born in Pattern II	Y	Y
11. Rec'd Blood Transfusion	Y	Y
12. Worked in Health Care Setting?	Y	Y
13. Sex for Drugs/Money?	Y	Y

1. Pre-Test Counseled? Y N
2. Tested for HIV? Y N
3. Post-Test Counseled? Y N

Previous HIV Test: No P N I U
Date? _____
Provider: [ ]

Current HIV Test: No P N I U
Date? _____
Provider: [ ]

Onset Date	Duration (Days)	Description	Lab Results Date	Test	Results	Treatment	Other Infections
						1.	
						2.	

Init No.	Date of Interview	Type	P/CL	Ref	Exposure Dates First	Freq.	Last	FR Num	Name	Sex	Disease 1 Disp	Disp Date	Diag	Wkr No.	Disease 2 Disp	Disp Date	Diag	Wkr No.	Post Test CNSL	SO SP	Invst Ager
1.																					
2.																					
1.																					
2.																					
1.																					
2.																					
1.																					
2.																					
1.																					
2.																					
1.																					
2.																					
1.																					
2.																					

Local Use: A B C D E F G

Date Closed (1): _____ Date Closed (2): _____

U.S. Department of Health And Human Services
Public Health Service
Centers for Disease Control

CDC 73.54 8-91

Section C Immunizations

1. General. Immunizations and Chemoprophylaxis, COMDTINST M6230.4 (series), lists policy, procedure, and responsibility for immunizations and chemoprophylaxis. This section contains guidelines not specifically defined there.

2. Unit Responsibilities.

   a. Active duty and reserve unit commanding officers are responsible for immunizing all individuals under their purview and maintaining appropriate records of these immunizations. If local conditions warrant and pertinent justification supports the cognizant MLC may grant authority to deviate from specified immunization procedures on request.

   b. Unit commanding officers will arrange local immunizations for their unit's members. If this is not possible, he or she will request assistance from the Coast Guard Medical Treatment Facility overseeing units in the geographic area.

3. Equipment and Certification Requirement.

   a. All immunization sites must have the capability to administer emergency medical care if anaphylaxis or other allergic reactions occur. A designated Coast Guard medical officer must certify the registered nurse or HS selected to administer immunizations is qualified to do so because he or she has received instruction and displayed proficiency in these areas:

      (1) Vaccine dosages;

      (2) Injection techniques;

      (3) Recognizing vaccine contraindications;

      (4) Recognizing and treating allergic and vasovagal reactions resulting from the vaccination process;

      (5) Proper use of anaphylaxis medications and related equipment (e.g., oxygen, airways; and

      (6) Verification the individual is currently certified in Basic Cardiac Life Support (BCLS).

   b. The immunization site must have available: syringes with 1:1000 aqueous solution of epinephrine, emergency airways, oxygen, hand operated resuscitator, and intravenous (IV) fluids with an IV injection set.

4. Immunization Site Responsibilities.

   a. Where available, a medical officer shall be present when routine immunizations are given.

b. In the event a medical officer cannot be present, a registered nurse or HS3 or above can be certified to administer the immunization process of active duty and reserve personnel when the following guidelines and procedures are met:

(1) The designated Coast Guard medical officer who normally would oversee their independent activity must train and certify in writing registered nurses and HSs conducting immunizations in a medical officer's absence.

(2) An emergency-equipped vehicle must be readily available to transport patients to a nearby (within 10 minutes) health care facility staffed with an ACLS-certified physician or an EMS with ACLS capability must be within a 10-minute response time of the site.

(3) Hypovolemic shock often is present in cases of anaphylaxis. Therefore medical personnel must be ready and able to restore fluid to the central circulation. In anaphylaxis treatment, epinephrine administration, airway management, summoning help are critical steps toward the treatment of this condition.

c. The individual(s) administering the immunizations shall review the SF-601(Immunization Record) and PHS-731 (International Certificate of Vaccination) for each unit member to be immunized. Only a medical officer has authority to immunize persons sensitive to an immunizing agent. The unit health record custodian or HS will ensure proper entries are made on each immunize person's SF-601 and PHS-731.

d. In some clinical situations, the medical indication may be to immunize even though the circumstances above cannot be met (e.g., tetanus toxoid for wound prophylaxis, gamma globulin for hepatitis A exposure, etc.). Such incidents commonly occur at sea and remote units or during time-sensitive situations (SAR, etc.). If the medical benefits outweigh the chance of a serious allergic reaction, take every available precaution possible, and administer the vaccine. When available, obtain radio, telephone, or message advice from the Medical Officer.

e. If an adverse reaction to a vaccine is suspected, the facility shall notify the Vaccine Adverse Event Reporting System (VAERS) using form VAERS-1. Obtain this form from the FDA by calling 1-800-822-7967. Units providing vaccinations shall maintain a supply of these forms. A copy of each submitted VAERS-1 will be forwarded to G-WKH.

f. Every health care provider who administers vaccines shall provide a Vaccine Information Sheet (VIS) if available from the Centers for Disease Control and Prevention (CDC). As of 1 Feb 2002, the following VIS's are available: diphtheria, tetanus, pertussis (DTaP); diphtheria, tetanus (Td); measles, mumps, rubella (MMR); polio (IPV); hepatitis B; haemophilus influenza type b (Hib); varicella; pneumococcal conjugate; influenza; hepatitis A; pneumococcal polysaccharide; meningococcal; lyme disease; and anthrax. This list includes vaccines covered by the National Childhood Injury Act, as well as several others. The VISs are available

from the CDC, National Immunization Hotline, at telephone number (800) 232-2522 or at http://www.cdc.gov/nip/publications/VIS/default.htm.

g. Per the National Childhood Vaccine Injury Act (NCVIA) of 1986, health care providers are not required to obtain the signature of the vaccine recipient, parent or legal guardian acknowledging receipt of the VIS. However, to document that the VIS was given, health care providers must note in the patient's permanent medical record (1) the date printed on the VIS and (2) the date the VIS is given to the patient or legal guardian. In addition, the NCVIA requires, for all vaccines, that health care providers document in the patient's permanent medical record the following: (1) date the vaccine was given, (2) the vaccine manufacturer and lot number and (3) the name and address of the health care provider administering the vaccine. For all beneficiaries, the health care provider will make a notation on the SF-600 stating that the vaccine recipient or legal guardian/representative has been given information on the vaccine(s) prior to the vaccine(s) being given, if applicable. For all vaccines, facilities administering vaccines must record in the recipient's health record, and, in the service member's International Certificate of Vaccination (PHS-731), the manufacturer and lot number of the vaccine, and the name, address and title of the person administering the vaccine.

5. Immunization on Reporting for Active Duty for Training.

a. When a member reports for active duty for training, the receiving unit shall review the individual's SF-601 and PHS-731 for completeness, administer any delinquent immunizations whenever possible, enter on SF-601 and PHS-731, and return these to the individual when active duty for training terminates.

b. The individual's Reserve unit shall give the member a re-immunization schedule for the following year if one is needed for that period.

Section D Tuberculosis Prevention and Control Program

1. Introduction.

   a. Description. Tuberculosis (TB) is an infectious disease transmitted from person to person by very small (1-5 microns) particles called droplet nuclei, which can remain suspended in any indoor air space for long time periods. An individual with active pulmonary tuberculosis propels droplet nuclei into the air by coughing, speaking, or sneezing. They also can be produced by manipulating tuberculous lesions or discharging infected secretions. Inhaling droplet nuclei can carry them to the lung alveoli, where the bacteria suspended in the particles can multiply, causing a pulmonary infection.

   b. Problem. In the United States, reported cases of tuberculosis declined steadily until 1984. Since then, however, the disease has unexpectedly rebounded in this country. Many experts agree this resurgence is due at least partially to a deterioration in the infrastructure of our health care delivery system. An additional concern is the domestic increase of drug-resistant forms of tuberculosis, resulting in increased costs, longer duration of treatment, and higher mortality rates.

   c. Purpose. This section prescribes policy and procedure to ensure Coast Guard members can conduct their mission without undue risk of tuberculosis transmission and, further, the highest quality medical follow-up for those infected with the disease.

   d. Definitions.

      (1) Active Case. A person who has a clinical disease demonstrated by radiograph (x-ray) and culture or signs and symptoms of extrapulmonary TB. This term does not include a person whose only finding is a positive skin test.

      (2) Casual Contact. A person acquainted with an individual with active tuberculosis who has spent some time with the infected person in a possibly contagious, though brief, situation.

      (3) Clinically Significant Exposure. An exposure to someone with active tuberculosis which could be expected to result in transmitting the infection. This generally means repeated, close contact with a person with active pulmonary TB, particularly when in a confined environment such as a room or residence, such as family members who share the same household as persons with TB or health care workers who routinely care for TB patients.

      (4) Close Contact. A person who has spent extended periods of time with a person who has active tuberculosis, especially in enclosed spaces, e.g., living in the same household.

      (5) Contact. A person who has had some association with an active case .

(6) Edema. The escape of a fluid, usually serous (pertaining to the watery part of the blood) fluid, from its natural vessel into body tissues or cavities. Soft tissue edema causes pitting.

(7) Erythema. An area of abnormally red skin due to inflammation.

(8) Fomites. Any materials, including clothing or bedding, capable of absorbing and spreading a disease's infecting organism.

(9) High-Risk Groups. Defined groups of persons among whom the prevalence and incidence of tuberculosis is substantially higher than the general population.

(10) Induration. A firm, hardened, usually raised area of soft tissue congestion; erythema may or may not be present. Must be distinguished from edema by the absence of pitting.

(11) Mantoux Test. An intracutaneous (within the skin) test for tuberculin sensitivity, using a purified protein derivative (PPD) of tuberculin.

(12) MDRTB. Multiple drug resistant tuberculosis.

(13) *Mycobacterium tuberculosis.* The organism that causes tuberculosis disease.

(14) Positive Skin Test Reaction. See 3.C.(2).(f).

(15) Pulmonary. Referring to the lungs. The most common and most infectious form of TB occurs in the lungs (pulmonary TB), but many other parts of the body can be sites of infection.

(16) Tuberculin Conversion/Convertor. A TST reaction that has increased from what is considered non-reactive to reactive within two years. Both reactions must be documented.

(17) TB. Tuberculosis, a communicable disease of humans and animals caused by the *Mycobacterium tuberculosis* microorganism, manifesting itself in lesions of the lung, bone, and other organs.

(18) TST. Tuberculin Skin Test, a test based on a hypersensitivity-type immune reaction to tuberculin. The test is used to determine past or present infection from *Mycobacterium tuberculosis*.

(19) Tuberculin. A substance derived from *Mycobacterium tuberculosis* cultures used to diagnose tuberculosis.

(20) Tuberculin Non-reactive/Non-reactor. A TST reaction which is too small to be considered evidence of infection. (See Figure 7-D-1). Sometime imprecisely referred to as a "negative" test.

(21) Tuberculin Reactive/Reactor. A TST reaction considered evidence of infection. (See Figure 7-D-1). Sometimes imprecisely referred to as a "positive" test.

(22) Vesiculated. Having small, blister-like, fluid-filled sacs or cysts.

e. Program Summary. The Tuberculosis Prevention and Control Program consists of four parts: the TB screening and contact investigation programs, personal protective measures and patient management.

2. Tuberculosis Screening Program. The program is intended to identify both persons who have only been infected by *Mycobacterium tuberculosis* and those who have active, clinical disease. The former may benefit from preventive therapy, and the latter from treatment.

a. Type of testing: Different testing procedures are used:

(1) Tuberculosis Skin Testing. The Purified Protein Derivative (PPD) is the primary method for routine TB screening. It is used for individuals with previously non-reactive, doubtful, or unrecorded skin tests.

(2) Chest Radiograph. This method is if active TB is suspected in persons with a previously reactive tuberculin skin test (TST). Routine periodic chest radiographs will generally not be performed.

b. Summary of Testing Procedures. At a minimum, TB screening is required when a person enters military service and during periodic physical examinations. A medical officer or this manual describe when to test more frequently.

c. When to Test Personnel.

(1) Initial Tuberculosis Screening. A PPD is mandatory in the physical examination of any person entering initial active duty for 30 days or more and any other active duty member whose records contain no report of a completed tuberculin test.

(2) Screening Personnel at Low Risk of Exposure.

(a) Tuberculin Non-reactive Personnel. All active duty personnel whose last recorded reaction was recorded as non-reactive at a minimum must have a PPD during their quinquennial physical examination.

(b) Tuberculin Reactive Personnel. All personnel whose last recorded TST reaction was considered reactive receive chest radiographs only when previous medical follow-up has not been done and properly documented in the individual's health record, or when a medical officer deems it clinically indicated. All TST reactors or their medical records must be medically reviewed annually to screen for indicators of active disease.

(3) Screening Personnel at Increased Risk of Exposure.

(a) Tuberculosis Non-reactive Personnel. Personnel whose last recorded TST reaction was considered to be nonreactive and who are at increased risk of TB, such as health care workers, will be skin tested annually, usually during routine immunizations. EMT or law enforcement and other personnel, in addition to testing at their quinquennial physical

examination, will be tested after clinically significant contact with high risk groups (e.g., following interdiction of and prolonged, confined contact with migrants who have signs of active tuberculosis). (COMDTINST M6220.9 (series) provides more information regarding tuberculosis and AMIO, but this instruction is the definitive guidance on frequency of testing.)

(b) Tuberculin Reactive Personnel. Personnel whose last recorded TST was considered reactive will receive chest radiographs or sputum smear examinations only when a medical officer deems necessary.

(4) Separation from Service. Those individuals whose last test was nonreactive shall have a PPD as part of their separation process. A chest radiograph will be done for a separation physical only if the individual has a confirmed positive PPD. Results of the PPD or chest radiograph must be evaluated and recorded in the health record prior to separation.

d. Testing Procedures.

(1) Tuberculin Skin Test Materials.

(a) Tuberculin, Purified Protein Derivative (PPD). The only approved tuberculin skin test material for a routine Mantoux test is premixed Tween-80-stabilized intermediate strength PPD (5 Tuberculin Units (TU) equivalent). Multiple puncture tuberculin tests (e.g., Tine tests) are not authorized. A medical officer can direct using first-strength PPD (1 TU) when a person has a verbal or questionable history of a reactive TST but no documentation of such.

(b) Syringes and Needles. The disposable 1 ml tuberculin syringe graduated in 0.1 ml intervals and fitted with a 25-gauge 5/8-inch needle is a convenient combination for administering the PPD.

(2) Tuberculin Skin Test Methods.

(a) Personnel Authorized to Perform the Tuberculin Test. Only trained health services personnel are authorized to perform PPDs. The local medical authority shall verify they are competent to administer and read the PPD.

(b) Techniques. Following aseptic preparation of the skin, an intradermal injection of 0.1 ml of the tuberculin solution shall be made upon the volar aspect of the left forearm. The point of the needle should be visible just within the dermis, beneath the outer layers of the epidermis. The results should be a definite wheal, pale and sharply demarcated. Be careful to avoid subcutaneous or epidermis injection. If it is recognized that the first test was improperly planted, another test dose can be given at once, selecting a site several centimeters away from the original

injection. A note in the record should indicate the site chosen for both the first and second tests.

(c) Documentation. Document the PPD test in the SF-601 under Sensitivity Tests with the date tested. Do not record results until the actual time of reading.

(d) Two-Step TST. Because of delayed hypersensitivity, an adult who has never been skin tested and will receive periodic skin testing should receive two-step skin testing to distinguish boosted reactions from reactions due to new infection. Persons in this category include new accessions to the Coast Guard (officer and enlisted). In such cases consult a medical officer for procedure.

(e) Measuring and Recording Results.

1 After an interval of between 48 and 72 hours examine the PPD site. Classify injection response according to the extent of the induration (not erythema or edema) measured in millimeters (mm) at the widest diameter transverse to the long axis of the forearm.

2 When reading the PPD, the forearm should be in good light and flexed a little at the elbow. Lightly pass a forefinger over the test area. The induration can be felt even when it does not produce a visible elevation. For those skilled in its use, the pen-tracking method is both authorized and more accurate. To measure, mark induration borders with a ball-point pen.

3 To record the result, enter by hand this information under Sensitivity Tests on SF-601 and PHS 731: date, type of tuberculin, its strength or dilution (e.g., PPD 5 TU), and the resulting diameter of induration expressed in millimeters. Report absence of induration as "zero mm." If induration is present, use Arabic numerals to record the widest diameter. A sample entry is: "17 SEP 86 PPD (5TU) 6mm induration." Also measure and record any vesiculation. In red ink record the result indicating a PPD converter on the Sensitivity Sticker (section 4-B-2) and the Problem Summary List (section 4-B-3). Using rubber stamps or automatic imprinting devices to record results or recording results as “negative” are both prohibited.

4 A medical officer must evaluate grossly vesiculated reactions. Warn the person about possible secondary bacterial infection from scratching the reaction.

(f) Failure to Return for Skin Test Reading. Personnel who do not return at the proper time to have the skin test interpreted must be retested. Do not

under any circumstances record the PPD as "zero mm" if the person does not return within the prescribed time frame. Each time a person fails to return for timely reading, document the SF-601 with "no reading done" and the date.

(g) Interpreting Skin Test Readings. Consider a skin test reactive according to Figure 7-D-2.

Figure 7-D-2

Size of Induration	Considered Reactive for
Reactions < 5mm are considered non-reactive	
5 mm	• Persons with HIV infection or risk factors for HIV infection but unknown HIV status; • Persons who have had recent close contact with persons who have active TB; • Persons who have fibrotic chest radiograph consistent with healed tuberculosis; • Patients with organ transplants and other immunosuppressed patient.
10mm	• Injecting drug users known to be HIV seronegative; • Persons with other medical conditions with reported increased risk for progressing from latent TB infection to active TB. These medical conditions include diabetes mellitus, chronic renal failure, some hematologic disorders and other malignancies, weight loss of ≥10% below ideal body weight, silicosis, gastrectomy, and jejunoileal bypass;) • Residents and employees of high-risk congregate settings: prisons, long-term care facilitiess, health-care facilities, and homeless shelters; • Some medically underserved, low income populations, including migrant workers and homeless persons; • Foreign-born persons recently arrived (i.e., within the last five years) from countries with a high TB prevalence; • Children < 4 years of age, any child or adolescent exposed to adults in high-risks categories.
15mm	• Persons who meet none of the above criteria.

(3) Chest Radiographs. Those individuals who have been determined to need a chest radiograph will have a standard, erect posteroanterior view. A medical officer may determine other appropriate views.

e. Responsibility for Local Program Management.

(1) The command holding affected persons' health records is responsible for monitoring health records and managing local skin testing and chest radiograph programs.

(2) The activity maintaining the health record assures the tuberculin skin test status is clearly and properly documented on SF-601 and PHS-731 Immunization Records of each active duty member's health record; the activity also must clearly, properly record tuberculin reactors' chest radiograph status on SF-600, Chronological Record of Medical Care, and NAVMED 6150/20, Problem Summary List. Further, the activity is responsible for initiating tests for persons whose health records do not contain appropriate, timely entries.

3. Tuberculosis Contact Investigation Program.

a. Contact Investigation Procedures. On discovering a case of active TB in a command, take these actions:

(1) Submit a Disease Alert Report. (See Figure 7-B-2, and 7-B-3).

(2) Determine the patient's close contacts.

(3) Screen or give these contacts a TST test for TB and repeat the screening 3, 6, 9, and 12 months later.

(4) Report summary results of the investigation to Commandant (G-WKH) through the appropriate chain of command.

(5) Evaluate possible secondary cases.

b. Initiating a Contact Investigation. Initiate a contact investigation when notified a member of the command has diagnosed active PMTB or when a medical officer so requests.

c. Performing a Contact Investigation.

(1) Conducting an investigation
Initial Investigation of Contacts. Each person who is a close contact of an known case of active, infectious tuberculosis shall undergo a screening examination for TB. Those personnel who are previous tuberculin reactors, and do not have a document of appropriate medical follow-up, or have signs of PMTB, shall receive a chest radiograph [unless otherwise contraindicated, see 7-D-4.b.(5)(c)]. All other contacts shall receive a PPD. Individuals identified to be close contacts who are not eligible for health care through the Coast Guard should be referred to the local public health department or private medical facility of choice.

(a) Establishing Limits for Contact Investigations. The infectiousness of a source case is determined by first evaluating close contacts for evidence of new infection or disease. If there is no evidence of infection in this

group no further investigation is necessary. Remember that TB is a slow progressing disease and initial screening results should only be interpreted as baseline information if it is determined that the source case may have a recent infection or disease. If there is evidence of infection in close contacts (as determined after an appropriate time-lapse), extend the investigation to progressively lower-risk contacts, e.g., casual or other contacts. This should proceed until the levels of infection detected approximate the levels of infection in the local community. NOTE: If a newborn or an immunocompromised person (e.g., HIV infected person) is identified as a close contact, they should be evaluated for prophylaxis per current Centers for Disease Control and Prevention Guidelines. Figure 7.D.3 shows a decision tree for establishing contact limits.

(2) Determining Close Contacts.

(a) Active Tuberculosis at a Shore Facility. The local medical officer must classify a TB patient's "close contacts" at a shore facility, generally including all those sharing the same berthing facilities, in close contact during duty hours, regular liberty mates, and the patient's cohabitants. Consult the appropriate MLC (k) for advice in specific instances.

(b) Active Tuberculosis Aboard a Cutter. When a case of active TB is discovered aboard the cutter the entire ship's company shall be considered close contacts included in the contact investigation.

(c) Other Situations. Commands or activities in which exceptionally close conditions occur, such as isolated duty stations, shall follow the procedures listed for cutters.

(3) Follow-up Investigation of Contacts.

(a) Follow-up Period. Follow up tuberculosis contacts for 12 months (see paragraph 5.a.(3)). Record follow-up results on an SF-600 in each contact's medical record. Take particular care to record all items before an involved member from the command transfers.

4. Protective measures

a. General. Depending on the level, nature, and intensity of exposure, a person's risk of TB infection can be reduced. Tuberculosis spreads almost exclusively by airborne transmission from persons who have active pulmonary TB. The risk of infection is negligible for those who have casual or brief contact with high-risk persons, particularly if exposure occurs in a open space. Special personal protective equipment, e.g., masks, gloves, or gowns, is not required for routine limited contact in such a setting.

b. Respiratory protective devices (RPD).

(1) RPDs may be warranted if TB exposure is longer or more intense. Coast Guard personnel will comply with guidelines established by the Centers for Disease Control and Prevention (CDC), the National Institute of Occupational Safety and Health (NIOSH), and pertinent Coast Guard directives, e.g., COMDINST M6260.2 (series), governing using RPDs or other personal protective equipment.

(2) Surgical masks do not filter small enough particles to protect a wearer from TB infection, and must not be used for this purpose. However, surgical masks can help contain infectious droplets from the infected person, and when worn by this person, may reduce the risk of passing the infection.

(3) The minimum RPD for wearer safety is a NIOSH-approved, high-efficiency particulate air (HEPA) respirator. Respiratory protective devices must fit and be worn correctly to be effective. Technical Guide: Practices for Respiratory Protection, COMDTINST M6260.2 (series), describes how to evaluate, fit, and train persons to wear RPDs to protect against TB transmission.

c. Air Circulation. At least 6 air exchanges per hour (ACH) are required to reduce concentrations of droplet nuclei in the air in an enclosed space requires; higher ACH rates eliminate more bacteria. If possible 12 ACH or more is recommended. Recirculated air should filter through fixed HEPA filters. Fresh or filtered air should be provided in optimum airflow patterns that prevent stagnation.

d. Handling High-Risk Populations. When transporting or otherwise in a confined space with a person known or suspected to have active TB, take these precautions:

(1) If he or she can tolerate one, have the patient wear a mask.

(2) Take measures to increase airflow within the enclosed space. Vent air to the outside whenever possible.

(3) Avoid unnecessary close contact with the patient.

(4) Separate suspected TB cases from others if conditions permit.

(5) Emergency Medical Technicians (EMTs) should wear HEPA respirators when working with persons demonstrating clinical signs of TB.

(6) Consult competent medical authority to determine if specific circumstances warrant HEPA mask use.

5. Managing Personnel with Reactive Tuberculin Tests or Suspected TB.

a. Evaluation for Tuberculosis.

(1) Personnel Requiring Evaluation. As soon as possible evaluate persons who meet any of these criteria for the presence of active tuberculosis:

(a) Tuberculin reactor on initial testing.

(b) Tuberculin skin test converter.

(c) Close contact of an active case of TB who develops a TST reaction ≥5mm..

(d) Previous tuberculin reactor but never evaluated for active TB.

(e) Previous tuberculin reactor, now with suspicious chest radiograph findings.

(f) Anyone with history, signs, symptoms, or laboratory tests suggesting TB.

(2) Initial Examination. Persons listed in Paragraph 4.a.(1) will have a medical history, physical examination and chest radiograph.

(3) Further Examination. A medical officer or a civilian physician most evaluate more thoroughly those individuals whose findings suggest active TB.

b. Managing Tuberculin Reactors Without Evidence of Active TB.

(1) Personnel evaluated and found not to have active TB will be considered for preventive therapy according to Figure 7-D-3. Prophylaxis is intended to prevent latent infections from progressing to clinically active disease.

Figure 7-D-3

Age	Induration Size	Risk Factor
Any Age	> 5mm	Known or suspected HIV infection Close contact with newly diagnosed active TB Previously untreated or inadequately treated persons with chest radiographs showing fibrotic lesions compatible with old healed tuberculosis. If diagnosis is doubtful after consulting with a medical officer, administer a booster TST
	> 10mm	Injecting drug users Persons with medical conditions reported to increase tuberculosis risk including silicosis; gastrectomy; jejunoileal bypass; weight 10% or more below ideal body weight; chronic renal failure; conditions requiring prolonged high-dose corticosteroid therapy or other immunosuppressive drugs; some hematologic disorders (leukemia and lymphomas); and other malignancies
Under 35	> 10mm	Foreign-born persons from high-prevalence countries including those in Asia, Africa, Central and South America, and eastern Europe Residents of correctional facilities
	> 15mm	No risk factors, but not previously treated

Recent TST converters		
Under 35		> 10mm *increase* within a 2 year period
Over 35		> 15mm *increase* within a 2 year period
Previously known (old) tuberculin reactor not properly evaluated in the past or who did not complete appropriate preventive therapy		
Under 35		If risk factors and induration sizes listed above are present
Over 35		Generally not a candidate for INH unless specific risk factors for active disease are present

Note: A previously known tuberculin reactor may be treated without repeat testing if a properly documented tuberculin TST result is in the medical record. If a person gives an undocumented history of a tuberculin reaction and INH prophylaxis may be indicated, a first strength PPD (1 TU) may be administered under the direction of a medical officer, to confirm the reported reaction.

(2) Initial Evaluation for Prophylaxis. Before initiating a course of prophylaxis a medical officer must evaluate the person as follows:

(a) An appropriate history and physical examination.

(b) Chest radiograph for newly identified tuberculin reactors, unless otherwise contraindicated. Give one to previously known reactors only if no documents exist of proper medical evaluation with radiograph at time of reactive TST or if clinically indicated.

(c) Baseline liver function tests (LFT), including AST, ALT, LDH, total bili, and GGT, and a CBC.

(d) Perform HIV antibody testing on all newly identified active duty tuberculin reactors. Query civilian employees and dependents with newly-identified reactive TSTs about HIV risk behaviors. Counsel persons with HIV risk factors and offer them an HIV serological screening test.

(e) Review conditions that may contraindicate prophylaxis as follows: pregnancy, breast feeding, ETOH abuse, known sensitivity to the agent, peripheral neuropathy, IV drug abuse, acute or chronic liver disease, therapy with medication with a potential for significant interaction (Tegretol, phenytoin, etc.). If any of these conditions exist, the provider must decide whether to initiate prophylaxis, weighing therapeutic risks and benefits.

(3) Prophylaxis. Recommended regimens are listed in Figure 7-D-4. There are other considerations not listed in the Figure for HIV infected persons.

Figure 7-D-4

Drug	Interval and Duration	Comments
Isoniazid (INH)	Daily X 9 Mo[1,2]	In HIV-infected patients, INH may be administered concurrently with NRTIs or NNRTIs.
	2X Weekly X 9 Mo[1,2]	Directly observed therapy (DOT) must be used.
INH	Daily X 6 Mo[2]	Not indicated for HIV-infected persons or those with fibrotic lesions on chest X-ray.
	2X Weekly X 6 Mo[2]	DOT must be used.
Rifampin plus pyrazinamide	Daily X 2 Mo	May also be offered to persons who are contacts of patients with IHN-resistant, rifampin-susceptible TB; In HIV-infected patients protease inhibitors or NNRTIs should generally not be administered concurrently with rifampin.
	2X Weekly X 2-3 Mo	DPT must be used
Rifampin	Daily X 4 Mo	For persons who cannot tolerate pyrazinamide.

Notes: [1]Recommended regimen for children younger than 18 years of age.
[2]Recommended regimen for pregnant women.

(a) Supervision. Persons whose risk of developing active TB is high and whose compliance is questionable may require directly observed therapy (DOT).

(b) (b) Monitoring. Appropriately trained personnel must monitor persons taking INH monthly for the first two months and at least every two months thereafter. Follow persons 35 and older monthly for the first three months. Initially dispense a maximum of one month's supply of medication and up to two months' supply thereafter to coincide with follow-up visits. If signs or symptoms of toxicity appear, discontinue INH immediately; a medical officer should reevaluate. Prophylaxis should not be prescribed if periodic monitoring cannot be done. Monitoring consists of:

1 Reviewing significant symptoms of INH side effects: fever, rash, jaundice, fatigue, anorexia, dark urine, joint pain, paresthesia of hands, feet, or eyelids.

2 Obtaining follow-up LFTs as follows:

One month after instituting INH; then at least at three month intervals for all individuals.

At 1, 2, 3, and 5-6 months (8-10 month interval for those with a one-year course) for all persons 35 and older.

If evidence of possible reaction to therapy occurs.

3 Upon termination of INH prophylaxis, LFTs and a CBC will be done.

4 The periodic evaluations will be documented in the patient medical record.

c. Patient Education. The health services representative must ensure the patient understands the meaning of the skin test result or TB exposure, INH chemoprophylaxis hazards (hepatitis, drug fever, severe rash, etc.) and benefits, the warning signs of the drug's potential side effects; and the danger of alcohol consumption while taking INH. The necessity for faithful adherence to the course of treatment, in the absence of side effects, cannot be too strongly stressed. A notation of the counseling offered shall be made on an SF-600 in the medical record.

d. Persons Leaving the Service While on Chemoprophylaxis.

(1) Members who retire prior to completing chemoprophylaxis shall be advised that continued treatment is necessary and may be obtained at most Uniformed Services Medical Treatment Facilities.

(2) Members who are discharged or released to inactive duty prior to completing Isoniazid chemoprophylaxis shall be advised of the importance of continuing the program. Care may be provided by the Veterans Administration, county health department, private physicians, etc. To facilitate follow-up, personnel shall be provided with a statement signed by a medical officer containing the date treatment began, the type and dosage of prescribed medications, course of therapy, and the present status. At a minimum, the local Health Department where the individual plans to reside should be notified.

(3) A medical board or limiting duties is not indicated for those with no evidence of active disease except as noted in paragraph 4.b.(6) regardless of the status of preventive therapy.

(4) Special Situations and Procedures.

(a) Exposure to Drug-resistant TB. Consult with CDC or a state health department before starting prophylaxis for persons known to be exposed to patients with drug-resistant strains of TB.

(b) Children. A pediatrician or medical officer with training in pediatrics must follow children receiving TB prophylaxis.

(c) Pregnant Women. Complete the same initial procedures for adults except DO NOT PERFORM A RADIOGRAPH unless an actual clinical indication of pulmonary disease exists. Consult the patient's obstetrician. Generally, defer treatment until after delivery or breast feeding. Place

the patient's name in a "tickler" so that she can be contacted upon termination of pregnancy.

(d) Child Care Workers. Child care workers must receive annual PPDs or medical evaluations, as appropriate.

(5) Aviators.

(a) Personnel on flying status shall be grounded for the first seven days of chemoprophylaxis because of the slight risk (less than 1%) of convulsions among persons taking INH. At the end of seven days of treatment, flight surgeon must be consulted to return the member to flying status.

(b) A flight surgeon shall evaluate aviators receiving INH monthly to carefully brief the individual about possible adverse reactions.

(c) Aviation personnel should be considered for grounding if, at any time during treatment, liver function test are significantly abnormal or symptoms of liver dysfunction appear.

e. Managing Suspected Cases of Active TB. When a patient is evaluated and suspected of having TB:

(1) Submit a Disease Alert Report (see Figure 7-B-2).

(2) Expeditiously refer the patient to the nearest USMTF, including those initially admitted to civilian medical facilities. If at all possible, refer before beginning definitive treatment.

(3) Initiate contact tracing.

(4) Decontaminate spaces (see Paragraph 7-D-7).

f. Reporting Requirements. The health services division chief of the medical treatment facility where the diagnosis of active TB is suspected or established, shall notify the patient's commanding officer within 48 hours. The notification shall include the date that the diagnosis was established or suspected and the probability that the patient is infectious. If, in the case of suspected active TB, the diagnosis of TB is subsequently ruled out, a message to that effect must be sent to both the patient's commanding officer and to the address of the Disease Alert Report, immediately.

(1) Follow-up Procedures. The command investigating TB contacts shall maintain a "tickler" file or similar effective system to assure prompt evaluation of persons requiring periodic examination and testing. Medical evaluations and other indicated procedures are an appropriate part of the periodic examination.

(2) Completing Follow-up. When the 12 months expire, those individuals whose tuberculin response or chest radiograph were unchanged shall revert to routine program screening.

(3) Separated Members. Contacts separated from the Coast Guard shall be counseled regarding the need for medical evaluation and the appropriate referrals made.

(4) Managing Tuberculin Converters or Possible Cases. Those individuals found to have "converted" or who developed changes on a chest radiograph shall be evaluated as outlined in Section 7-D-4 of this manual. Close contacts who increase the size of induration on a TST, even though the reaction is still considered nonreactive, should also be considered for evaluation.

(5) Secondary Cases. If a subsequent active TB case is discovered among the contacts, it is not necessary to begin an entirely new investigation. However, start contact studies on any personnel exposed to the secondary case not tested in the original investigation.

g. Responsibility for Managing the Contact Investigation Program.

(1) The commanding officer of the permanent duty station of a person diagnosed with active TB shall initiate the contact investigation. If the individual has a permanent change of station during the preceding year, the commanding officer of the former duty station shall be notified to initiate a contact investigation if determined appropriate by the medical officer or civilian physician making the diagnosis. If assistance is required contact the appropriate MLC (k).

(2) The commanding officer of any activity is responsible for successfully continuing or completing contact studies under way among members assigned to or transferred to the unit. Additionally, the commanding officer shall ensure:

(a) The records of members transferred from the unit while undergoing contact studies are complete (including radiographs) so the member's gaining unit can continue the studies.

(b) Prompt submission of the summary letter report on the tuberculosis contact investigation to Commandant (G-WKH) through the chain of command.

h. Reporting Requirements. The command initiating the contact investigation shall prepare and submit study summaries to Commandant (G-WKH) with a copy to the appropriate MLC (k). Submit progress summary reports and the final RCS-G-K-13012, Disease Alert Report, with this information:

(1) Unit identification.

(2) Source case(s)'s name, grade, rate, and Social Security Number .

(3) Status of investigation, e.g., initial, 3-, 6-, 9-, or 12-month summary reports.

(4) For each reporting period provide:

(a) Number of tuberculin non-reactive individuals skin-tested.

(b) Number of skin-tested tuberculin non-reactive persons found to be converters.

(c) Number of tuberculin-reactive individuals receiving chest radiographs.

(d) Number of tuberculin-reactive persons found to have suspicious changes on the chest radiograph.

(e) Number of contacts placed on or receiving isoniazid chemoprophylaxis.

(f) Name, grade, rate, Social Security Number, and exact diagnosis of each secondary tuberculosis case.

(g) Comments on investigation including any problems.

6. Tuberculosis Control Among Dependents and Other Civilians.

a. Dependents.

(1) As part of health education efforts, commands shall impress upon dependents the importance of routine TB preventive measures. Within their capabilities, commands in known high-risk areas should extend the active duty program to those dependents residing in the area. Dependent contacts of active cases of TB shall be given periodic screening with either tuberculin test or chest radiographs, as appropriate. Chemoprophylaxis will be administered, when indicated.

(2) If active TB is diagnosed in a military dependent, the medical treatment facility (MTF) establishing the diagnosis shall notify the appropriate public health authorities. Dependents may obtain care through the local public health department, military MTF, or through civilian sources, as appropriate. The MTF making the diagnosis should provide advice on available treatment alternatives.

b. Positive Skin Tests in Children Under 6 Years of Age. Preventive treatment is definitely recommended for all positive tuberculin reactors under six years old. The Mantoux method shall be used to confirm “positive” responses elicited by other tuberculin testing methods.

c. Alien Dependents. See "Tuberculosis Among Foreign-Born Persons Entering the United States," Centers for Disease Control and Prevention, MMWR, Dec 28, 1990 (Vol. 39), and the U.S. Immigration and Naturalization Act for the waiver procedure an alien with PMTB to enter CONUS.

d. Civilian Personnel. If a civilian employee under Coast Guard cognizance is discovered to have active TB, the medical administrative officer or the medical officer of the activity shall make arrangements for contact investigation of close work associates. Local public health authorities shall be notified. Coast Guard

personnel who are close contacts of the employee shall have detailed entries made in their medical records and receive appropriate follow-up.

7. Decontaminating Spaces Occupied by Persons with Active PMTB.

   a. Pulmonary tuberculosis is transmitted by small airborne droplets or droplet nuclei from persons in close contact or possibly through ventilation systems, such as on ships. Other dried secretions and fomites in themselves do not pose significant hazards unless aerosolized. Therefore, only normal laundry and cleaning procedures with sodium hypochlorite (household bleach) are necessary for linen and bedding of a person with active PMTB. Take care not to shake dirty linen to launch particles on it into the air.

   b. When a case of PMTB is discovered aboard a ship, the filters in the ventilation system exhausting the berthing, messing areas, work spaces, and medical spaces must be replaced and cleaned. In this situation contact the Commandant (G-WKH) or appropriate MLC (k), for specific instructions. Increase circulation of fresh air and, if possible, exposure of spaces to natural light (sunlight) will rapidly clear any infectious, airborne droplet nuclei from the spaces.

   c. No other sanitation measures are necessary. Consult a medical officer for advice in specific instances.

FIGURE 7-D-1

SUMMARY OF TESTING PROCEDURES

TUBERCULIN (PPD) SKIN TEST	RECOMMENDED ACTION
Unknown	Perform a PPD, using intermediate strength PPD (5 TU).
History of strongly reactive or vesiculated reaction	Perform a PPD using the regular dose of first strength PPD (1TU). If this test's results are negative, follow up with a subsequent test using a full dose of intermediate strength PPD (5TU).
Last test reactive	Determine if an appropriate medical follow-up and/or chemoprophylaxis has been pursued. If not, perform a standard posterior-anterior chest radiograph. If the chest radiograph and a review of signs and symptoms reveal no findings, consider prophylaxis. If proper medical follow-up previously has been pursued, counsel the patient on the need to monitor him- or herself for signs of active pulmonary tuberculosis. Further follow-up is not indicated.

Evaluate these classes of personnel as Section 7-D-4 outlines.

1. Those with unknown or previously nonreactive tuberculin status who are found upon testing to be PPD reactors.
2. Those with reactive skin tests who have not been medically examined for tuberculoses before.
3. Those with suspicious chest radiograph findings.

NOTE: A reactive single/multiple puncture TB skin test, i.e., Monovac or Tine Test, to test children; must always be verified by PPD.

(1) These types of eyewear are available:

Type of Correction	Cellulose acetate frame	
	Glass Lens	**Plastic Lens**
Single Vision, white [1]	X	X
Single Vision, tinted [1, 2]	X	X
Bifocal, 25mm segment, white [1]	X	X
Bifocal, 25mm segment, tinted [1, 2]	X	X
Trifocal, white	X	
Cataract Aspheric		X
Trifocal, white and tinted [1, 2]		X
(1) Eyewear provided in FG-58 (Flight Goggle) mounting for authorized personnel (2) Only N-15 and N-32 tints authorized		

(2) Process all requests for standard prescription eyewear through the below military optical laboratory; this is the only optical laboratory from which Coast Guard units are authorized to order standard prescription eyewear.

Naval Ophthalmic Support and Training Activity Yorktown, VA 23691-5071

(a) The Coast Guard pays only for glasses ordered and processed for Coast Guard active duty or retired personnel; therefore, it is extremely important to properly complete the DD-771 service identification block to indicate the patient's service affiliation.

(3) Procurement Procedures. Order all prescription eyewear using DD-771, Eyewear Prescription. It is extremely important to accurately complete the prescription form. If the prescription is wrong, the patient is inconvenienced; the Coast Guard is required to pay for eyewear even if it cannot be used; and the supply activity will reject an improperly prepared prescription, resulting in delay. Use these guidelines to prepare DD-771. See Section 4-B for more detailed instructions.

(a) Use a separate DD-771 for each type of eyewear.

(b) If no health services personnel are available at the unit, send the prescription obtained from the health record or local civilian source to the health record custodian to prepare and submit the DD-771.

(c) Submit all three DD-771 copies to the approving authority or supply activity; disregard the distribution instructions. Remove all carbon sheets before submission. File a photocopy of the DD-771 in the member's health record.

(d) TRACEN Cape May shall send recruits' eyewear prescriptions separately and mark the envelope, "RECRUIT—PLEASE EXPEDITE".

(e) Report delays longer than eight weeks in receiving eyeglasses to the appropriate MLC (k).

(4) Health Record Entries. Record on a separate DD-771 the current prescription, including frame measurements and all other data necessary to reorder eyewear, for each individual requiring eyeglasses.

4. Aviation Prescription Lenses. These personnel are authorized two pair of clear aviation spectacles (FG-58) and one pair of tinted spectacles (N-15) in matte chrome only:

a. Aviators Engaged in Actual Flight Operations. Aviation spectacles may be ordered for distant vision correction , or for distant vision and near vision correction (bifocal lenses). Those aviation personnel engaged in flight operation who desire near vision only correction in aviation frames must order bifocal lenses containing plano top portion and the near vision correction on the bottom. Spectacles containing only near vision correction are not authorized in aviation frames. This type correction will only be order in cellulose acetate frames.

b. Landing Signal Officers (LSO).

c. Coast Guard Ceremonial Honor Guard personnel.

d. Small Boat Crew required to wear a helmet while performing their assigned duties.

5. Contact Lenses. Contact lenses are issued only to active duty personnel for postocular surgical difficulties or to enable a member to overcome a handicapping disease or impairment. MLC (k) will not approve contact lenses solely for cosmetic reasons.

a. Submit letter requests for contact lenses to MLC (k) under Section 2-A-6.d.; include the type of lenses and cost.

b. If MLC (k) approves, he or she will provide an authorization number by return correspondence. Units will write this number on all correspondence and billings before submitting to MLC (k).

Section B- Controlled Substances

1. General.

   a. Controlled substances, as used here, are defined as:

      (1) drugs or chemicals in DEA Schedules I-V: (for example, the manufacturers label for Acetaminophen with Codeine #3(30 mg.) carries the DEA symbol for Schedule III (C-III) and will be treated as a Schedule III by Coast Guard units.)

      (2) precious metals;

      (3) ethyl alcohol (excluding denatured);

      (4) other drugs or materials the local commanding officer or Pharmacy and Therapeutics Committee determine to have significant abuse potential.

   b. Coast Guard authorized uses for controlled substances are:

      (1) medicinal purposes;

      (2) retention as evidence in legal or disciplinary actions; or

      (3) other uses CG Regulations specifically authorize.

   c. Quantity Definitions. Due to the potential for abuse and associated audits required, Coast Guard units should strive to minimize the quantities of controlled substances used. Two types of quantities are recognized for controlled substances:

      (1) Working Stock. Working stock is defined as a 30 day supply (under routine conditions) of a controlled substance or limited amounts of emergency drug as might be required. For smaller facilities, with limited quantities of controlled substances, working stock may surpass the 30 day limit when quantities are less than 1000 dosage units (tablets, capsules, etc.). It is also acceptable for partial containers to temporarily surpass this 1000 dosage unit limit.

      (2) Bulk Stock. Bulk stock is defined as a larger quantity beyond the normal working stock quantity. Bulk stock should primarily be sealed in sealed manufacturer's containers.

2. Custody and Controlled Substance Audits.

   a. Controlled Substance Custodian (CSC).

      (1) Pharmacy officers, when assigned, shall be appointed in writing as the CSC by the commanding officer.

      (2) In the absence of a pharmacy officer, COs shall designate the clinic administrator as CSC.

      (3) Medical and dental officers may serve as alternate CSCs.

      (4) Temporarily assigned personnel shall not serve as CSCs or alternates.

      (5) Under Coast Guard Regulations, COMDTINST M5000.3A, Chapter 6-2-3-A.(6), the Executive Officer is directly responsible for medical matters if a

medical officer is not assigned. For sickbays, the CO shall designate a commissioned officer as the CSC.

(6) CSCs may permit Health Services Technicians to assume custody of a "working stock" quantity of controlled substances.

(7) An audit of all controlled substances (working and bulk stock) is required when the CSC is changed. The results of this inventory shall be filled in the command's permanent file and in the Health Services Log. All keys should be transferred and/or combination locks changed at the time of this inventory.

b. Unit Controlled Substance Audits.

(1) Controlled Substance Audit Boards (CSAB). Each unit procuring, storing, or dispensing controlled substances shall have a CSAB.

(a) Membership: The CSAB shall consist of two or more disinterested officers or if unavailable, two or more disinterested senior petty officers (E-6 or above). Designated in writing by the Commanding Officer. CSAB letters of designation will remain in effect until the members are relieved in writing or detached from the command. In no case may the controlled substance custodian be a member of the CSAB.

(b) The CSAB shall conduct monthly audits of controlled substances at clinics (quarterly at ashore or afloat sickbays) and submit its report to the commanding officer within 5 working days after its audit. Commands shall maintain these reports for three years after which they may be destroyed.

(c) Monthly CSABs shall audit all working and bulk stock of C-II through C-V controlled substances, precious metals, ethyl alcohol, and drugs or other items locally designated as controlled substances due to abuse potential and report all quantities on CG-5353, Monthly Report for Narcotics and Other Controlled Drugs.

(d) During monthly audits, CSABs shall inspect controlled substances for expiration, deterioration, and inadequate or improper labeling. Expired products or those with other discrepancies shall be removed for disposal.

(e) The CSAB shall count required controlled substances; review a representative random sample of prescriptions, receipts, and issue documents; and report the results on Monthly Report for Narcotics and Other Controlled Drugs, CG-5353. For sealed containers, a bottle count is sufficient; for open containers an exact count is required. For open liquid containers, an estimate other than an exact volume measurement is adequate. CSABs may use tamper-proof seals on open containers to avoid future counting of partial quantities.

CHAPTER 11

HEALTH CARE PROCUREMENT

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CHAPTER 11. HEALTH CARE PROCUREMENT

Section A - Contracting For Health Care Services

1. General. Commandant (G-WK) has fiscal responsibility for health care for all Coast Guard beneficiaries. The necessary care can be obtained through contracts with private concerns and individuals and interagency and other agreements with military facilities. Commanding officers are responsible for obtaining the necessary services for each fiscal year, subject to MLC (k) review and approval. MLC (k) first authorizes all non-emergency, non-Federal health care. The MLC is responsible for all health services contracting in its area and shall comply with Federal Acquisition Regulations Part 37. The MLC (k) oversees all non-Federal care acquired and minimizes expenses by ensuring competitive contracting procedures take place.

2. Type of Services. The following services may be procured by contract as determined by MLC (k).

   a. Allergist;

   b. Dental Prosthetic Laboratory;

   c. Dentist, Dental Hygienist, or chairside Dental Assistant;

   d. General medicine (Physician or Midlevel Providers);

   e. Group Practice Hospital;

   f. Gynecologist;

   g. Medical Laboratory;

   h. Neurologist;

   i. Nurse (Registered or Licensed Practical);

   j. Obstetrician;

   k. Occupational Health Services (for OCCMED Physicals);

   l. Optometrist;

   m. Orthopedist;

   n. Pharmacist;

   o. Physical Therapist or Certified Athletic Trainer;

   p. Psychiatrist or Psychologist; and

q. Radiologist.

3. Eligibility For Contract Health Care Services. Eligibility for contract health care services is the same as described in Chapter 2.

   a. The following persons are NOT eligible for health care services rendered by contract providers:

      (1) Family members of Coast Guard personnel and retired and retired members of the Coast Guard (however, they may receive health care services when the contractor performs the service at a Coast Guard Clinic or sickbay and/or if the Coast Guard has contracted with a health care provider as a demonstration project).

      (2) Active duty beneficiaries separated from the Service while undergoing treatment (eligibility for treatment terminates and becomes the member's responsibility).

      (3) Coast Guard civilian employees except for required Occupational Medical Surveillance and Evaluation Program (OMSEP) physical examinations and required pre-appointment examinations, all funded using either MLC (k) or unit AFC-57 funds.

   b. Dental laboratory fees for non-active duty beneficiaries:

      (1) Retirees. Retirees are authorized to use private sector dental laboratories. Pay retirees' dental laboratory fees in the same manner as for active duty members.

      (2) Dependents. The dependent receiving the treatment shall pay all private sector laboratory fees resulting from space-available treatment . A suggested way to handle such payments is to require dependents to submit a check or money order payable to the private sector laboratory before delivery of appliances. The attending dental officer then photocopies the check or money order, pays the laboratory, and retains the photocopy in the dental record.

4. Approval to Contract for Services.

   a. Units shall submit letter requests for contract health care services through the appropriate chain of command to MLC (k). All requests must contain this information:

      (1) Description of services required (e.g., general health care, pharmacy, lab, or specialty care such as OB/GYN, optometry, or psychiatry), including desired days and hours of availability;

      (2) A justification of the need for the service;

      (3) Estimated annual cost of the required services;

      (4) A list of USMTFs within 40 miles of the unit and whether they could perform the desired service;

      (5) A list of Coast Guard units benefiting from the services;

(6) The number of active duty members assigned to each unit;

(7) Either the names and mailing addresses of all interested, recommended providers or a justification of other than full, open competition (see paragraph 11-A-7, Pre-contract Award Actions, below);

(8) Preferred solicitation area and the rationale for it (e.g. "provider must be located within 20 miles of the unit", etc.);

(9) Estimated number of annual Coast Guard visits to the provider; and

(10) A list (by type) of any other approved or requested health care contracts.

b. Each request must be able to stand on its own merits and fulfill cost-to-benefit criteria. MLC (k) will analyze each request and provide written approval or disapproval (with alternative proposals) to the requesting unit through the chain of command. If approved, the MLC contracting officer will undertake procurement.

c. MLC will not renew existing contracts simply as a matter of convenience. Each contract must continue to prove its value annually on a cost-to-benefit basis before its renewal. MLC (k) will review each contract's current fiscal year activity. If the contract passes review, it may be renewed; if it does not, MLC (k) will so advise the unit receiving the contract services.

5. Funding.

a. The MLC shall budget, review, and pay for all MLC (k)-authorized non-Federal health care obtained in its area. These documents contain detailed instructions:

(1) Maintenance and Logistics Command, Atlantic Standing Operating Procedures (MLCLANT SOP), Annex D; and

(2) Maintenance and Logistics Command, Pacific Instruction M6000.1 (series).

b. Charge all MLC (k)-authorized non-Federal health care expenditures to the MLC AFC-57 account. MLCs can find detailed object class and cost center information in the Accounting Manual, COMDTINST M7300.4 (series).

6. Pre-contract Award Actions.

a. The contracting officer issues solicitations to obtain supplies and services from industry on a competitive (more than 1 source) or non-competitive (1 source) basis. The Competition in Contracting Act of 1984 (PL-98-369) requires the Government to contract for supplies and services by means of full, open competition to the maximum extent possible. This means all responsible firms or individuals who can provide the supplies or services must be allowed to compete for a government contract. Contracting officers locate potential contractors by publishing the proposed procurement in the *Commerce Business Daily* as required by Federal Acquisition Regulation (FAR), Part 5.

(1) Non-competitive Procurements. Pre-awarding a firm a Government contract violates the Competition in Contracting Act of 1984. If it is claimed only one firm can provide the supplies or service, the purchasing office must justify in writing other than full, open competition, setting forth the facts and rationale (see FAR, Part 6) to support this claim. The justification must be certified that it is accurate and complete and send it with the purchase request when sending it to the contracting officer for procurement action.

(2) Competitive Procurements. The contracting officer also may require certain information before contracting on a competitive basis. The contracting officer may request the types of information below to determinate responsibility within the meaning of Federal Acquisition Regulation, Part 9.

(a) Organizational structure and plan to accomplish the service;

(b) Summary of experience in performing the same or similar work;

(c) Evidence of pertinent state and local licenses;

(d) Evidence of professional liability insurance, or that the offeror can obtain such insurance;

(e) Membership in professional organizations;

(f) Resume of key personnel with particular emphasis on academic achievements pertinent to the proposed services; and

(g) Information about the firm or its key individuals that reflects their status or professional recognition in their field, e.g., awards, published articles, and the like.

b. Subject to the contracting officer's approval, a visit may be made to the offeror's facility before the award (pre-award survey) to review some of the above data to reduce submitted data. The following paragraphs are examples of the information that may be required from an offeror.

(1) Brief description of the facility, how long established, where located relative to the required mile radius, daily operating hours, weekly operating hours (include holidays, Saturdays, and Sundays).

(2) Brief description of similar work performed under Government contracts including the government agency's name, contract number, contract price, and name and telephone number of the agency's contracting officer.

(3) A resume, X pages maximum, including education, past and present experience over the last X years, certificates, association membership, etc., of the key persons who will perform the work under the contract and their letter of intent indicating they intend to work for the offeror if it is awarded the medical services contract.

c. Minimum qualifications required to perform the contract may be stated; however, these qualification requirements must be justified. For example:

(1) Personnel.

(a) Physician. At a minimum, a X year degree in medicine from an accredited college, license to practice medicine in the location where the services will be performed, member of the AMA; X years' experience in practicing general medicine.

(b) Nurse. RN or LPN. B.S. degree (or equivalent) in nursing from an accredited college; ANA-certified or equivalent; X years' experience in handling patients, administering patient records, etc.

(c) Laboratory Technician. HHS certified, ASCP or eligible, X years' experience in all phases of laboratory work; e.g., x-rays, blood samples, etc.

(2) Facility.

(a) Within a X mile radius of the Coast Guard facility requiring the services.

(b) Capable of accommodating or rendering services for at least X patients simultaneously.

7. Award Evaluation Factors.

a. State the steps or procedures to be used to evaluate the proposals.

b. List the evaluation criteria in the descending order of relative importance and state whether one factor will have predominant consideration over another. For example:

(1) Personnel,

(2) Experience,

(3) Facility, and

(4) Price.

c. Establish the criteria to be used in evaluating the proposal. They must be the same as the evaluation factors for award the solicitation cited. The weights assigned to the factors may be in any form, e.g., adjective (acceptable, outstanding), numerical (50). Give this information to the contracting officer, preferably before he or she issues the solicitation, but in any event before receiving the proposals for evaluation.

8. Post-Contract Award Actions.

a. Referring for Contract Services. Before referring any person to a medical services contractor, the cognizant authority shall determine whether:

(1) The person is eligible;

(2) Services are available in-house;

(3) Services are available from a USMTF; and

(4) Services are available from another Federal facility, e.g., Department of Veterans Affairs, under an interagency support agreement.

b. Contracting Officer's Technical Representative. The contracting office that awarded the contract administers it. If the requiring office requests, a Contracting Officer's Technical Representative (COTR) may be assigned to the contract. The COTR is preferably a health services program manager or medical administration officer having jurisdiction in the contract services area. The contracting officer designates the contracting officer's technical representative in a written, signed letter of appointment describing the COTR's responsibilities and limitations. These responsibilities and limitations must strictly be adhered to avoid any conflicts with the contractor about changes to contract terms and conditions.

c. Health Care Invoices.

(1) Contractor Invoices.

(a) All invoices for health care services contractors by contractors shall be processed for payment under the applicable contract's terms and conditions. This Manual's Chapter 6-B-8 describes certifying and processing non-Federal health care invoices. The contracting officer is responsible for including the applicable invoice and payment clauses (e.g., Federal Acquisition Regulations 52.204-3, Taxpayer Identification, 52.232-25, Prompt Payment, etc.) in the contract. Ensure the contracting officer also includes these invoice requirements in the contract so the invoice is proper for payment:

1 An itemized, priced list of the services by contract or order line item number; and

2 Any additional information deemed necessary to process the invoice for payment.

(b) In addition to the invoice requirements above :Any invoice without the following supporting documentation will not be paid.

1 Services Rendered Under Non-Emergent Conditions. A referral slip or written confirmation of patient's eligibility from cognizant health services department representative.

2 Services Rendered Under Emergent Conditions. A written statement from the patient describing the emergent condition(s). The cognizant health services department representative must certify the patient's eligibility and emergent condition.

(c) If the eligible patient pays the contractor for services rendered under a contract and requests reimbursement, the reimbursement claim must be submitted to the appropriate accounting office on SF-1034, Public Voucher for Purchases or Services Other Than Personal. A patient's invoice cannot be reimbursed from funds obligated under a contract even though the contractor rendered the services. These documents must accompany the claim:

1 The contractor's itemized invoice,

2 A copy of the invoice and receipt showing payment to the contractor,

3 The patient's written statement of the circumstances justifying the claim, and

4 The cognizant health services department representative's approval of the claim.

(2) Invoices Outside the CONUS.

(a) The nearest Coast Guard facility having an authorized certifying officer shall process invoices for emergency health care civilian facilities furnish to Coast Guard members. The invoices and justification explaining the reasons for the emergency health care must be in duplicate and attached to SF-1166, Voucher and Schedule of Payments.

(b) Every attempt to pay for emergency health care should be made before departing from a foreign port to reduce paperwork and pay at the exchange rate. If payment before departure is not feasible, advise the facility rendering the service to send all invoices to the United States Embassy or appropriate consular office for the area.

Figure 11.A.1

STATEMENT OF WORK

1. Scope. Provide all labor, materials, and facilities necessary to perform the tasks herein.
2. Definitions.

   a. Patient. An eligible U.S. Coast Guard military member.

   b. Emergency. Treatment required to curtail the patient's undue suffering or loss of life or limb.

   c. Non-Elective Condition. A condition that, if untreated, would render the patient unfit for duty.

   d. Elective Procedure. Treatment the patient *desires*, e.g., vasectomy, tubal ligation, sterility test, contact lenses, orthodontics, etc.

   e. Duty Status. A determination of the patient's ability to perform the assigned tasks at the assigned work station. These statuses apply:

      (1) Fit for Full Duty (FFFD). Patient is not physically restricted or limited.

      (2) Fit for Limited Duty (FFLD). Patient is physically restricted or limited, e.g., office work only; no lifting, stooping, prolonged standing, walking, running, jumping, sea duty, etc.

      (3) Not Fit for Duty (NFFD). Patient cannot perform any assigned tasks at assigned work station.

3. The contractor shall perform these tasks:

   a. Task I. Eligibility Determination. Provide service to the Coast Guard military personnel listed below. Each patient must show the required authorizations before the Contractor renders service.

   b. Task II. Physical Examinations. Examine the patient according to Attachment (1) requirements. [Attach copy of appropriate section of Medical Manual, COMDTINST M6000.lA (series).]

   c. Task III. Immunization. Immunize the patient and document appropriately on Standard Form 601 (Immunization Record) or Public Health Form 731 (International Certificate of Vaccination) in the Coast Guard Health Record the patient presents the contractor. Record also any sensitivity reactions to the immunization. The contractor shall use only those immunizing agents approved by the Department of Health and Human Services. Immunize the patient at the time intervals Attachment 2 specifies. [Attach a copy of Immunization and Chemoprophylaxis, COMDTINST M6230.4D (series).]

d. Task IV. Emergency Hospitalization. Provide all necessary services to patient while he or she is hospitalized, to a maximum of seven days. If the patient requires hospitalization for eight or more days, the contractor shall notify the Coast Guard Point of Contact by telephone. If the Coast Guard elects to transfer the patient to a military hospital, the contractor shall complete all necessary documents the civilian hospital may require to effect the transfer.

e. Task V. Prosthetic and Orthopedic Appliances. The contractor shall provide prosthetic or orthopedic appliances to the patient only under emergency conditions (required immediately due to his or her condition). The contractor shall document the emergency condition on the Coast Guard Health Record. Under non-emergency conditions, the contractor shall refer the patient to a military hospital to obtain these appliances.

f. Task VI. Communicable Disease. The contractor shall report all communicable diseases and recommended control measures to the Coast Guard Point of Contact immediately after detecting the disease. The contractor also shall report to local authorities as required by local regulations.

g. Task VII. Notification. The contractor shall notify the Coast Guard Point of Contact if a patient is seriously ill, injured, or dies.

h. Task VIII. Records and Reports. For all patients the contractor shall maintain a record with this information:

(1) Outpatient Record. Record the name, rank or rating, Social Security Number, address, date of treatment, history of present illness, physical findings, diagnostic procedures including x-rays and laboratory, therapy provided, fitness for duty determination, duration and limitations if unfit or fit for limited duty, and the contractor's printed name and signature.

(2) Inpatient Report. On discharge from the hospital, furnish the patient's medical report written using diagnostic nomenclature (standard disease and operation nomenclature) to summarize the course of the case, laboratory and x-ray findings, surgeries and treatments, complications, current condition, final diagnosis, and a fitness for duty determination with duration and limitations if unfit or fit for limited duty.

i. Task IX. Certificate of Services. After rendering services to the patient, complete Attachment (3) and obtain the patient's signature before he or she departs from the contractor's facility or location where the services were rendered. [Attach copy of certification form.]

4. The contractor shall not execute any oral or written agreements with the patient to render a more expensive type of service than that described in the contract in which the patient pays the difference in price between the contract unit price and the price the contractor charges (for eyeglasses, see Section 8-E-3

5. The contractor must obtain written authority from the patient's Coast Guard unit before filling any prescriptions.
6. The contractor must obtain written authority from the patient's Coast Guard unit before performing any elective procedure.

Personnel	Required Authorization
Active Duty	1. Valid Green I.D. Card (DD Form 2CG (ACTIVE)) 2. a referral slip signed by an authorized Coast Guard official
Reservists (Active Duty)	3. Valid Green I.D. Card (DD Form 2CG (RESERVE)) 4. copy of active duty orders 5. a referral slip signed by an authorized Coast Guard official
Reservists	6. Valid Green I.D. Card (DD Form 2CG (RESERVE)) 7. a copy of Inactive Duty letter signed by the Coast Guard Reserve unit's commanding officer 8. **or** CG-4671 and a letter signed by the Coast Guard unit's commanding officer
PHS Commissioned Officers on Coast Guard Active Duty	Valid Green I.D. Card (DD Form 2CG (ACTIVE))
Prospective Coast Guard Recruit	A letter signed by an authorized official at the Coast Guard recruiting unit
The contractor shall not provide services under this contract to personnel who do not have the required authorizations listed above.	

Section B - Health Care Services Invoice Review and Auditing

1. General.

   a. All health care invoices are subject to review and audit to ensure the Coast Guard pays only for necessary, appropriate health care for its beneficiaries.

      (1) The auditing process ensures the contractor's invoice charges for services provided at either reasonable fees or those in agreement with the contract.

      (2) The review process determines the appropriateness of care for the diagnosis.

   b. Personnel performing the review and audit functions must remember if they find discrepancies, they must give the care provider the opportunity to comment on the findings.

   c. The process of health care invoice auditing and review is complex and lends itself to errors; thus, most reviews and audit inquiries are not dismissed. Finding must be presented in a non-threatening manner, demonstrating the Coast Guard's willingness to cooperate with our health care providers in determining fair, equitable charges.

2. Invoices Subject to Review and Audit. These contract and non-contract health services invoices are subject to review and audit. The unit processing the invoice should review bills in these categories before paying them:

   a. All outpatient invoices contractors submit;

   b. All inpatient and outpatient supplemental care.

3. Review and Audit Procedures. The personnel processing health care invoices should perform these procedures:

   a. Review.

      (1) Is the diagnosis compatible with the prescribed care?

      (2) Are ancillary services (e.g., lab, x-ray, pharmacy, electrodiagnostic tests, etc.) prescribed appropriately in amount and frequency?

      (3) Is the length of care appropriate for the diagnosis?

   b. Audit. Does the contractor's invoice meet the contract definition of a proper invoice? If not, notify the contracting officer immediately.

      (1) Is the bill mathematically correct?

      (2) Does it bill only for authorized care and services?

      (3) Were services and billed care actually furnished?

      (4) Do the charges agree with the provider's regular fee schedule or the prices listed in the contract?

(5) Does the bill give credit for incomplete, canceled, or partial treatments?

(6) Do dates of care match the time period the patient received the care or services?

(7) Have previous audits of this provider demonstrated billing errors?

Section C - Claims Processing

1. General. The Maintenance and Logistics Command, Health and Safety Division (MLC (k)) is responsible for processing Federal and nonfederal health care claims in compliance with the Federal Law and CG Regulations.

2. Certification. Certification ensures that only authorized payment services to eligible beneficiaries receiving health care within their entitlements and the care and related charges are appropriate. Commanders, MLC (k) shall

   a. Administratively screen each claim and supporting documents according to paragraph 3 below. Claims submission procedures from field units is provided by the MLC (k) Standard Operating Procedures.

   b. Technically screen claims and supporting document according to paragraph 4. below.. In screening, perform these actions:

      (1) Refer claims that do not satisfy the Technical Screen criteria to a medical audit staff for Appropriateness Review and/or audit.

      (2) Enter information from these claims into the Non-Federal Invoice Processing System (NIPS) data base and approve them for payment in this manner:

         (a) Claims that satisfy Administrative and Technical Screen criteria (including Active Duty Claims Program (ADCP) claims coded through a TRICARE Fiscal Intermediary).

         (b) Claims referred for Appropriateness Review and/or audit recommended for payment.

   c. Transmit payment data electronically to the Coast Guard Finance Center.

   d. Certify batch transmissions.

   e. Correct batch errors.

   f. Update vendor files.

3. Administrative Screen.

   a. Administrative screening of a claim package determines the patient's authorization and eligibility to receive billed services and also ensures the package contains all appropriate, necessary documents. At a minimum, administrative screening includes:

      (1) Patient information is present and complete.

      (2) Public Voucher for Purchases and Services other than Personal (SF-1164) is completed for reimbursement requests.

      (3) The claim is a complete, itemized original.

(4) A copy of CG-4899, Report of Potential Third Party Liability, is attached if a third party potentially is liable.

(5) Verification of pre-authorization number.

(6) Support documentation is complete for Reservists' bills.

(7) Claims for formal contracts have the contracting officer's signature and amount to be paid.

(8) Claims for clinic support contracts have a Coast Guard beneficiary breakdown.

b. Ensure that all claims that fail to satisfy the administrative screening are corrected by the unit through the most expeditious means possible.

4. Technical Screen.

a. Health care claims must be reviewed to ensure they comply with Federal regulations. Part of that process compares claim packages to standard criteria to withstand the scrutiny of Departmental Accounting and Financial Information System (DAFIS) for payment. Technical screening of claim packages includes:

(1) Comparing charges against contract fee schedules, pre-authorizations, blanket purchase agreements, or the geographic area's usual and customary fees; claims falling within ADCP guidelines are exempt from fee review;

(2) Entering relevant claim information into NIPS;

(3) Determining whether services were appropriate for the diagnosis; and

(4) Identifying claims requiring further review under these circumstances:

(a) Unrelated charges to the initial diagnosis or injury.

(b) Duplicate charges for services received on a given day.

(c) Care was unauthorized or unnecessary.

(d) Claims submitted by different providers for the same service (e.g., anesthesiology charges from more than one provider).

(e) NIPS "flagged" the claim.

(f) The reviewer "feels" a need for further review.

b. Claims a Technical Screen identifies for further review and/or audit require:

(1) Documentation of the problem, and

(2) A recommended course of action.

5. Appropriateness Review.

a. An appropriateness Review is performed under these circumstances:

(1) MLC (k) selects or NIPS flags a claim for further review and/or audit for a Technical Screen; and/or

(2) Periodically for quality assurance.

b. An Appropriateness Review requires:

(1) An itemized claim;

(2) A patient's signed "Request for Medical Records" DD-877 or it's equivalent, to request medical records and other information about an individual's care. Various records, which may include:

(a) Hospital records,

(b) Physician's orders,

(c) Physician and nursing progress notes,

(d) Lab and x-ray reports,

(e) Operative or endoscopic reports,

(f) Admission records (history and physical examinations), and

(g) Discharge summaries.

c. An Appropriateness Review process often involves these activities:

(1) Reviewing records to verify:

(a) The treatment or therapy was:

1 Appropriate for the diagnosis,

2 Consistent with currently accepted medical practice, and

3 Not duplicated unnecessarily.

(b) The length of inpatient hospitalization was appropriate for the diagnosis and course of care.

(c) The charges were reasonable; claims falling within ADCP guidelines are exempt from fee review.

(2) Obtaining additional documentation and/or correspondence from health care providers.

(3) Initially notifying health care providers of this information:

(a) Their claims are being reviewed and audited.

(b) The audit is a normal part of the Coast Guard's health care review process and does not indicate or allege the health care provider committed a offense; and

(c) If reviewing cases for longer than 30 days, periodically communicate with health care providers to inform them of claim status.

d. An Appropriateness Review may recommend:

(1) Full payment for services. Enter data into and process through NIPS.

(2) Partial payment for services. Attach decision documents; recommend the amount of payment; and enter data into NIPS. Initiate a reimbursement request if the claim initially was overpaid.

(3) Consulting a specialist for peer review.

(4) Referral to a contractor for further review or an on-site hospital audit.

(5) Closing the case with no further action.

e. An Appropriateness Review includes:

(1) Fully documenting the decision process,

(2) Initiating payment or the provider's reimbursement, and

(3) Drafting appropriate correspondence.

6. Peer Review.

a. A Peer Review will be performed under these circumstances:

(1) A health care provider objects to other reviews' findings, or

(2) An Appropriateness Review reveals the need for a more sophisticated evaluation of the diagnosis, prognosis, or specific medical procedures employed.

b. Send the case and health care provider's additional documentation (if any) to a qualified medical, pharmaceutical, or dental specialist for review. These services should be contracted if in-house specialists are not available

c. Peer Review may include these detailed examinations:

(1) Diagnosis;

(2) Prognosis;

(3) Appropriateness of the care provided;

(4) Claims submitted to a Fiscal Intermediary for pricing are exempt from fee review.

(5) Selection of the most cost-effective therapy.

d. Among other things a pharmacist's review of pharmaceutical bills and supporting documents may:

(1) Determine the efficacy of prescribed medication;

(2) Identify cost-effective choices; or

(3) Recommend stocking pharmaceuticals for future issuance.

7. Guidelines for Initial Appropriateness and Peer Reviews. These common health care services guidelines are not all-inclusive. Appropriateness and Peer Reviews should be used to assist reviewers in deciding whether in-hospital audits or contracted review services are required.

a. Trauma. Answer these questions:

(1) Does the level of care correspond to the diagnosis?

(2) Were appropriate facilities used?

(3) Were laboratory and x-ray procedures appropriate? Include justification for:

(a) Repeating procedures on a given day;

(b) Repeating normal procedures;

(c) Failing to follow up abnormal tests.

(4) Were iatrogenic complications were identified appropriately? Include:

(a) Sepsis,

(b) Wound dehiscence,

(c) Hemorrhage,

(d) Pulmonary complications,

(e) Cardiovascular complications (thrombophlebitis, etc.),

(f) Urinary tract infection,

(g) Anesthetic or other drug reactions (appropriate drug and dosage, known allergies), and

(h) Other associated injuries.

(5) The length of stay was appropriate for the diagnosis and indicated complications.

(6) The discharge diagnosis was compatible with admission diagnosis and the patient's history.

(7) The patient's physical status on discharge:

(a) Alive,

(b) Complications were controlled,

(c) Wound(s) condition was satisfactory,

(d) Required follow-up arrangements are listed, and/or

(e) Medications were prescribed.

(8) Follow-up care was appropriate, including:

(a) Therapy,

(b) Office visits, and

(c) Additional hospitalization was for a good reason, e.g., iatrogenic complications, continued therapy, or additional surgeries.

(9) Fees are usual and customary for the geographic area (claims falling within ADCP guidelines are exempt from fee review).

(10) The use of multiply providers is explained.

(11) Providers' and reviewers' differences in medical opinion (particularly involving altered treatment and length of hospital stay) are significant enough to warrant negotiation.

b. Laboratory Services. Answer these questions:

(1) Are tests related to or necessary for the diagnosis?

(2) Were ICU standing orders in effect?

(3) Were tests repeated excessively?

(4) Were charges duplicated for the same procedure on the same day?

(5) Were tests repeated due to equipment or operator error?

(6) Were tests repeated despite normal previous test(s) (justification is required)?

(7) Were there multiple charges for the same or similar tests?

(8) Were multiple tests performed in a logical sequence (i.e., the most invasive or sophisticated performed last)?

(9) Were fees usual and customary (claims falling within ADCP guidelines are exempt from fee review);

(10) For a laboratory under Coast Guard contract, were:

(a) Tests covered by the contract?

(b) Charges within fee schedule?

c. Radiology Services. Considerations:

(1) Was the examination required given the diagnosis?

(2) Were charges for portable radiology of an ambulatory patient?

(3) Were examinations repeated?

(4) Were bilateral x-rays appropriate (patients over 12 years of age)?

(5) Were charges or exams of the same anatomical part duplicated?

(6) Do examinations and in-patient dates coincide?

(7) Were examinations repeated despite normal findings in previous examinations?

d. Physical Therapy. Considerations:

(1) Was the injury or diagnosis properly documented? Did it include:

(a) Objective findings?

(b) Functional findings?

(c) Multiple provider discrepancies?

(d) Documentation of improvement?

(2) Did a physician prescribe treatment?

(3) Were injury management and treatments reasonable and necessary? Did they cover these:

(a) Was the treatment plan documented?

(b) Did objective findings permit the therapist and/or physician to monitor treatment results?

(c) Were changes in the treatment program due to unsuccessful results?

(d) Was treatment only for subjective complaints?

(e) Was the treatment related to diagnosis?

(f) Did the treatment follow standard procedures and protocols?

(g) Did the treatment plan include goals and objectives?

(4) Was the length or number of treatments excessive?

(5) Was treatment consistent or continuous or did patient attend sporadically?

(6) Did therapy continue after "Fit-For-Duty" status?

(7) Did therapy charges continue during stays in cardiac or intensive care units.

(8) Were charges duplicated for same-day, apparently inappropriate treatments?

(9) Was therapy frequency within accepted standards?

(10) Were same-day charges for three or more modalities during a single therapy session.?

(11) Were charges usual and customary (claims falling within ADCP guidelines are exempt from fee review).

e. Dentistry.

(1) For provider contract care, were:

(a) Services within the contract scope?

(b) Charges within fee schedules?

(2) For emergency care, were:

(a) Services within the scope of entitlements?

(b) Charges reasonable and customary?

(3) For care pre-authorized in Chapter 2-A-6, did any of these occur?

(a) Did the MLC assign a pre-authorization number?

(b) Were services within the authorized, standard treatment plan?

(c) Were treatments split to circumvent pre-authorization requirements?

(4) For all dental services, do any of these apply?

(a) Were services duplicated?

(b) Were billings for the same service duplicated?

(c) Were diagnosis charges consistent with services received?

(d) Were crowns constructed of precious metals?

(e) Are laboratory charges consistent with the service provided (bridges, crowns, partial or full dentures)?

f. Pharmacy.

(1) For contract providers, were services within the scope of the contract?

(2) For inpatient care, do any of these apply?

(a) Were billings duplicated?

(b) Was credit received for returned or unused medications?

(c) Did medication and in-patient dates coincide?

(d) Did medications' cost exceed 250 percent of Annual Pharmacists' Reference ("Red Book") average wholesale price (Note: This equals a 150 percent markup.)? Claims falling within ADCP guidelines are exempt from fee review.

CHAPTER 12

OCCUPATIONAL MEDICAL SURVEILLANCE AND EVALUATION PROGRAM (OMSEP)

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CHAPTER 12. OCCUPATIONAL MEDICAL SURVEILLANCE AND EVALUATION PROGRAM (OMSEP)

Section A - General Requirements.

1. Description.

   a. The work environment and occupational activities inherent to Coast Guard missions can expose personnel to health hazards with the potential for disease or injury. The Occupational Medical Surveillance and Evaluation Program (OMSEP) is designed to identify work related diseases or conditions, through baseline and periodic examinations, at a stage when modifying the exposure or providing medical intervention could potentially arrest disease progression or prevent recurrences. The fundamental purpose of this program is to identify pre-existing health conditions, provide risk specific periodic screenings, and monitor clinical laboratory tests and biologic functions suggestive of work related environmental exposures. All OMSEP enrollees receive periodic physical examinations, in accordance with Occupational Safety and Health Administration (OSHA) requirements, for the duration of their health hazard exposure or end of their employment. Individuals are released from active surveillance at the end of their exposure. In accordance with OSHA regulations, the OMSEP personnel tracking database containing the name, social security number, billet or occupation code, applicable examination protocols, and next physical examination due date remains active for an additional 30 years.

   b. The OMSEP is the physical examination process for the Coast Guard's Occupational Health Program. The guidance for this program is outlined in the Safety and Environmental Health Manual, COMDTINST M5100.47 (series). OMSEP replaces the present version of the physical exam process described in the SEH Manual as the Occupational Medical Monitoring Program (OMMP).

2. Enrollment**.**

   a. Coast Guard Medical Surveillance Action Level: The medical surveillance action level (MSAL) is the level of worker exposure, determined by workplace sampling, at or above which occupational medical surveillance examinations will be performed. The Coast Guard MSAL will be 50% of the most stringent of the current OSHA permissible exposure limit (PEL),or, the most current American Conference of Governmental Hygienists (ACGIH) Threshold Limit Value (TLV).

   b. Determination of Occupational Exposure.

      (1) An employee is considered occupationally exposed for OMSEP purposes if a noise exposure or hazardous condition is likely to occur **30 or more days per year**. Documentation of the exposure must meet the following criteria: quantitative work-site sampling measurements indicate hazard levels at or above the MSAL or that the exposure can reasonably be determined, in the absence of quantitative sampling, to exceed the MSAL.

      (2) Quantitative sampling is the primary and definitive means to characterize workplace health hazards, although personal sampling measurement is preferred to workplace sampling. Coast Guard Safety and Environmental Health Officers

(SEHOs) using guidance contained in the Safety and Environmental Health Manual, COMDTINST M5100.47 (series) will generally perform this function. SEHOs will normally characterize workplaces by frequency of exposure, type of exposure, and risk groups.

(3) Certain occupations or exposures may require surveillance by federal statutes, DOT regulations, or Safety and Environmental Health Manual, COMDTINST M5100.47 (series) without regard to the 30-day exposure threshold.

(4) Competent environmental health authority is considered to be the cognizant SEHO but the authority may be delegated to other recognized and approved personnel with the necessary technical training and abilities. Qualitative assessments must be based on expected type, frequency, mode, and duration of hazard exposure, and are considered temporary until validated by quantitative means.

c. Enrollment Criteria: Recommendations for enrollment are based on specific job assignments and the level of worker exposure. This process is initiated at the unit level and must be finalized by the IH or cognizant SEHO, with recommendations from the supervising medical officer (if necessary), before forwarding to Maintenance and Logistics Command (MLC (k)) for inclusion into the OMSEP database (see section 12-A-3-(a)-3). This centralized database will be maintained by MLC (k) and will be accessible to the commands in accordance with privacy act requirements. Personnel will be enrolled in the OMSEP if either of the following criteria are met:

(1) Personnel identified as occupationally at risk/exposed to hazardous chemicals or physical agents at levels documented or reasonably determined to be above the CG Medical Surveillance Action Level (MSAL) for that hazard,

(2) Personnel actively engaged for 30 or more days per calendar year in the following occupations will be enrolled in OMSEP, unless an IH investigation determines individuals are not exposed to toxic chemicals or physical hazards: resident inspectors, pollution investigators, marine safety (general), port safety (general), vessel inspectors or marine investigators; and fire fighters.

(3) Note: New OMSEP enrollees maybe considered for enrollment under the guidelines of the Hazardous Waste protocol, which provides the most through surveillance for those with unknown hazardous risks and no prior history of exposures. However, the unit IH or cognizant SEHO may recommend enrollment using the medical surveillance protocol considered most appropriate.

3. Reporting Requirements.

a. Examination Reports:

(1) Required forms: OMSEP physical examinations require completion of the most current version of CG Form 5447 (6-01) in addition to forms DD-2808 and DD-2807-1. Other OMSEP specific forms and their uses are presented in Section 12-B (also see Table 12-B-1.) Uses of routine medical record forms are presented in Chapter 4 of this Manual.

(2) Record keeping: OMSEP personnel records will be handled in the same manner as other medical records (see Chapter 4 of this Manual) with the following exceptions: all x-ray, laboratory test, and related reports of examinations or

procedures done for OMSEP purposes, as well as the medical record cover, shall be clearly labeled "OMSEP." All OMSEP examination reports, including all laboratory data, must be entered into the individual's health record and maintained in accordance with OSHA regulations. The member's medical record custodian will maintain all OMSEP medical records on file for the duration of employment. Upon separation or retirement, all records concurrently labeled "OMSEP" will be maintained, for an additional 30 years, as required by OSHA regulations [29 CFR 1915.1120].

(3) OMSEP database: MLC (k)'s will maintain an electronic database of all OMSEP enrollees based on enrollment information provided by the local units. The OMSEP personnel tracking database should include, at a minimum, the member's name, social security number (SSN), billet or occupation code, applicable examination protocols, and next physical examination due date. The handling of all data in the OMSEP database will comply with Privacy Act requirements.

(4) Substitutions: OMSEP examination forms may **not** be substituted for other examination forms. If another examination is anticipated/required, (i.e. FLIGHT, RELAD) at the same time as the OMSEP examination the appropriate forms for each particular examination should be provided to the examiner so they may be completed at the same time. Duplicate laboratory tests are not required, so long as all specific tests and procedures required for each exam are completed and reported.

(5) Exposure data records: Any available exposure data, from workplace surveys, industrial hygiene personal or area monitoring, material safety data sheets, or assigned IH/SEHO other appropriate sources, will be provided by OMSEP coordinator to the examining medical officer as part of the examination packet. These data should be supplied by the local unit, in coordination with the supporting industrial hygienist, prior to the examination. The protocols in Section 12-C, in addition to OSHA regulations, specify what exposure surveillance data must be maintained and made available to the examining medical officer.

b. Tracking Report: Individual units, in coordination with the cognizant SEHO, are responsible for creating and managing a roster of all OMSEP enrollees and providing the designated medical officer advisor (DMOA)/clinic and MLC(k)'s with an updated report. Once fully implemented medical officers will be able to access this information through the OMSEP database. Updates to the tracking report will be possible by placing the information directly into the database. This will preclude the need for any additional written reports. The report should include all information cited in Section 12-A-3(a)(3) and will form the basis for the OMSEP database.

c. Sentinel Occupational Health Event Reporting: The occurrence of a new illness or disease, which is likely associated with an occupational exposure or condition, may be considered a "sentinel event." Such an event may serve as a warning signal that the quality of preventive measures may need to be improved. In order to facilitate timely intervention, the initial diagnosis of any such diseases must be reported IAW Section 7-B of this Manual. A complete list of reportable occupational diseases is found in Figure 7-B-2.

4. Medical Removal Protection. It is the responsibility of the commanding officer to assure a safe and healthy working environment. The finding of a work-related illness or injury, which could be further exacerbated by continued exposure to a workplace hazard or condition, requires immediate evaluation to determine whether the worker must be at least temporarily removed from further exposure. A recommendation to remove the member should be made by the examining medical officer and cognizant SEHO, in coordination with the unit's Commanding Officer. (See section 12-B-4-b).

5. Roles and Responsibilities**.** The OMSEP is part of a larger and more comprehensive surveillance process requiring the coordinated effort of various district units and local commands working to secure the safety and health of Coast Guard workers. Key personnel have been identified as essential in maintaining a sound occupational health prevention program. Following is a description of their expected roles and responsibilities in this process: NOTE: For the purposes of this Chapter all references to employees, workers, personnel will be assumed to be part of the ONE DOT/CG TEAM concept. Rules, regulations, and directives apply equally to ALL unless otherwise specified.

   a. Units/Commands: Each unit must appoint an OMSEP coordinator, usually the Safety Coordinator (SC) or the Safety and Occupational Health Coordinator (SOHC), or Independent Duty Corpsman. Even if units are under one servicing clinic, the unit is still required to appoint an OMSEP coordinator and manage their respective database. The OMSEP coordinator is responsible for updating the roster of OMSEP enrollees and maintaining the unit's OMSEP personnel tracking report, ensuring OMSEP examinations are completed in a timely fashion, and ensuring all available exposure data is available to the medical officer at the time of the OMSEP examination.

   b. MLC (k): MLC (k)'s will ensure that SEHO/IH work-site monitoring and reporting is completed and entered into the appropriate database. Additionally they will provide oversight to the local units ensuring the accuracy and completeness of the OMSEP personnel tracking report. The MLC (k)'s medical officers will provide oversight over the physical examination consultation and referral process. MLC (k)'s will also provide indicated guidance and or training to HS personnel on examination practices and procedures.

   c. SEHOs: SEHOs will be required to review all requested OMSEP enrollments from the unit OMSEP Coordinators. SEHOs will approve or disapprove requested enrollments through the on-line database. Disapprovals need to be explained to the requesting unit. To substantiate enrollments, SEHOs will be required to conduct and update quantitative and/or qualitative IH assessments of their units' workplace environment. SEHOs will be required to have these written assessments available to the medical officer for review, if requested, to determine the appropriate medical surveillance protocol to use. SEHOs will also be required to provide training and day-to-day consultation with their unit OMSEP Coordinators on database management.

   d. Commandant (G-WKS): Commandant (G-WKS) will provide planning, development, and expertise on occupational health issues. G-WKS is responsible for policy making, procedural decisions, and ensuring currency of Chapter 12 of the Medical Manual with OSHA standards. The G-WKS occupational medicine medical officer will provide support on physical examination problems and review all diagnosed occupational health related abnormalities encountered by the on-site provider. A yearly report, updating the

status of the member's abnormalities, will be provided to onsite providers. G-WKS is the final authority on decisions of any OMSEP related problems.

e. Medical Officer's Responsibilities:

(1) Medical Diagnosis coding. The examining medical officer is responsible for explaining and/or following any abnormalities through to a resolution. All diagnoses made must be appropriately coded using ICD-9CM diagnostic coding, or most current version. ICD codes should be noted in parentheses next to the diagnosis on the examination report and be reported to the fifth digit.

(2) Written assessment or opinion. Whenever a physical exam is performed, the examining medical officer must include the following information **in writing** as part of the record of each examination. This information should be included in the appropriate blocks.

(a) The occupationally pertinent results of the medical examination.

(b) An opinion about adequacy of the information available to support any diagnosed occupational disease(s), if appropriate.

(c) Any recommended limitations to the employee's assigned work.

(d) A statement that the employee has been informed about the results of the examination.

(e) Any additional written information required by the protocols listed in Section 12-C.

f. Medical Administrators:

(1) Support. Medical Administrators are responsible for providing administrative assistance on all OMSEP related matters. This support should extend to :

(a) All units within the designated AOR.

(b) Contracted medical providers and their respective facilities.

(c) IDT's.

(2) OMSEP report/worksite data. Medical Administrators should interact with OMSEP coordinators within their AOR to ensure currency of the roster of enrollees and ensure that work-site information is received in a timely matter. Worksite exposure information, reported history of past exposures and safety data sheets should precede the physical examination to give the medical officer ample time to reach an educated decision.

(3) Physical Examinations/Medical Records. The Medical Administrator is responsible for the following clinic functions in support of OMSEP:

(a) Timely scheduling of physicals.

(b) Providing qualified technicians to perform the indicated laboratory and radiological procedures.

(c) Ensuring proper calibration of equipment, and

(d) Compliance with quality assurance standards.

g. Civilian Employees: Civilian OMSEP enrollees may be entitled to services provided by Coast Guard medical facilities should a determination be made by a medical provider, that an adverse health condition resulted from a work place exposure. Employees are expected to report and explain any illnesses or injuries resulting from exposure sources outside their primary duty station or from other non-occupational settings. Should a determination of an injury or illness, resulting from an exposure at the workplace, be made by a medical provider, civilian appropriated fund employees should contact their servicing civilian Command Staff Advisor (CSA) for assistance in making a claim with the Department of Labor. Non-appropriated fund employees (NAF) should contact their immediate supervisor and/or personnel liaison office. The services provided by the Coast Guard facilities will be only to establish an occupationally-related illness/injury. Further medical care should be provided by the civilian employee's health care provider.

h. Others: In the event of an emergency situation with heavy exposure (e.g., fire, spill), 24-hour assistance is available from the Agency for Toxic Substances Disease Registry (ATSDR) at the Centers for Disease Control and Prevention. Call 404-498-0210.

Disease Registry (ATSDR) at the Centers for Disease Control and Prevention. Call 404-639-0615-6360.

LIST OF ABBREVIATIONS

ACGIH	American Conference of Governmental Industrial Hygienists
ALT	Alanine aminotransferase
AST	Aspartate amino transferase
BUN	Blood urea nitrogen
CBC	Complete blood count
CNS	Central nervous system
CXR	Chest x-ray
DOT	Department of Transportation
EL	Excursion limit (OSHA mandated maximal "safe" airborne concentration of a substance)
FVC	Forced vital capacity
FEV-1	Forced expiratory volume at one second
ICD-9	International Classification of Diseases, 9th Revision (coding system for medical diagnoses.)
IH	Industrial hygiene or industrial hygienist
LDH	Lactic dehydrogenase
MCV	Mean corpuscular volume
MCH	Mean corpuscular hemoglobin
MCHC	Mean corpuscular hemoglobin concentration
MLC (k)/(kse)	Maintenance and Logistics Command: (k)-medical; ((kse)-safety & environmental health.
MO	Medical officer (physician, physician's assistant or nurse practitioner)
MSAL	Medical surveillance action level (Defined in 12-A-3)
OMSEP	Occupational Medical Surveillance and Evaluation Program
OSHA	Occupational Safety and Health Administration
PEL	Permissible exposure limit (The OSHA mandated TWA airborne exposure limit)
PFTs	Pulmonary function tests

LIST OF ABBREVIATIONS (continued)

RBC	red blood cell
SC	Safety Coordinator
SEHO	Safety and Environmental Health Officer
SOHC	Safety and Occupational Health Coordinator
STEL	Short-term exposure limit (The maximal "safe" airborne concentration of a substance)
STEL/C	Short-term exposure limit/ceiling (maximal "safe" airborne concentration of a substance)
STS	Significant threshold shift
TB	Tuberculosis
TLV	Threshold limit value (ACGIH) (The TWA airborne concentration of a substance)
TST	tuberculin skin test (Mantoux)
TWA	time-weighted average
U/A	Urinalysis

Section B - Administrative Procedures.

1. General: All medical examinations and procedures required under the OMSEP shall be performed by or under the supervision of a licensed medical officer and an accredited laboratory shall perform all laboratory tests. Timely completion and monitoring of scheduled examinations is essential in identifying work related health hazards and any specific health effects. All tests required as part of an OMSEP examination should be completed prior to and the results made available to the health care provider at the time of the physical examination. This requirement may be waived if travel or time costs make separate visits impractical. **The provider is required to review, approve (sign), and explain any abnormalities. Any unexplained, examination finding, laboratory abnormality, or test result must be referred to a certified Occupational Health Clinic/provider for further evaluation.**

2. Examination Types.

   a. Initial/baseline. Baseline examinations are required before placement in a specific job in order to assess whether the worker will be able to do the job safely, to meet any established physical standards, and to obtain baseline measurements for future comparison. Each baseline examination shall consist of all of the elements specified under the appropriate surveillance protocol(s) in Section 12-C. Table 12-B-1 also summarizes the required forms and tests for a baseline examination under each of the surveillance protocols. In the event that the employee is being monitored under more than one protocol, each unique form or test need only be completed once for a particular examination.

      (1) An initial examination is required for all employees prior to employment. The employee may not be exposed to a potential health hazard until the physical examination is completed. In the event of scheduling delays, this requirement may be waived, if the employee completes ALL the necessary laboratory tests specified under the appropriate surveillance protocol(s). The physical examination must still be completed at the earliest possible date, but not beyond 30 days after the initial date of employment. Longer delays will require temporary removal. Workers who transfer from operational to administrative positions on a frequent basis during the same duty assignment may, with medical officer approval, receive a periodic physical vice a complete baseline examination upon re-entering the hazardous work site.

      (2) All employees must have a physical examination prior to reassignment to any position with an occupational health hazard exposure as defined in Section 12-A-2-b. This requirement is subject to the stipulation described above in Section 12-B-2-a-1.

      (3) Any employee actively monitored in the OMSEP, identified, as at risk of exposure to a new health hazard requiring additional protocols, should have an initial examination performed for the new potential exposure(s). The employee may not be placed at risk of exposure until the examination is completed. During such an examination, both the initial examination requirements for the additional protocol and the periodic examination requirements for the original protocol(s) should be met. This requirement is subject to the stipulation described above in Section 12-B-2-a-1.

b. Periodic.

(1) Once enrolled in the OMSEP, periodic examinations will be performed at the required interval for the duration of the health hazard exposure. Periodic examinations are generally provided at twelve-month intervals, though under some exposure protocols, the period between exams may vary. Each periodic examination shall consist of all of the elements specified under the appropriate surveillance protocol(s). See Section 12-C. and Table 12-B-1. If an employee is being monitored under more than one protocol, each form or test need only be completed once during a particular examination.

(2) Periodic laboratory monitoring may be required under certain protocols (e.g., lead, pesticides) or special situations. These examinations consist of the specified **laboratory tests only**, and are usually performed in accordance with the specific protocol or as often as deemed necessary by the medical provider.

c. Acute Exposure.

(1) An acute health hazard exposure examination is required, under some protocols, (e.g., benzene, hazardous waste, noise, solvents), when the applicable short-term exposure limit (STEL) ceiling limit of the substance(s) in question is exceeded. The requirement applies whether or not the employee exhibits any overt symptoms of acute exposure. Specific requirements, if any, for an acute exposure examination are found under the protocols in Section 12-C.

(2) An acute health hazard exposure examination is recommended if the employee exhibits any adverse effects following an acute exposure to a suspected hazardous substance. If the substance(s) is identified, an examination should be performed following the specific protocol(s) for that substance(s). In the event no specific substance is identified, an examination should be directed according to the "Unspecified" examination protocol and presenting symptoms. The Acute Chemical Exposure Information form (Figure 12-B-1) should be used to collect and organize information when an acute exposure occurs. The information on this form must accompany the employee to his/her examination.

(3) All HAZMAT response personnel with a documented exposure event, including Coast Guard Strike Team members and firefighters, must complete an Acute Chemical Exposure Information form (Figure 12-B-1) at the end of each HAZMAT response. Special attention must be provided to the type, duration and degree of toxicity of the agent(s) encountered as well as the type of contact (inhalation, skin absorption, ingestion). The type of PPE utilized, type of respirator (if any), and protective clothing worn should also be noted. This information is to be entered in the member's medical record.

d. Exit/Separation (Employment/Exposure). Exit exams are designed to assess pertinent aspects of the worker's health when the worker leaves employment or when exposure to a specific hazard has ceased. Results may be beneficial in assessing the relationship of any future medical problem to an exposure in the workplace. Exit physical examinations must be completed within 30 days of the last day of exposure or employment. The worker may not be re-assigned to a hazardous area once the examination is completed. In the event the worker is exposed to a hazardous substance, after completing the examination, ALL laboratory tests required by the specific protocol for that particular

substance must be repeated (see Table 12-B-1 and Section 12-C). The following conditions also apply:

(1) End of Exposure:

(a) OMSEP enrollees assigned to a non-hazardous work environment but likely to be assigned to a designated area later in their career.

(b) Workers who transfer from operational to administrative positions on a frequent basis may, with medical officer approval, receive an update to their periodic physical vice a complete exit (end of exposure) examination. This does not preclude a complete exit/separation examination upon the end of employment.

(c) Individuals enrolled in the OMSEP, with exposures to known carcinogens or agents with prolonged latency periods for disease development (e.g., asbestos, benzene), will receive an end of exposure exam upon reassignment to non-hazardous area and continue to receive updates to their periodic physicals according to the designated protocol(s). These individuals will be monitored for the duration of their Coast Guard career unless the responsible supervising medical officer or other cognizant medical authority determines such monitoring is not required.

(2) End of Employment:

(a) OMSEP enrollees permanently separating from Coast Guard employment should receive an end of employment examination.

(b) The member's permanent home of record and phone number must be secured for notification of any abnormalities.

(c) A copy of the member's occupational health history, including all potential exposure agents, severity and duration of exposure, and any recommendations on future protocol testing or examinations, must be placed in the member's medical record. A personal copy should also be provided to the member. (see Section 12-B-3-j).

e. Timing of next examination. The default interval between examinations is one year for all protocols except respirator wear and prior (not current) exposure to asbestos, in which case the default interval is **five years**. However, exams may be recommended as infrequently as biennially for employees monitored solely under the protocols for chromium compounds, hazardous waste, solvents, and unspecified exposures. **A medical officer may recommend for any individual patient a shorter interval between examinations than the default period, if such is medically indicated**. Any recommendation on the timing of the next examination should be included as part of the physician's written assessment.

3. Use of OMSEP Forms.

a. CG Form 5447 (6-01) (History and Report of OMSEP Examination).

(1) This form must be completed whenever an OMSEP physical examination is required, except when only annual hearing conservation program is needed. Ensure that the examinee and medical officer identifying information are accurately recorded, including phone numbers.

(2) For an initial examination, all history sections on the CG-5447 must be completed. For subsequent examinations, as an alternative to completing all the blocks in history Sections I through IV, the examinee may choose to initial the statement above each section noting that there have been no changes during the interval from the last examination.

b. OSHA Respirator Medical Evaluation Questionnaire-(mandatory). This questionnaire is to be completed by any worker who is to be issued a respirator or assigned to a task that may require a respirator.

c. CG-5140 (Audiometric Biological Calibration Check). This form is to be used to record calibration of the audiometric equipment.

d. CG-5552 (Audiology History Questionnaire). This form provides a chronological record of audiologic symptoms and recreational noise exposure. It should be initiated at the time of enrollment in the hearing conservation program and OMSEP surveillance for occupational noise exposure. This form must be updated at each subsequent annual audiogram and reviewed by the responsible medical officer.

e. DD Form 2215 (Reference Audiogram). This form is used to record initial audiometric test results.

f. DD Form 2216 (Hearing Conservation Data). This form is used to record the results of periodic and follow-up audiometry for individuals routinely exposed to hazardous noise. This form should be preceded by a reference audiogram (DD Form 2215 or other record) already on file in the individual's health record.

g. Notification of Summary Results. A sample of this form is provided in Figure12-B-2. A photocopy or a locally generated form may be used to provide the required notification to the enrollee of the results of his/her OMSEP examination.

h. Acute Chemical Exposure Information Form. This form is used to record the results of any unexpected exposures and for verification of notification of the appropriate agencies. A sample of this form is provided in Figure 12-B-1.

i. Separation Letter. This letter serves as notification of the member's documented exposure(s) while serving in the US Coast Guard. It provides the nature and levels of exposure(s), if known, and the medical provider's comments and recommendations A copy is to be placed in the member's record and another provided directly to the member. A sample of the separation letter is provided as Figure 12-B-4.

j. Patient Notification. The medical officer is responsible for notifying the patient of any and all abnormalities found or diagnoses made, whether or not they are occupationally related or simply an incidental finding. Notification must be made within 30 days of

completion of the examination and should be documented as a medical record entry (see Figure 12-B-2).

4. Medical Removal Standards

   a. The following abnormal laboratory findings during an OMSEP examination mandate immediate removal of the employee from further workplace exposure to the hazard listed, pending resolution of the abnormality or a determination that the abnormality is not due to a workplace exposure. The medical officer should coordinate all medical removal recommendations with the cognizant SEHO before forwarding to the commanding officer (CO).

      (1) Benzene (**any** of the following):

         (a) The hemoglobin/hematocrit falls below the laboratory's normal limit and/or these indices show a persistent downward trend from the individual's pre-exposure norms; provided these findings cannot be explained by other means.

         (b) The thrombocyte (platelet) count varies more than 20% below the employee's most recent prior values or falls below the laboratory's normal limit.

         (c) The leukocyte count is below 4,000 per mm3 or there is an abnormal differential count.

      (2) Lead: A blood lead level at or above 40µg/100 ml of whole blood.

      (3) Noise: A loss of hearing of $\geq$ 35 dB in either ear at one or more of the speech frequencies (500, 1,000, 2000, or 3000 Hz), compared with the **current** reference audiogram.

      (4) Organophosphate pesticides: cholinesterase level at or below 50% of the pre-exposure baseline.

   b. Pregnancy is not a reason for automatic medical removal from the workplace. A decision to remove or restrict a pregnant woman must be based on sound clinical judgment after careful consideration of the workplace environment and the woman's physical capabilities. The woman's pre-natal health care provider (obstetrician) should be apprised early of any/all potential hazards and safety precautions available.

5. Reporting of Examination Results.

   a. Coast Guard medical officers will have 30 days from completion of the examination to meet all medical officer responsibilities in Section 12-B-4.

   b. Contractual providers, IDTs, and other detached HSs/units must forward all OMSEP examination questions, problems, and any unresolved matters, with accompanying supporting information, to the assigned CG medical officer for review within 15 days of receipt (includes the examination and any additional testing or consultations).

   c. All records must be forwarded to the record custodian upon compliance with Sections 12-B-6- (a) and 12-B-6 (b) above.

TABLE 12-B-1

REQUIRED FORMS AND TESTS FOR VARIOUS OMSEP EXAMINATIONS AND PROTOCOLS

Exam Type Exposure Protocol	Initial/ Baseline	Periodic	Exit/Separation	Acute Exposure	Biological Monitoring
Asbestos	CG 5447 *OSHA Resp. Quest. DD-2808/ DD-2807-1 Stool guaiac (a)* PFTs "B" reader CXR CBC Multichem panel U/A w/ micro	CG 5447 (update) Stool guaiac (a)* PFTs "B" reader CXR(b)* CBC Multichem panel U/A w/ micro	CG 5447 (update) Stool guaiac (a)* PFTs "B" reader CXR CBC Multichem panel U/A w/ micro	N/A	N/A
Benzene	CG 5447 DD-2808/ DD-2807-1 CBC w/ diff Multichem panel U/A w/ micro	CG 5447 (update) CBC w/ diff Multichem panel U/A w/ micro	CG 5447 (update) CBC w/diff Multichem panel U/A w/ micro	CG 5447 (update) Urinary phenol CBC w/ diff Acute Exposure Form	Only under special circumstances . Contact G-WKS-3.
Chromates	CG 5447 DD-2808/ DD-2807-1 CXR PFTs CBC Multichem panel U/A w/ micro	CG 5447 (update) PFTs CBC Multichem panel U/A w/ micro	CG 5447 (update) CXR PFTs CBC Multichem panel U/A w/ micro	N/A	N/A

* OSHA Medical Evaluation Respiratory Questionnaire. Note: DD Forms 2493-1/2493-2 Asbestos Report may be required at medical DOD facilities.

TABLE 12-B-1 (Continued)

Exam Type Exposure Protocol	Initial/ Baseline	Periodic	Exit/Separation	Acute Exposure	Biological Monitoring
Hazardous Waste	CG 5447 DD-2808/ DD2807-1 vision screening CXR PFTs CBC w/ diff Multichem panel U/A w/ micro	CG 5447 (update) vision screening PFTs CBC w/ diff Multichem panel U/A w/ micro	CG 5447 (update) vision screening CXR PFTs CBC w/ diff Multichem panel U/A w/ micro	CG 5447 (update) Acute Exposure Form PFTs CBC w/ diff Multichem panel U/A w/ micro Heavy metal screen (c)*	Only under special circumstances. Contact G-WKS-3.

NOTES: *(a) only if patient is age 35+ or otherwise clinically indicated.

*(b) B-reader chest x-rays will be done at periodic examinations according to the following schedule:

Years since first exposure	Age of examinee 15 to 35	36 to 45	over 45
0 to 10	Every 5 yrs.	Every 5 yrs.	Every 5 yrs.
Over 10	Every 5 yrs.	Every 2 yrs.	Annually

*(c) Heavy metal screen includes blood lead, cadmium, mercury, and arsenic levels.

TABLE 12-B-1 (Continued)

Exam Type Exposure Protocol	Initial/ Baseline	Periodic	Exit/Separation	Acute Exposure	Biological Monitoring
Lead	CG 5447 DD-2808 DD-2807-1 Blood lead & ZPP CBC w/ diff Multichem panel U/A w/ micro	CG 5447 (update) Blood lead & ZPP CBC w/ diff Multichem panel U/A w/ micro	CG 5447 (update) Blood lead & ZPP CBC w/ diff Multichem panel U/A w/ micro	CG 5447 (update) **Acute Exposure Form** Blood lead & ZPP CBC w/ diff Multichem panel U/A w/ micro	Blood lead, ZPP
Noise	CG-5552 DD Form 2215 *	CG-5552 (update) DD Form 2216 *	CG-5552 (update) DD Form 2216 *	CG-5447 (update) DD Form 2216 *	N/A
Pesticides	CG 5447 DD-2808 Dd-2807-1 Blood cholin-esterase, twice PFTs CBC w/ diff Multichem panel U/A w/ micro	CG 5447 (update) Blood cholin-esterase (d)* PFTs CBC w/ diff Multichem panel U/A w/ micro	CG 5447 (update) Blood cholin-esterase (d)* PFTs CBC w/ diff Multichem panel U/A w/ micro	CG 5447 (update) Acute Exposure Form Blood cholin-esterase (d)* PFTs	Blood cholinester ase (c)*

Note: DD Forms 2215/2216 remain active and are to be properly recorded and maintained in the member's medical record. DOD facilities continue to use these forms or an electronic equivalent.

CG facilities may continue to use these forms; an equivalent locally reproduced form or electronic version as long as they comply with regulations set forth in Chapter 4 of this Manual.
NOTES: *(d) Blood cholinesterase only required if exposure includes organophosphate and/or carbamate pesticides.

TABLE 12-B-1 (Continued)

Exam Type Exposure Protocol	Initial/ Baseline	Periodic	Exit/Separation	Acute Exposure	Biological Monitoring
Respiratory Sensitizers	CG 5447 DD-2808 DD-2807-1 PFTs CBC w/ diff Multichem panel U/A w/ micro	CG 5447 (update) PFTs CBC w/ diff Multichem panel U/A w/ micro	CG 5447 (update) PFTs CBC w/ diff Multichem panel U/A w/ micro	CG 5447 (update) Acute Exposure Form PFTs	N/A
Solvents	CG 5447 DD-2808 DD-2807-1 CBC w/ diff Multichem panel U/A w/ micro	CG 5447 (update) CBC w/ diff Multichem panel U/A w/ micro Biological moni-toring (if possible)	CG 5447 (update) CBC w/ diff Multichem panel U/A w/ micro	CG 5447 (update) Acute Exposure Form Specific blood or urine tests for specific solvents.	Specific blood or urine tests for specific solvents. (See Section 12-C-11.d.)
Respirator wear only	CG 5447 ** OSHA Resp Quest	**ORQ (update)	N/A	N/A	N/A

* Respiratory: OSHA Respiratory Questionnaire, this form is provided at the unit level (worksite), (Reference Section 12-c-9.

TABLE 12-B-1 (Continued)

Exam Type Exposure Protocol	Initial/ Baseline	Periodic	Exit/Separation	Acute Exposure	Biological Monitoring
Tuberculosis	CG 5447 DD-2808 DD-2807-1 Mantoux skin test (e)*	Mantoux skin test (e)*	Mantoux skin test (e)*	Mantoux skin test (e)*	N/A
Unspecified	CG 5447 DD-2808 DD-2807-1 CBC Multichem panel U/A w/ micro	CG 5447 (update) CBC Multichem panel U/A w/ micro	CG 5447 (update) CBC Multichem panel U/A w/ micro	CG 5447 (update) CBC Multichem panel U/A w/ micro	Only under special circumstances. Contact G-WKS-3.

NOTES: *(e) Personnel with a history of reactive tuberculin skin tests should be monitored for development of symptoms of active TB. A CXR should be done **only** if the skin test is newly reactive.

FIGURE 12-B-1

ACUTE CHEMICAL EXPOSURE INFORMATION

Last Name, First Name, M.I.			**Rank/Rate** **SSN**
1. Name(s) of chemical(s):	_____	_____	_____
2. CAS number(s), if known:	_____	_____	_____
3. Physical form:	☐ Solid ☐ Liquid ☐ Gas/Vapor ☐ Aerosol	☐ Solid ☐ Liquid ☐ Gas/Vapor ☐ Aerosol	☐ Solid ☐ Liquid ☐ Gas/Vapor ☐ Aerosol
4. Chemical form:	☐ Acid ☐ Alkali ☐ Organic solvent	☐ Acid ☐ Alkali ☐ Organic solvent	☐ Acid ☐ Alkali ☐ Organic solvent
5. Modes or routes of exposure:	☐ Inhalation ☐ Ingestion ☐ Skin	☐ Inhalation ☐ Ingestion ☐ Skin	☐ Inhalation ☐ Ingestion ☐ Skin
6. Exposure date, time & duration:	Date/time _____ Duration _____ minutes	Date/time _____ Duration _____ minutes	Date/time _____ Duration _____ minutes

7. Brief description of the incident:

8. Observed symptoms: _____

9. Associated injuries: _____

10. Personal Protective Equipment Used:

Notify District/ISC Safety & Environmental Health Officer, cognizant MLC (kse), and G-WKH-3.

11 Further guidance received:

Contact ATSDR emergency response line at 404-498-0210 to obtain further guidance.

12. ATSDR guidance:	Prescribed tests:	Time limits for specimens	Other

Attach Material Safety Data Sheet (MSDS) and shipping manifest to this form, if available.

(Use reverse for continuation or reporting of additional information.)

FIGURE 12-B-2

OMSEP

NOTIFICATION OF SUMMARY RESULTS

Date of Examination: _____
Patient: _____ SS#:_____

Address:	Phone #

Reference. (a) Medical Manual, COMDTINST M6000.1(series).

1) An environmental health evaluation has determined that you may have been exposed to the following health hazards at your workplace:

_____

_____

2) Your physical examination was conducted in accordance to reference (a).
There ***ARE*** / ARE ***NOT*** abnormalities in your physical examination and laboratory testing.

NOTED ABNORMAL PHYSICAL FINDINGS OR LABORATORY TESTS	RESULT/INTERPRETATION

3) Additional comments on your Occupational Medical Surveillance and Evaluation physical

_____

_____

_____

_____

Name and Title of Health Care Provider: _____

_____

Signature of Health Care Provider: _____
Date:_____

FIGURE 12-B-3

HISTORY AND REPORT OF OMSEP EXAMINATION

1. Last Name, First Name, M.I.	2. Grade/Rate/Rank	SSN	Date of Examination
5. Home Address (apt#, street#, street name, city, state, zip)	6. Work/duty phone ( )	8. Unit Name and Location (*city & state)*	
	7. Home phone ( )	9. Unit OPFAC#	10. Unit Zip Code

11. Date of birth & age	12. Sex (*M or F)*	13. Race or Ethnicity	14. Occupation or usual duties (describe)
16. Examining facility name & location *(○city, state)*		17. Purpose of Examination O Initial/Baseline O Periodic O Acute exposure O Exit/Separation	15. How many years have you worked in this occupation?

I. Occupational History *(patient must complete)*

_____ Initial here if there have been **NO** changes to your occupational history since your last exam and go to section **II**.

18. Are you exposed to any of the following in your *present job,* yes or no?

Y	N		Y	N	
		Asbestos (fibers, dust)			Hazardous wastes (or spills)
		Benzene (liquid or vapor)			Radiation (x-ray, microwave
		Lead (dust or fumes)			Loud noise
		Liquid chemicals (various)			Vibration (jackhammer)
		Chemical vapors or gases			Extreme heat
		Dust (sawdust, blasting)			Extreme cold
		Metals or metal fumes			Mental or emotional stress
		Entry into closed spaces (tanks, voids)			Human bodily fluids, or infectious agents

19. Do you wear any of the following on your present job, yes or no?

Y	N		Y	N	
		Earplugs or muffs			Safety glasses
		Dust mask			Welding face-mask
		Half-face respirator			Rubber gloves
		Full-face respirator			Protective body suit
		Air-line respirator			Other, list below:

Y	N	
		20. Have you had any difficulty wearing your protective clothing or equipment? (If you don't need to wear any, answer "no.")
		21. Have you had any work-related illness or injury?
		22. Have you been limited in your work for health reasons?
		23. Have you left or changed jobs due to health reasons?
		24. Have you had a work-related experience, which you believe may have affected your health or the health of fellow workers?
		25. Do you have any hobbies or outside activities, which would expose you to any of the hazards listed in 18, above? If Yes, explain:

II. Family History *(patient must complete)*

_____Initial here if there have been **NO** changes in the answers to the following questions since your last exam and go to section **III**.

26. Have any of your blood relatives (mother, father, brother, sister, grandparents, aunts, uncles, children) had any of the following illnesses or problems, yes or no?

Y	N	
		Anemia, blood disease, or bleeding tendency
		Asthma, hayfever, or allergies
		Birth defects or multiple miscarriages
		Cancer, leukemia, or other malignancy
		Diabetes (high blood sugar)
		Eye trouble or blindness
		Epilepsy, fits, or convulsions
		Hearing trouble or deafness
		Heart trouble, high blood pressure, or stroke
		Kidney trouble (stones or kidney failure)
		Lung trouble (cystic fibrosis, bronchitis, emphysema)
		Some other disease or condition which runs in your family, if so list:

III. Social History*(patient must complete)*

_____Initial here is there have been **NO** changes in the answers to the following questions since your last exam and go on to section IV.

27. Cigarette smoking history.

Y	N		
		Do you smoke cigarettes now?	
		If NO: Did you ever smoke cigarettes?	
		If you smoked before, what year did you stop?	
		How many years had you smoked?	
		How many packs per day?	
		If YES: How many years have you smoked?	
		How many packs per day?	

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Section III. Social History (continued)

28. Other smoking history:				29. Alcohol use history:			
Y	**N**			**Y**	**N**		
		Do you smoke cigars or a pipe now?				Do you drink any alcoholic beverages (beer, wine, liquor)?	
		If NO: Did you ever smoke cigars or a pipe?				If YES: How many bottles/cans of beer per week?	
		If you smoked before, what year did you stop?				How many glasses of wine per week?	
		How many years had you smoked?				How many ounces of liquor per week?	
		How many cigars or pouches per week?				30. Do you use any other recreational drugs? If so, list below.	
		If YES: How many years have you smoked?					
		How many cigars or pouches per week?					

IV. Personal Health History *(patient must complete)*

_____ Initial here if the answers to the following questions are all "**NO**" and there have been no changes since your last exam, then go to item 32.

31. Have you *recently* had or do you *now have any* of the following symptoms or complaints, yes or no?

Y	N		Y	N		Y	N		Y	N	
		Unexplained weight loss			Difficulty sleeping			Chest pain or angina			Birth defects in your children
		Fever or chills			Red or irritated eyes			Palpitations or irregular heart			Pain or blood with urination
		Skin rashes or ulcers			Visual disturbances or changes			Other heart trouble			Muscle pain or weakness
		Lumps you can feel			Sinus trouble (pain, discharge)			Abdominal pain			Joint pain or swelling
		Severe or recurrent headaches			Nosebleeds			Gastritis or peptic ulcers			Limitations of motion
		Dizziness or vertigo			Sore throat, trouble swallowing			Jaundice or yellowing skin			Back pain
		Fainting or passing out			Pain or swelling in neck			Nausea or vomiting			Numbness, tingling in extremities
		Seizures or epilepsy			Frequent coughing			Constipation			Anemia ("low blood")
		Trouble concentrating			Coughing phlegm or blood			Diarrhea or runny stools			Easy bruising or bleeding
		Mood changes, irritability			Wheezing or asthma			Bloody or tarry stools			HIV/AIDS
		Tiredness or fatigue			Shortness of breath			Infertility or miscarriages			Cancer or leukemia

32. In general, would you say your health is (check one): Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐

33. List any medications you are currently using, or state "none".

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34. List any allergies you know you have, or state 'none".

35. Additional space for comments and explanations of your "yes" answers:

All information provided will be handled in accordance with Privacy Act requirements, and will not be otherwise disclosed.

I hereby certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge.	Signature of patient	Date

FIGURE 12-B-3 (cont'd)

Occupational Exposure History

_____Patient initial here if there have been **NO** changes in the answers to the following questions since last exam and proceed to Part 2.	_____Medical Officer/SEHO initial here for verification of hazardous exposure and monitoring.

INSTRUCTIONS: Please complete the following history beginning with present job or military assignment. Additional copies of this sheet may be added if necessary

36. List all known hazardous exposures:

Agents(s) (noise-metals-solvents)	Date (from - to)	Location (work site)	Protective equipment used

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All information provided will be handled in accordance with Privacy Act requirements, and will not be otherwise disclosed.

I hereby certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge.	Signature of patient	Date

FIGURE 12-B-3 (cont'd)

MEDICAL OFFICER'S SECTION

Part 2

1. Last Name, First Name, M.I. *(of patient)*	2. Grade/Rate/Rank *(of patient)*	3. SSN *(of patient)*	4. Date of Examination
5. Examining facility or examiner name and address:			6. Facility phone number ( )

7. Surveillance protocols followed *(check all that apply)*

☐ Asbestos ☐ Chromium compounds ☐ Lead ☐ Pesticides ☐ Respiratory sensitizers ☐ Unspecified

☐ Benzene ☐ Hazardous waste ☐ Noise ☐ Respirator wear ☐ Solvents ☐ Other:____

8. Medical Officer Initial Here: _____ Verify completion of DD-2808 & DD-2807-1. Initial Baseline _____

9. General prevention counseling provided to patient 9check any that were addressed with patient)

☐ Tobacco cessation ☐ Physical activity ☐ Weight reduction ☐ HIV/STD's avoidance ☐ Injury prevention

☐ Alcohol or drug abuse ☐ Nutrition (low-fat/salt) ☐ Stress reduction ☐ Breast/testicular self exam ☐ Other:_____

10. List current diagnoses by ICD-9 code number and name: *(If no exactly corresponding ICD-9 code is available, use the closest code to the named diagnosis.)*

ICD-9	Diagnosis	ICD-9	Diagnosis

11. In your opinion, was the information to you adequate to support any listed diagnoses of occupational disease? ☐ YES ☐ NO

12. Respirator wear This examinee ☐ Is medically approved for respirator wear. *(Comment on any restrictions or limitations)* ☐ Is not

13. CONCLUSIONS: This examinee ☐ Has medical conditions which limit his/her performance of duties. *(Specify any limitations)* ☐ Does not have

14. Next OMSEP examination should be in ☐ 12 mos. ☐ Other_____

15. Examinee was informed about the results of this examination_____(date).

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Printed or typed name (rank) and degree of examining medical officer	Signature of examining medical officer	Date

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FIGURE 12-B-4

OMSEP

SEPARATION LETTER

NAME: _____ SSN:_____
DATE:_____

You have been enrolled in the Coast Guard's OCCUPATIONAL MEDICAL SURVEILLANCE AND EVALUATION PROGRAM (OMSEP). During the past _____years you received periodic physical examinations based on Occupational Health Safety Organization (OSHA) protocols for the following known potentially hazardous exposures:

_____
_____
_____
_____

Your occupational (work-related) history also indicates suspected exposure to the following agents:

_____
_____
_____
_____
_____

At the time of your EXIT/SEPARATION medical examination you were found to be in good health with no evidence occupational induced disease. However, it is recommended that you continue to receive medical examinations on a periodic basis based on age indicated guidelines. In addition, the periodicity of the examination should be modified to allow for adequate detection and prompt intervention on disease processes resulting from the latent effects of occupational hazardous substances. Your medical provider should follow OSHA mandated recommendations, for the aforementioned hazardous substances, in determining the frequency and level of care you require. NOTE: if a member is found to have an occupational related disease process at the time of separation, indicated medical referral measures will be instituted.

Any questions relating to this member's occupational health history can be obtained by contacting the US Coast Guard's Office of Safety and Environmental Health at # 202-267-1883.

Medical officer signature

- This letter should printed on official Coast Guard Letterhead for inclusion in members official health record.

Section C - Medical Examination Protocols.

1. General.

   a. The following protocols follow the same format. Each contains a brief description of the hazard and its possible effects; the conditions required for an individual to be surveyed under that protocol; information which must be provided to the examining medical officer; specific requirements of the history and physical, including laboratory tests and special procedures; and any additional written requirements on the part of the examining medical officer. The protocols are summarized in Figures 12-C-1 through 12-C-12. Copies of these figures may be locally reproduced. The unit OMSEP coordinator should complete the information in the first eight blocks at the very top, and the appropriate protocol summary figure(s) should be provided to the examining medical officer with the examination packet.

   b. Multiple protocols for a single individual. In the event that an individual is being monitored on more than one protocol (e.g., asbestos and noise), the final examination packet must include each of the required items for each of the protocols. However, each required form or test need only be completed once.

   c. *Past* exposure. Personnel who have a documented history of workplace exposure to known carcinogens**,** but who are not currently exposed, shall be offered an annual medical examination, according to this protocol until end of employment. Undergoing this examination is strictly voluntary.

2. Asbestos (Figure 12-C-1).

   a. Exposure effects. Asbestos exposure can cause asbestosis, bronchogenic carcinomas, mesothelioma, and gastric carcinoma. It may also be associated with multiple myeloma and renal carcinoma. Disease risk is dose dependent. There is a synergistic effect between asbestos exposure and cigarette smoking, so that the risk of lung cancer is roughly ten times greater in asbestos-exposed workers who smoke as opposed to nonsmoking asbestos-exposed workers. The primary route of exposure is inhalation, though ingestion of fibers may also occur.

   b. Required surveillance.

      (1) All personnel with current employment exposure to airborne asbestos, who meet the MSAL criteria in Section 12-C-2- (4) below, shall undergo medical surveillance. These personnel shall be included in the OMSEP and be examined according to the protocol in Section 12-C-2.d below. Medical examinations shall be provided upon enrollment and at least annually thereafter, throughout the duration of exposure or until end of employment, whichever comes first. Under current Coast Guard policies for management of asbestos, very few non-shipyard workers should be currently exposed at or above the PEL or EL.

      (2) Construction worker standard. The OSHA standard for asbestos applies to, but is not limited to, workers who demolish, remove, alter, repair, maintain, install, clean up, transport, dispose of, or store asbestos containing materials.

      (3) The current MSALs are based on the OSHA exposure standard for shipyards [29 CFR 1915.1001].

(a) For other than shipyard and construction workers, medical surveillance is required for those employees who are or will be exposed at or above the PEL as an 8 hour time-weighted average, or above the EL averaged over 30 minutes, regardless of the number of days of exposure.

(b) For shipyard and construction workers, medical surveillance is required for those workers:

1 Who remove any asbestos-containing materials, or who perform repair and maintenance operations in which asbestos-containing materials are likely to be disturbed, is such work is performed for a combined total of 30 or more days per year, regardless of fiber levels;

2 Who are exposed at or above the PEL or EL for a combined total of 30 or more days per year; or

3 Who are required to wear positive pressure respirators while performing asbestos-related work, regardless of the number of days respirators are worn.

c. Information to medical officer. The following information must be provided to the examining medical officer, by the OMSEP coordinator, prior to the examination taking place:

(1) A copy of the OSHA asbestos standards [29 CFR 1915.1001], with appendices D and E.

(2) A description of the affected employee's duties as they relate to the employee's exposure.

(3) The employee's representative exposure level or anticipated exposure level.

(4) A description of any personal protective or respiratory equipment used or to be used.

d. Examination protocol.

(1) Each initial, periodic, and exit examination shall include, as a minimum:

(a) A medical and work history. Emphasis should be placed on the member's history of tobacco use (smoking), and associated symptoms of dyspnea on exertion, recurrent epigastric discomfort, pleuritic chest pains or unexplained cough.

(b) Completion of the OSHA Respiratory Medical Evaluation Questionnaire Appendix C to RP Standard 29CFR 1910.134. Note: additional information on asbestos reporting guidelines may be found at www.osha.gov.

(c) A complete physical examination of all systems, with emphasis on the respiratory system, the cardiovascular system, and digestive tract.

(d) A stool guaiac test, if the patient is age 35 or over.

(e) PFTs, including FVC and FEV1.

(f) Routine screening labs, including a CBC, multichemistry panel (including glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, LDH, and alkaline phosphatase), and U/A with microscopic.

(g) A postero-anterior (PA) CXR, in accordance with the schedule and interpretation requirements in Section 12-C-2-d(2) below;

(h) Any other tests or procedures deemed appropriate by the examining physician, including specialty consultations.

(2) Chest x-ray requirements:

(a) A PA CXR shall be performed at the initial examination and then according to the following schedule:

Years since	Age of examinee		
First exposure	15 to 35	36 to 45	over 45
0 to 10	Every 5 yrs.	Every 5 yrs.	Every 5 yrs.
Over 10	Every 5 yrs.	Every 2 yrs.	Annually

(b) A PA chest-x-ray shall be performed at the exit examination.

(c) All CXRs shall be interpreted and classified in accordance with a professionally accepted classification system and recorded following the format of the CDC/NIOSH (M) 2.8 form. A B-reader or a board eligible/certified radiologist using the ILO-U/C International Classification of Radiographs for Pneumoconiosis references shall only do the interpretation.

(d) Assistance in obtaining the location of the nearest B-reader is available from MLC (k).

e. Specific written requirements. In addition to the general requirements specified in Section 12-B-4-b, the examining physician must address the following in writing:

(1) Any detected medical conditions placing the employee at increased risk of health impairment from further asbestos exposure.

(2) The employee's ability to use respiratory and other personal protective equipment (see Section 12-C-9), and any limitations thereof.

(3) Employee notification of the results of the examination and any medical conditions resulting from asbestos exposure that might require follow-up.

(4) Employee notification of the increased risk of lung cancer attributable to the synergistic effects of asbestos and smoking.

3. Benzene (Figure 12-C-2).

a. Exposure effects. Benzene exposure can cause central nervous system depression, leukemia, aplastic anemia, and dermatitis. The primary route of exposure is inhalation

of vapors, though skin absorption may also occur. Within the Coast Guard, most benzene exposure occurs among marine inspectors and oil spill responders.

b. Required surveillance.

(1) The Coast Guard MSALs are based on the OSHA action level and PEL standards. Enrollment in the OMSEP is required for all personnel:

(a) who are or may be exposed to benzene at or above the current average exposure action level 30 or more days per year,

(b) who are or may be exposed to benzene at or above the current short-term exposure action level 10 or more days per year, or

(c) who served as resident inspectors, pollution investigators, marine safety officers, port safety officers, vessel inspectors, or marine investigators prior to 1990. These personnel are considered to have been exposed at/or above the MSAL unless otherwise documented.

(2) In addition to routine surveillance requirements above, if an employee is exposed to benzene in an emergency (fire, spill) situation, a urine specimen will be collected as soon as possible thereafter, but not later than 24 hrs. after the exposure, and an acute exposure examination will be performed within 72 hrs. of the exposure. Such an examination must contain a urinary phenol test on the collected urine specimen.

c. Information to medical officer. The following information must be provided to the examining physician, by the OMSEP coordinator, prior to the examination taking place:

(1) A description of the affected employee's duties as they relate to the employee's exposure.

(2) The employee's representative exposure level or anticipated exposure level.

(3) A description of any personal protective or respiratory equipment used or to be used.

d. Examination protocols.

(1) Each routine (non-acute exposure) initial, periodic, and exit examination shall include, as a minimum:

(a) A detailed history which includes:

1 past occupational exposure to benzene or any other hematological toxins, at work or at home;

2 a family history of blood dyscrasias, including hematological neoplasms;

3 a personal history of blood dyscrasias, including genetic hemoglobin abnormalities, bleeding abnormalities, abnormal function of formed blood elements; and of renal or liver dysfunction;

4 history of exposure to ionizing radiation;

5 smoking history, alcohol usage history, and all medicinal drugs routinely taken;

6 any current history of headache, difficulty concentrating, decreased attention span, short-term memory loss, mood lability, fatigue, dry skin, abnormal bleeding, anemia, or weight loss.

(b) a complete physical examination, (Ensure the patient is examined for mental status changes, dermatitis, and pallor.);

(c) a CBC and differential, with platelet count and RBC indices (MCV, MCH, MCHC);

(d) a multichemistry panel (includes glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, LDH, and alkaline phosphatase) and U/A with microscopic;

(e) any other tests or procedures deemed appropriate by the examining physician.

(2) Each acute exposure examination shall include, as a minimum:

(a) a brief summary of the nature of the exposure and investigation of any symptoms or complaints;

(b) a total urinary phenol level (mg/L) or a urinary phenol adjusted for urinary creatinine (mg/g creatinine), plus a CBC and differential, with platelet count, and RBC indices (MCV, MCH, MCHC). Plasma folate and B12 levels to rule out megaloblastic anemia if the MCV is elevated.

(c) any other test or procedure deemed appropriate by the examining physician may be performed, if available. Coast Guard medical providers are encouraged to contact G-WKS for advise and consultation in selecting the most applicable test or procedure. Alternatively, medical providers may contact any certified Occupational Health clinic provider, available in the local community.

(d) If either the total urinary phenol level is below 50 mg phenol/L of urine, or the urinary phenol adjusted for urinary creatinine is less than 250 mg/g creatinine, and the CBC is normal, no further testing is required. Otherwise, contact Commandant (G-WKS-3) for further requirements.

e. Specific written requirements. In addition to the general requirements specified in Section 12-B-4-b, the following must be addressed in writing by the examining medical officer:

(1) Any detected medical conditions, which would place the employee's health at greater than normal risk of material impairment from exposure to benzene.

(2) The medical officer's recommended limitations upon the employee's exposure to benzene or upon the employee's use of protective clothing or equipment and respirators.

(3) A statement that the employee has been informed by the medical officer of the results of the examination and any medical conditions resulting from benzene exposure which require further explanation or treatment.

4. Chromium Compounds (Figure 12-C-3).

a. Exposure effects. Hexavalent chromium compounds are known human carcinogens. They may also cause dermatitis, skin ulceration, occupational asthma, and nasal septum perforation. The primary routes of exposure are percutaneous absorption and inhalation. Chromates may be found in certain metal alloys, paints, and masonry cements. Within the Coast Guard, most chromate exposure is from the use of chromium containing paints.

b. Required surveillance. The Coast Guard MSALs are based on the ACGIH threshold limit values (TLVs). Medical surveillance is required for all personnel who are or may be exposed to chromium IV compounds at or above the current exposure action level 30 or more days per year.

c. Information to medical officer. The following information must be provided by the OMSEP coordinator to the examining physician prior to the examination taking place:

(1) A description of the affected employee's duties as they relate to the employee's exposure.

(2) The employee's representative exposure level or anticipated exposure level.

(3) A description of any personal protective or respiratory equipment used or to be used.

d. Examination protocols. Each routine initial, annual (periodic), and exit examination must include:

(1) A detailed history, which includes:

(a) Past and current occupational exposures to chromate, asbestos, or any other pulmonary carcinogens at work or at home;

(b) Smoking history and alcohol usage history;

(c) Any past or current history of dry skin, skin ulcers—usually painless, nosebleeds, asthma, shortness of breath, wheezing, or cough;

(2) A directed physical examination, with attention to the skin, mucous membranes, and respiratory tract, both upper and lower (ensure the patient is examined for erosion of the nasal mucosa and septum, respiratory rhonchi, dermatitis, and cutaneous ulcers);

(3) A CBC, multichemistry panel (includes glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, LDH, and alkaline phosphatase), and a U/A with microscopic;

(4) PFTs (including FVC & FEV_1);

(5) A PA CXR **only** for an initial/baseline or exit examination, unless there is a current clinical indication (cough, shortness of breath, wheezing, etc.);

(6) Any other tests or procedures deemed appropriate by the examining physician.

e. Specific written requirements. Other than the general requirements specified in Section 12-B-4-b, the physician should address:

(1) The periodicity of the next routine medical surveillance examination. Examinations will be provided annually unless the physician recommends a longer interval.

(2) The employee's ability to use respiratory and other personal protective equipment (see Section 12-C-9), and any limitations thereof.

5. Hazardous Waste (Figure 12-C-4).

a. Exposure effects. The OSHA medical surveillance protocol for hazardous waste operations and emergency response (HAZWOPER)[29 CFR 1910.120] involves medical surveillance for potential exposure to numerous metals and chemicals, usually in uncontrolled—spill, fire, disposal—situations. Therefore, there are no specific exposure effects to describe.

b. Required surveillance.

(1) Routine medical surveillance is required for employees involved in hazardous waste operations when any of the following conditions are met:

(a) Exposure or potential exposure to hazardous substances or health hazards at or above the MSAL for that substance (as defined in Section 12-A-4), without regard to the use of respirators or personal protective equipment, for 30 or more days per year.

(b) All hazardous waste operation employees who wear a respirator for 30 or more days per year or as required under Section 12-C-9.

(c) All employees who are injured, become ill, or develop signs or symptoms due to possible overexposure involving hazardous substances or health hazards from an emergency response or hazardous waste operation.

(d) Members of HAZMAT response teams, including all Coast Guard Strike Team members and firefighters.

(2) In addition to routine surveillance requirements above, if an employee is exposed to a hazardous substance above the Coast Guard MSAL in an emergency (fire, spill) situation, a urine specimen will be collected as soon as possible thereafter, but not later than 24 hrs after the exposure, and an acute exposure examination will be performed within 72 hrs of the exposure.

c. Information to medical officer. The examining medical officer shall be provided, by the OMSEP coordinator, one copy of the OSHA HAZWOPER standard [29 CFR 1910.120] and its appendices, plus the following specific information:

(1) A description of the employee's duties as they relate to the employee's exposures.

(2) The employee's exposure levels or anticipated exposure levels.

(3) A description of any personal protective equipment used or to be used, including any respirators.

(4) Information from previous medical examinations of the employee which is not readily available to the examining physician.

d. Examination protocols.

(1) Each routine (non-acute exposure) initial, periodic, and exit examination shall include, as a minimum:

(a) A medical and occupational history which includes:

1 past and current occupational exposure to hazardous chemicals, metals, dusts, fumes, and heat stress;

2 any history of heat illness, allergies, sensitivities, or physical abnormalities;

3 current medications, and immunization history;

4 smoking history, and alcohol usage history;

5 a complete review of organ systems.

(b) A complete physical examination with attention to the skin, eyes, nose, throat, and respiratory, cardiovascular, genitourinary, and neurologic systems;

(c) A CBC and differential, with platelet count, and RBC indices (MCV, MCH, MCHC);

(d) A multichemistry panel (includes glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, LDH, and alkaline phosphatase) and U/A with microscopic;

(e) PFTs (including FVC & FEV1);

(f) Vision screening;

(g) A PA CXR only for an initial/baseline or exit examination, unless there is a current clinical indication (cough, shortness of breath, wheezing, etc.);

(h) Any other tests or procedures deemed appropriate by the examining physician. (Consider a stool guaiac and/or electrocardiogram, if indicated by age or physical findings).

(2) Each acute exposure examination shall include, as a minimum:

(a) A brief summary of the nature of the exposure and investigation of any symptoms or complaints;

(b) A CBC and differential, with platelet count, and RBC indices (MCV, MCH, MCHC), a multichemistry panel (includes glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, LDH, and alkaline phosphatase) and a U/A with microscopic;

(c) PFTs (including FVC & FEV1);

(d) Appropriate biological monitoring tests (e.g., blood metal screen) depending on the exposure in question. Contact Commandant (G-WKS-3) for further information and requirements.

e. Specific written requirements. Other than the general requirements specified in Section 12-B-4-b, the physician should address:

(1) Whether the employee has any detected medical conditions which would place the employee at increased risk of material impairment of the employee's health from work in hazardous waste operations or emergency response, or from respirator use.

(2) The employee's ability to use respiratory and other personal protective equipment (see Section 12-C-9), and any limitations thereof.

(3) The periodicity of the next routine medical surveillance examination. Examinations will be provided annually unless the physician recommends a longer interval.

6. Lead (Figure 12-C-5).

a. Exposure effects. In adults, excessive lead exposure can cause hypertension, anemia, peripheral neuropathy, encephalopathy, spontaneous abortions in women, and decreased fertility in men. The primary route of exposure in adults is inhalation of lead containing dust or fumes. Most exposure in the Coast Guard occurs during removal of previously applied lead-based paint coatings, or during environmental recovery of previously discarded lead-acid batteries. Some welders may be exposed to lead fumes.

b. Required surveillance. The Coast Guard MSAL is based on the OSHA PEL standard for shipyards [29 CFR 1915.1025]. Enrollment in the OMSEP is required for all personnel who are or may be exposed to lead at or above the current exposure action level for 30 or more days per year.

c. Information to medical officer. The OMSEP coordinator shall provide the medical officer with one copy of the OSHA lead standard [29 CFR 1915.1025] and its appendices, plus the following specific information:

(1) A description of the employee's duties as they relate to the employee's exposure.

(2) The employee's exposure level or anticipated exposure levels to lead and to any other toxic substance (if applicable).

(3) A description of any personal protective equipment used or to be used, including any respirators (if known).

(4) Prior blood lead determinations.

(5) Information from previous medical examinations of the employee which is not readily available to the examining physician. This includes all available prior written medical opinions concerning the employee.

d. Examination protocols.

(1) Biological monitoring or "blood lead only" examinations must be provided to each employee exposed at or above the OSHA action level (currently TWA of 30 mg/ m^3 air) **every six months**. Otherwise, only annual examinations must be performed, unless an employee's blood lead level is found to be elevated at or above 40 mg/100 ml of whole blood.

(2) Each routine initial, periodic, exit, and acute exposure examination shall include, as a minimum:

(a) A detailed work history and a medical history, with particular attention to:

1 past lead exposure (occupational and non-occupational);

2 personal habits (smoking, handwashing after work and before eating);

3 past and current gastrointestinal, hematological, renal, cardiovascular, reproductive, and neurological problems.

(b) A complete physical examination with particular attention to:

1 occular fundi, teeth, gums, hematological, gastrointestinal, renal, cardiovascular, and neurological systems;

2 blood pressure (must be recorded);

3 pulmonary status should be evaluated if respiratory protection is to be used. (See Section 12-C-9).

(c) The following routine laboratory tests:

1 a CBC and differential, with platelet count, and RBC indices (MCV, MCH, MCHC), plus examination of peripheral smear morphology;

2 blood lead level and zinc protoporphyrin (must be performed by a laboratory licensed by the CDC for proficiency in blood lead testing);

3 a multi-chemistry panel (includes glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, LDH, and alkaline phosphatase);

4 a U/A with microscopic examination; and,

5 PFTs (including FVC & FEV 1).

(d) Any other tests or procedures deemed appropriate by the examining physician (pregnancy testing, laboratory examination of male fertility).

e. Specific written requirements. In addition to the general requirements specified in Section 12-B-4-b, the physician should address:

(1) Any detected medical conditions which would place the employee at increased risk of material impairment of the employee's health from exposure from lead, or from respirator use.

(2) The employee's ability to use respiratory and other personal protective equipment (see Section 12-C-9), and any limitations thereof.

(3) The results of the blood lead determinations.

7. Noise (Figure 12-C-6).

a. Exposure effects. The primary effect of excessive noise is to cause loss of hearing. This hearing loss may be described by three "p-words:" painless, progressive, and permanent. Cumulative overexposures to hazardous noise levels cause millions of people to lose hearing during their working lives.

b. Required surveillance. The Coast Guard MSAL is based on DOD Instruction 6055.12, DOD Hearing Conservation Program, as well as OSHA guidance [29 CFR 1910.95]. Enrollment in the OMSEP is required for all personnel who are or may be exposed to hazardous noise at or above the current exposure action level for 30 or more days per year. However, personnel who infrequently or incidentally enter designated "hazardous noise areas" need not participate in the audiometric testing program.

(1) Enrollment is required in accordance with the following criteria:

(a) When the member is exposed to continuous and intermittent noise that has an 8-hour time-weighted average (TWA) noise level of >85 decibels A-weighted (dBA), or is exposed to impulse noise sound pressure levels (SPLs) of 140 decibels (dB) peak, or greater, or

(b) When a threshold shift of > 35 dB is noted in the speech frequencies.

(2) Reference (baseline) audiograms:

(a) All personnel shall receive a reference audiogram prior to any Coast Guard occupational noise exposure or before they are assigned to duties in "hazardous noise areas".

(b) Every effort should be made to schedule the reference audiogram on civilian workers in order to avoid conflicts with assigned duties; military personnel shall receive their reference audiogram at initial entry training.

(c) Testing to establish a reference audiogram shall be preceded by at least 14 hours without exposure to workplace noise. Hearing protectors that attenuate workplace noise below a TWA of 85 dBA, may be used to meet this requirement, in place of exclusion from the noisy workplace.

(3) Exit audiograms: shall be conducted on all employees, previously enrolled in the "hearing conservation program", if it is determined the employee no longer works in a designated "hazardous noise area," unless that employee is moving to another Coast Guard position that also involves work in such areas. However, if the employee's audiogram shows hearing losses (compared to the reference audiogram) of greater than 35 dB in the speech frequencies (500 - 3000 Hz) the employee must continue to receive annual audiograms until end of employment.

c. Information to medical officer. The OMSEP coordinator must provide the examining medical officer with a description of the employee's duties as they relate to the employee's exposure, the dB level of the hazardous work area and a description of any personal protective equipment used or to be used (e.g., earplugs or earmuffs).

d. Examination protocols.

(1) Each routine (non-acute exposure) initial, periodic, and exit examination shall include completion or updating of an Audiology History Questionnaire (CG 5552) and audiometric testing (audiogram). All audiometric testing shall:

(a) Be performed by a licensed or certified audiologist, otolaryngologist, or other physician; or by a technician who is certified by the Council for Accreditation in Occupational Hearing Conservation or who has completed CG HS "A" school. A technician who performs audiometric tests shall be responsible to an audiologist, otolaryngologist, or other physician. Standard instructions shall be given to individuals before testing.

(b) Be conducted in a testing environment with background octave band SPLs not greater than 27 dB at 500 Hz, 29 dB at 1000 Hz, 34 dB at 200 Hz, 39 dB at 4000 Hz, and 41 dB at 8000 Hz. The test environment shall be surveyed annually to ensure these levels are not exceeded.

(c) Include pure tone, air conduction, and hearing threshold examinations of each ear at the test frequencies of 500, 1000, 2000, 3000, 4000, and 6000 Hz.

(d) Be performed on audiometers conforming to the most current calibration specifications of the American National Standards Institute (ANSI). Audiometers currently in operation must receive annual electroacoustic calibration to maintain certification.

(e) Occur on audiometers that have received a functional operations check before each day's use for specifications in the OSHA Occupational Noise Exposure standard [29 CFR 1910.95]

(f) Be recorded on DD Form 2215 (Reference Audiogram), or DD Form 2216 (Hearing Conservation Data), or equivalent locally reproduced versions as appropriate.

(2) Significant Threshold Shift (STS). Transcribe the reference audiogram test results into the "Reference Audiogram" spaces on the DD Form 2216, Hearing

Conservation Data (or equivalent). The reference levels are subtracted from the current levels at 2000, 3000, and 4000 Hz. The differences in hearing levels calculated at 2000, 3000, and 4000 Hz are added together and divided by three, for each ear. STS exists if the resulting average hearing loss in either ear is greater than or equal to ±10 dB [29 CFR 1910.95]. Additionally, any change of ±15 dB at 2000, 3000, or 4000 Hz in either ear shall constitute an STS. Results shall be recorded on DD Form 2216. Aging (presbycusis) can contribute to the change in hearing level. When determining whether an STS has occurred, note the following: The TRACOR microprocessor audiometer automatically corrects for aging. The National Institute for Occupational Safety and Health (NIOSH) age corrections shall **not** be applied when determining STS if a microprocessor audiometer is used for the test.

(3) A follow-up audiogram shall be conducted when an individual's audiogram shows an STS, in either ear, relative to the current reference audiogram. Medical evaluation is required to validate the existence of a permanent noise-induced threshold shift and/or to determine if further medical referral is required. An audiologist, otolaryngologist, or other knowledgeable physician shall perform the evaluation and determine if the noise-induced STS is/is not work-related or has/has not been aggravated by occupational noise exposure.

(4) When a negative STS (improvement in hearing threshold from the reference audiogram) is noted on the periodic audiogram, one 14-hour noise-free follow-up test is required. That may be administered on the same day as the periodic test. The results of the follow-up test may be used to create a re-established reference audiogram.

(5) When a positive STS (decrease in hearing threshold form the reference audiogram) is noted on the periodic audiogram, two consecutive 14-hour noise-free follow-up tests **must** be administered to confirm if the decrease in hearing is permanent. The follow-up exams may not be performed on the same day as the periodic audiogram The results of the second follow-up test may be used to reestablish a reference audiogram, **if the required medical evaluation validates the existence of a permanent noise induced threshold shift (see Section 12-3-d.(3) above)**. If the results of the first follow-up test do not indicate an STS, a second follow-up test is not required.

(6) A new reference audiogram shall replace the original reference audiogram when the medical evaluation confirms that the STS noted during the annual and follow-up audiograms is permanent. The original reference audiogram shall be retained in the patient's medical record.

(7) Acute exposure examinations (formerly called the Detailed Surveillance Program). These examinations are designed to observe any dynamic hearing loss, to identify those who demonstrate unusual noise sensitivity, or to monitor personnel acutely exposed to unprotected high levels of noise (impulse >140dba).

(a) The initial acute exposure examination shall consist of all elements described in Sections 12-C-7.d. (1)-(6), above. Additional follow-up audiograms will be performed at 30 and 90 days, or at more frequent intervals at the discretion of the medical officer.

(b) If any of the follow-up audiograms demonstrate an average loss of no more than 10 dB in 2000, 3000, and 4000 Hz in either ear, when compared to the revised reference audiogram, hearing may be considered stable. The reference audiogram (per Section 12-C-7-d (5) and (6)) remains the audiogram against which further testing is compared. The individual is returned to annual monitoring.

(c) If these reevaluation audiograms exhibit a loss greater than an average threshold of 10 dB in 2000, 3000, and 4000 Hz in either ear when compared to the revised reference audiogram, the individual must be referred to an otolaryngologist for a consultation. Final disposition will depend on the consultant's diagnosis and recommendations.

e. Specific written requirements. In addition to the general requirements specified in Section 12-B-4-b, the medical officer must do the following:

(1) The employee shall be notified in writing within 21 days, when an audiologist or a physician confirms a threshold shift is permanent. Such determination must be entered in the employee's medical record.

(2) Supervisors shall be notified, in writing, that the worker has experienced a decrease in hearing. Release of medical information must conform to privacy act requirements.

(3) Document that the patient was counseled concerning the potential seriousness of repeated unprotected exposures to excessive noise and provided additional information on hearing protection and avoidance of hazardous noise exposures.

8. Pesticides (Figure 12-C-7).

a. Exposure effects. There are over 1,200 chemical compounds currently classified as pesticides. However, this surveillance protocol is primarily concerned with only two classes of pesticides: organophosphate and carbamate insecticides, and chlorophenoxyacetic acid herbicides. Organophosphates and carbamates are inhibitors of the enzyme acetylcholinesterase and they cause parasympathetic nervous system hyperactivity (miosis, urination, diarrhea, defecation, lacrimation, salivation), neuromuscular paralysis, CNS dysfunction (irritability, anxiety, impaired cognition, seizures, coma), peripheral neuropathy, and depression of RBC cholinesterase activity. Chlorophenoxyacetic acid herbicides cause skin, eye, and respiratory tract irritation, cough, nausea, vomiting, diarrhea, abdominal pain, and peripheral neuropathy. In the past, some chlorophenoxyacetic herbicides were contaminated with dioxins during manufacture.

b. Required surveillance. The Coast Guard MSALs for carbaryl, chlorpyrifos, malathion, parathion, 2,4, -D, and 2,4,5,-T are based on the ACGIH threshold limit values. Enrollment in the OMSEP is required for all personnel who are or may be exposed to **any** identified pesticide at or above the MSAL (as defined in Sect. 12-A-2) for 30 or more days per year.

c. Information to medical officer. The OMSEP coordinator must provide the examining medical officer with:

(1) A description of the employee's duties as they relate to the employee's exposure.

(2) The employee's exposure level or potential exposure level to any pesticides.

(3) A description of any personal protective equipment used or to be used, including any respirators.

d. Examination protocols.

(1) Biological monitoring or "RBC cholinesterase only" examinations must be provided at least **every six months** to each employee exposed to organophosphate or carbamate pesticides at or above the MSAL. If an employee's RBC cholinesterase activity is found on any testing to be less than 80% of the pre-exposure baseline, the frequency of biological monitoring will be increased to at least **every three months during the application season**. Non-seasonal, acute exposures will be monitored at a frequency determined by the supervising medical officer based on exposure information data.

(2) Each routine (non-acute exposure) initial, periodic, and exit examination shall include, as a minimum:

(a) A detailed work history and a medical history, with particular attention to:

1 past and current exposure to pesticides or other chemicals (occupational and non-occupational);

2 smoking and alcohol use history;

3 any symptoms of eye, nose, or throat irritation; cough; nausea, vomiting, diarrhea, or abdominal pain; irritability, anxiety, difficulty concentrating, impaired short-term memory, fatigue, or seizures; numbness, tingling, or weakness in the extremities; and

4 allergic skin conditions or dermatitis.

(b) A complete physical examination, with attention to the skin, respiratory, and nervous systems, including a mental status examination, should be performed. Pulmonary status must be evaluated if respiratory protection is used. (See Section 12-C-9).

(c) The following routine laboratory tests:

1 A CBC, a multichemistry panel (includes glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, LDH, and alkaline phosphatase), and a dipstick U/A;

2 An erythrocyte (RBC) cholinesterase level.

3 **Initial examination only—two RBC cholinesterase tests must be drawn at least 24 hrs. apart**. The results of these two tests will be averaged to provide the pre-exposure baseline for future reference, unless they differ by more than 15% from each other, in which case,

additional testing must be performed until successive tests do not differ by more than 15%. The pre-exposure baseline blood tests must be drawn after a period of at least 60 days without known exposure to organophosphates.

(d) Any other tests or procedures deemed appropriate by the examining physician (e.g., cognitive function testing). Pulmonary function testing should be performed at least once every 4 years if the employee wears a respirator.

(3) Each acute exposure examination shall include, as a minimum:

(a) A medical and work history with emphasis on any evidence of eye, nose, or throat irritation; cough; nausea, vomiting, diarrhea, or abdominal pain; irritability, anxiety, difficulty concentrating, impaired short-term memory, fatigue, or seizures; numbness, tingling, or weakness in the extremities.

(b) A complete physical examination with attention to any reported symptoms as well as the skin, respiratory, and nervous systems. A mental status examination must be performed.

(c) An erythrocyte (RBC) cholinesterase level.

(d) Any other tests or procedures deemed appropriate by the examining physician (e.g., CBC, CXR, cognitive function testing, urinary metabolites—if less than 24 hrs. post acute exposure). Pulmonary function testing should be performed at least every 4 years if the employee wears a respirator.

e. Specific written requirements. In addition to the general requirements specified in Section 12-B-4, the physician should address:

(1) Any detected medical conditions, which would place the employee's health at increased risk from exposure to identified pesticides or from respiratory wear.

(2) Counseling on the possible increased risk of health impairment from working with certain pesticides, in the event that the employee was found to have skin disease, chronic lung disease, or abnormalities of the central or peripheral nervous system that could directly or indirectly be aggravated by such exposure.

9. Respirator Wear (Figure 12-C-8).

a. Exposure effects. The OSHA medical surveillance protocol for respirator wear is a means to assess the effectiveness of respiratory protection among exposed workers. Periodic examinations are required to assess continued fitness for duties and to assess whether the present respiratory protection program provides adequate protection against illness. Respirators are often extremely uncomfortable to wear for long periods. Workers with asthma, claustrophobia, angina, and other conditions may not be able to wear respirators effectively. The worker should be questioned for a history or symptoms of past and current exposures to hazardous chemicals; fumes and dusts; smoking and alcohol use histories; wheezing or abnormal breath sounds; clubbing; and cardiac arrhythmia.

b. Required surveillance.

(1) Initial Medical Determination. An initial/baseline examination will be performed at the time of assignment to a job requiring respirator wear. Before an employee may be issued a respirator or assigned to a task that may require a respirator, that worker must complete a mandatory OSHA Respirator Medical Evaluation Questionnaire. This questionnaire will be provided, at the local unit by the cognizant SEHO, to all workers expected to require the use of a respirator. This questionnaire serves as the initial medical examination. A health care professional (nurse, nurse practitioner, physician assistant, and physician) must review this questionnaire to determine if a follow- up medical examination is required. Independent duty technicians (IDT'S) are authorized to review the questionnaire but must refer any positive responses on questionnaire (or any other concerns) to the supervising medical officer for further review. Any employee who gives a positive response to any questions among questions 1-8 in section two of the questionnaire shall be subject to a follow-up medical examination. This examination will determine whether the worker is physically and mentally capable of performing the work and using a respirator [29 CFR 1910.134].

(2) Additional Medical Evaluation and Medical Examination.

(a) Additional medical examinations maybe required to assess continued fitness for duties involving respirator wear. The following conditions will dictate the need for a follow-up evaluation:

1 The member reports signs and symptoms related to the ability to use a respirator;

2 The health care provider, supervisor, or respirator program coordinator informs the command of the need for evaluation;

3 Observations are made during fit testing, respirator use, or program evaluation that indicate the need for evaluation;

4 When changes in workplace conditions such as physical work effort, protective clothing or climate conditions result in substantial increase in physiological burden;

5 A member's scheduled quintennial physical examination.

(b) Periodic physical examinations will be provided at least once every five years. The periodic physical examination requires a review and update of the respirator questionnaire. A health care provider must review the questionnaire to determine the need for a follow-up examination. A follow-up medical examination is required for anyone with positive responses to questions 1-8 in section two of the questionnaire.

c. Information to medical officer. The OMSEP coordinator must provide the examining medical officer with:

(1) A description of the employee's duties as they relate to the employee's respirator wear.

(2) The employee's exposures or potential exposures to any hazardous chemicals or physical agents.

(3) A description of the respirator(s) used or to be used.

d. Examination protocol. Each routine (non-acute exposure) initial and periodic examination shall include, as a minimum the completion of the mandatory OSHA Respirator Medical Evaluation Questionnaire.

e. Specific written requirements. In addition to the general requirements specified in Section 12-B-4, the physician should address:

(1) Any detected medical conditions that would place the employee at increased risk of material impairment of the employee's health from respirator use.

(2) Asthmatics with normal or mildly impaired lung function should be evaluated based on the job requirements, but disapproval should be strongly considered for asthmatics that require regular medications to maintain airflow, or who have a history of airway reactivity or sensitization to extrinsic materials (dusts, fumes, vapors, or cold).

(3) Note: There currently exists no consensus standard by which physicians may assess a worker's ability to wear a respirator. As a general rule, however, anyone with documented respiratory impairment of moderate to severe degree (FEV_1 or FVC <70% of predicted) should not be routinely approved to wear a respirator.

10. Respiratory Sensitizers (Figure 12-C-9).

a. Exposure effects. Respiratory sensitizers include numerous compounds which cause both occupational asthma and/or hypersensitivity pneumonitis (extrinsic allergic alveolitis). Respiratory sensitizers include vegetable dusts and woods, molds and spores, animal danders, metals (platinum, chromium, nickel, cobalt, vanadium), and chemicals (isocyanates, formaldehyde, trimellitic anhydride).

b. Required surveillance. The Coast Guard MSALs for formaldehyde, toluene diisocyanate, and vanadium, are based on the ACGIH threshold limit values. Enrollment in the OMSEP is required for all personnel who are or may be exposed to **any** identified respiratory sensitizer at or above the MSAL (as defined in Sect. 12-A-2) for 30 or more days per year. In the Coast Guard, exposure to respiratory sensitizers is primarily associated with industrial operations, though some marine inspection activities may also lead to exposures.

c. Information to medical officer. The OMSEP coordinator must provide the examining medical officer with:

(1) A description of the employee's duties as they relate to the employee's exposure.

(2) The employee's exposure level or anticipated exposure level to any respiratory sensitizers.

(3) A description of any personal protective equipment used or to be used, including any respirators.

d. Examination protocols.

(1) Each routine (non-acute exposure) initial, periodic, and exit examination shall include, as a minimum:

(a) A detailed work history and a medical history, with particular attention to:

1 past and current exposure to respiratory sensitizers (occupational and non-occupational);

2 smoking history;

3 any symptoms of eye, nose, or throat irritation;

4 chronic airway problems or hyperactive airway disease; and

5 allergic skin conditions or dermatitis.

(b) In the event that the employee is not required to wear a respirator and the history and routine laboratory tests are unremarkable, the medical officer may determine that a complete physical examination is not required. Otherwise, at a minimum, a system specific physical examination with attention to the respiratory system must be completed. Pulmonary status must be evaluated if respiratory protection is used. (See Section 12-C-9).

(c) The following routine laboratory tests:

1 a CBC, a multichemistry panel (includes glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, LDH, and alkaline phosphatase), and a dipstick U/A;

2 PFTs (including FVC & FEV_1).

(d) Any other tests or procedures deemed appropriate by the examining physician (e.g., CXR, bronchial provocation tests).

(2) Each acute exposure examination shall include, as a minimum:

(a) A medical and work history with emphasis on any evidence of upper or lower respiratory problems, allergic conditions, skin reaction or hypersensitivity, and any evidence of eye, nose, or throat irritation.

(b) A directed physical examination with attention to the respiratory system.

(c) PFTs (including FVC & FEV1).

(d) Any other tests or procedures deemed appropriate by the examining physician (e.g., CBC, CXR, bronchial provocation tests).

e. Specific written requirements. In addition to the general requirements specified in Section 12-B-4-b, the physician should address:

(1) Any detected medical conditions which would place the employee at increased risk of material impairment of the employee's health from exposure to identified respiratory sensitizers, or from respirator use.

(2) The employee's ability to use respiratory and other personal protective equipment (see Section 12-C-9), and any limitations thereof.

11. Solvents (Figure 12-C-10).

a. Exposure effects. There are over 30,000 industrial solvents. This protocol is designed to survey for the most frequent health effects of solvents when considered as an admittedly broad group. These effects are skin disorders (acute irritant dermatitis, chronic eczema), acute CNS effects (headache, nausea and vomiting, dizziness, light-headedness, vertigo, disequilibrium, fatigue, weakness, nervousness, irritability, depression, confusion, coma), and chronic CNS effects (chronic solvent intoxication, neurobehavioral abnormalities, cognitive dysfunction). Some other less frequent effects of solvents involve the hematopoietic, hepatic, peripheral nervous system, renal, reproductive, and respiratory systems. Most solvents are **not** carcinogenic to humans; benzene being a notable exception (see Section 12-C-3, above). In the Coast Guard, exposure to solvents is primarily associated with industrial and maintenance operations (e.g., painting).

b. Required surveillance. The Coast Guard MSALs for ethylene glycol, methyl ethyl ketone, VM & P naphtha, and xylene are based on the ACGIH threshold limit values. Enrollment in the OMSEP is required for all personnel who are or may be exposed to **any** identified hazardous solvent at or above the MSAL (as defined in Section 12-A-2) for 30 or more days per year. An acute exposure examination is required in the event of any documented overexposure (above the TLV or STEL) to a solvent or any presumed overexposure where symptoms are present. In the case of an acute overexposure, an appropriate urine or blood specimen should be collected as soon as possible after the overexposure incident.

c. Information to medical officer. The OMSEP coordinator must provide the examining medical officer with:

(1) A description of the employee's duties as they relate to the employee's exposure.

(2) The employee's exposure level or potential exposure level to any solvents.

(3) A description of any personal protective equipment used or to be used, including any respirators.

d. Examination protocols.

(1) Each routine (non-acute exposure) initial, periodic, and exit examination shall include, as a minimum:

(a) A detailed work history and a medical history, with particular attention to:

1 past and current exposure to solvents (occupational and non-occupational);

2 smoking history and alcohol use history;

3 any symptoms of dry skin, skin irritation, or dermatitis;

4 any CNS symptoms, including headache, nausea and vomiting, dizziness, light-headedness, vertigo, disequilibrium, fatigue, weakness, nervousness, irritability, depression, difficulty concentrating, mood changes, or confusion;

5 a review of symptoms with attention to the hematopoietic, hepatic, peripheral nervous system, renal, reproductive, and respiratory systems.

(b) A system specific physical examination, with attention to the skin and nervous systems, including a mental status examination, should be performed. Pulmonary status must be evaluated if respiratory protection is used. (See Section 12-C-9).

(c) The following routine laboratory tests:

1 a CBC and differential, with platelet count, and RBC indices (MCV, MCH, MCHC); and

2 a multichemistry panel (includes glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, LDH, and alkaline phosphatase) and a U/A with microscopic.

(d) Consideration should be given to biological monitoring tests for ongoing overexposure to certain solvents, if specimens can be obtained in a timely manner during the exposure period. For non-acute exposures, a timely manner generally implies that the specimen be obtained at the end of a work shift or the end of a workweek.

1 For toluene, measure urinary hippuric acid, at the end of a full work shift.

2 For xylene, measure urinary methyl-hippuric acid, at the end of a full work shift.

3 For methylethylketone (MEK), measure urinary MEK, at the end of a full work shift.

4 For trichloroethylene, measure urinary trichloroacetic acid, at the end of a full workweek.

(e) Any other tests or procedures deemed appropriate by the examining physician (e.g., cognitive function tests. Note that skin (patch) testing is generally of little value in solvent-induced dermatitis, since the

pathophysiology is generally not allergic. Pulmonary function testing should be performed at least once every 4 years if the employee wears a respirator.

(2) Each acute exposure examination shall include, as a minimum:

(a) A medical and work history with emphasis on any evidence of skin disorders or acute CNS effects (headache, nausea and vomiting, dizziness, light-headedness, vertigo, disequilibrium, fatigue, weakness, nervousness, irritability, depression, confusion, coma).

(b) A system specific physical examination with attention to the skin and nervous systems.

(c) If at all possible, a biological monitoring test for overexposure to the solvent in question should be performed, if such a test is available and a specimen can be obtained in a timely manner. For acute exposures, a timely manner implies within the first half-life of the chemical within the human body, generally a matter of a few hours after the overexposure.

(d) Any other tests or procedures deemed appropriate by the examining physician (e.g., CBC, CXR, and bronchial provocation tests).

e. Specific written requirements. In addition to the general requirements specified in Section 12-B-4-b, the physician should address:

(1) Any detected medical conditions, which would place the employee at increased risk of material impairment of the employee's health from any identified exposures to solvents, or from respirator use.

(2) The periodicity of the next routine medical surveillance examination. Examinations will be provided annually unless the physician recommends a longer interval.

12. Tuberculosis (Figure 12-C-11).

a. Exposure effects. Tuberculous droplet nuclei are coughed, spoken, or sneezed into the air by an individual with active pulmonary tuberculosis. Exposure to these airborne droplet nuclei may cause infection with the bacterium that causes tuberculosis.

b. Required surveillance. Employees who are occupationally exposed to active TB cases will be enrolled in the OMSEP and undergo annual screening for tuberculosis. See section 7-D-3 of this Manual, Tuberculosis Screening Program, for complete details. In the Coast Guard, medical personnel and personnel involved in alien migrant interdiction operations (AMIO) are at potential risk for exposure to active TB cases.

c. Information to medical personnel. In order to assess whether the employee should remain under active surveillance for TB exposure, the OMSEP coordinator must provide the examining medical officer with the following information:

(1) A description of the employee's duties as they relate to the employee's exposure.

(2) The employee's exposure level or potential exposure level active TB cases.

(3) A description of any personal protective equipment used or to be used.

d. Examination protocols.

(1) Routine screening for exposed individuals is covered in section 7-D-3.

(a) Personnel with a history of non-reactive tuberculin skin tests will receive annual skin testing. Routine skin testing does not require an examination by a medical officer.

(b) Personnel with a history of reactive skin test(s) will be monitored for development of symptoms of active TB (cough, hemoptysis, fatigue, weight loss, night sweats) annually. A health services technician or a medical officer may complete such monitoring. Routine annual CXRs will not be done.

(2) Evaluation of personnel with newly reactive tuberculin skin tests or suspected active TB is covered in section 7-D-4. A medical officer shall perform a physical examination and obtain a complete medical history in such personnel. A CXR should be done.

e. Specific written requirements. Requirements for recording routine skin test results are covered in Section 7-D-3-c. In addition, medical personnel should make a written recommendation as to whether continued annual TB surveillance is required.

13. Unspecified (Figure 12-C-12).

a. Exposure effects. Individuals undergoing surveillance in this category have exposures to hazards, which are not included in any of the other protocols. Exposure effects will vary with the nature of the exposure, so there are no specific effects to describe.

b. Required surveillance. Enrollment in the OMSEP is required whenever an employee is exposed to an identified hazard, at or above the MSAL, for 30 or more days per year.

c. Information to medical officer. The OMSEP coordinator must provide the examining medical officer with:

(1) A description of the employee's duties as they relate to the employee's exposure.

(2) The employee's exposure level or anticipated exposure level to any hazardous chemicals or physical agents.

(3) A description of any personal protective equipment used or to be used.

d. Examination protocols. Each routine initial, periodic, and exit examination shall include, as a minimum:

(1) A medical and work history. Ensure the patient is questioned about past exposure to chemical and physical hazards, smoking history and alcohol use, a complete review of systems.

(2) A complete physical examination of all systems, with attention to any organ systems with a significant history or current symptoms. Pulmonary status must be evaluated if respiratory protection is used. (See Section 12-C-9).

(3) A CBC, a multichemistry panel (includes glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, LDH, and alkaline phosphatase), and a dipstick U/A.

(4) Any other tests or procedures deemed appropriate by the examining physician. Pulmonary function testing should be performed at least once every 4 years if the employee wears a respirator.

e. Specific written requirements. In addition to the general requirements specified in Section 12-B-4-b, the physician should address:

(1) Any detected medical conditions which would place the employee at increased risk of material impairment of the employee's health from any identified exposures to identified hazards, or from respirator use.

(2) The periodicity of the next routine medical surveillance examination. Examinations will be provided annually unless the physician recommends a longer interval.

FIGURE 12-C-1

Date:	Unit:	OPFAC:	Unit POC:
Patient name:		SSN:	Unit Phone:
Exam type: ☐ Initial/Baseline ☐ Periodic ☐ Exit/Separation ☐ Other ___ Acute Exposure ☐			

Examination Protocol for Exposure to

ASBESTOS

IF EXAM TYPE IS	✓	DO or COMPLETE THESE ITEMS
Initial/Baseline	____ ____	CG-5447 History and Report of OMSEP Examination / DD-2808/DD-2807-1
	____	DD Form 2493-1 or OSHA Respiratory Disease Questionnaire (Part 1) (optional)
Periodic/Separation or Acute Exposure	____ ____	DD Form 2493-2 or OSHA Respiratory Disease Questionnaire (Part 2) (optional) CG 5447 (update)
All types	____	Complete blood count (CBC); multichemistry panel (includes liver function tests, BUN, creatinine); urinalysis with microscopic (U/A).
All types	____	Pulmonary function tests (FVC & FEV_1).
Acute Exposure	____	*Acute Exposure Form*
All types	____	Chest x-ray (PA) with "B-reader" or board certified radiologist evaluation at initial exam then per table:

	Years since first exposure		
	Age 15-35	*Age 36-45*	*Age >45*
0-10	Every 5 years	Every 5 years	Every 5 years
Over 10	Every 5 years	Every 2 years	Every year

All types	_____	Physician's notification regarding examination results. (Final action.)

To the examining medical officer:

You must follow-up any significant abnormality through to a physical diagnosis. Provide ICD codes.

Ensure that the patient is questioned about the following history or symptoms: smoking history, dyspnea on exertion, cough, pleuritic pain, heartburn or epigastric pain. (See OSHA Respiratory Disease Questionnaire.)

Ensure that the patient is examined for the following possible signs: clubbing, basilar rales.

You must address the following four items in writing: 1) whether the employee has any detected medical conditions placing him/her at increased risk of health impairment from further asbestos exposure; 2) any recommended limitations on use of personal protective equipment; 3) that the employee has been informed by you of the results of the examination and any medical conditions resulting from asbestos exposure that require follow-up; 4) that the employee has been informed of the increased risk of lung cancer attributable to the synergistic effects of asbestos and smoking.

Asbestos exposure can cause asbestosis, bronchogenic carcinomas, mesothelioma, and gastric carcinoma. It may also be associated with multiple myeloma and renal carcinoma. Disease risk is dose dependent.

Asbestos was used in shipbuilding until the 1970s. Exposure among OMSEP participants is mostly associated with repair and overhaul of vessels built prior to that time

If the patient is on multiple monitoring protocols, ensure each unique item is completed. However, it is not necessary to duplicate tests and forms.

FIGURE 12-C-2

Date:	Unit:	OPFAC:	Unit POC:
Patient name:		SSN:	Unit Phone:
Exam type: ☐ Initial/Baseline ☐ Periodic ☐ Exit/Separation ☐ Acute exposure ☐ Other _____			

Examination Protocol for Exposure to

BENZENE

IF EXAM TYPE IS	✓	DO or COMPLETE THESE ITEMS
Initial/Baseline	____ ____	CG-5447 History and Report of OMSEP Examination. DD-2808/DD-2807-1
All types	____	CBC and differential, with platelet count and RBC indices (MCV, MCH, MCHC).
Initial/Baseline, Periodic, or Separation	____ ____	Multichemistry panel (includes glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, GTT, LDH, and alkaline phosphatase) U/A with microscopic
Periodic /Separation/Acute Exposure	____	CG 5447 (update)
Acute exposure	____ ____	Urinary phenol. (Only immediately after acute exposure) **Blood or breath benzene level (optional-if available)** Acute Exposure Form
All types	____	Physician's notification regarding examination results. (Final action.)

To the examining medical officer:

- You must follow-up any significant abnormality through to a physical diagnosis. Provide ICD codes.
- Ensure that the patient is questioned about the following history or symptoms: smoking history, headache, difficulty concentrating, decreased attention span, short-term memory loss, mood lability, fatigue, dry skin, abnormal bleeding, anemia, weight loss.
- Ensure that the patient is examined for the following signs: mental status changes, dermatitis, pallor.
- Benzene exposure causes CNS depression, leukemia, aplastic anemia, and dermatitis.
- The employee should be medically removed from the workplace if any of the following are noted on the exam:
  - The hemoglobin/hematocrit is below the laboratory's normal limit and/or these indices show a persistent downward trend from the individual's pre-exposure norms; provided these findings cannot be explained by other means.
  - The thrombocyte (platelet) count has dropped more than 20% below the employee's most recent prior values or falls below the laboratory's normal limit.
  - The leukocyte count is below 4,000 per mm^3 or there is an abnormal differential count.
- Benzene is commonly associated with petrochemical manufacturing. Exposure among OMSEP participants is generally related to marine vessel inspection or disaster response (oil spill, fire). Commercial gasoline is about 3% benzene.
- If the patient is on multiple monitoring protocols, ensure each unique item is completed. However, it is not necessary to duplicate tests and forms.

FIGURE 12-C-3

Date:	Unit:	OPFAC:	Unit POC:
Patient name:		SSN:	Unit Phone:
Exam type: ☐ Initial/Baseline ☐ Periodic ☐ Exit/Separation ☐ Other _____ Acute Exposure ☐			

Examination Protocol for Exposure to

CHROMATES

IF EXAM TYPE IS	✓	DO or COMPLETE THESE ITEMS
Initial/Baseline	____ ____	CG-5447 History and Report of OMSEP Examination/ DD-2808/DD-2807-1
Initial/Baseline or Separation	____	Chest x-ray (PA)
Periodic/Separation/ Acute Exposure	____	CG 5447 (update)
All types	____	Pulmonary function tests (FVC & FEV_1).
All types	____	Complete blood count (CBC)
All types	____	Multichemistry panel (includes glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, LDH, and alkaline phosphatase)
All types	____	U/A with microscopic
All types	____	Physician's notification regarding examination results. (Final action.)

To the examining medical officer:

- You must follow-up any significant abnormality through to a physical diagnosis. Provide ICD codes.
- Ensure that the patient is questioned about the following history or symptoms: smoking history, shortness of breath, wheezing, cough, dry skin, skin ulcers.
- Ensure that the patient is examined for the following signs: erosion of nasal mucosa and septum, respiratory rhonchi, dermatitis, cutaneous ulcers.
- Make a recommendation as to when the next OMSEP examination for this employee should take place. The default interval is 1 year, but you may recommend a longer period of 18 or 24 months, if exposures are limited and there is no evidence of occupationally significant illness.
- Chromium exposure causes lung cancer, dermatitis, skin ulcers, and nasal septum perforation.
- Chromic acid may cause acute burns or irritation to skin, eyes, and upper respiratory tract. Inhalation may cause acute epiglottitis, laryngospasm, pneumonitis, and pulmonary edema.
- Some chromium compounds cause occupational asthma.
- Chromium compounds are commonly associated with steel and chemical manufacturing. Exposure among OMSEP participants is generally related to working with chromium containing paints.
- If the patient is on multiple monitoring protocols, ensure each unique item is completed. However, it is not necessary to duplicate tests and forms.

FIGURE 12-C-4

Date:	Unit:	OPFAC:	Unit POC:
Patient name:		SSN:	Unit Phone:
Exam type: ☐ Initial/Baseline ☐ Periodic ☐ Exit/Separation ☐ Acute exposure ☐ Other _____			

Examination Protocol for Exposure to

Hazardous Waste

IF EXAM TYPE IS	✓	DO or COMPLETE THESE ITEMS
Initial/Baseline	____ ____	CG-5447 History and Report of OMSEP Examination DD-2808/DD-2807-1
Initial/Baseline or Separation	____	Chest x-ray (PA)
Periodic/Separation /Acute Exposure	____	CG 5447 (update)
All types except acute exposure	____	Vision screening (distant and near)
All types	____	Pulmonary function tests (FVC & FEV_1).
All types	____	CBC and differential, with platelet count and RBC indices (MCV, MCH, MCHC).
All types	____	Multichemistry panel (includes glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, LDH, and alkaline phosphatase)
All types	____	U/A with microscopic
Acute exposure	____	Blood lead and/or heavy metal screen, if indicated.
All types	____	Physician's notification regarding examination results. (Final action.)

To the examining medical officer:

- You must follow-up any significant abnormality through to a physical diagnosis. Provide ICD codes.
- Ensure that the patient is questioned about the following history or symptoms: smoking history, weight loss, headache, visual disturbances, difficulty concentrating, decreased attention span, short-term memory loss, confusion, mood lability, fatigue, ataxia, peripheral numbness or paresthesias, weakness, shortness of breath, anemia.
- Ensure that the patient is examined for the following signs: gingivitis, sialorrhea, tremor, mental status changes, decreased deep tendon reflexes, decreased vibratory sensation, respiratory rhonchi and hyperresonance, dermatitis, edema.
- Make a recommendation as to when the next OMSEP examination for this employee should take place. The default interval is 1 year, but you may recommend a longer period of 18 or 24 months, if exposures are limited and there is no evidence of occupationally significant illness.
- The hazardous waste protocol involves medical surveillance for effects of exposure to a variety of heavy metals and chemical compounds. Neurotoxicity, pulmonary disease, dermatitis, and cancer are possible effects of excessive exposures to hazardous wastes.
- OMSEP participants monitored under this protocol are primarily members of HAZMAT and spill response teams, firefighters, and marine safety inspectors. Individual, specific exposure histories are often ill defined. If the patient is on multiple monitoring protocols, ensure each unique item is completed. However, it is not necessary to duplicate tests and forms.

FIGURE 12-C-5

Date:	Unit:	OPFAC:	Unit POC:
Patient name:		SSN:	Unit Phone:
Exam type: ☐ Initial/Baseline ☐ Periodic ☐ Exit/Separation ☐ Acute exposure ☐ Other _____			

Examination Protocol for Exposure to

Lead

IF EXAM TYPE IS	✓	DO or COMPLETE THESE ITEMS
Initial/Baseline	____ ____	CG-5447 History and Report of OMSEP Examination DD-2808/DD-2807-1
All types	____	Blood lead and zinc protoporphyrin (ZPP)
All types	____	CBC and differential, with platelet count and RBC indices (MCV, MCH, MCHC), plus examination of peripheral smear morphology.
Periodic/Separation/Acute Exposure	____	CG 5447 (update)
All types	____	Multichemistry panel (includes glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, LDH, alkaline phosphatase, and uric acid)
Acute Exposure	____	Acute Exposure Form
All types	____	U/A with microscopic
All types	____	Physician's notification regarding examination results. (Final action.)

To the examining medical officer:

- You must follow-up any significant abnormality through to a physical diagnosis. Provide ICD codes.
- Ensure that the patient is questioned about the following history or symptoms: past lead exposure, smoking history, abdominal pain and cramping, joint and extremity pain, difficulty concentrating, irritability, short-term memory loss, confusion, mood lability, fatigue, ataxia, peripheral numbness or paresthesias, weakness, anemia, and infertility.
- Ensure that the patient is examined for the following signs: hypertension, papilledema, gum "lead lines", pallor, mental status changes, decreased deep tendon reflexes, decreased vibratory sensation, extensor motor weakness.
- Lead exposure can cause fatigue, anemia, arthralgias and myalgias, peripheral motor neuropathy, neurobehavioral disturbances and encephalopathy, acute abdominal pain, gout and gouty nephropathy, acute and chronic renal failure, spontaneous abortions, and male infertility.
- If the blood lead level is greater than 40 µg/100 g of whole blood, the employee must be medically removed from any workplace exposure.
- If the patient is on multiple monitoring protocols, ensure each unique item is completed. However, it is not necessary to duplicate tests and forms.

FIGURE 12-C-6

Date:	Unit:	OPFAC:	Unit POC:
Patient name:		SSN:	Unit Phone:
Exam type: ☐ Initial/Baseline ☐ Periodic ☐ Exit/Separation ☐ Acute exposure ☐ Other _____			

Examination Protocol for Exposure to

Noise

IF EXAM TYPE IS	✓	DO or COMPLETE THESE ITEMS
Initial/Baseline	____	CG-5447 History and Report of OMSEP Examination
	____	DD-2808/DD-2807-1
	____	CG-5552 Audiology History Questionnaire
	____	DD Form 2215 (optional) or equivalent locally reproduced version.
Periodic, Separation, or Acute Exposure	____	DD Form 2216 (optional) or equivalent locally reproduced version.
All types	____	Physician's notification regarding examination results. (Final action.)

To the examining medical officer**:**

- You must follow-up any significant abnormality through to a physical diagnosis. Provide ICD codes.
- Review and initial the CG-5552 Audiology History Questionnaire and the audiogram results.
- A significant threshold shift (STS) exists if the average change in hearing from the reference audiogram at, 2000, 3000, and 4000 Hz is greater than or equal to $\pm$10 dB in either ear.
- Additionally, any change of $\pm$15 dB at 1000, 2000, 3000, or 4000 Hz in either ear constitutes an STS.
- Do not apply the National Institute for Occupational Safety and Health (NIOSH) age corrections when determining STS.
- Follow-up audiograms must be conducted when an individual's audiogram shows an STS relative to the current reference audiogram in either ear. When a positive STS (decrease in hearing threshold) is noted, two 14-hour noise-free follow-up tests must be administered to confirm that the decrease in hearing is permanent. When a negative STS (improvement in hearing) is noted, one 14-hour noise-free follow-up tests must be administered.
- Medical evaluation is required to validate the existence of a permanent noise-induced threshold shift and/or to determine if further medical referral is required. That evaluation must be performed by an audiologist, and otolaryngologist, or other knowledgeable physician.
- If, compared with the current reference audiogram, a loss of hearing of $\geq$ 35 dB in either ear at one or more of the speech frequencies (500, 1,000, 2000, or 3000 Hz) is noted , the employee must be medically removed from further workplace exposure.
- If the patient is on multiple monitoring protocols, ensure each unique item is completed. However, it is not necessary to duplicate tests and forms.

FIGURE 12-C-7

Date:	Unit:	OPFAC:	Unit POC:
Patient name:		SSN:	Unit Phone:
Exam type: ☐ Initial/Baseline ☐ Periodic ☐ Exit/Separation ☐ Acute exposure ☐ Other _____			

Examination Protocol for Exposure to

Pesticides

IF EXAM TYPE IS	✓	DO or COMPLETE THESE ITEMS
Initial/baseline	____	CG-5447 History and Report of OMSEP Examination
	____	DD-2808/DD-2807-1
	____	Blood cholinesterase level, two specimens at least 24 hrs. apart
Periodic/ Separation or Acute Exposure	____	Blood cholinesterase level, if current exposure involves organophosphate or carbamate pesticides
	____	CG 5447 (update)
All types	____	Pulmonary function tests (FVC & FEV_1).
All types except acute exposure	____	CBC and differential, with platelet count and RBC indices (MCV, MCH, MCHC)
All types except acute exposure	____	Multichemistry panel (includes glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, LDH, alkaline phosphatase)
All types except acute exposure	____	U/A with microscopic
Acute Exposure	____	Acute Exposure Form
All types	____	Physician's notification regarding examination results. (Final action.)

To the examining medical officer:

- You must follow-up any significant abnormality through to a physical diagnosis. Provide ICD codes.
- Ensure that the patient is questioned about the following history or symptoms: past and current exposures to pesticides, smoking and alcohol use history; eye, nose or throat irritation; cough; nausea, vomiting, diarrhea or abdominal pain; irritability, anxiety, difficulty concentrating, impaired short-term memory, fatigue, or seizures; numbness, tingling, or weakness in the extremities; allergic skin conditions or dermatitis.
- Ensure the patient is examined for the following possible signs: dermatitis, meiosis, rhinitis, mental status changes. Pulmonary system must be examined if respiratory protection is used.
- If the cholinesterase level is at or below 50% of the pre-exposure baseline, the employee must be medically removed from any further workplace exposure.
- Organophosphates and carbamates are inhibitors of the enzyme acetylcholinesterase. They cause parasympathetic nervous system hyperactivity, neuromuscular paralysis, CNS dysfunction, peripheral neuropathy, and depression of RBC cholinesterase activity. Chlorophenoxyacetic acid herbicides cause skin, eye, and respiratory tract irritation, cough, nausea, vomiting, diarrhea, abdominal pain, and peripheral neuropathy.
- If the patient is on multiple monitoring protocols, ensure each unique item is completed. However, it is not necessary to duplicate tests and forms.

FIGURE 12-C-8

Date:	Unit:	OPFAC:	Unit POC:
Patient name:		SSN:	Unit Phone:
Exam type: ☐ Initial/Baseline ☐ Periodic ☐ Exit/Separation ☐ Other _____			

Examination Protocol for Exposure to

Respirator Wear

IF EXAM TYPE IS	✓	DO or COMPLETE THESE ITEMS
Initial/Baseline	____	OSHA Respiratory Medical Evaluation Questionnaire
Periodic/Exit/Separation	____	OSHA Respiratory Medical Evaluation Questionnaire (update).
All types	____	Physician's notification regarding examination results. (Final action.)

To the examining medical officer**:**

- You must follow-up any significant abnormality through to a physical diagnosis. Provide ICD codes.
- This protocol applies to all employees required to wear a respirator in the course of their work.
- Ensure that the patient is questioned about the following history or symptoms: past and current exposures to hazardous chemicals, fumes, and dusts; smoking and alcohol use history; any history of claustrophobia, asthma, angina, syncope, and other respiratory or cardiovascular disease.
- Ensure the patient is examined for the following possible signs: wheezing or other abnormal breath **sounds,** clubbing, and cardiac arrhythmias**.**
- You must address whether the employee as any detected medical conditions which would place him or her at increased risk of material health impairment from the required respirator use. Consider whether the employee's health will allow him or her to tolerate respirator wear.
    - ∗ Note: There currently exists no consensus standard by which physicians may assess a worker's ability to wear a respirator. As a general rule, however, anyone with documented respiratory impairment of moderate to severe degree (FEV1 or FVC <70% of predicted) should not be routinely approved to wear a respirator. Asthmatics with normal or mildly impaired lung function should be evaluated based on the job requirements, but disapproval should be strongly considered for asthmatics that require regular medications to maintain airflow, or who have a history of airway reactivity or sensitization to extrinsic materials (dusts, fumes, vapors, or cold).
- If the patient is on multiple monitoring protocols, ensure each unique item is completed. However, it is not necessary to duplicate tests and forms.

FIGURE 12-C-9

Date:	Unit:	OPFAC:	Unit POC:
Patient name:		SSN:	Unit Phone:
Exam type: ☐ Initial/Baseline ☐ Periodic ☐ Exit/Separation ☐ Acute exposure ☐ Other _____			

Examination Protocol for Exposure to

Respiratory Sensitizers

IF EXAM TYPE IS	✓	DO or COMPLETE THESE ITEMS
Initial/Baseline	____ ____	CG-5447 History and Report of OMSEP Examination DD-2808/DD-2807-1
Periodic/Exit/Acute Exposure	____	CG 5447 (update)
All types	____	Pulmonary function tests (FVC & FEV_1).
All types except acute exposure	____	CBC (complete blood count)
All types except acute exposure	____	Multichemistry panel (includes glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, LDH, alkaline phosphatase)
All types except acute exposure	____	U/A (dipstick sufficient)
Acute Exposure	____	Acute Exposure Form
All types	____	Physician's notification regarding examination results. (Final action.)

To the examining medical officer:

- You must follow-up any significant abnormality through to a physical diagnosis. Provide ICD codes.
- Ensure that the patient is questioned about the following history or symptoms: past and current exposures to respiratory sensitizers, smoking history; eye, nose or throat irritation; cough; asthma or other chronic airway problems; allergic skin conditions or dermatitis.
- In the event that the employee is not required to wear a respirator, and the history and routine laboratory tests are unremarkable, the medical officer may determine that a complete physical examination is not required. Otherwise, at a minimum, a directed physical examination with attention to the respiratory system must be completed. Pulmonary status must be evaluated if respiratory protection is used.
- Respiratory sensitizers include numerous compounds which cause both occupational asthma and/or hypersensitivity pneumonitis (extrinsic allergic alveolitis). Respiratory sensitizers include vegetable dusts and woods, molds and spores, animal danders, metals (platinum, chromium, nickel, cobalt, vanadium), and chemicals (isocyanates, formaldehyde, trimellitic anhydride).
- In the Coast Guard, exposure to respiratory sensitizers is primarily associated with industrial operations, though some marine inspection activities may also lead to exposures.
- If the patient is on multiple monitoring protocols, ensure each unique item is completed. However, it is not necessary to duplicate tests and forms.

FIGURE 12-C-10

Date:	Unit:	OPFAC:	Unit POC:
Patient name:		SSN:	Unit Phone:
Exam type: ☐ Initial/Baseline ☐ Periodic ☐ Exit/Separation ☐ Acute exposure ☐ Other _____			

Examination Protocol for Exposure to

Solvents

IF EXAM TYPE IS	✓	DO or COMPLETE THESE ITEMS
Initial/Baseline	____ ____	CG-5447 History and Report of OMSEP Examination DD-2808/DD-2807-1
All types	____	Pulmonary function tests (FVC & FEV_1).
All types except acute exposure	____	CBC and differential, with platelet count and RBC indices (MCV, MCH, MCHC)
Periodic/Exit/Acute Exposure	____	CG 5447 (update)
All types except acute exposure	____	Multichemistry panel (includes glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, LDH, alkaline phosphatase)
All types except acute exposure	____	U/A with microscopic
Acute exposure	____	Acute Exposure Form
All types	____	Physician's notification regarding examination results. (Final action.)

To the examining medical officer:

- You must follow-up any significant abnormality through to a physical diagnosis. Provide ICD codes.
- Ensure that the patient is questioned about the following history or symptoms: past and current exposures to solvents, smoking and alcohol use history; allergic skin conditions, dry skin, or dermatitis ; eye, nose or throat irritation; headache, nausea, vomiting, dizziness, vertigo; fatigue, weakness, irritability, depression, difficulty concentrating, or impaired short-term memory; and numbness, tingling, or weakness in the extremities.
- Ensure the patient is examined for the following possible signs: dermatitis, peripheral neuropathy, cognitive dysfunction, and mental status changes.
- If the particular solvent exposure is well characterized and specific laboratory tests are available, biological monitoring should be considered.
- Make a recommendation as to when the next OMSEP examination for this employee should take place. The default interval is 1 year, but you may recommend a longer period of 18 or 24 months, if exposures are limited and there is no evidence of occupationally significant illness.
- There are over 30,000 industrial solvents. This protocol is designed to survey for the most frequent health effects of solvents when taken as a broad group. These effects are skin disorders, and acute and chronic CNS effects. Some other less frequent effects of solvents involve the hematopoietic, hepatic, peripheral nervous system, renal, reproductive, and respiratory systems. Most solvents are **not** carcinogenic in humans; benzene being a notable exception.
- In the Coast Guard, exposure to solvents is primarily associated with industrial and maintenance operations (e.g., painting).
- If the patient is on multiple monitoring protocols, ensure each unique item is completed. However, it is not necessary to duplicate tests and forms.

FIGURE 12-C-11

Date:	Unit:	OPFAC:	Unit POC:
Patient name:		SSN:	Unit Phone:
Exam type: ☐ Initial/Baseline ☐ Periodic ☐ Exit/Separation ☐ Acute exposure ☐ Other _____			

Examination Protocol for Exposure to

Tuberculosis

IF EXAM TYPE IS	✓	DO or COMPLETE THESE ITEMS
Initial/Baseline	____ ____	CG-5447 History and report of OMSEP Examination DD-2808/DD-2807-1
All types, **no** history of prior reactive skin test	____	Mantoux tuberculin skin test (TST) Enter results on SF 601 and PHS 731
All types, history of prior reactive skin test	____	SF 600 entry
Follow-up on newly reactive TST	____ ____	CG-5447 (update) CXR (only if TST is newly reactive)
All types	____	Physician's notification regarding examination results. (Final action.)

To the examining medical officer:

- You must follow-up any significant abnormality through to a physical diagnosis. Provide ICD codes.
- For personnel with a prior history of a reactive TST, ensure the patient is questioned about the following symptoms of active TB: fever, night sweats, weight loss, cough, and hemoptysis. This questioning may be completed by a nurse or health services technician.
- See section 7-D of the Medical Manual for full information on the tuberculosis control program.
- Forward a copy of all test results to the unit OMSEP coordinator.
- If the patient is on multiple monitoring protocols, ensure each unique item is completed. However, it is not necessary to duplicate tests and forms.

FIGURE 12-C-12

Date:	Unit:	OPFAC:	Unit POC:
Patient name:		SSN:	Unit Phone:
Exam type: ☐ Initial/Baseline ☐ Periodic ☐ Exit/Separation ☐ Acute exposure ☐ Other _____			

Examination Protocol for Exposure to

Unspecified

IF EXAM TYPE IS	✓	DO or COMPLETE THESE ITEMS
Initial/Baseline	____ ____	CG-5447 History and Report of OMSEP Examination DD-2808/DD-2807-1
All types	____	CBC (complete blood count)
All types	____	Multichemistry panel (includes glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, LDH, alkaline phosphatase)
Periodic/Exit/Acute Exposure	____	CG 5447 (update)
All types	____	U/A (dipstick)
Acute exposure	____	Acute Exposure Form
All types	____	Physician's notification regarding examination results. (Final action.)

To the examining medical officer:

- You must follow-up any significant abnormality through to a physical diagnosis. Provide ICD codes.
- Ensure that the patient is questioned about his or her general medical and work history, including: past and current exposure to chemical and physical hazards, smoking history and alcohol use, and a complete review of systems.
- Ensure the patient is receives a complete physical examination of all systems, with attention to any organ systems with a significant history or current systems.
- Make a recommendation as to when the next OMSEP examination for this employee should take place. The default interval is 1 year, but you may recommend a longer period of 18 or 24 months, if exposures are limited and there is no evidence of occupationally significant illness.
- Individuals under going surveillance in this protocol have exposures to hazards which are not included in any of the other protocols.
- If the patient is on multiple monitoring protocols, ensure each unique item is completed. However, it is not necessary to duplicate tests and forms.

d. Copies of state licenses for all states in which the practitioner is licensed (active or inactive), current renewal certificates, and Educational Commission for Foreign Medical Graduates (ECFMG) certification if the practitioner graduated from a medical school not in the Continental U. S., Hawaii, Alaska, or from a medical school not accredited by the American Association Liaison Committee on Medical Education in Puerto Rico. The practitioner must attach a statement of explanation for lapsed state licenses or those subject to disciplinary action. The primary source must verify all licenses or renewal certificates.

e. Copies of specialty board and fellowship certificates with primary source verification of these documents.

f. Proof of current (within one year) competence, i.e., two letters of reference for initial appointment and a description of recent clinical privileges held (practitioner's supervisor must note concurrence with and approval of privilege performance).

(1) The official reviewing letters of reference is authorized to contact the author of the letters to verify authorship and authenticity of letters. The official is also authorized to request a second letter of reference from an author when the first letter is deemed unclear. The official reviewing a letter of reference is authorized to contact the author via telephone in cases in which the author declines to respond in writing. In such cases, the official will document in a telephone log the site, date, time, identity of call participants and a detailed description of the conversation.

g. A statement explaining any involvement in malpractice cases and claims, including a brief review of the facts about the practitioner's involvement.

h. A statement about any hospitals', licensing boards', or other agencies' disciplinary action.

i. A copy of current certification in Cardiopulmonary Resuscitation from the American Heart Association or American Red Cross.

j. Copies of all current and prior Drug Enforcement Agency (DEA) registration, as appropriate.

k. National Practitioner Data Bank (NPDB) query.

5. Documentation.

a. Documents will be placed into a U. S. Coast Guard Training Record (CG-5285) folder. Commandant (G-WKH-2) will maintain files in a locked cabinet. PCFs and their contents are Class III (maximum security) records and protected from disclosure under the Privacy Act. Do not release documents in the PCF to any other individual or entity unless the provider has given express written permission.

b. Place documents in the six-section folder are as follows:

(2) Section One: Coast Guard clinical privilege documents.

(3) Section Two: Reference letters.

(4) Section Three: Adverse actions, malpractice documents, proof of malpractice coverage, statements about adverse information or malpractice claims.

(5) Section Four: Copies of CPR certification cards, continuing education certificates (CME), other military or civilian courses other than initial qualifying degree.

(a) By 31 December **every other year**, each provider shall submit a summary of CME completed during the **prior 2 years** to Commandant (G-WKH-2).

(b) The CME summary will be in the form of a list in tabular format and will include the name of the course, date taken, sponsoring organization and CME earned.

(c) Providers who are members of the professional organizations that maintain transcripts can submit a transcript in lieu of a summary of CME.

(6) Section Five: JCAHO-accredited hospital letter on admitting privileges, privileges granted by other or previous institutions, curriculum vitae.

(7) Section Six: Copies of license(s), diploma(s) or degree certificates, ECFMG certificate (if applicable), Internship certificate, Residency Certificate, Fellowship documents, and Board Certification. Primary sources must verify all documents in Section Six.

c. See Figure 13-B-1 for a list of required documents by provider category.

6. Verification.

a. To verify education, training, licensure or registration, certification, ECFMG and board certification, obtain either an original letter from the educational institution or certifying body attesting to successful completion of specialty training, or verify by telephone call between the Coast Guard representative and educational institution or specialty board. Record telephone verification on the document itself and on official letterhead signed and dated by the person making the call. Place all verification documents with their source documents in PCF Section Six.

b. Commandant (G-WKH) will verify uniformed services persons before appointment.

c. Before selection of Civil Service and contract providers, there will be a verification of education, training, licensure, experience, certification or registration, and current competence.

d. To verify experience and current competence requires at least two recommendation letters from appropriate sources as listed below. Commandant (G-WKH-2) or the appropriate MLC shall receive direct letters from the person providing the reference. Verify descriptions of recent clinical privileges as above.

(8) A letter either from the hospital chief of staff, clinic administrator, professional head, or department head if the individual has professional or clinical privileges or is associated with a hospital or clinic; or

(9) A letter from the director or a faculty member of the individual's training program if he or she has been in a training program in the previous two years; or

(10) A letter from a practitioner in the appointee's discipline who is in a position to evaluate the appointee's peer and a professional association or society association (mandatory if the appointee is self-employed).

7. Contract Provider Credentials Review.

e. All contract providers who perform any part of their work in a Coast Guard health care facility will submit credentials documents to the appropriate MLC per Paragraph 13.B.6. above and MLC SOPs.

f. The contracting officer will verify documents.

g. At the contracting officer's request, MLC (K) will perform a technical review of the providers' credentials.

8. Reverification.

h. These credentials are renewable and will be primary source on renewal: License, PA certification, Board certification, and contract providers' malpractice coverage. Reverify contract providers' credentials at contract renewal.

i. Reverify these credentials by original letter or telephone contact. The person making the call will record telephone contact on the document and by a separate, signed memorandum.

9. National Practitioner Data Bank.

j. Commandant (G-WK) possesses sole authority to report to the National Practitioner Data Bank. Commandant (G-WKH-2) is designated as the appropriate entity for National Practitioner Data Bank queries. Coordinate all queries for patient care providers through this branch.

k. A reply from the NPDB is not required before the practitioner begins providing services. However, any provider whose credential verification is not fully completed will be considered to have a conditional appointment until all credentials are verified as required.

FIGURE 13-B-1

REQUIRED CREDENTIALS BY PROVIDER CATEGORY

	A	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**	**J**	**K**
Physicians	X	X	X	X	X	X	X	X	X	X	X
General Practice Physicians*	X	X	X	X		X	X	X	X	X	X
Dentists	X	X	X	X			X	X	X	X	X
Physician Assistants	X	X	X	X			X	X	X		X
Nurse Practitioners	X	X	X	X			X	X	X		X
Optometrists	X	X		X			X	X	X		X
Physical Therapists	X	X	X	X			X	X	X		X
Dental Hygienists	X	X		X			X	X	X		X

A. Current curriculum vitae

B. Copies of qualifying educational degrees

C. Copies of required postgraduate training certificates for the area of work; for example, internship, residency, fellowship, nurse practitioner or physician assistant schooling

D. Copies of state license(s)

E. Copies of specialty board certification and fellowship certificates

F. Proof of current competence, recent clinical privileges

G. Proof of malpractice coverage (contractors only)

H. Statement explaining malpractice claims, other adverse actions

I. CPR certification

J. DEA certification

K. NPDB query

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* General Practitioners. Physicians who have completed one year of Graduate Medical Education (Internship) and have not completed a full residency in a medical specialty.

CHAPTER 11

HEALTH CARE PROCUREMENT

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CHAPTER 11. HEALTH CARE PROCUREMENT

Section A - Contracting For Health Care Services

1. General. Commandant (G-WK) has fiscal responsibility for health care for all Coast Guard beneficiaries. The necessary care can be obtained through contracts with private concerns and individuals and interagency and other agreements with military facilities. Commanding officers are responsible for obtaining the necessary services for each fiscal year, subject to MLC (k) review and approval. MLC (k) first authorizes all non-emergency, non-Federal health care. The MLC is responsible for all health services contracting in its area and shall comply with Federal Acquisition Regulations Part 37. The MLC (k) oversees all non-Federal care acquired and minimizes expenses by ensuring competitive contracting procedures take place.

2. Type of Services. The following services may be procured by contract as determined by MLC (k).

   a. Allergist;

   b. Dental Prosthetic Laboratory;

   c. Dentist, Dental Hygienist, or chairside Dental Assistant;

   d. General medicine (Physician or Midlevel Providers);

   e. Group Practice Hospital;

   f. Gynecologist;

   g. Medical Laboratory;

   h. Neurologist;

   i. Nurse (Registered or Licensed Practical);

   j. Obstetrician;

   k. Occupational Health Services (for OCCMED Physicals);

   l. Optometrist;

   m. Orthopedist;

   n. Pharmacist;

   o. Physical Therapist or Certified Athletic Trainer;

   p. Psychiatrist or Psychologist; and

q. Radiologist.

3. Eligibility For Contract Health Care Services. Eligibility for contract health care services is the same as described in Chapter 2.

   a. The following persons are NOT eligible for health care services rendered by contract providers:

      (1) Family members of Coast Guard personnel and retired and retired members of the Coast Guard (however, they may receive health care services when the contractor performs the service at a Coast Guard Clinic or sickbay and/or if the Coast Guard has contracted with a health care provider as a demonstration project).

      (2) Active duty beneficiaries separated from the Service while undergoing treatment (eligibility for treatment terminates and becomes the member's responsibility).

      (3) Coast Guard civilian employees except for required Occupational Medical Surveillance and Evaluation Program (OMSEP) physical examinations and required pre-appointment examinations, all funded using either MLC (k) or unit AFC-57 funds.

   b. Dental laboratory fees for non-active duty beneficiaries:

      (1) Retirees. Retirees are authorized to use private sector dental laboratories. Pay retirees' dental laboratory fees in the same manner as for active duty members.

      (2) Dependents. The dependent receiving the treatment shall pay all private sector laboratory fees resulting from space-available treatment . A suggested way to handle such payments is to require dependents to submit a check or money order payable to the private sector laboratory before delivery of appliances. The attending dental officer then photocopies the check or money order, pays the laboratory, and retains the photocopy in the dental record.

4. Approval to Contract for Services.

   a. Units shall submit letter requests for contract health care services through the appropriate chain of command to MLC (k). All requests must contain this information:

      (1) Description of services required (e.g., general health care, pharmacy, lab, or specialty care such as OB/GYN, optometry, or psychiatry), including desired days and hours of availability;

      (2) A justification of the need for the service;

      (3) Estimated annual cost of the required services;

      (4) A list of USMTFs within 40 miles of the unit and whether they could perform the desired service;

      (5) A list of Coast Guard units benefiting from the services;

(6) The number of active duty members assigned to each unit;

(7) Either the names and mailing addresses of all interested, recommended providers or a justification of other than full, open competition (see paragraph 11-A-7, Pre-contract Award Actions, below);

(8) Preferred solicitation area and the rationale for it (e.g. "provider must be located within 20 miles of the unit", etc.);

(9) Estimated number of annual Coast Guard visits to the provider; and

(10) A list (by type) of any other approved or requested health care contracts.

b. Each request must be able to stand on its own merits and fulfill cost-to-benefit criteria. MLC (k) will analyze each request and provide written approval or disapproval (with alternative proposals) to the requesting unit through the chain of command. If approved, the MLC contracting officer will undertake procurement.

c. MLC will not renew existing contracts simply as a matter of convenience. Each contract must continue to prove its value annually on a cost-to-benefit basis before its renewal. MLC (k) will review each contract's current fiscal year activity. If the contract passes review, it may be renewed; if it does not, MLC (k) will so advise the unit receiving the contract services.

5. Funding.

a. The MLC shall budget, review, and pay for all MLC (k)-authorized non-Federal health care obtained in its area. These documents contain detailed instructions:

(1) Maintenance and Logistics Command, Atlantic Standing Operating Procedures (MLCLANT SOP), Annex D; and

(2) Maintenance and Logistics Command, Pacific Instruction M6000.1 (series).

b. Charge all MLC (k)-authorized non-Federal health care expenditures to the MLC AFC-57 account. MLCs can find detailed object class and cost center information in the Accounting Manual, COMDTINST M7300.4 (series).

6. Pre-contract Award Actions.

a. The contracting officer issues solicitations to obtain supplies and services from industry on a competitive (more than 1 source) or non-competitive (1 source) basis. The Competition in Contracting Act of 1984 (PL-98-369) requires the Government to contract for supplies and services by means of full, open competition to the maximum extent possible. This means all responsible firms or individuals who can provide the supplies or services must be allowed to compete for a government contract. Contracting officers locate potential contractors by publishing the proposed procurement in the *Commerce Business Daily* as required by Federal Acquisition Regulation (FAR), Part 5.

(1) Non-competitive Procurements. Pre-awarding a firm a Government contract violates the Competition in Contracting Act of 1984. If it is claimed only one firm can provide the supplies or service, the purchasing office must justify in writing other than full, open competition, setting forth the facts and rationale (see FAR, Part 6) to support this claim. The justification must be certified that it is accurate and complete and send it with the purchase request when sending it to the contracting officer for procurement action.

(2) Competitive Procurements. The contracting officer also may require certain information before contracting on a competitive basis. The contracting officer may request the types of information below to determinate responsibility within the meaning of Federal Acquisition Regulation, Part 9.

(a) Organizational structure and plan to accomplish the service;

(b) Summary of experience in performing the same or similar work;

(c) Evidence of pertinent state and local licenses;

(d) Evidence of professional liability insurance, or that the offeror can obtain such insurance;

(e) Membership in professional organizations;

(f) Resume of key personnel with particular emphasis on academic achievements pertinent to the proposed services; and

(g) Information about the firm or its key individuals that reflects their status or professional recognition in their field, e.g., awards, published articles, and the like.

b. Subject to the contracting officer's approval, a visit may be made to the offeror's facility before the award (pre-award survey) to review some of the above data to reduce submitted data. The following paragraphs are examples of the information that may be required from an offeror.

(1) Brief description of the facility, how long established, where located relative to the required mile radius, daily operating hours, weekly operating hours (include holidays, Saturdays, and Sundays).

(2) Brief description of similar work performed under Government contracts including the government agency's name, contract number, contract price, and name and telephone number of the agency's contracting officer.

(3) A resume, X pages maximum, including education, past and present experience over the last X years, certificates, association membership, etc., of the key persons who will perform the work under the contract and their letter of intent indicating they intend to work for the offeror if it is awarded the medical services contract.

c. Minimum qualifications required to perform the contract may be stated; however, these qualification requirements must be justified. For example:

(1) Personnel.

(a) Physician. At a minimum, a X year degree in medicine from an accredited college, license to practice medicine in the location where the services will be performed, member of the AMA; X years' experience in practicing general medicine.

(b) Nurse. RN or LPN. B.S. degree (or equivalent) in nursing from an accredited college; ANA-certified or equivalent; X years' experience in handling patients, administering patient records, etc.

(c) Laboratory Technician. HHS certified, ASCP or eligible, X years' experience in all phases of laboratory work; e.g., x-rays, blood samples, etc.

(2) Facility.

(a) Within a X mile radius of the Coast Guard facility requiring the services.

(b) Capable of accommodating or rendering services for at least X patients simultaneously.

7. Award Evaluation Factors.

a. State the steps or procedures to be used to evaluate the proposals.

b. List the evaluation criteria in the descending order of relative importance and state whether one factor will have predominant consideration over another. For example:

(1) Personnel,

(2) Experience,

(3) Facility, and

(4) Price.

c. Establish the criteria to be used in evaluating the proposal. They must be the same as the evaluation factors for award the solicitation cited. The weights assigned to the factors may be in any form, e.g., adjective (acceptable, outstanding), numerical (50). Give this information to the contracting officer, preferably before he or she issues the solicitation, but in any event before receiving the proposals for evaluation.

8. Post-Contract Award Actions.

a. Referring for Contract Services. Before referring any person to a medical services contractor, the cognizant authority shall determine whether:

(1) The person is eligible;

(2) Services are available in-house;

(3) Services are available from a USMTF; and

(4) Services are available from another Federal facility, e.g., Department of Veterans Affairs, under an interagency support agreement.

b. Contracting Officer's Technical Representative. The contracting office that awarded the contract administers it. If the requiring office requests, a Contracting Officer's Technical Representative (COTR) may be assigned to the contract. The COTR is preferably a health services program manager or medical administration officer having jurisdiction in the contract services area. The contracting officer designates the contracting officer's technical representative in a written, signed letter of appointment describing the COTR's responsibilities and limitations. These responsibilities and limitations must strictly be adhered to avoid any conflicts with the contractor about changes to contract terms and conditions.

c. Health Care Invoices.

(1) Contractor Invoices.

(a) All invoices for health care services contractors by contractors shall be processed for payment under the applicable contract's terms and conditions. This Manual's Chapter 6-B-8 describes certifying and processing non-Federal health care invoices. The contracting officer is responsible for including the applicable invoice and payment clauses (e.g., Federal Acquisition Regulations 52.204-3, Taxpayer Identification, 52.232-25, Prompt Payment, etc.) in the contract. Ensure the contracting officer also includes these invoice requirements in the contract so the invoice is proper for payment:

1 An itemized, priced list of the services by contract or order line item number; and

2 Any additional information deemed necessary to process the invoice for payment.

(b) In addition to the invoice requirements above :Any invoice without the following supporting documentation will not be paid.

1 Services Rendered Under Non-Emergent Conditions. A referral slip or written confirmation of patient's eligibility from cognizant health services department representative.

2 Services Rendered Under Emergent Conditions. A written statement from the patient describing the emergent condition(s). The cognizant health services department representative must certify the patient's eligibility and emergent condition.

(c) If the eligible patient pays the contractor for services rendered under a contract and requests reimbursement, the reimbursement claim must be submitted to the appropriate accounting office on SF-1034, Public Voucher for Purchases or Services Other Than Personal. A patient's invoice cannot be reimbursed from funds obligated under a contract even though the contractor rendered the services. These documents must accompany the claim:

1 The contractor's itemized invoice,

2 A copy of the invoice and receipt showing payment to the contractor,

3 The patient's written statement of the circumstances justifying the claim, and

4 The cognizant health services department representative's approval of the claim.

(2) Invoices Outside the CONUS.

(a) The nearest Coast Guard facility having an authorized certifying officer shall process invoices for emergency health care civilian facilities furnish to Coast Guard members. The invoices and justification explaining the reasons for the emergency health care must be in duplicate and attached to SF-1166, Voucher and Schedule of Payments.

(b) Every attempt to pay for emergency health care should be made before departing from a foreign port to reduce paperwork and pay at the exchange rate. If payment before departure is not feasible, advise the facility rendering the service to send all invoices to the United States Embassy or appropriate consular office for the area.

Figure 11.A.1

STATEMENT OF WORK

1. Scope. Provide all labor, materials, and facilities necessary to perform the tasks herein.
2. Definitions.

   a. Patient. An eligible U.S. Coast Guard military member.

   b. Emergency. Treatment required to curtail the patient's undue suffering or loss of life or limb.

   c. Non-Elective Condition. A condition that, if untreated, would render the patient unfit for duty.

   d. Elective Procedure. Treatment the patient *desires*, e.g., vasectomy, tubal ligation, sterility test, contact lenses, orthodontics, etc.

   e. Duty Status. A determination of the patient's ability to perform the assigned tasks at the assigned work station. These statuses apply:

      (1) Fit for Full Duty (FFFD). Patient is not physically restricted or limited.

      (2) Fit for Limited Duty (FFLD). Patient is physically restricted or limited, e.g., office work only; no lifting, stooping, prolonged standing, walking, running, jumping, sea duty, etc.

      (3) Not Fit for Duty (NFFD). Patient cannot perform any assigned tasks at assigned work station.

3. The contractor shall perform these tasks:

   a. Task I. Eligibility Determination. Provide service to the Coast Guard military personnel listed below. Each patient must show the required authorizations before the Contractor renders service.

   b. Task II. Physical Examinations. Examine the patient according to Attachment (1) requirements. [Attach copy of appropriate section of Medical Manual, COMDTINST M6000.lA (series).]

   c. Task III. Immunization. Immunize the patient and document appropriately on Standard Form 601 (Immunization Record) or Public Health Form 731 (International Certificate of Vaccination) in the Coast Guard Health Record the patient presents the contractor. Record also any sensitivity reactions to the immunization. The contractor shall use only those immunizing agents approved by the Department of Health and Human Services. Immunize the patient at the time intervals Attachment 2 specifies. [Attach a copy of Immunization and Chemoprophylaxis, COMDTINST M6230.4D (series).]

d. Task IV. Emergency Hospitalization. Provide all necessary services to patient while he or she is hospitalized, to a maximum of seven days. If the patient requires hospitalization for eight or more days, the contractor shall notify the Coast Guard Point of Contact by telephone. If the Coast Guard elects to transfer the patient to a military hospital, the contractor shall complete all necessary documents the civilian hospital may require to effect the transfer.

e. Task V. Prosthetic and Orthopedic Appliances. The contractor shall provide prosthetic or orthopedic appliances to the patient only under emergency conditions (required immediately due to his or her condition). The contractor shall document the emergency condition on the Coast Guard Health Record. Under non-emergency conditions, the contractor shall refer the patient to a military hospital to obtain these appliances.

f. Task VI. Communicable Disease. The contractor shall report all communicable diseases and recommended control measures to the Coast Guard Point of Contact immediately after detecting the disease. The contractor also shall report to local authorities as required by local regulations.

g. Task VII. Notification. The contractor shall notify the Coast Guard Point of Contact if a patient is seriously ill, injured, or dies.

h. Task VIII. Records and Reports. For all patients the contractor shall maintain a record with this information:

(1) Outpatient Record. Record the name, rank or rating, Social Security Number, address, date of treatment, history of present illness, physical findings, diagnostic procedures including x-rays and laboratory, therapy provided, fitness for duty determination, duration and limitations if unfit or fit for limited duty, and the contractor's printed name and signature.

(2) Inpatient Report. On discharge from the hospital, furnish the patient's medical report written using diagnostic nomenclature (standard disease and operation nomenclature) to summarize the course of the case, laboratory and x-ray findings, surgeries and treatments, complications, current condition, final diagnosis, and a fitness for duty determination with duration and limitations if unfit or fit for limited duty.

i. Task IX. Certificate of Services. After rendering services to the patient, complete Attachment (3) and obtain the patient's signature before he or she departs from the contractor's facility or location where the services were rendered. [Attach copy of certification form.]

4. The contractor shall not execute any oral or written agreements with the patient to render a more expensive type of service than that described in the contract in which the patient pays the difference in price between the contract unit price and the price the contractor charges (for eyeglasses, see Section 8-E-3

5. The contractor must obtain written authority from the patient's Coast Guard unit before filling any prescriptions.
6. The contractor must obtain written authority from the patient's Coast Guard unit before performing any elective procedure.

Personnel	Required Authorization
Active Duty	1. Valid Green I.D. Card (DD Form 2CG (ACTIVE)) 2. a referral slip signed by an authorized Coast Guard official
Reservists (Active Duty)	3. Valid Green I.D. Card (DD Form 2CG (RESERVE)) 4. copy of active duty orders 5. a referral slip signed by an authorized Coast Guard official
Reservists	6. Valid Green I.D. Card (DD Form 2CG (RESERVE)) 7. a copy of Inactive Duty letter signed by the Coast Guard Reserve unit's commanding officer 8. **or** CG-4671 and a letter signed by the Coast Guard unit's commanding officer
PHS Commissioned Officers on Coast Guard Active Duty	Valid Green I.D. Card (DD Form 2CG (ACTIVE))
Prospective Coast Guard Recruit	A letter signed by an authorized official at the Coast Guard recruiting unit
The contractor shall not provide services under this contract to personnel who do not have the required authorizations listed above.	

Section B - Health Care Services Invoice Review and Auditing

1. General.

   a. All health care invoices are subject to review and audit to ensure the Coast Guard pays only for necessary, appropriate health care for its beneficiaries.

      (1) The auditing process ensures the contractor's invoice charges for services provided at either reasonable fees or those in agreement with the contract.

      (2) The review process determines the appropriateness of care for the diagnosis.

   b. Personnel performing the review and audit functions must remember if they find discrepancies, they must give the care provider the opportunity to comment on the findings.

   c. The process of health care invoice auditing and review is complex and lends itself to errors; thus, most reviews and audit inquiries are not dismissed. Finding must be presented in a non-threatening manner, demonstrating the Coast Guard's willingness to cooperate with our health care providers in determining fair, equitable charges.

2. Invoices Subject to Review and Audit. These contract and non-contract health services invoices are subject to review and audit. The unit processing the invoice should review bills in these categories before paying them:

   a. All outpatient invoices contractors submit;

   b. All inpatient and outpatient supplemental care.

3. Review and Audit Procedures. The personnel processing health care invoices should perform these procedures:

   a. Review.

      (1) Is the diagnosis compatible with the prescribed care?

      (2) Are ancillary services (e.g., lab, x-ray, pharmacy, electrodiagnostic tests, etc.) prescribed appropriately in amount and frequency?

      (3) Is the length of care appropriate for the diagnosis?

   b. Audit. Does the contractor's invoice meet the contract definition of a proper invoice? If not, notify the contracting officer immediately.

      (1) Is the bill mathematically correct?

      (2) Does it bill only for authorized care and services?

      (3) Were services and billed care actually furnished?

      (4) Do the charges agree with the provider's regular fee schedule or the prices listed in the contract?

(5) Does the bill give credit for incomplete, canceled, or partial treatments?

(6) Do dates of care match the time period the patient received the care or services?

(7) Have previous audits of this provider demonstrated billing errors?

Section C - Claims Processing

1. General. The Maintenance and Logistics Command, Health and Safety Division (MLC (k)) is responsible for processing Federal and nonfederal health care claims in compliance with the Federal Law and CG Regulations.

2. Certification. Certification ensures that only authorized payment services to eligible beneficiaries receiving health care within their entitlements and the care and related charges are appropriate. Commanders, MLC (k) shall

   a. Administratively screen each claim and supporting documents according to paragraph 3 below. Claims submission procedures from field units is provided by the MLC (k) Standard Operating Procedures.

   b. Technically screen claims and supporting document according to paragraph 4. below.. In screening, perform these actions:

      (1) Refer claims that do not satisfy the Technical Screen criteria to a medical audit staff for Appropriateness Review and/or audit.

      (2) Enter information from these claims into the Non-Federal Invoice Processing System (NIPS) data base and approve them for payment in this manner:

         (a) Claims that satisfy Administrative and Technical Screen criteria (including Active Duty Claims Program (ADCP) claims coded through a TRICARE Fiscal Intermediary).

         (b) Claims referred for Appropriateness Review and/or audit recommended for payment.

   c. Transmit payment data electronically to the Coast Guard Finance Center.

   d. Certify batch transmissions.

   e. Correct batch errors.

   f. Update vendor files.

3. Administrative Screen.

   a. Administrative screening of a claim package determines the patient's authorization and eligibility to receive billed services and also ensures the package contains all appropriate, necessary documents. At a minimum, administrative screening includes:

      (1) Patient information is present and complete.

      (2) Public Voucher for Purchases and Services other than Personal (SF-1164) is completed for reimbursement requests.

      (3) The claim is a complete, itemized original.

(4) A copy of CG-4899, Report of Potential Third Party Liability, is attached if a third party potentially is liable.

(5) Verification of pre-authorization number.

(6) Support documentation is complete for Reservists' bills.

(7) Claims for formal contracts have the contracting officer's signature and amount to be paid.

(8) Claims for clinic support contracts have a Coast Guard beneficiary breakdown.

b. Ensure that all claims that fail to satisfy the administrative screening are corrected by the unit through the most expeditious means possible.

4. Technical Screen.

a. Health care claims must be reviewed to ensure they comply with Federal regulations. Part of that process compares claim packages to standard criteria to withstand the scrutiny of Departmental Accounting and Financial Information System (DAFIS) for payment. Technical screening of claim packages includes:

(1) Comparing charges against contract fee schedules, pre-authorizations, blanket purchase agreements, or the geographic area's usual and customary fees; claims falling within ADCP guidelines are exempt from fee review;

(2) Entering relevant claim information into NIPS;

(3) Determining whether services were appropriate for the diagnosis; and

(4) Identifying claims requiring further review under these circumstances:

(a) Unrelated charges to the initial diagnosis or injury.

(b) Duplicate charges for services received on a given day.

(c) Care was unauthorized or unnecessary.

(d) Claims submitted by different providers for the same service (e.g., anesthesiology charges from more than one provider).

(e) NIPS "flagged" the claim.

(f) The reviewer "feels" a need for further review.

b. Claims a Technical Screen identifies for further review and/or audit require:

(1) Documentation of the problem, and

(2) A recommended course of action.

5. Appropriateness Review.

a. An appropriateness Review is performed under these circumstances:

(1) MLC (k) selects or NIPS flags a claim for further review and/or audit for a Technical Screen; and/or

(2) Periodically for quality assurance.

b. An Appropriateness Review requires:

(1) An itemized claim;

(2) A patient's signed "Request for Medical Records" DD-877 or it's equivalent, to request medical records and other information about an individual's care. Various records, which may include:

(a) Hospital records,

(b) Physician's orders,

(c) Physician and nursing progress notes,

(d) Lab and x-ray reports,

(e) Operative or endoscopic reports,

(f) Admission records (history and physical examinations), and

(g) Discharge summaries.

c. An Appropriateness Review process often involves these activities:

(1) Reviewing records to verify:

(a) The treatment or therapy was:

1 Appropriate for the diagnosis,

2 Consistent with currently accepted medical practice, and

3 Not duplicated unnecessarily.

(b) The length of inpatient hospitalization was appropriate for the diagnosis and course of care.

(c) The charges were reasonable; claims falling within ADCP guidelines are exempt from fee review.

(2) Obtaining additional documentation and/or correspondence from health care providers.

(3) Initially notifying health care providers of this information:

(a) Their claims are being reviewed and audited.

(b) The audit is a normal part of the Coast Guard's health care review process and does not indicate or allege the health care provider committed a offense; and

(c) If reviewing cases for longer than 30 days, periodically communicate with health care providers to inform them of claim status.

d. An Appropriateness Review may recommend:

(1) Full payment for services. Enter data into and process through NIPS.

(2) Partial payment for services. Attach decision documents; recommend the amount of payment; and enter data into NIPS. Initiate a reimbursement request if the claim initially was overpaid.

(3) Consulting a specialist for peer review.

(4) Referral to a contractor for further review or an on-site hospital audit.

(5) Closing the case with no further action.

e. An Appropriateness Review includes:

(1) Fully documenting the decision process,

(2) Initiating payment or the provider's reimbursement, and

(3) Drafting appropriate correspondence.

6. Peer Review.

a. A Peer Review will be performed under these circumstances:

(1) A health care provider objects to other reviews' findings, or

(2) An Appropriateness Review reveals the need for a more sophisticated evaluation of the diagnosis, prognosis, or specific medical procedures employed.

b. Send the case and health care provider's additional documentation (if any) to a qualified medical, pharmaceutical, or dental specialist for review. These services should be contracted if in-house specialists are not available

c. Peer Review may include these detailed examinations:

(1) Diagnosis;

(2) Prognosis;

(3) Appropriateness of the care provided;

(4) Claims submitted to a Fiscal Intermediary for pricing are exempt from fee review.

(5) Selection of the most cost-effective therapy.

d. Among other things a pharmacist's review of pharmaceutical bills and supporting documents may:

(1) Determine the efficacy of prescribed medication;

(2) Identify cost-effective choices; or

(3) Recommend stocking pharmaceuticals for future issuance.

7. Guidelines for Initial Appropriateness and Peer Reviews. These common health care services guidelines are not all-inclusive. Appropriateness and Peer Reviews should be used to assist reviewers in deciding whether in-hospital audits or contracted review services are required.

a. Trauma. Answer these questions:

(1) Does the level of care correspond to the diagnosis?

(2) Were appropriate facilities used?

(3) Were laboratory and x-ray procedures appropriate? Include justification for:

(a) Repeating procedures on a given day;

(b) Repeating normal procedures;

(c) Failing to follow up abnormal tests.

(4) Were iatrogenic complications were identified appropriately? Include:

(a) Sepsis,

(b) Wound dehiscence,

(c) Hemorrhage,

(d) Pulmonary complications,

(e) Cardiovascular complications (thrombophlebitis, etc.),

(f) Urinary tract infection,

(g) Anesthetic or other drug reactions (appropriate drug and dosage, known allergies), and

(h) Other associated injuries.

(5) The length of stay was appropriate for the diagnosis and indicated complications.

(6) The discharge diagnosis was compatible with admission diagnosis and the patient's history.

(7) The patient's physical status on discharge:

(a) Alive,

(b) Complications were controlled,

(c) Wound(s) condition was satisfactory,

(d) Required follow-up arrangements are listed, and/or

(e) Medications were prescribed.

(8) Follow-up care was appropriate, including:

(a) Therapy,

(b) Office visits, and

(c) Additional hospitalization was for a good reason, e.g., iatrogenic complications, continued therapy, or additional surgeries.

(9) Fees are usual and customary for the geographic area (claims falling within ADCP guidelines are exempt from fee review).

(10) The use of multiply providers is explained.

(11) Providers' and reviewers' differences in medical opinion (particularly involving altered treatment and length of hospital stay) are significant enough to warrant negotiation.

b. Laboratory Services. Answer these questions:

(1) Are tests related to or necessary for the diagnosis?

(2) Were ICU standing orders in effect?

(3) Were tests repeated excessively?

(4) Were charges duplicated for the same procedure on the same day?

(5) Were tests repeated due to equipment or operator error?

(6) Were tests repeated despite normal previous test(s) (justification is required)?

(7) Were there multiple charges for the same or similar tests?

(8) Were multiple tests performed in a logical sequence (i.e., the most invasive or sophisticated performed last)?

(9) Were fees usual and customary (claims falling within ADCP guidelines are exempt from fee review);

(10) For a laboratory under Coast Guard contract, were:

(a) Tests covered by the contract?

(b) Charges within fee schedule?

c. Radiology Services. Considerations:

(1) Was the examination required given the diagnosis?

(2) Were charges for portable radiology of an ambulatory patient?

(3) Were examinations repeated?

(4) Were bilateral x-rays appropriate (patients over 12 years of age)?

(5) Were charges or exams of the same anatomical part duplicated?

(6) Do examinations and in-patient dates coincide?

(7) Were examinations repeated despite normal findings in previous examinations?

d. Physical Therapy. Considerations:

(1) Was the injury or diagnosis properly documented? Did it include:

(a) Objective findings?

(b) Functional findings?

(c) Multiple provider discrepancies?

(d) Documentation of improvement?

(2) Did a physician prescribe treatment?

(3) Were injury management and treatments reasonable and necessary? Did they cover these:

(a) Was the treatment plan documented?

(b) Did objective findings permit the therapist and/or physician to monitor treatment results?

(c) Were changes in the treatment program due to unsuccessful results?

(d) Was treatment only for subjective complaints?

(e) Was the treatment related to diagnosis?

(f) Did the treatment follow standard procedures and protocols?

(g) Did the treatment plan include goals and objectives?

(4) Was the length or number of treatments excessive?

(5) Was treatment consistent or continuous or did patient attend sporadically?

(6) Did therapy continue after "Fit-For-Duty" status?

(7) Did therapy charges continue during stays in cardiac or intensive care units.

(8) Were charges duplicated for same-day, apparently inappropriate treatments?

(9) Was therapy frequency within accepted standards?

(10) Were same-day charges for three or more modalities during a single therapy session.?

(11) Were charges usual and customary (claims falling within ADCP guidelines are exempt from fee review).

e. Dentistry.

(1) For provider contract care, were:

(a) Services within the contract scope?

(b) Charges within fee schedules?

(2) For emergency care, were:

(a) Services within the scope of entitlements?

(b) Charges reasonable and customary?

(3) For care pre-authorized in Chapter 2-A-6, did any of these occur?

(a) Did the MLC assign a pre-authorization number?

(b) Were services within the authorized, standard treatment plan?

(c) Were treatments split to circumvent pre-authorization requirements?

(4) For all dental services, do any of these apply?

(a) Were services duplicated?

(b) Were billings for the same service duplicated?

(c) Were diagnosis charges consistent with services received?

(d) Were crowns constructed of precious metals?

(e) Are laboratory charges consistent with the service provided (bridges, crowns, partial or full dentures)?

f. Pharmacy.

(1) For contract providers, were services within the scope of the contract?

(2) For inpatient care, do any of these apply?

(a) Were billings duplicated?

(b) Was credit received for returned or unused medications?

(c) Did medication and in-patient dates coincide?

(d) Did medications' cost exceed 250 percent of Annual Pharmacists' Reference ("Red Book") average wholesale price (Note: This equals a 150 percent markup.)? Claims falling within ADCP guidelines are exempt from fee review.

CHAPTER 12

OCCUPATIONAL MEDICAL SURVEILLANCE AND EVALUATION PROGRAM (OMSEP)

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CHAPTER 12. OCCUPATIONAL MEDICAL SURVEILLANCE AND EVALUATION PROGRAM (OMSEP)

Section A - General Requirements.

1. Description.

   a. The work environment and occupational activities inherent to Coast Guard missions can expose personnel to health hazards with the potential for disease or injury. The Occupational Medical Surveillance and Evaluation Program (OMSEP) is designed to identify work related diseases or conditions, through baseline and periodic examinations, at a stage when modifying the exposure or providing medical intervention could potentially arrest disease progression or prevent recurrences. The fundamental purpose of this program is to identify pre-existing health conditions, provide risk specific periodic screenings, and monitor clinical laboratory tests and biologic functions suggestive of work related environmental exposures. All OMSEP enrollees receive periodic physical examinations, in accordance with Occupational Safety and Health Administration (OSHA) requirements, for the duration of their health hazard exposure or end of their employment. Individuals are released from active surveillance at the end of their exposure. In accordance with OSHA regulations, the OMSEP personnel tracking database containing the name, social security number, billet or occupation code, applicable examination protocols, and next physical examination due date remains active for an additional 30 years.

   b. The OMSEP is the physical examination process for the Coast Guard's Occupational Health Program. The guidance for this program is outlined in the Safety and Environmental Health Manual, COMDTINST M5100.47 (series). OMSEP replaces the present version of the physical exam process described in the SEH Manual as the Occupational Medical Monitoring Program (OMMP).

2. Enrollment**.**

   a. Coast Guard Medical Surveillance Action Level: The medical surveillance action level (MSAL) is the level of worker exposure, determined by workplace sampling, at or above which occupational medical surveillance examinations will be performed. The Coast Guard MSAL will be 50% of the most stringent of the current OSHA permissible exposure limit (PEL),or, the most current American Conference of Governmental Hygienists (ACGIH) Threshold Limit Value (TLV).

   b. Determination of Occupational Exposure.

      (1) An employee is considered occupationally exposed for OMSEP purposes if a noise exposure or hazardous condition is likely to occur **30 or more days per year**. Documentation of the exposure must meet the following criteria: quantitative work-site sampling measurements indicate hazard levels at or above the MSAL or that the exposure can reasonably be determined, in the absence of quantitative sampling, to exceed the MSAL.

      (2) Quantitative sampling is the primary and definitive means to characterize workplace health hazards, although personal sampling measurement is preferred to workplace sampling. Coast Guard Safety and Environmental Health Officers

(SEHOs) using guidance contained in the Safety and Environmental Health Manual, COMDTINST M5100.47 (series) will generally perform this function. SEHOs will normally characterize workplaces by frequency of exposure, type of exposure, and risk groups.

(3) Certain occupations or exposures may require surveillance by federal statutes, DOT regulations, or Safety and Environmental Health Manual, COMDTINST M5100.47 (series) without regard to the 30-day exposure threshold.

(4) Competent environmental health authority is considered to be the cognizant SEHO but the authority may be delegated to other recognized and approved personnel with the necessary technical training and abilities. Qualitative assessments must be based on expected type, frequency, mode, and duration of hazard exposure, and are considered temporary until validated by quantitative means.

c. Enrollment Criteria: Recommendations for enrollment are based on specific job assignments and the level of worker exposure. This process is initiated at the unit level and must be finalized by the IH or cognizant SEHO, with recommendations from the supervising medical officer (if necessary), before forwarding to Maintenance and Logistics Command (MLC (k)) for inclusion into the OMSEP database (see section 12-A-3-(a)-3). This centralized database will be maintained by MLC (k) and will be accessible to the commands in accordance with privacy act requirements. Personnel will be enrolled in the OMSEP if either of the following criteria are met:

(1) Personnel identified as occupationally at risk/exposed to hazardous chemicals or physical agents at levels documented or reasonably determined to be above the CG Medical Surveillance Action Level (MSAL) for that hazard,

(2) Personnel actively engaged for 30 or more days per calendar year in the following occupations will be enrolled in OMSEP, unless an IH investigation determines individuals are not exposed to toxic chemicals or physical hazards: resident inspectors, pollution investigators, marine safety (general), port safety (general), vessel inspectors or marine investigators; and fire fighters.

(3) Note: New OMSEP enrollees maybe considered for enrollment under the guidelines of the Hazardous Waste protocol, which provides the most through surveillance for those with unknown hazardous risks and no prior history of exposures. However, the unit IH or cognizant SEHO may recommend enrollment using the medical surveillance protocol considered most appropriate.

3. Reporting Requirements.

a. Examination Reports:

(1) Required forms: OMSEP physical examinations require completion of the most current version of CG Form 5447 (6-01) in addition to forms DD-2808 and DD-2807-1. Other OMSEP specific forms and their uses are presented in Section 12-B (also see Table 12-B-1.) Uses of routine medical record forms are presented in Chapter 4 of this Manual.

(2) Record keeping: OMSEP personnel records will be handled in the same manner as other medical records (see Chapter 4 of this Manual) with the following exceptions: all x-ray, laboratory test, and related reports of examinations or

procedures done for OMSEP purposes, as well as the medical record cover, shall be clearly labeled "OMSEP." All OMSEP examination reports, including all laboratory data, must be entered into the individual's health record and maintained in accordance with OSHA regulations. The member's medical record custodian will maintain all OMSEP medical records on file for the duration of employment. Upon separation or retirement, all records concurrently labeled "OMSEP" will be maintained, for an additional 30 years, as required by OSHA regulations [29 CFR 1915.1120].

(3) OMSEP database: MLC (k)'s will maintain an electronic database of all OMSEP enrollees based on enrollment information provided by the local units. The OMSEP personnel tracking database should include, at a minimum, the member's name, social security number (SSN), billet or occupation code, applicable examination protocols, and next physical examination due date. The handling of all data in the OMSEP database will comply with Privacy Act requirements.

(4) Substitutions: OMSEP examination forms may **not** be substituted for other examination forms. If another examination is anticipated/required, (i.e. FLIGHT, RELAD) at the same time as the OMSEP examination the appropriate forms for each particular examination should be provided to the examiner so they may be completed at the same time. Duplicate laboratory tests are not required, so long as all specific tests and procedures required for each exam are completed and reported.

(5) Exposure data records: Any available exposure data, from workplace surveys, industrial hygiene personal or area monitoring, material safety data sheets, or assigned IH/SEHO other appropriate sources, will be provided by OMSEP coordinator to the examining medical officer as part of the examination packet. These data should be supplied by the local unit, in coordination with the supporting industrial hygienist, prior to the examination. The protocols in Section 12-C, in addition to OSHA regulations, specify what exposure surveillance data must be maintained and made available to the examining medical officer.

b. Tracking Report: Individual units, in coordination with the cognizant SEHO, are responsible for creating and managing a roster of all OMSEP enrollees and providing the designated medical officer advisor (DMOA)/clinic and MLC(k)'s with an updated report. Once fully implemented medical officers will be able to access this information through the OMSEP database. Updates to the tracking report will be possible by placing the information directly into the database. This will preclude the need for any additional written reports. The report should include all information cited in Section 12-A-3(a)(3) and will form the basis for the OMSEP database.

c. Sentinel Occupational Health Event Reporting: The occurrence of a new illness or disease, which is likely associated with an occupational exposure or condition, may be considered a "sentinel event." Such an event may serve as a warning signal that the quality of preventive measures may need to be improved. In order to facilitate timely intervention, the initial diagnosis of any such diseases must be reported IAW Section 7-B of this Manual. A complete list of reportable occupational diseases is found in Figure 7-B-2.

4. Medical Removal Protection. It is the responsibility of the commanding officer to assure a safe and healthy working environment. The finding of a work-related illness or injury, which could be further exacerbated by continued exposure to a workplace hazard or condition, requires immediate evaluation to determine whether the worker must be at least temporarily removed from further exposure. A recommendation to remove the member should be made by the examining medical officer and cognizant SEHO, in coordination with the unit's Commanding Officer. (See section 12-B-4-b).

5. Roles and Responsibilities**.** The OMSEP is part of a larger and more comprehensive surveillance process requiring the coordinated effort of various district units and local commands working to secure the safety and health of Coast Guard workers. Key personnel have been identified as essential in maintaining a sound occupational health prevention program. Following is a description of their expected roles and responsibilities in this process: NOTE: For the purposes of this Chapter all references to employees, workers, personnel will be assumed to be part of the ONE DOT/CG TEAM concept. Rules, regulations, and directives apply equally to ALL unless otherwise specified.

   a. Units/Commands: Each unit must appoint an OMSEP coordinator, usually the Safety Coordinator (SC) or the Safety and Occupational Health Coordinator (SOHC), or Independent Duty Corpsman. Even if units are under one servicing clinic, the unit is still required to appoint an OMSEP coordinator and manage their respective database. The OMSEP coordinator is responsible for updating the roster of OMSEP enrollees and maintaining the unit's OMSEP personnel tracking report, ensuring OMSEP examinations are completed in a timely fashion, and ensuring all available exposure data is available to the medical officer at the time of the OMSEP examination.

   b. MLC (k): MLC (k)'s will ensure that SEHO/IH work-site monitoring and reporting is completed and entered into the appropriate database. Additionally they will provide oversight to the local units ensuring the accuracy and completeness of the OMSEP personnel tracking report. The MLC (k)'s medical officers will provide oversight over the physical examination consultation and referral process. MLC (k)'s will also provide indicated guidance and or training to HS personnel on examination practices and procedures.

   c. SEHOs: SEHOs will be required to review all requested OMSEP enrollments from the unit OMSEP Coordinators. SEHOs will approve or disapprove requested enrollments through the on-line database. Disapprovals need to be explained to the requesting unit. To substantiate enrollments, SEHOs will be required to conduct and update quantitative and/or qualitative IH assessments of their units' workplace environment. SEHOs will be required to have these written assessments available to the medical officer for review, if requested, to determine the appropriate medical surveillance protocol to use. SEHOs will also be required to provide training and day-to-day consultation with their unit OMSEP Coordinators on database management.

   d. Commandant (G-WKS): Commandant (G-WKS) will provide planning, development, and expertise on occupational health issues. G-WKS is responsible for policy making, procedural decisions, and ensuring currency of Chapter 12 of the Medical Manual with OSHA standards. The G-WKS occupational medicine medical officer will provide support on physical examination problems and review all diagnosed occupational health related abnormalities encountered by the on-site provider. A yearly report, updating the

status of the member's abnormalities, will be provided to onsite providers. G-WKS is the final authority on decisions of any OMSEP related problems.

e. Medical Officer's Responsibilities:

(1) Medical Diagnosis coding. The examining medical officer is responsible for explaining and/or following any abnormalities through to a resolution. All diagnoses made must be appropriately coded using ICD-9CM diagnostic coding, or most current version. ICD codes should be noted in parentheses next to the diagnosis on the examination report and be reported to the fifth digit.

(2) Written assessment or opinion. Whenever a physical exam is performed, the examining medical officer must include the following information **in writing** as part of the record of each examination. This information should be included in the appropriate blocks.

(a) The occupationally pertinent results of the medical examination.

(b) An opinion about adequacy of the information available to support any diagnosed occupational disease(s), if appropriate.

(c) Any recommended limitations to the employee's assigned work.

(d) A statement that the employee has been informed about the results of the examination.

(e) Any additional written information required by the protocols listed in Section 12-C.

f. Medical Administrators:

(1) Support. Medical Administrators are responsible for providing administrative assistance on all OMSEP related matters. This support should extend to :

(a) All units within the designated AOR.

(b) Contracted medical providers and their respective facilities.

(c) IDT's.

(2) OMSEP report/worksite data. Medical Administrators should interact with OMSEP coordinators within their AOR to ensure currency of the roster of enrollees and ensure that work-site information is received in a timely matter. Worksite exposure information, reported history of past exposures and safety data sheets should precede the physical examination to give the medical officer ample time to reach an educated decision.

(3) Physical Examinations/Medical Records. The Medical Administrator is responsible for the following clinic functions in support of OMSEP:

(a) Timely scheduling of physicals.

(b) Providing qualified technicians to perform the indicated laboratory and radiological procedures.

(c) Ensuring proper calibration of equipment, and

(d) Compliance with quality assurance standards.

g. Civilian Employees: Civilian OMSEP enrollees may be entitled to services provided by Coast Guard medical facilities should a determination be made by a medical provider, that an adverse health condition resulted from a work place exposure. Employees are expected to report and explain any illnesses or injuries resulting from exposure sources outside their primary duty station or from other non-occupational settings. Should a determination of an injury or illness, resulting from an exposure at the workplace, be made by a medical provider, civilian appropriated fund employees should contact their servicing civilian Command Staff Advisor (CSA) for assistance in making a claim with the Department of Labor. Non-appropriated fund employees (NAF) should contact their immediate supervisor and/or personnel liaison office. The services provided by the Coast Guard facilities will be only to establish an occupationally-related illness/injury. Further medical care should be provided by the civilian employee's health care provider.

h. Others: In the event of an emergency situation with heavy exposure (e.g., fire, spill), 24-hour assistance is available from the Agency for Toxic Substances Disease Registry (ATSDR) at the Centers for Disease Control and Prevention. Call 404-498-0210.

Disease Registry (ATSDR) at the Centers for Disease Control and Prevention. Call 404-639-0615-6360.

LIST OF ABBREVIATIONS

ACGIH	American Conference of Governmental Industrial Hygienists
ALT	Alanine aminotransferase
AST	Aspartate amino transferase
BUN	Blood urea nitrogen
CBC	Complete blood count
CNS	Central nervous system
CXR	Chest x-ray
DOT	Department of Transportation
EL	Excursion limit (OSHA mandated maximal "safe" airborne concentration of a substance)
FVC	Forced vital capacity
FEV-1	Forced expiratory volume at one second
ICD-9	International Classification of Diseases, 9th Revision (coding system for medical diagnoses.)
IH	Industrial hygiene or industrial hygienist
LDH	Lactic dehydrogenase
MCV	Mean corpuscular volume
MCH	Mean corpuscular hemoglobin
MCHC	Mean corpuscular hemoglobin concentration
MLC (k)/(kse)	Maintenance and Logistics Command: (k)-medical; ((kse)-safety & environmental health.
MO	Medical officer (physician, physician's assistant or nurse practitioner)
MSAL	Medical surveillance action level (Defined in 12-A-3)
OMSEP	Occupational Medical Surveillance and Evaluation Program
OSHA	Occupational Safety and Health Administration
PEL	Permissible exposure limit (The OSHA mandated TWA airborne exposure limit)
PFTs	Pulmonary function tests

LIST OF ABBREVIATIONS (continued)

RBC	red blood cell
SC	Safety Coordinator
SEHO	Safety and Environmental Health Officer
SOHC	Safety and Occupational Health Coordinator
STEL	Short-term exposure limit (The maximal "safe" airborne concentration of a substance)
STEL/C	Short-term exposure limit/ceiling (maximal "safe" airborne concentration of a substance)
STS	Significant threshold shift
TB	Tuberculosis
TLV	Threshold limit value (ACGIH) (The TWA airborne concentration of a substance)
TST	tuberculin skin test (Mantoux)
TWA	time-weighted average
U/A	Urinalysis

Section B - Administrative Procedures.

1. General: All medical examinations and procedures required under the OMSEP shall be performed by or under the supervision of a licensed medical officer and an accredited laboratory shall perform all laboratory tests. Timely completion and monitoring of scheduled examinations is essential in identifying work related health hazards and any specific health effects. All tests required as part of an OMSEP examination should be completed prior to and the results made available to the health care provider at the time of the physical examination. This requirement may be waived if travel or time costs make separate visits impractical. **The provider is required to review, approve (sign), and explain any abnormalities. Any unexplained, examination finding, laboratory abnormality, or test result must be referred to a certified Occupational Health Clinic/provider for further evaluation.**

2. Examination Types.

   a. Initial/baseline. Baseline examinations are required before placement in a specific job in order to assess whether the worker will be able to do the job safely, to meet any established physical standards, and to obtain baseline measurements for future comparison. Each baseline examination shall consist of all of the elements specified under the appropriate surveillance protocol(s) in Section 12-C. Table 12-B-1 also summarizes the required forms and tests for a baseline examination under each of the surveillance protocols. In the event that the employee is being monitored under more than one protocol, each unique form or test need only be completed once for a particular examination.

      (1) An initial examination is required for all employees prior to employment. The employee may not be exposed to a potential health hazard until the physical examination is completed. In the event of scheduling delays, this requirement may be waived, if the employee completes ALL the necessary laboratory tests specified under the appropriate surveillance protocol(s). The physical examination must still be completed at the earliest possible date, but not beyond 30 days after the initial date of employment. Longer delays will require temporary removal. Workers who transfer from operational to administrative positions on a frequent basis during the same duty assignment may, with medical officer approval, receive a periodic physical vice a complete baseline examination upon re-entering the hazardous work site.

      (2) All employees must have a physical examination prior to reassignment to any position with an occupational health hazard exposure as defined in Section 12-A-2-b. This requirement is subject to the stipulation described above in Section 12-B-2-a-1.

      (3) Any employee actively monitored in the OMSEP, identified, as at risk of exposure to a new health hazard requiring additional protocols, should have an initial examination performed for the new potential exposure(s). The employee may not be placed at risk of exposure until the examination is completed. During such an examination, both the initial examination requirements for the additional protocol and the periodic examination requirements for the original protocol(s) should be met. This requirement is subject to the stipulation described above in Section 12-B-2-a-1.

b. Periodic.

(1) Once enrolled in the OMSEP, periodic examinations will be performed at the required interval for the duration of the health hazard exposure. Periodic examinations are generally provided at twelve-month intervals, though under some exposure protocols, the period between exams may vary. Each periodic examination shall consist of all of the elements specified under the appropriate surveillance protocol(s). See Section 12-C. and Table 12-B-1. If an employee is being monitored under more than one protocol, each form or test need only be completed once during a particular examination.

(2) Periodic laboratory monitoring may be required under certain protocols (e.g., lead, pesticides) or special situations. These examinations consist of the specified **laboratory tests only**, and are usually performed in accordance with the specific protocol or as often as deemed necessary by the medical provider.

c. Acute Exposure.

(1) An acute health hazard exposure examination is required, under some protocols, (e.g., benzene, hazardous waste, noise, solvents), when the applicable short-term exposure limit (STEL) ceiling limit of the substance(s) in question is exceeded. The requirement applies whether or not the employee exhibits any overt symptoms of acute exposure. Specific requirements, if any, for an acute exposure examination are found under the protocols in Section 12-C.

(2) An acute health hazard exposure examination is recommended if the employee exhibits any adverse effects following an acute exposure to a suspected hazardous substance. If the substance(s) is identified, an examination should be performed following the specific protocol(s) for that substance(s). In the event no specific substance is identified, an examination should be directed according to the "Unspecified" examination protocol and presenting symptoms. The Acute Chemical Exposure Information form (Figure 12-B-1) should be used to collect and organize information when an acute exposure occurs. The information on this form must accompany the employee to his/her examination.

(3) All HAZMAT response personnel with a documented exposure event, including Coast Guard Strike Team members and firefighters, must complete an Acute Chemical Exposure Information form (Figure 12-B-1) at the end of each HAZMAT response. Special attention must be provided to the type, duration and degree of toxicity of the agent(s) encountered as well as the type of contact (inhalation, skin absorption, ingestion). The type of PPE utilized, type of respirator (if any), and protective clothing worn should also be noted. This information is to be entered in the member's medical record.

d. Exit/Separation (Employment/Exposure). Exit exams are designed to assess pertinent aspects of the worker's health when the worker leaves employment or when exposure to a specific hazard has ceased. Results may be beneficial in assessing the relationship of any future medical problem to an exposure in the workplace. Exit physical examinations must be completed within 30 days of the last day of exposure or employment. The worker may not be re-assigned to a hazardous area once the examination is completed. In the event the worker is exposed to a hazardous substance, after completing the examination, ALL laboratory tests required by the specific protocol for that particular

substance must be repeated (see Table 12-B-1 and Section 12-C). The following conditions also apply:

(1) End of Exposure:

(a) OMSEP enrollees assigned to a non-hazardous work environment but likely to be assigned to a designated area later in their career.

(b) Workers who transfer from operational to administrative positions on a frequent basis may, with medical officer approval, receive an update to their periodic physical vice a complete exit (end of exposure) examination. This does not preclude a complete exit/separation examination upon the end of employment.

(c) Individuals enrolled in the OMSEP, with exposures to known carcinogens or agents with prolonged latency periods for disease development (e.g., asbestos, benzene), will receive an end of exposure exam upon reassignment to non-hazardous area and continue to receive updates to their periodic physicals according to the designated protocol(s). These individuals will be monitored for the duration of their Coast Guard career unless the responsible supervising medical officer or other cognizant medical authority determines such monitoring is not required.

(2) End of Employment:

(a) OMSEP enrollees permanently separating from Coast Guard employment should receive an end of employment examination.

(b) The member's permanent home of record and phone number must be secured for notification of any abnormalities.

(c) A copy of the member's occupational health history, including all potential exposure agents, severity and duration of exposure, and any recommendations on future protocol testing or examinations, must be placed in the member's medical record. A personal copy should also be provided to the member. (see Section 12-B-3-j).

e. Timing of next examination. The default interval between examinations is one year for all protocols except respirator wear and prior (not current) exposure to asbestos, in which case the default interval is **five years**. However, exams may be recommended as infrequently as biennially for employees monitored solely under the protocols for chromium compounds, hazardous waste, solvents, and unspecified exposures. **A medical officer may recommend for any individual patient a shorter interval between examinations than the default period, if such is medically indicated**. Any recommendation on the timing of the next examination should be included as part of the physician's written assessment.

3. Use of OMSEP Forms.

a. CG Form 5447 (6-01) (History and Report of OMSEP Examination).

(1) This form must be completed whenever an OMSEP physical examination is required, except when only annual hearing conservation program is needed. Ensure that the examinee and medical officer identifying information are accurately recorded, including phone numbers.

(2) For an initial examination, all history sections on the CG-5447 must be completed. For subsequent examinations, as an alternative to completing all the blocks in history Sections I through IV, the examinee may choose to initial the statement above each section noting that there have been no changes during the interval from the last examination.

b. OSHA Respirator Medical Evaluation Questionnaire-(mandatory). This questionnaire is to be completed by any worker who is to be issued a respirator or assigned to a task that may require a respirator.

c. CG-5140 (Audiometric Biological Calibration Check). This form is to be used to record calibration of the audiometric equipment.

d. CG-5552 (Audiology History Questionnaire). This form provides a chronological record of audiologic symptoms and recreational noise exposure. It should be initiated at the time of enrollment in the hearing conservation program and OMSEP surveillance for occupational noise exposure. This form must be updated at each subsequent annual audiogram and reviewed by the responsible medical officer.

e. DD Form 2215 (Reference Audiogram). This form is used to record initial audiometric test results.

f. DD Form 2216 (Hearing Conservation Data). This form is used to record the results of periodic and follow-up audiometry for individuals routinely exposed to hazardous noise. This form should be preceded by a reference audiogram (DD Form 2215 or other record) already on file in the individual's health record.

g. Notification of Summary Results. A sample of this form is provided in Figure12-B-2. A photocopy or a locally generated form may be used to provide the required notification to the enrollee of the results of his/her OMSEP examination.

h. Acute Chemical Exposure Information Form. This form is used to record the results of any unexpected exposures and for verification of notification of the appropriate agencies. A sample of this form is provided in Figure 12-B-1.

i. Separation Letter. This letter serves as notification of the member's documented exposure(s) while serving in the US Coast Guard. It provides the nature and levels of exposure(s), if known, and the medical provider's comments and recommendations A copy is to be placed in the member's record and another provided directly to the member. A sample of the separation letter is provided as Figure 12-B-4.

j. Patient Notification. The medical officer is responsible for notifying the patient of any and all abnormalities found or diagnoses made, whether or not they are occupationally related or simply an incidental finding. Notification must be made within 30 days of

completion of the examination and should be documented as a medical record entry (see Figure 12-B-2).

4. Medical Removal Standards

   a. The following abnormal laboratory findings during an OMSEP examination mandate immediate removal of the employee from further workplace exposure to the hazard listed, pending resolution of the abnormality or a determination that the abnormality is not due to a workplace exposure. The medical officer should coordinate all medical removal recommendations with the cognizant SEHO before forwarding to the commanding officer (CO).

      (1) Benzene (**any** of the following):

         (a) The hemoglobin/hematocrit falls below the laboratory's normal limit and/or these indices show a persistent downward trend from the individual's pre-exposure norms; provided these findings cannot be explained by other means.

         (b) The thrombocyte (platelet) count varies more than 20% below the employee's most recent prior values or falls below the laboratory's normal limit.

         (c) The leukocyte count is below 4,000 per mm3 or there is an abnormal differential count.

      (2) Lead: A blood lead level at or above 40µg/100 ml of whole blood.

      (3) Noise: A loss of hearing of $\geq$ 35 dB in either ear at one or more of the speech frequencies (500, 1,000, 2000, or 3000 Hz), compared with the **current** reference audiogram.

      (4) Organophosphate pesticides: cholinesterase level at or below 50% of the pre-exposure baseline.

   b. Pregnancy is not a reason for automatic medical removal from the workplace. A decision to remove or restrict a pregnant woman must be based on sound clinical judgment after careful consideration of the workplace environment and the woman's physical capabilities. The woman's pre-natal health care provider (obstetrician) should be apprised early of any/all potential hazards and safety precautions available.

5. Reporting of Examination Results.

   a. Coast Guard medical officers will have 30 days from completion of the examination to meet all medical officer responsibilities in Section 12-B-4.

   b. Contractual providers, IDTs, and other detached HSs/units must forward all OMSEP examination questions, problems, and any unresolved matters, with accompanying supporting information, to the assigned CG medical officer for review within 15 days of receipt (includes the examination and any additional testing or consultations).

   c. All records must be forwarded to the record custodian upon compliance with Sections 12-B-6- (a) and 12-B-6 (b) above.

TABLE 12-B-1

REQUIRED FORMS AND TESTS FOR VARIOUS OMSEP EXAMINATIONS AND PROTOCOLS

Exam Type Exposure Protocol	Initial/ Baseline	Periodic	Exit/Separation	Acute Exposure	Biological Monitoring
Asbestos	CG 5447 *OSHA Resp. Quest. DD-2808/ DD-2807-1 Stool guaiac (a)* PFTs "B" reader CXR CBC Multichem panel U/A w/ micro	CG 5447 (update) Stool guaiac (a)* PFTs "B" reader CXR(b)* CBC Multichem panel U/A w/ micro	CG 5447 (update) Stool guaiac (a)* PFTs "B" reader CXR CBC Multichem panel U/A w/ micro	N/A	N/A
Benzene	CG 5447 DD-2808/ DD-2807-1 CBC w/ diff Multichem panel U/A w/ micro	CG 5447 (update) CBC w/ diff Multichem panel U/A w/ micro	CG 5447 (update) CBC w/diff Multichem panel U/A w/ micro	CG 5447 (update) Urinary phenol CBC w/ diff Acute Exposure Form	Only under special circumstances . Contact G-WKS-3.
Chromates	CG 5447 DD-2808/ DD-2807-1 CXR PFTs CBC Multichem panel U/A w/ micro	CG 5447 (update) PFTs CBC Multichem panel U/A w/ micro	CG 5447 (update) CXR PFTs CBC Multichem panel U/A w/ micro	N/A	N/A

* OSHA Medical Evaluation Respiratory Questionnaire. Note: DD Forms 2493-1/2493-2 Asbestos Report may be required at medical DOD facilities.

TABLE 12-B-1 (Continued)

Exam Type Exposure Protocol	Initial/ Baseline	Periodic	Exit/Separation	Acute Exposure	Biological Monitoring
Hazardous Waste	CG 5447 DD-2808/ DD2807-1 vision screening CXR PFTs CBC w/ diff Multichem panel U/A w/ micro	CG 5447 (update) vision screening PFTs CBC w/ diff Multichem panel U/A w/ micro	CG 5447 (update) vision screening CXR PFTs CBC w/ diff Multichem panel U/A w/ micro	CG 5447 (update) Acute Exposure Form PFTs CBC w/ diff Multichem panel U/A w/ micro Heavy metal screen (c)*	Only under special circumstances. Contact G-WKS-3.

NOTES: *(a) only if patient is age 35+ or otherwise clinically indicated.

*(b) B-reader chest x-rays will be done at periodic examinations according to the following schedule:

Years since first exposure	Age of examinee 15 to 35	36 to 45	over 45
0 to 10	Every 5 yrs.	Every 5 yrs.	Every 5 yrs.
Over 10	Every 5 yrs.	Every 2 yrs.	Annually

*(c) Heavy metal screen includes blood lead, cadmium, mercury, and arsenic levels.

TABLE 12-B-1 (Continued)

Exam Type Exposure Protocol	Initial/ Baseline	Periodic	Exit/Separation	Acute Exposure	Biological Monitoring
Lead	CG 5447 DD-2808 DD-2807-1 Blood lead & ZPP CBC w/ diff Multichem panel U/A w/ micro	CG 5447 (update) Blood lead & ZPP CBC w/ diff Multichem panel U/A w/ micro	CG 5447 (update) Blood lead & ZPP CBC w/ diff Multichem panel U/A w/ micro	CG 5447 (update) **Acute Exposure Form** Blood lead & ZPP CBC w/ diff Multichem panel U/A w/ micro	Blood lead, ZPP
Noise	CG-5552 DD Form 2215 *	CG-5552 (update) DD Form 2216 *	CG-5552 (update) DD Form 2216 *	CG-5447 (update) DD Form 2216 *	N/A
Pesticides	CG 5447 DD-2808 Dd-2807-1 Blood cholin-esterase, twice PFTs CBC w/ diff Multichem panel U/A w/ micro	CG 5447 (update) Blood cholin-esterase (d)* PFTs CBC w/ diff Multichem panel U/A w/ micro	CG 5447 (update) Blood cholin-esterase (d)* PFTs CBC w/ diff Multichem panel U/A w/ micro	CG 5447 (update) Acute Exposure Form Blood cholin-esterase (d)* PFTs	Blood cholinester ase (c)*

Note: DD Forms 2215/2216 remain active and are to be properly recorded and maintained in the member's medical record. DOD facilities continue to use these forms or an electronic equivalent.

CG facilities may continue to use these forms; an equivalent locally reproduced form or electronic version as long as they comply with regulations set forth in Chapter 4 of this Manual.
NOTES: *(d) Blood cholinesterase only required if exposure includes organophosphate and/or carbamate pesticides.

TABLE 12-B-1 (Continued)

Exam Type Exposure Protocol	Initial/ Baseline	Periodic	Exit/Separation	Acute Exposure	Biological Monitoring
Respiratory Sensitizers	CG 5447 DD-2808 DD-2807-1 PFTs CBC w/ diff Multichem panel U/A w/ micro	CG 5447 (update) PFTs CBC w/ diff Multichem panel U/A w/ micro	CG 5447 (update) PFTs CBC w/ diff Multichem panel U/A w/ micro	CG 5447 (update) Acute Exposure Form PFTs	N/A
Solvents	CG 5447 DD-2808 DD-2807-1 CBC w/ diff Multichem panel U/A w/ micro	CG 5447 (update) CBC w/ diff Multichem panel U/A w/ micro Biological moni-toring (if possible)	CG 5447 (update) CBC w/ diff Multichem panel U/A w/ micro	CG 5447 (update) Acute Exposure Form Specific blood or urine tests for specific solvents.	Specific blood or urine tests for specific solvents. (See Section 12-C-11.d.)
Respirator wear only	CG 5447 ** OSHA Resp Quest	**ORQ (update)	N/A	N/A	N/A

* Respiratory: OSHA Respiratory Questionnaire, this form is provided at the unit level (worksite), (Reference Section 12-c-9.

TABLE 12-B-1 (Continued)

Exam Type Exposure Protocol	Initial/ Baseline	Periodic	Exit/Separation	Acute Exposure	Biological Monitoring
Tuberculosis	CG 5447 DD-2808 DD-2807-1 Mantoux skin test (e)*	Mantoux skin test (e)*	Mantoux skin test (e)*	Mantoux skin test (e)*	N/A
Unspecified	CG 5447 DD-2808 DD-2807-1 CBC Multichem panel U/A w/ micro	CG 5447 (update) CBC Multichem panel U/A w/ micro	CG 5447 (update) CBC Multichem panel U/A w/ micro	CG 5447 (update) CBC Multichem panel U/A w/ micro	Only under special circumstances. Contact G-WKS-3.

NOTES: *(e) Personnel with a history of reactive tuberculin skin tests should be monitored for development of symptoms of active TB. A CXR should be done **only** if the skin test is newly reactive.

FIGURE 12-B-1

ACUTE CHEMICAL EXPOSURE INFORMATION

Last Name, First Name, M.I.			**Rank/Rate** **SSN**
1. Name(s) of chemical(s):	_____	_____	_____
2. CAS number(s), if known:	_____	_____	_____
3. Physical form:	☐ Solid ☐ Liquid ☐ Gas/Vapor ☐ Aerosol	☐ Solid ☐ Liquid ☐ Gas/Vapor ☐ Aerosol	☐ Solid ☐ Liquid ☐ Gas/Vapor ☐ Aerosol
4. Chemical form:	☐ Acid ☐ Alkali ☐ Organic solvent	☐ Acid ☐ Alkali ☐ Organic solvent	☐ Acid ☐ Alkali ☐ Organic solvent
5. Modes or routes of exposure:	☐ Inhalation ☐ Ingestion ☐ Skin	☐ Inhalation ☐ Ingestion ☐ Skin	☐ Inhalation ☐ Ingestion ☐ Skin
6. Exposure date, time & duration:	Date/time _____ Duration _____ minutes	Date/time _____ Duration _____ minutes	Date/time _____ Duration _____ minutes

7. Brief description of the incident:

8. Observed symptoms: _____

9. Associated injuries: _____

10. Personal Protective Equipment Used:

Notify District/ISC Safety & Environmental Health Officer, cognizant MLC (kse), and G-WKH-3.

11 Further guidance received:

Contact ATSDR emergency response line at 404-498-0210 to obtain further guidance.

12. ATSDR guidance:	Prescribed tests:	Time limits for specimens	Other

Attach Material Safety Data Sheet (MSDS) and shipping manifest to this form, if available.

(Use reverse for continuation or reporting of additional information.)

FIGURE 12-B-2

OMSEP

NOTIFICATION OF SUMMARY RESULTS

Date of Examination: _____
Patient: _____ SS#:_____

Address:	Phone #

Reference. (a) Medical Manual, COMDTINST M6000.1(series).

1) An environmental health evaluation has determined that you may have been exposed to the following health hazards at your workplace:

_____

_____

2) Your physical examination was conducted in accordance to reference (a).
There ***ARE*** / ARE ***NOT*** abnormalities in your physical examination and laboratory testing.

NOTED ABNORMAL PHYSICAL FINDINGS OR LABORATORY TESTS	RESULT/INTERPRETATION

3) Additional comments on your Occupational Medical Surveillance and Evaluation physical

_____

_____

_____

_____

Name and Title of Health Care Provider: _____

_____

Signature of Health Care Provider: _____
Date:_____

FIGURE 12-B-3

HISTORY AND REPORT OF OMSEP EXAMINATION

1. Last Name, First Name, M.I.	2. Grade/Rate/Rank	SSN	Date of Examination
5. Home Address (apt#, street#, street name, city, state, zip)	6. Work/duty phone ( )	8. Unit Name and Location (*city & state)*	
	7. Home phone ( )	9. Unit OPFAC#	10. Unit Zip Code

11. Date of birth & age	12. Sex (*M or F)*	13. Race or Ethnicity	14. Occupation or usual duties (describe)
16. Examining facility name & location *(○city, state)*		17. Purpose of Examination O Initial/Baseline O Periodic O Acute exposure O Exit/Separation	15. How many years have you worked in this occupation?

I. Occupational History *(patient must complete)*

_____ Initial here if there have been **NO** changes to your occupational history since your last exam and go to section **II**.

18. Are you exposed to any of the following in your *present job,* yes or no?

Y	N		Y	N	
		Asbestos (fibers, dust)			Hazardous waste(oil spill)
		Benzene (liquid or vapor)			Radiation x-ray, microwave
		Lead (dust or fumes)			Loud noise
		Liquid chemicals (various)			Vibration (jackhammer)
		Chemical vapors or gases			Extreme heat
		Dust (sawdust, blasting)			Extreme cold
		Metals or metal fumes			Mental or emotional stress
		Entry into closed spaces (tanks, voids)			Human bodily fluids, or infectious agents

19. Do you wear any of the following on your present job, yes or no?

Y	N		Y	N	
		Earplugs or muffs			Safety glasses
		Dust mask			Welding face-mask
		Half-face respirator			Rubber gloves
		Full-face respirator			Protective body suit
		Air-line respirator			Other, list below:

II. Family History *(patient must complete)*

_____Initial here if there have been **NO** changes in the answers to the following questions since your last exam and go to section **III**.

26. Have any of your blood relatives (mother, father, brother, sister, grandparents, aunts, uncles, children) had any of the following illnesses or problems, yes or no?

Y	N	
		Anemia, blood disease, or bleeding tendency
		Asthma, hayfever, or allergies
		Birth defects or multiple miscarriages
		Cancer, leukemia, or other malignancy
		Diabetes (high blood sugar)
		Eye trouble or blindness
		Epilepsy, fits, or convulsions
		Hearing trouble or deafness
		Heart trouble, high blood pressure, or stroke
		Kidney trouble (stones or kidney failure)
		Lung trouble (cystic fibrosis, bronchitis, emphysema)
		Some other disease or condition which runs in your family, if so list:

III. Social History*(patient must complete)*

_____Initial here is there have been **NO** changes in the answers to the following questions since your last exam and go on to section IV.

Y	N	
		20. Have you had any difficulty wearing your protective clothing or equipment? (If you don't need to wear any, answer "no.")
		21. Have you had any work-related illness or injury?
		22. Have you been limited in your work for health reasons?
		23. Have you left or changed jobs due to health reasons?
		24. Have you had a work-related experience, which you believe may have affected your health or the health of fellow workers?
		25. Do you have any hobbies or outside activities, which would expose you to any of the hazards listed in 18, above? If Yes, explain:

27. Cigarette smoking history.

Y	N		
		Do you smoke cigarettes now?	
		If NO: Did you ever smoke cigarettes?	
		If you smoked before, what year did you stop?	
		How many years had you smoked?	
		How many packs per day?	
		If YES: How many years have you smoked?	
		How many packs per day?	

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Section III. Social History (continued)

28. Other smoking history:				29. Alcohol use history:		
Y	**N**			**Y**	**N**	
		Do you smoke cigars or a pipe now?				Do you drink any alcoholic beverages (beer, wine, liquor)?
		If NO: Did you ever smoke cigars or a pipe?				If YES: How many bottles/cans of beer per week?
		If you smoked before, what year did you stop?				How many glasses of wine per week?
		How many years had you smoked?				How many ounces of liquor per week?
		How many cigars or pouches per week?				30. Do you use any other recreational drugs? If so, list below.
		If YES: How many years have you smoked?				
		How many cigars or pouches per week?				

IV. Personal Health History *(patient must complete)*

_____ Initial here if the answers to the following questions are all "**NO**" and there have been no changes since your last exam, then go to item 32.

31. Have you *recently* had or do you *now have any* of the following symptoms or complaints, yes or no?

Y	N		Y	N		Y	N		Y	N	
		Unexplained weight loss			Difficulty sleeping			Chest pain or angina			Birth defects in your children
		Fever or chills			Red or irritated eyes			Palpitations or irregular heart			Pain or blood with urination
		Skin rashes or ulcers			Visual disturbances or changes			Other heart trouble			Muscle pain or weakness
		Lumps you can feel			Sinus trouble (pain, discharge)			Abdominal pain			Joint pain or swelling
		Severe or recurrent headaches			Nosebleeds			Gastritis or peptic ulcers			Limitations of motion
		Dizziness or vertigo			Sore throat, trouble swallowing			Jaundice or yellowing skin			Back pain
		Fainting or passing out			Pain or swelling in neck			Nausea or vomiting			Numbness, tingling in extremities
		Seizures or epilepsy			Frequent coughing			Constipation			Anemia ("low blood")
		Trouble concentrating			Coughing phlegm or blood			Diarrhea or runny stools			Easy bruising or bleeding
		Mood changes, irritability			Wheezing or asthma			Bloody or tarry stools			HIV/AIDS
		Tiredness or fatigue			Shortness of breath			Infertility or miscarriages			Cancer or leukemia

32. In general, would you say your health is (check one): Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐

33. List any medications you are currently using, or state "none".

34. List any allergies you know you have, or state 'none".

35. Additional space for comments and explanations of your "yes" answers:

All information provided will be handled in accordance with Privacy Act requirements, and will not be otherwise disclosed.

I hereby certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge.	Signature of patient	Date

FIGURE 12-B-3 (cont'd)

Occupational Exposure History

_____Patient initial here if there have been **NO** changes in the answers to the following questions since last exam and proceed to Part 2.	_____Medical Officer/SEHO initial here for verification of hazardous exposure and monitoring.

INSTRUCTIONS: Please complete the following history beginning with present job or military assignment. Additional copies of this sheet may be added if necessary

36. List all known hazardous exposures:

Agents(s) (noise-metals-solvents)	Date (from - to)	Location (work site)	Protective equipment used

All information provided will be handled in accordance with Privacy Act requirements, and will not be otherwise disclosed.

I hereby certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge.	Signature of patient	Date

FIGURE 12-B-3 (cont'd)

MEDICAL OFFICER'S SECTION

Part 2

1. Last Name, First Name, M.I. *(of patient)*	2. Grade/Rate/Rank *(of patient)*	3. SSN *(of patient)*	4. Date of Examination
5. Examining facility or examiner name and address:			6. Facility phone number ( )

7. Surveillance protocols followed *(check all that apply)*

☐ Asbestos ☐ Chromium compounds ☐ Lead ☐ Pesticides ☐ Respiratory sensitizers ☐ Unspecified

☐ Benzene ☐ Hazardous waste ☐ Noise ☐ Respirator wear ☐ Solvents ☐ Other:____

8. Medical Officer Initial Here: _____ Verify completion of DD-2808 & DD-2807-1. Initial Baseline _____

9. General prevention counseling provided to patient 9check any that were addressed with patient)

☐ Tobacco cessation ☐ Physical activity ☐ Weight reduction ☐ HIV/STD's avoidance ☐ Injury prevention

☐ Alcohol or drug abuse ☐ Nutrition (low-fat/salt) ☐ Stress reduction ☐ Breast/testicular self exam ☐ Other:_____

10. List current diagnoses by ICD-9 code number and name: *(If no exactly corresponding ICD-9 code is available, use the closest code to the named diagnosis.)*

ICD-9	Diagnosis	ICD-9	Diagnosis

11. In your opinion, was the information to you adequate to support any listed diagnoses of occupational disease? ☐ YES ☐ NO

12. Respirator wear This examinee ☐ Is medically approved for respirator wear. *(Comment on any restrictions or limitations)* ☐ Is not

13. CONCLUSIONS: This examinee ☐ Has medical conditions which limit his/her performance of duties. *(Specify any limitations)* ☐ Does not have

14. Next OMSEP examination should be in ☐ 12 mos. ☐ Other_____

15. Examinee was informed about the results of this examination_____(date).

Printed or typed name (rank) and degree of examining medical officer	Signature of examining medical officer	Date

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FIGURE 12-B-4

OMSEP

SEPARATION LETTER

NAME: _____ SSN:_____
DATE:_____

You have been enrolled in the Coast Guard's OCCUPATIONAL MEDICAL SURVEILLANCE AND EVALUATION PROGRAM (OMSEP). During the past _____years you received periodic physical examinations based on Occupational Health Safety Organization (OSHA) protocols for the following known potentially hazardous exposures:

_____
_____
_____
_____

Your occupational (work-related) history also indicates suspected exposure to the following agents:

_____
_____
_____
_____
_____

At the time of your EXIT/SEPARATION medical examination you were found to be in good health with no evidence occupational induced disease. However, it is recommended that you continue to receive medical examinations on a periodic basis based on age indicated guidelines. In addition, the periodicity of the examination should be modified to allow for adequate detection and prompt intervention on disease processes resulting from the latent effects of occupational hazardous substances. Your medical provider should follow OSHA mandated recommendations, for the aforementioned hazardous substances, in determining the frequency and level of care you require. NOTE: if a member is found to have an occupational related disease process at the time of separation, indicated medical referral measures will be instituted.

Any questions relating to this member's occupational health history can be obtained by contacting the US Coast Guard's Office of Safety and Environmental Health at # 202-267-1883.

Medical officer signature

- This letter should printed on official Coast Guard Letterhead for inclusion in members official health record.

Section C - Medical Examination Protocols.

1. General.

   a. The following protocols follow the same format. Each contains a brief description of the hazard and its possible effects; the conditions required for an individual to be surveyed under that protocol; information which must be provided to the examining medical officer; specific requirements of the history and physical, including laboratory tests and special procedures; and any additional written requirements on the part of the examining medical officer. The protocols are summarized in Figures 12-C-1 through 12-C-12. Copies of these figures may be locally reproduced. The unit OMSEP coordinator should complete the information in the first eight blocks at the very top, and the appropriate protocol summary figure(s) should be provided to the examining medical officer with the examination packet.

   b. Multiple protocols for a single individual. In the event that an individual is being monitored on more than one protocol (e.g., asbestos and noise), the final examination packet must include each of the required items for each of the protocols. However, each required form or test need only be completed once.

   c. *Past* exposure. Personnel who have a documented history of workplace exposure to known carcinogens**,** but who are not currently exposed, shall be offered an annual medical examination, according to this protocol until end of employment. Undergoing this examination is strictly voluntary.

2. Asbestos (Figure 12-C-1).

   a. Exposure effects. Asbestos exposure can cause asbestosis, bronchogenic carcinomas, mesothelioma, and gastric carcinoma. It may also be associated with multiple myeloma and renal carcinoma. Disease risk is dose dependent. There is a synergistic effect between asbestos exposure and cigarette smoking, so that the risk of lung cancer is roughly ten times greater in asbestos-exposed workers who smoke as opposed to nonsmoking asbestos-exposed workers. The primary route of exposure is inhalation, though ingestion of fibers may also occur.

   b. Required surveillance.

      (1) All personnel with current employment exposure to airborne asbestos, who meet the MSAL criteria in Section 12-C-2- (4) below, shall undergo medical surveillance. These personnel shall be included in the OMSEP and be examined according to the protocol in Section 12-C-2.d below. Medical examinations shall be provided upon enrollment and at least annually thereafter, throughout the duration of exposure or until end of employment, whichever comes first. Under current Coast Guard policies for management of asbestos, very few non-shipyard workers should be currently exposed at or above the PEL or EL.

      (2) Construction worker standard. The OSHA standard for asbestos applies to, but is not limited to, workers who demolish, remove, alter, repair, maintain, install, clean up, transport, dispose of, or store asbestos containing materials.

      (3) The current MSALs are based on the OSHA exposure standard for shipyards [29 CFR 1915.1001].

(a) For other than shipyard and construction workers, medical surveillance is required for those employees who are or will be exposed at or above the PEL as an 8 hour time-weighted average, or above the EL averaged over 30 minutes, regardless of the number of days of exposure.

(b) For shipyard and construction workers, medical surveillance is required for those workers:

1 Who remove any asbestos-containing materials, or who perform repair and maintenance operations in which asbestos-containing materials are likely to be disturbed, is such work is performed for a combined total of 30 or more days per year, regardless of fiber levels;

2 Who are exposed at or above the PEL or EL for a combined total of 30 or more days per year; or

3 Who are required to wear positive pressure respirators while performing asbestos-related work, regardless of the number of days respirators are worn.

c. Information to medical officer. The following information must be provided to the examining medical officer, by the OMSEP coordinator, prior to the examination taking place:

(1) A copy of the OSHA asbestos standards [29 CFR 1915.1001], with appendices D and E.

(2) A description of the affected employee's duties as they relate to the employee's exposure.

(3) The employee's representative exposure level or anticipated exposure level.

(4) A description of any personal protective or respiratory equipment used or to be used.

d. Examination protocol.

(1) Each initial, periodic, and exit examination shall include, as a minimum:

(a) A medical and work history. Emphasis should be placed on the member's history of tobacco use (smoking), and associated symptoms of dyspnea on exertion, recurrent epigastric discomfort, pleuritic chest pains or unexplained cough.

(b) Completion of the OSHA Respiratory Medical Evaluation Questionnaire Appendix C to RP Standard 29CFR 1910.134. Note: additional information on asbestos reporting guidelines may be found at www.osha.gov.

(c) A complete physical examination of all systems, with emphasis on the respiratory system, the cardiovascular system, and digestive tract.

(d) A stool guaiac test, if the patient is age 35 or over.

(e) PFTs, including FVC and FEV1.

(f) Routine screening labs, including a CBC, multichemistry panel (including glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, LDH, and alkaline phosphatase), and U/A with microscopic.

(g) A postero-anterior (PA) CXR, in accordance with the schedule and interpretation requirements in Section 12-C-2-d(2) below;

(h) Any other tests or procedures deemed appropriate by the examining physician, including specialty consultations.

(2) Chest x-ray requirements:

(a) A PA CXR shall be performed at the initial examination and then according to the following schedule:

Years since	Age of examinee		
First exposure	15 to 35	36 to 45	over 45
0 to 10	Every 5 yrs.	Every 5 yrs.	Every 5 yrs.
Over 10	Every 5 yrs.	Every 2 yrs.	Annually

(b) A PA chest-x-ray shall be performed at the exit examination.

(c) All CXRs shall be interpreted and classified in accordance with a professionally accepted classification system and recorded following the format of the CDC/NIOSH (M) 2.8 form. A B-reader or a board eligible/certified radiologist using the ILO-U/C International Classification of Radiographs for Pneumoconiosis references shall only do the interpretation.

(d) Assistance in obtaining the location of the nearest B-reader is available from MLC (k).

e. Specific written requirements. In addition to the general requirements specified in Section 12-B-4-b, the examining physician must address the following in writing:

(1) Any detected medical conditions placing the employee at increased risk of health impairment from further asbestos exposure.

(2) The employee's ability to use respiratory and other personal protective equipment (see Section 12-C-9), and any limitations thereof.

(3) Employee notification of the results of the examination and any medical conditions resulting from asbestos exposure that might require follow-up.

(4) Employee notification of the increased risk of lung cancer attributable to the synergistic effects of asbestos and smoking.

3. Benzene (Figure 12-C-2).

a. Exposure effects. Benzene exposure can cause central nervous system depression, leukemia, aplastic anemia, and dermatitis. The primary route of exposure is inhalation

of vapors, though skin absorption may also occur. Within the Coast Guard, most benzene exposure occurs among marine inspectors and oil spill responders.

b. Required surveillance.

(1) The Coast Guard MSALs are based on the OSHA action level and PEL standards. Enrollment in the OMSEP is required for all personnel:

(a) who are or may be exposed to benzene at or above the current average exposure action level 30 or more days per year,

(b) who are or may be exposed to benzene at or above the current short-term exposure action level 10 or more days per year, or

(c) who served as resident inspectors, pollution investigators, marine safety officers, port safety officers, vessel inspectors, or marine investigators prior to 1990. These personnel are considered to have been exposed at/or above the MSAL unless otherwise documented.

(2) In addition to routine surveillance requirements above, if an employee is exposed to benzene in an emergency (fire, spill) situation, a urine specimen will be collected as soon as possible thereafter, but not later than 24 hrs. after the exposure, and an acute exposure examination will be performed within 72 hrs. of the exposure. Such an examination must contain a urinary phenol test on the collected urine specimen.

c. Information to medical officer. The following information must be provided to the examining physician, by the OMSEP coordinator, prior to the examination taking place:

(1) A description of the affected employee's duties as they relate to the employee's exposure.

(2) The employee's representative exposure level or anticipated exposure level.

(3) A description of any personal protective or respiratory equipment used or to be used.

d. Examination protocols.

(1) Each routine (non-acute exposure) initial, periodic, and exit examination shall include, as a minimum:

(a) A detailed history which includes:

1 past occupational exposure to benzene or any other hematological toxins, at work or at home;

2 a family history of blood dyscrasias, including hematological neoplasms;

3 a personal history of blood dyscrasias, including genetic hemoglobin abnormalities, bleeding abnormalities, abnormal function of formed blood elements; and of renal or liver dysfunction;

4 history of exposure to ionizing radiation;

5 smoking history, alcohol usage history, and all medicinal drugs routinely taken;

6 any current history of headache, difficulty concentrating, decreased attention span, short-term memory loss, mood lability, fatigue, dry skin, abnormal bleeding, anemia, or weight loss.

(b) a complete physical examination, (Ensure the patient is examined for mental status changes, dermatitis, and pallor.);

(c) a CBC and differential, with platelet count and RBC indices (MCV, MCH, MCHC);

(d) a multichemistry panel (includes glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, LDH, and alkaline phosphatase) and U/A with microscopic;

(e) any other tests or procedures deemed appropriate by the examining physician.

(2) Each acute exposure examination shall include, as a minimum:

(a) a brief summary of the nature of the exposure and investigation of any symptoms or complaints;

(b) a total urinary phenol level (mg/L) or a urinary phenol adjusted for urinary creatinine (mg/g creatinine), plus a CBC and differential, with platelet count, and RBC indices (MCV, MCH, MCHC). Plasma folate and B12 levels to rule out megaloblastic anemia if the MCV is elevated.

(c) any other test or procedure deemed appropriate by the examining physician may be performed, if available. Coast Guard medical providers are encouraged to contact G-WKS for advise and consultation in selecting the most applicable test or procedure. Alternatively, medical providers may contact any certified Occupational Health clinic provider, available in the local community.

(d) If either the total urinary phenol level is below 50 mg phenol/L of urine, or the urinary phenol adjusted for urinary creatinine is less than 250 mg/g creatinine, and the CBC is normal, no further testing is required. Otherwise, contact Commandant (G-WKS-3) for further requirements.

e. Specific written requirements. In addition to the general requirements specified in Section 12-B-4-b, the following must be addressed in writing by the examining medical officer:

(1) Any detected medical conditions, which would place the employee's health at greater than normal risk of material impairment from exposure to benzene.

(2) The medical officer's recommended limitations upon the employee's exposure to benzene or upon the employee's use of protective clothing or equipment and respirators.

(3) A statement that the employee has been informed by the medical officer of the results of the examination and any medical conditions resulting from benzene exposure which require further explanation or treatment.

4. Chromium Compounds (Figure 12-C-3).

a. Exposure effects. Hexavalent chromium compounds are known human carcinogens. They may also cause dermatitis, skin ulceration, occupational asthma, and nasal septum perforation. The primary routes of exposure are percutaneous absorption and inhalation. Chromates may be found in certain metal alloys, paints, and masonry cements. Within the Coast Guard, most chromate exposure is from the use of chromium containing paints.

b. Required surveillance. The Coast Guard MSALs are based on the ACGIH threshold limit values (TLVs). Medical surveillance is required for all personnel who are or may be exposed to chromium IV compounds at or above the current exposure action level 30 or more days per year.

c. Information to medical officer. The following information must be provided by the OMSEP coordinator to the examining physician prior to the examination taking place:

(1) A description of the affected employee's duties as they relate to the employee's exposure.

(2) The employee's representative exposure level or anticipated exposure level.

(3) A description of any personal protective or respiratory equipment used or to be used.

d. Examination protocols. Each routine initial, annual (periodic), and exit examination must include:

(1) A detailed history, which includes:

(a) Past and current occupational exposures to chromate, asbestos, or any other pulmonary carcinogens at work or at home;

(b) Smoking history and alcohol usage history;

(c) Any past or current history of dry skin, skin ulcers—usually painless, nosebleeds, asthma, shortness of breath, wheezing, or cough;

(2) A directed physical examination, with attention to the skin, mucous membranes, and respiratory tract, both upper and lower (ensure the patient is examined for erosion of the nasal mucosa and septum, respiratory rhonchi, dermatitis, and cutaneous ulcers);

(3) A CBC, multichemistry panel (includes glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, LDH, and alkaline phosphatase), and a U/A with microscopic;

(4) PFTs (including FVC & FEV_1);

(5) A PA CXR **only** for an initial/baseline or exit examination, unless there is a current clinical indication (cough, shortness of breath, wheezing, etc.);

(6) Any other tests or procedures deemed appropriate by the examining physician.

e. Specific written requirements. Other than the general requirements specified in Section 12-B-4-b, the physician should address:

(1) The periodicity of the next routine medical surveillance examination. Examinations will be provided annually unless the physician recommends a longer interval.

(2) The employee's ability to use respiratory and other personal protective equipment (see Section 12-C-9), and any limitations thereof.

5. Hazardous Waste (Figure 12-C-4).

a. Exposure effects. The OSHA medical surveillance protocol for hazardous waste operations and emergency response (HAZWOPER)[29 CFR 1910.120] involves medical surveillance for potential exposure to numerous metals and chemicals, usually in uncontrolled—spill, fire, disposal—situations. Therefore, there are no specific exposure effects to describe.

b. Required surveillance.

(1) Routine medical surveillance is required for employees involved in hazardous waste operations when any of the following conditions are met:

(a) Exposure or potential exposure to hazardous substances or health hazards at or above the MSAL for that substance (as defined in Section 12-A-4), without regard to the use of respirators or personal protective equipment, for 30 or more days per year.

(b) All hazardous waste operation employees who wear a respirator for 30 or more days per year or as required under Section 12-C-9.

(c) All employees who are injured, become ill, or develop signs or symptoms due to possible overexposure involving hazardous substances or health hazards from an emergency response or hazardous waste operation.

(d) Members of HAZMAT response teams, including all Coast Guard Strike Team members and firefighters.

(2) In addition to routine surveillance requirements above, if an employee is exposed to a hazardous substance above the Coast Guard MSAL in an emergency (fire, spill) situation, a urine specimen will be collected as soon as possible thereafter, but not later than 24 hrs after the exposure, and an acute exposure examination will be performed within 72 hrs of the exposure.

c. Information to medical officer. The examining medical officer shall be provided, by the OMSEP coordinator, one copy of the OSHA HAZWOPER standard [29 CFR 1910.120] and its appendices, plus the following specific information:

(1) A description of the employee's duties as they relate to the employee's exposures.

(2) The employee's exposure levels or anticipated exposure levels.

(3) A description of any personal protective equipment used or to be used, including any respirators.

(4) Information from previous medical examinations of the employee which is not readily available to the examining physician.

d. Examination protocols.

(1) Each routine (non-acute exposure) initial, periodic, and exit examination shall include, as a minimum:

(a) A medical and occupational history which includes:

1 past and current occupational exposure to hazardous chemicals, metals, dusts, fumes, and heat stress;

2 any history of heat illness, allergies, sensitivities, or physical abnormalities;

3 current medications, and immunization history;

4 smoking history, and alcohol usage history;

5 a complete review of organ systems.

(b) A complete physical examination with attention to the skin, eyes, nose, throat, and respiratory, cardiovascular, genitourinary, and neurologic systems;

(c) A CBC and differential, with platelet count, and RBC indices (MCV, MCH, MCHC);

(d) A multichemistry panel (includes glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, LDH, and alkaline phosphatase) and U/A with microscopic;

(e) PFTs (including FVC & FEV1);

(f) Vision screening;

(g) A PA CXR only for an initial/baseline or exit examination, unless there is a current clinical indication (cough, shortness of breath, wheezing, etc.);

(h) Any other tests or procedures deemed appropriate by the examining physician. (Consider a stool guaiac and/or electrocardiogram, if indicated by age or physical findings).

(2) Each acute exposure examination shall include, as a minimum:

(a) A brief summary of the nature of the exposure and investigation of any symptoms or complaints;

(b) A CBC and differential, with platelet count, and RBC indices (MCV, MCH, MCHC), a multichemistry panel (includes glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, LDH, and alkaline phosphatase) and a U/A with microscopic;

(c) PFTs (including FVC & FEV1);

(d) Appropriate biological monitoring tests (e.g., blood metal screen) depending on the exposure in question. Contact Commandant (G-WKS-3) for further information and requirements.

e. Specific written requirements. Other than the general requirements specified in Section 12-B-4-b, the physician should address:

(1) Whether the employee has any detected medical conditions which would place the employee at increased risk of material impairment of the employee's health from work in hazardous waste operations or emergency response, or from respirator use.

(2) The employee's ability to use respiratory and other personal protective equipment (see Section 12-C-9), and any limitations thereof.

(3) The periodicity of the next routine medical surveillance examination. Examinations will be provided annually unless the physician recommends a longer interval.

6. Lead (Figure 12-C-5).

a. Exposure effects. In adults, excessive lead exposure can cause hypertension, anemia, peripheral neuropathy, encephalopathy, spontaneous abortions in women, and decreased fertility in men. The primary route of exposure in adults is inhalation of lead containing dust or fumes. Most exposure in the Coast Guard occurs during removal of previously applied lead-based paint coatings, or during environmental recovery of previously discarded lead-acid batteries. Some welders may be exposed to lead fumes.

b. Required surveillance. The Coast Guard MSAL is based on the OSHA PEL standard for shipyards [29 CFR 1915.1025]. Enrollment in the OMSEP is required for all personnel who are or may be exposed to lead at or above the current exposure action level for 30 or more days per year.

c. Information to medical officer. The OMSEP coordinator shall provide the medical officer with one copy of the OSHA lead standard [29 CFR 1915.1025] and its appendices, plus the following specific information:

(1) A description of the employee's duties as they relate to the employee's exposure.

(2) The employee's exposure level or anticipated exposure levels to lead and to any other toxic substance (if applicable).

(3) A description of any personal protective equipment used or to be used, including any respirators (if known).

(4) Prior blood lead determinations.

(5) Information from previous medical examinations of the employee which is not readily available to the examining physician. This includes all available prior written medical opinions concerning the employee.

d. Examination protocols.

(1) Biological monitoring or "blood lead only" examinations must be provided to each employee exposed at or above the OSHA action level (currently TWA of 30 mg/ m^3 air) **every six months**. Otherwise, only annual examinations must be performed, unless an employee's blood lead level is found to be elevated at or above 40 mg/100 ml of whole blood.

(2) Each routine initial, periodic, exit, and acute exposure examination shall include, as a minimum:

(a) A detailed work history and a medical history, with particular attention to:

1 past lead exposure (occupational and non-occupational);

2 personal habits (smoking, handwashing after work and before eating);

3 past and current gastrointestinal, hematological, renal, cardiovascular, reproductive, and neurological problems.

(b) A complete physical examination with particular attention to:

1 occular fundi, teeth, gums, hematological, gastrointestinal, renal, cardiovascular, and neurological systems;

2 blood pressure (must be recorded);

3 pulmonary status should be evaluated if respiratory protection is to be used. (See Section 12-C-9).

(c) The following routine laboratory tests:

1 a CBC and differential, with platelet count, and RBC indices (MCV, MCH, MCHC), plus examination of peripheral smear morphology;

2 blood lead level and zinc protoporphyrin (must be performed by a laboratory licensed by the CDC for proficiency in blood lead testing);

3 a multi-chemistry panel (includes glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, LDH, and alkaline phosphatase);

4 a U/A with microscopic examination; and,

5 PFTs (including FVC & FEV 1).

(d) Any other tests or procedures deemed appropriate by the examining physician (pregnancy testing, laboratory examination of male fertility).

e. Specific written requirements. In addition to the general requirements specified in Section 12-B-4-b, the physician should address:

(1) Any detected medical conditions which would place the employee at increased risk of material impairment of the employee's health from exposure from lead, or from respirator use.

(2) The employee's ability to use respiratory and other personal protective equipment (see Section 12-C-9), and any limitations thereof.

(3) The results of the blood lead determinations.

7. Noise (Figure 12-C-6).

a. Exposure effects. The primary effect of excessive noise is to cause loss of hearing. This hearing loss may be described by three "p-words:" painless, progressive, and permanent. Cumulative overexposures to hazardous noise levels cause millions of people to lose hearing during their working lives.

b. Required surveillance. The Coast Guard MSAL is based on DOD Instruction 6055.12, DOD Hearing Conservation Program, as well as OSHA guidance [29 CFR 1910.95]. Enrollment in the OMSEP is required for all personnel who are or may be exposed to hazardous noise at or above the current exposure action level for 30 or more days per year. However, personnel who infrequently or incidentally enter designated "hazardous noise areas" need not participate in the audiometric testing program.

(1) Enrollment is required in accordance with the following criteria:

(a) When the member is exposed to continuous and intermittent noise that has an 8-hour time-weighted average (TWA) noise level of >85 decibels A-weighted (dBA), or is exposed to impulse noise sound pressure levels (SPLs) of 140 decibels (dB) peak, or greater, or

(b) When a threshold shift of > 35 dB is noted in the speech frequencies.

(2) Reference (baseline) audiograms:

(a) All personnel shall receive a reference audiogram prior to any Coast Guard occupational noise exposure or before they are assigned to duties in "hazardous noise areas".

(b) Every effort should be made to schedule the reference audiogram on civilian workers in order to avoid conflicts with assigned duties; military personnel shall receive their reference audiogram at initial entry training.

(c) Testing to establish a reference audiogram shall be preceded by at least 14 hours without exposure to workplace noise. Hearing protectors that attenuate workplace noise below a TWA of 85 dBA, may be used to meet this requirement, in place of exclusion from the noisy workplace.

(3) Exit audiograms: shall be conducted on all employees, previously enrolled in the "hearing conservation program", if it is determined the employee no longer works in a designated "hazardous noise area," unless that employee is moving to another Coast Guard position that also involves work in such areas. However, if the employee's audiogram shows hearing losses (compared to the reference audiogram) of greater than 35 dB in the speech frequencies (500 - 3000 Hz) the employee must continue to receive annual audiograms until end of employment.

c. Information to medical officer. The OMSEP coordinator must provide the examining medical officer with a description of the employee's duties as they relate to the employee's exposure, the dB level of the hazardous work area and a description of any personal protective equipment used or to be used (e.g., earplugs or earmuffs).

d. Examination protocols.

(1) Each routine (non-acute exposure) initial, periodic, and exit examination shall include completion or updating of an Audiology History Questionnaire (CG 5552) and audiometric testing (audiogram). All audiometric testing shall:

(a) Be performed by a licensed or certified audiologist, otolaryngologist, or other physician; or by a technician who is certified by the Council for Accreditation in Occupational Hearing Conservation or who has completed CG HS "A" school. A technician who performs audiometric tests shall be responsible to an audiologist, otolaryngologist, or other physician. Standard instructions shall be given to individuals before testing.

(b) Be conducted in a testing environment with background octave band SPLs not greater than 27 dB at 500 Hz, 29 dB at 1000 Hz, 34 dB at 200 Hz, 39 dB at 4000 Hz, and 41 dB at 8000 Hz. The test environment shall be surveyed annually to ensure these levels are not exceeded.

(c) Include pure tone, air conduction, and hearing threshold examinations of each ear at the test frequencies of 500, 1000, 2000, 3000, 4000, and 6000 Hz.

(d) Be performed on audiometers conforming to the most current calibration specifications of the American National Standards Institute (ANSI). Audiometers currently in operation must receive annual electroacoustic calibration to maintain certification.

(e) Occur on audiometers that have received a functional operations check before each day's use for specifications in the OSHA Occupational Noise Exposure standard [29 CFR 1910.95]

(f) Be recorded on DD Form 2215 (Reference Audiogram), or DD Form 2216 (Hearing Conservation Data), or equivalent locally reproduced versions as appropriate.

(2) Significant Threshold Shift (STS). Transcribe the reference audiogram test results into the "Reference Audiogram" spaces on the DD Form 2216, Hearing

Conservation Data (or equivalent). The reference levels are subtracted from the current levels at 2000, 3000, and 4000 Hz. The differences in hearing levels calculated at 2000, 3000, and 4000 Hz are added together and divided by three, for each ear. STS exists if the resulting average hearing loss in either ear is greater than or equal to ±10 dB [29 CFR 1910.95]. Additionally, any change of ±15 dB at 2000, 3000, or 4000 Hz in either ear shall constitute an STS. Results shall be recorded on DD Form 2216. Aging (presbycusis) can contribute to the change in hearing level. When determining whether an STS has occurred, note the following: The TRACOR microprocessor audiometer automatically corrects for aging. The National Institute for Occupational Safety and Health (NIOSH) age corrections shall **not** be applied when determining STS if a microprocessor audiometer is used for the test.

(3) A follow-up audiogram shall be conducted when an individual's audiogram shows an STS, in either ear, relative to the current reference audiogram. Medical evaluation is required to validate the existence of a permanent noise-induced threshold shift and/or to determine if further medical referral is required. An audiologist, otolaryngologist, or other knowledgeable physician shall perform the evaluation and determine if the noise-induced STS is/is not work-related or has/has not been aggravated by occupational noise exposure.

(4) When a negative STS (improvement in hearing threshold from the reference audiogram) is noted on the periodic audiogram, one 14-hour noise-free follow-up test is required. That may be administered on the same day as the periodic test. The results of the follow-up test may be used to create a re-established reference audiogram.

(5) When a positive STS (decrease in hearing threshold form the reference audiogram) is noted on the periodic audiogram, two consecutive 14-hour noise-free follow-up tests **must** be administered to confirm if the decrease in hearing is permanent. The follow-up exams may not be performed on the same day as the periodic audiogram The results of the second follow-up test may be used to reestablish a reference audiogram, **if the required medical evaluation validates the existence of a permanent noise induced threshold shift (see Section 12-3-d.(3) above)**. If the results of the first follow-up test do not indicate an STS, a second follow-up test is not required.

(6) A new reference audiogram shall replace the original reference audiogram when the medical evaluation confirms that the STS noted during the annual and follow-up audiograms is permanent. The original reference audiogram shall be retained in the patient's medical record.

(7) Acute exposure examinations (formerly called the Detailed Surveillance Program). These examinations are designed to observe any dynamic hearing loss, to identify those who demonstrate unusual noise sensitivity, or to monitor personnel acutely exposed to unprotected high levels of noise (impulse >140dba).

(a) The initial acute exposure examination shall consist of all elements described in Sections 12-C-7.d. (1)-(6), above. Additional follow-up audiograms will be performed at 30 and 90 days, or at more frequent intervals at the discretion of the medical officer.

(b) If any of the follow-up audiograms demonstrate an average loss of no more than 10 dB in 2000, 3000, and 4000 Hz in either ear, when compared to the revised reference audiogram, hearing may be considered stable. The reference audiogram (per Section 12-C-7-d (5) and (6)) remains the audiogram against which further testing is compared. The individual is returned to annual monitoring.

(c) If these reevaluation audiograms exhibit a loss greater than an average threshold of 10 dB in 2000, 3000, and 4000 Hz in either ear when compared to the revised reference audiogram, the individual must be referred to an otolaryngologist for a consultation. Final disposition will depend on the consultant's diagnosis and recommendations.

e. Specific written requirements. In addition to the general requirements specified in Section 12-B-4-b, the medical officer must do the following:

(1) The employee shall be notified in writing within 21 days, when an audiologist or a physician confirms a threshold shift is permanent. Such determination must be entered in the employee's medical record.

(2) Supervisors shall be notified, in writing, that the worker has experienced a decrease in hearing. Release of medical information must conform to privacy act requirements.

(3) Document that the patient was counseled concerning the potential seriousness of repeated unprotected exposures to excessive noise and provided additional information on hearing protection and avoidance of hazardous noise exposures.

8. Pesticides (Figure 12-C-7).

a. Exposure effects. There are over 1,200 chemical compounds currently classified as pesticides. However, this surveillance protocol is primarily concerned with only two classes of pesticides: organophosphate and carbamate insecticides, and chlorophenoxyacetic acid herbicides. Organophosphates and carbamates are inhibitors of the enzyme acetylcholinesterase and they cause parasympathetic nervous system hyperactivity (miosis, urination, diarrhea, defecation, lacrimation, salivation), neuromuscular paralysis, CNS dysfunction (irritability, anxiety, impaired cognition, seizures, coma), peripheral neuropathy, and depression of RBC cholinesterase activity. Chlorophenoxyacetic acid herbicides cause skin, eye, and respiratory tract irritation, cough, nausea, vomiting, diarrhea, abdominal pain, and peripheral neuropathy. In the past, some chlorophenoxyacetic herbicides were contaminated with dioxins during manufacture.

b. Required surveillance. The Coast Guard MSALs for carbaryl, chlorpyrifos, malathion, parathion, 2,4, -D, and 2,4,5,-T are based on the ACGIH threshold limit values. Enrollment in the OMSEP is required for all personnel who are or may be exposed to **any** identified pesticide at or above the MSAL (as defined in Sect. 12-A-2) for 30 or more days per year.

c. Information to medical officer. The OMSEP coordinator must provide the examining medical officer with:

(1) A description of the employee's duties as they relate to the employee's exposure.

(2) The employee's exposure level or potential exposure level to any pesticides.

(3) A description of any personal protective equipment used or to be used, including any respirators.

d. Examination protocols.

(1) Biological monitoring or "RBC cholinesterase only" examinations must be provided at least **every six months** to each employee exposed to organophosphate or carbamate pesticides at or above the MSAL. If an employee's RBC cholinesterase activity is found on any testing to be less than 80% of the pre-exposure baseline, the frequency of biological monitoring will be increased to at least **every three months during the application season**. Non-seasonal, acute exposures will be monitored at a frequency determined by the supervising medical officer based on exposure information data.

(2) Each routine (non-acute exposure) initial, periodic, and exit examination shall include, as a minimum:

(a) A detailed work history and a medical history, with particular attention to:

1 past and current exposure to pesticides or other chemicals (occupational and non-occupational);

2 smoking and alcohol use history;

3 any symptoms of eye, nose, or throat irritation; cough; nausea, vomiting, diarrhea, or abdominal pain; irritability, anxiety, difficulty concentrating, impaired short-term memory, fatigue, or seizures; numbness, tingling, or weakness in the extremities; and

4 allergic skin conditions or dermatitis.

(b) A complete physical examination, with attention to the skin, respiratory, and nervous systems, including a mental status examination, should be performed. Pulmonary status must be evaluated if respiratory protection is used. (See Section 12-C-9).

(c) The following routine laboratory tests:

1 A CBC, a multichemistry panel (includes glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, LDH, and alkaline phosphatase), and a dipstick U/A;

2 An erythrocyte (RBC) cholinesterase level.

3 **Initial examination only—two RBC cholinesterase tests must be drawn at least 24 hrs. apart**. The results of these two tests will be averaged to provide the pre-exposure baseline for future reference, unless they differ by more than 15% from each other, in which case,

additional testing must be performed until successive tests do not differ by more than 15%. The pre-exposure baseline blood tests must be drawn after a period of at least 60 days without known exposure to organophosphates.

(d) Any other tests or procedures deemed appropriate by the examining physician (e.g., cognitive function testing). Pulmonary function testing should be performed at least once every 4 years if the employee wears a respirator.

(3) Each acute exposure examination shall include, as a minimum:

(a) A medical and work history with emphasis on any evidence of eye, nose, or throat irritation; cough; nausea, vomiting, diarrhea, or abdominal pain; irritability, anxiety, difficulty concentrating, impaired short-term memory, fatigue, or seizures; numbness, tingling, or weakness in the extremities.

(b) A complete physical examination with attention to any reported symptoms as well as the skin, respiratory, and nervous systems. A mental status examination must be performed.

(c) An erythrocyte (RBC) cholinesterase level.

(d) Any other tests or procedures deemed appropriate by the examining physician (e.g., CBC, CXR, cognitive function testing, urinary metabolites—if less than 24 hrs. post acute exposure). Pulmonary function testing should be performed at least every 4 years if the employee wears a respirator.

e. Specific written requirements. In addition to the general requirements specified in Section 12-B-4, the physician should address:

(1) Any detected medical conditions, which would place the employee's health at increased risk from exposure to identified pesticides or from respiratory wear.

(2) Counseling on the possible increased risk of health impairment from working with certain pesticides, in the event that the employee was found to have skin disease, chronic lung disease, or abnormalities of the central or peripheral nervous system that could directly or indirectly be aggravated by such exposure.

9. Respirator Wear (Figure 12-C-8).

a. Exposure effects. The OSHA medical surveillance protocol for respirator wear is a means to assess the effectiveness of respiratory protection among exposed workers. Periodic examinations are required to assess continued fitness for duties and to assess whether the present respiratory protection program provides adequate protection against illness. Respirators are often extremely uncomfortable to wear for long periods. Workers with asthma, claustrophobia, angina, and other conditions may not be able to wear respirators effectively. The worker should be questioned for a history or symptoms of past and current exposures to hazardous chemicals; fumes and dusts; smoking and alcohol use histories; wheezing or abnormal breath sounds; clubbing; and cardiac arrhythmia.

b. Required surveillance.

(1) Initial Medical Determination. An initial/baseline examination will be performed at the time of assignment to a job requiring respirator wear. Before an employee may be issued a respirator or assigned to a task that may require a respirator, that worker must complete a mandatory OSHA Respirator Medical Evaluation Questionnaire. This questionnaire will be provided, at the local unit by the cognizant SEHO, to all workers expected to require the use of a respirator. This questionnaire serves as the initial medical examination. A health care professional (nurse, nurse practitioner, physician assistant, and physician) must review this questionnaire to determine if a follow- up medical examination is required. Independent duty technicians (IDT'S) are authorized to review the questionnaire but must refer any positive responses on questionnaire (or any other concerns) to the supervising medical officer for further review. Any employee who gives a positive response to any questions among questions 1-8 in section two of the questionnaire shall be subject to a follow-up medical examination. This examination will determine whether the worker is physically and mentally capable of performing the work and using a respirator [29 CFR 1910.134].

(2) Additional Medical Evaluation and Medical Examination.

(a) Additional medical examinations maybe required to assess continued fitness for duties involving respirator wear. The following conditions will dictate the need for a follow-up evaluation:

1 The member reports signs and symptoms related to the ability to use a respirator;

2 The health care provider, supervisor, or respirator program coordinator informs the command of the need for evaluation;

3 Observations are made during fit testing, respirator use, or program evaluation that indicate the need for evaluation;

4 When changes in workplace conditions such as physical work effort, protective clothing or climate conditions result in substantial increase in physiological burden;

5 A member's scheduled quintennial physical examination.

(b) Periodic physical examinations will be provided at least once every five years. The periodic physical examination requires a review and update of the respirator questionnaire. A health care provider must review the questionnaire to determine the need for a follow-up examination. A follow-up medical examination is required for anyone with positive responses to questions 1-8 in section two of the questionnaire.

c. Information to medical officer. The OMSEP coordinator must provide the examining medical officer with:

(1) A description of the employee's duties as they relate to the employee's respirator wear.

(2) The employee's exposures or potential exposures to any hazardous chemicals or physical agents.

(3) A description of the respirator(s) used or to be used.

d. Examination protocol. Each routine (non-acute exposure) initial and periodic examination shall include, as a minimum the completion of the mandatory OSHA Respirator Medical Evaluation Questionnaire.

e. Specific written requirements. In addition to the general requirements specified in Section 12-B-4, the physician should address:

(1) Any detected medical conditions that would place the employee at increased risk of material impairment of the employee's health from respirator use.

(2) Asthmatics with normal or mildly impaired lung function should be evaluated based on the job requirements, but disapproval should be strongly considered for asthmatics that require regular medications to maintain airflow, or who have a history of airway reactivity or sensitization to extrinsic materials (dusts, fumes, vapors, or cold).

(3) Note: There currently exists no consensus standard by which physicians may assess a worker's ability to wear a respirator. As a general rule, however, anyone with documented respiratory impairment of moderate to severe degree (FEV_1 or FVC <70% of predicted) should not be routinely approved to wear a respirator.

10. Respiratory Sensitizers (Figure 12-C-9).

a. Exposure effects. Respiratory sensitizers include numerous compounds which cause both occupational asthma and/or hypersensitivity pneumonitis (extrinsic allergic alveolitis). Respiratory sensitizers include vegetable dusts and woods, molds and spores, animal danders, metals (platinum, chromium, nickel, cobalt, vanadium), and chemicals (isocyanates, formaldehyde, trimellitic anhydride).

b. Required surveillance. The Coast Guard MSALs for formaldehyde, toluene diisocyanate, and vanadium, are based on the ACGIH threshold limit values. Enrollment in the OMSEP is required for all personnel who are or may be exposed to **any** identified respiratory sensitizer at or above the MSAL (as defined in Sect. 12-A-2) for 30 or more days per year. In the Coast Guard, exposure to respiratory sensitizers is primarily associated with industrial operations, though some marine inspection activities may also lead to exposures.

c. Information to medical officer. The OMSEP coordinator must provide the examining medical officer with:

(1) A description of the employee's duties as they relate to the employee's exposure.

(2) The employee's exposure level or anticipated exposure level to any respiratory sensitizers.

(3) A description of any personal protective equipment used or to be used, including any respirators.

d. Examination protocols.

(1) Each routine (non-acute exposure) initial, periodic, and exit examination shall include, as a minimum:

(a) A detailed work history and a medical history, with particular attention to:

1 past and current exposure to respiratory sensitizers (occupational and non-occupational);

2 smoking history;

3 any symptoms of eye, nose, or throat irritation;

4 chronic airway problems or hyperactive airway disease; and

5 allergic skin conditions or dermatitis.

(b) In the event that the employee is not required to wear a respirator and the history and routine laboratory tests are unremarkable, the medical officer may determine that a complete physical examination is not required. Otherwise, at a minimum, a system specific physical examination with attention to the respiratory system must be completed. Pulmonary status must be evaluated if respiratory protection is used. (See Section 12-C-9).

(c) The following routine laboratory tests:

1 a CBC, a multichemistry panel (includes glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, LDH, and alkaline phosphatase), and a dipstick U/A;

2 PFTs (including FVC & FEV_1).

(d) Any other tests or procedures deemed appropriate by the examining physician (e.g., CXR, bronchial provocation tests).

(2) Each acute exposure examination shall include, as a minimum:

(a) A medical and work history with emphasis on any evidence of upper or lower respiratory problems, allergic conditions, skin reaction or hypersensitivity, and any evidence of eye, nose, or throat irritation.

(b) A directed physical examination with attention to the respiratory system.

(c) PFTs (including FVC & FEV1).

(d) Any other tests or procedures deemed appropriate by the examining physician (e.g., CBC, CXR, bronchial provocation tests).

e. Specific written requirements. In addition to the general requirements specified in Section 12-B-4-b, the physician should address:

(1) Any detected medical conditions which would place the employee at increased risk of material impairment of the employee's health from exposure to identified respiratory sensitizers, or from respirator use.

(2) The employee's ability to use respiratory and other personal protective equipment (see Section 12-C-9), and any limitations thereof.

11. Solvents (Figure 12-C-10).

a. Exposure effects. There are over 30,000 industrial solvents. This protocol is designed to survey for the most frequent health effects of solvents when considered as an admittedly broad group. These effects are skin disorders (acute irritant dermatitis, chronic eczema), acute CNS effects (headache, nausea and vomiting, dizziness, light-headedness, vertigo, disequilibrium, fatigue, weakness, nervousness, irritability, depression, confusion, coma), and chronic CNS effects (chronic solvent intoxication, neurobehavioral abnormalities, cognitive dysfunction). Some other less frequent effects of solvents involve the hematopoietic, hepatic, peripheral nervous system, renal, reproductive, and respiratory systems. Most solvents are **not** carcinogenic to humans; benzene being a notable exception (see Section 12-C-3, above). In the Coast Guard, exposure to solvents is primarily associated with industrial and maintenance operations (e.g., painting).

b. Required surveillance. The Coast Guard MSALs for ethylene glycol, methyl ethyl ketone, VM & P naphtha, and xylene are based on the ACGIH threshold limit values. Enrollment in the OMSEP is required for all personnel who are or may be exposed to **any** identified hazardous solvent at or above the MSAL (as defined in Section 12-A-2) for 30 or more days per year. An acute exposure examination is required in the event of any documented overexposure (above the TLV or STEL) to a solvent or any presumed overexposure where symptoms are present. In the case of an acute overexposure, an appropriate urine or blood specimen should be collected as soon as possible after the overexposure incident.

c. Information to medical officer. The OMSEP coordinator must provide the examining medical officer with:

(1) A description of the employee's duties as they relate to the employee's exposure.

(2) The employee's exposure level or potential exposure level to any solvents.

(3) A description of any personal protective equipment used or to be used, including any respirators.

d. Examination protocols.

(1) Each routine (non-acute exposure) initial, periodic, and exit examination shall include, as a minimum:

(a) A detailed work history and a medical history, with particular attention to:

1 past and current exposure to solvents (occupational and non-occupational);

2 smoking history and alcohol use history;

3 any symptoms of dry skin, skin irritation, or dermatitis;

4 any CNS symptoms, including headache, nausea and vomiting, dizziness, light-headedness, vertigo, disequilibrium, fatigue, weakness, nervousness, irritability, depression, difficulty concentrating, mood changes, or confusion;

5 a review of symptoms with attention to the hematopoietic, hepatic, peripheral nervous system, renal, reproductive, and respiratory systems.

(b) A system specific physical examination, with attention to the skin and nervous systems, including a mental status examination, should be performed. Pulmonary status must be evaluated if respiratory protection is used. (See Section 12-C-9).

(c) The following routine laboratory tests:

1 a CBC and differential, with platelet count, and RBC indices (MCV, MCH, MCHC); and

2 a multichemistry panel (includes glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, LDH, and alkaline phosphatase) and a U/A with microscopic.

(d) Consideration should be given to biological monitoring tests for ongoing overexposure to certain solvents, if specimens can be obtained in a timely manner during the exposure period. For non-acute exposures, a timely manner generally implies that the specimen be obtained at the end of a work shift or the end of a workweek.

1 For toluene, measure urinary hippuric acid, at the end of a full work shift.

2 For xylene, measure urinary methyl-hippuric acid, at the end of a full work shift.

3 For methylethylketone (MEK), measure urinary MEK, at the end of a full work shift.

4 For trichloroethylene, measure urinary trichloroacetic acid, at the end of a full workweek.

(e) Any other tests or procedures deemed appropriate by the examining physician (e.g., cognitive function tests. Note that skin (patch) testing is generally of little value in solvent-induced dermatitis, since the

pathophysiology is generally not allergic. Pulmonary function testing should be performed at least once every 4 years if the employee wears a respirator.

(2) Each acute exposure examination shall include, as a minimum:

(a) A medical and work history with emphasis on any evidence of skin disorders or acute CNS effects (headache, nausea and vomiting, dizziness, light-headedness, vertigo, disequilibrium, fatigue, weakness, nervousness, irritability, depression, confusion, coma).

(b) A system specific physical examination with attention to the skin and nervous systems.

(c) If at all possible, a biological monitoring test for overexposure to the solvent in question should be performed, if such a test is available and a specimen can be obtained in a timely manner. For acute exposures, a timely manner implies within the first half-life of the chemical within the human body, generally a matter of a few hours after the overexposure.

(d) Any other tests or procedures deemed appropriate by the examining physician (e.g., CBC, CXR, and bronchial provocation tests).

e. Specific written requirements. In addition to the general requirements specified in Section 12-B-4-b, the physician should address:

(1) Any detected medical conditions, which would place the employee at increased risk of material impairment of the employee's health from any identified exposures to solvents, or from respirator use.

(2) The periodicity of the next routine medical surveillance examination. Examinations will be provided annually unless the physician recommends a longer interval.

12. Tuberculosis (Figure 12-C-11).

a. Exposure effects. Tuberculous droplet nuclei are coughed, spoken, or sneezed into the air by an individual with active pulmonary tuberculosis. Exposure to these airborne droplet nuclei may cause infection with the bacterium that causes tuberculosis.

b. Required surveillance. Employees who are occupationally exposed to active TB cases will be enrolled in the OMSEP and undergo annual screening for tuberculosis. See section 7-D-3 of this Manual, Tuberculosis Screening Program, for complete details. In the Coast Guard, medical personnel and personnel involved in alien migrant interdiction operations (AMIO) are at potential risk for exposure to active TB cases.

c. Information to medical personnel. In order to assess whether the employee should remain under active surveillance for TB exposure, the OMSEP coordinator must provide the examining medical officer with the following information:

(1) A description of the employee's duties as they relate to the employee's exposure.

(2) The employee's exposure level or potential exposure level active TB cases.

(3) A description of any personal protective equipment used or to be used.

d. Examination protocols.

(1) Routine screening for exposed individuals is covered in section 7-D-3.

(a) Personnel with a history of non-reactive tuberculin skin tests will receive annual skin testing. Routine skin testing does not require an examination by a medical officer.

(b) Personnel with a history of reactive skin test(s) will be monitored for development of symptoms of active TB (cough, hemoptysis, fatigue, weight loss, night sweats) annually. A health services technician or a medical officer may complete such monitoring. Routine annual CXRs will not be done.

(2) Evaluation of personnel with newly reactive tuberculin skin tests or suspected active TB is covered in section 7-D-4. A medical officer shall perform a physical examination and obtain a complete medical history in such personnel. A CXR should be done.

e. Specific written requirements. Requirements for recording routine skin test results are covered in Section 7-D-3-c. In addition, medical personnel should make a written recommendation as to whether continued annual TB surveillance is required.

13. Unspecified (Figure 12-C-12).

a. Exposure effects. Individuals undergoing surveillance in this category have exposures to hazards, which are not included in any of the other protocols. Exposure effects will vary with the nature of the exposure, so there are no specific effects to describe.

b. Required surveillance. Enrollment in the OMSEP is required whenever an employee is exposed to an identified hazard, at or above the MSAL, for 30 or more days per year.

c. Information to medical officer. The OMSEP coordinator must provide the examining medical officer with:

(1) A description of the employee's duties as they relate to the employee's exposure.

(2) The employee's exposure level or anticipated exposure level to any hazardous chemicals or physical agents.

(3) A description of any personal protective equipment used or to be used.

d. Examination protocols. Each routine initial, periodic, and exit examination shall include, as a minimum:

(1) A medical and work history. Ensure the patient is questioned about past exposure to chemical and physical hazards, smoking history and alcohol use, a complete review of systems.

(2) A complete physical examination of all systems, with attention to any organ systems with a significant history or current symptoms. Pulmonary status must be evaluated if respiratory protection is used. (See Section 12-C-9).

(3) A CBC, a multichemistry panel (includes glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, LDH, and alkaline phosphatase), and a dipstick U/A.

(4) Any other tests or procedures deemed appropriate by the examining physician. Pulmonary function testing should be performed at least once every 4 years if the employee wears a respirator.

e. Specific written requirements. In addition to the general requirements specified in Section 12-B-4-b, the physician should address:

(1) Any detected medical conditions which would place the employee at increased risk of material impairment of the employee's health from any identified exposures to identified hazards, or from respirator use.

(2) The periodicity of the next routine medical surveillance examination. Examinations will be provided annually unless the physician recommends a longer interval.

FIGURE 12-C-1

Date:	Unit:	OPFAC:	Unit POC:
Patient name:		SSN:	Unit Phone:
Exam type: ☐ Initial/Baseline ☐ Periodic ☐ Exit/Separation ☐ Other ___ Acute Exposure ☐			

Examination Protocol for Exposure to

ASBESTOS

IF EXAM TYPE IS	✓	DO or COMPLETE THESE ITEMS
Initial/Baseline	____ ____	CG-5447 History and Report of OMSEP Examination / DD-2808/DD-2807-1
	____	DD Form 2493-1 or OSHA Respiratory Disease Questionnaire (Part 1) (optional)
Periodic/Separation or Acute Exposure	____ ____	DD Form 2493-2 or OSHA Respiratory Disease Questionnaire (Part 2) (optional) CG 5447 (update)
All types	____	Complete blood count (CBC); multichemistry panel (includes liver function tests, BUN, creatinine); urinalysis with microscopic (U/A).
All types	____	Pulmonary function tests (FVC & FEV_1).
Acute Exposure	____	*Acute Exposure Form*
All types	____	Chest x-ray (PA) with "B-reader" or board certified radiologist evaluation at initial exam then per table:

	Years since first exposure		
	Age 15-35	*Age 36-45*	*Age >45*
0-10	Every 5 years	Every 5 years	Every 5 years
Over 10	Every 5 years	Every 2 years	Every year

All types	_____	Physician's notification regarding examination results. (Final action.)

To the examining medical officer:

You must follow-up any significant abnormality through to a physical diagnosis. Provide ICD codes.

Ensure that the patient is questioned about the following history or symptoms: smoking history, dyspnea on exertion, cough, pleuritic pain, heartburn or epigastric pain. (See OSHA Respiratory Disease Questionnaire.)

Ensure that the patient is examined for the following possible signs: clubbing, basilar rales.

You must address the following four items in writing: 1) whether the employee has any detected medical conditions placing him/her at increased risk of health impairment from further asbestos exposure; 2) any recommended limitations on use of personal protective equipment; 3) that the employee has been informed by you of the results of the examination and any medical conditions resulting from asbestos exposure that require follow-up; 4) that the employee has been informed of the increased risk of lung cancer attributable to the synergistic effects of asbestos and smoking.

Asbestos exposure can cause asbestosis, bronchogenic carcinomas, mesothelioma, and gastric carcinoma. It may also be associated with multiple myeloma and renal carcinoma. Disease risk is dose dependent.

Asbestos was used in shipbuilding until the 1970s. Exposure among OMSEP participants is mostly associated with repair and overhaul of vessels built prior to that time

If the patient is on multiple monitoring protocols, ensure each unique item is completed. However, it is not necessary to duplicate tests and forms.

FIGURE 12-C-2

Date:	Unit:	OPFAC:	Unit POC:
Patient name:		SSN:	Unit Phone:
Exam type: ☐ Initial/Baseline ☐ Periodic ☐ Exit/Separation ☐ Acute exposure ☐ Other _____			

Examination Protocol for Exposure to

BENZENE

IF EXAM TYPE IS	✓	DO or COMPLETE THESE ITEMS
Initial/Baseline	____ ____	CG-5447 History and Report of OMSEP Examination. DD-2808/DD-2807-1
All types	____	CBC and differential, with platelet count and RBC indices (MCV, MCH, MCHC).
Initial/Baseline, Periodic, or Separation	____ ____	Multichemistry panel (includes glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, GTT, LDH, and alkaline phosphatase) U/A with microscopic
Periodic /Separation/Acute Exposure	____	CG 5447 (update)
Acute exposure	____ ____	Urinary phenol. (Only immediately after acute exposure) **Blood or breath benzene level (optional-if available)** Acute Exposure Form
All types	____	Physician's notification regarding examination results. (Final action.)

To the examining medical officer:

- You must follow-up any significant abnormality through to a physical diagnosis. Provide ICD codes.
- Ensure that the patient is questioned about the following history or symptoms: smoking history, headache, difficulty concentrating, decreased attention span, short-term memory loss, mood lability, fatigue, dry skin, abnormal bleeding, anemia, weight loss.
- Ensure that the patient is examined for the following signs: mental status changes, dermatitis, pallor.
- Benzene exposure causes CNS depression, leukemia, aplastic anemia, and dermatitis.
- The employee should be medically removed from the workplace if any of the following are noted on the exam:
  - The hemoglobin/hematocrit is below the laboratory's normal limit and/or these indices show a persistent downward trend from the individual's pre-exposure norms; provided these findings cannot be explained by other means.
  - The thrombocyte (platelet) count has dropped more than 20% below the employee's most recent prior values or falls below the laboratory's normal limit.
  - The leukocyte count is below 4,000 per mm^3 or there is an abnormal differential count.
- Benzene is commonly associated with petrochemical manufacturing. Exposure among OMSEP participants is generally related to marine vessel inspection or disaster response (oil spill, fire). Commercial gasoline is about 3% benzene.
- If the patient is on multiple monitoring protocols, ensure each unique item is completed. However, it is not necessary to duplicate tests and forms.

FIGURE 12-C-3

Date:	Unit:	OPFAC:	Unit POC:
Patient name:		SSN:	Unit Phone:
Exam type: ☐ Initial/Baseline ☐ Periodic ☐ Exit/Separation ☐ Other _____ Acute Exposure ☐			

Examination Protocol for Exposure to

CHROMATES

IF EXAM TYPE IS	✓	DO or COMPLETE THESE ITEMS
Initial/Baseline	____ ____	CG-5447 History and Report of OMSEP Examination/ DD-2808/DD-2807-1
Initial/Baseline or Separation	____	Chest x-ray (PA)
Periodic/Separation/ Acute Exposure	____	CG 5447 (update)
All types	____	Pulmonary function tests (FVC & FEV_1).
All types	____	Complete blood count (CBC)
All types	____	Multichemistry panel (includes glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, LDH, and alkaline phosphatase)
All types	____	U/A with microscopic
All types	____	Physician's notification regarding examination results. (Final action.)

To the examining medical officer:

- You must follow-up any significant abnormality through to a physical diagnosis. Provide ICD codes.
- Ensure that the patient is questioned about the following history or symptoms: smoking history, shortness of breath, wheezing, cough, dry skin, skin ulcers.
- Ensure that the patient is examined for the following signs: erosion of nasal mucosa and septum, respiratory rhonchi, dermatitis, cutaneous ulcers.
- Make a recommendation as to when the next OMSEP examination for this employee should take place. The default interval is 1 year, but you may recommend a longer period of 18 or 24 months, if exposures are limited and there is no evidence of occupationally significant illness.
- Chromium exposure causes lung cancer, dermatitis, skin ulcers, and nasal septum perforation.
- Chromic acid may cause acute burns or irritation to skin, eyes, and upper respiratory tract. Inhalation may cause acute epiglottitis, laryngospasm, pneumonitis, and pulmonary edema.
- Some chromium compounds cause occupational asthma.
- Chromium compounds are commonly associated with steel and chemical manufacturing. Exposure among OMSEP participants is generally related to working with chromium containing paints.
- If the patient is on multiple monitoring protocols, ensure each unique item is completed. However, it is not necessary to duplicate tests and forms.

FIGURE 12-C-4

Date:	Unit:	OPFAC:	Unit POC:
Patient name:		SSN:	Unit Phone:
Exam type: ☐ Initial/Baseline ☐ Periodic ☐ Exit/Separation ☐ Acute exposure ☐ Other _____			

Examination Protocol for Exposure to

Hazardous Waste

IF EXAM TYPE IS	✓	DO or COMPLETE THESE ITEMS
Initial/Baseline	____ ____	CG-5447 History and Report of OMSEP Examination DD-2808/DD-2807-1
Initial/Baseline or Separation	____	Chest x-ray (PA)
Periodic/Separation /Acute Exposure	____	CG 5447 (update)
All types except acute exposure	____	Vision screening (distant and near)
All types	____	Pulmonary function tests (FVC & FEV_1).
All types	____	CBC and differential, with platelet count and RBC indices (MCV, MCH, MCHC).
All types	____	Multichemistry panel (includes glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, LDH, and alkaline phosphatase)
All types	____	U/A with microscopic
Acute exposure	____	Blood lead and/or heavy metal screen, if indicated.
All types	____	Physician's notification regarding examination results. (Final action.)

To the examining medical officer:

- You must follow-up any significant abnormality through to a physical diagnosis. Provide ICD codes.
- Ensure that the patient is questioned about the following history or symptoms: smoking history, weight loss, headache, visual disturbances, difficulty concentrating, decreased attention span, short-term memory loss, confusion, mood lability, fatigue, ataxia, peripheral numbness or paresthesias, weakness, shortness of breath, anemia.
- Ensure that the patient is examined for the following signs: gingivitis, sialorrhea, tremor, mental status changes, decreased deep tendon reflexes, decreased vibratory sensation, respiratory rhonchi and hyperresonance, dermatitis, edema.
- Make a recommendation as to when the next OMSEP examination for this employee should take place. The default interval is 1 year, but you may recommend a longer period of 18 or 24 months, if exposures are limited and there is no evidence of occupationally significant illness.
- The hazardous waste protocol involves medical surveillance for effects of exposure to a variety of heavy metals and chemical compounds. Neurotoxicity, pulmonary disease, dermatitis, and cancer are possible effects of excessive exposures to hazardous wastes.
- OMSEP participants monitored under this protocol are primarily members of HAZMAT and spill response teams, firefighters, and marine safety inspectors. Individual, specific exposure histories are often ill defined. If the patient is on multiple monitoring protocols, ensure each unique item is completed. However, it is not necessary to duplicate tests and forms.

FIGURE 12-C-5

Date:	Unit:	OPFAC:	Unit POC:
Patient name:		SSN:	Unit Phone:
Exam type: ☐ Initial/Baseline ☐ Periodic ☐ Exit/Separation ☐ Acute exposure ☐ Other _____			

Examination Protocol for Exposure to

Lead

IF EXAM TYPE IS	✓	DO or COMPLETE THESE ITEMS
Initial/Baseline	____ ____	CG-5447 History and Report of OMSEP Examination DD-2808/DD-2807-1
All types	____	Blood lead and zinc protoporphyrin (ZPP)
All types	____	CBC and differential, with platelet count and RBC indices (MCV, MCH, MCHC), plus examination of peripheral smear morphology.
Periodic/Separation/Acute Exposure	____	CG 5447 (update)
All types	____	Multichemistry panel (includes glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, LDH, alkaline phosphatase, and uric acid)
Acute Exposure	____	Acute Exposure Form
All types	____	U/A with microscopic
All types	____	Physician's notification regarding examination results. (Final action.)

To the examining medical officer:

- You must follow-up any significant abnormality through to a physical diagnosis. Provide ICD codes.
- Ensure that the patient is questioned about the following history or symptoms: past lead exposure, smoking history, abdominal pain and cramping, joint and extremity pain, difficulty concentrating, irritability, short-term memory loss, confusion, mood lability, fatigue, ataxia, peripheral numbness or paresthesias, weakness, anemia, and infertility.
- Ensure that the patient is examined for the following signs: hypertension, papilledema, gum "lead lines", pallor, mental status changes, decreased deep tendon reflexes, decreased vibratory sensation, extensor motor weakness.
- Lead exposure can cause fatigue, anemia, arthralgias and myalgias, peripheral motor neuropathy, neurobehavioral disturbances and encephalopathy, acute abdominal pain, gout and gouty nephropathy, acute and chronic renal failure, spontaneous abortions, and male infertility.
- If the blood lead level is greater than 40 µg/100 g of whole blood, the employee must be medically removed from any workplace exposure.
- If the patient is on multiple monitoring protocols, ensure each unique item is completed. However, it is not necessary to duplicate tests and forms.

FIGURE 12-C-6

Date:	Unit:	OPFAC:	Unit POC:
Patient name:		SSN:	Unit Phone:
Exam type: ☐ Initial/Baseline ☐ Periodic ☐ Exit/Separation ☐ Acute exposure ☐ Other _____			

Examination Protocol for Exposure to

Noise

IF EXAM TYPE IS	✓	DO or COMPLETE THESE ITEMS
Initial/Baseline	____	CG-5447 History and Report of OMSEP Examination
	____	DD-2808/DD-2807-1
	____	CG-5552 Audiology History Questionnaire
	____	DD Form 2215 (optional) or equivalent locally reproduced version.
Periodic, Separation, or Acute Exposure	____	DD Form 2216 (optional) or equivalent locally reproduced version.
All types	____	Physician's notification regarding examination results. (Final action.)

To the examining medical officer**:**

- You must follow-up any significant abnormality through to a physical diagnosis. Provide ICD codes.
- Review and initial the CG-5552 Audiology History Questionnaire and the audiogram results.
- A significant threshold shift (STS) exists if the average change in hearing from the reference audiogram at, 2000, 3000, and 4000 Hz is greater than or equal to $\pm$10 dB in either ear.
- Additionally, any change of $\pm$15 dB at 1000, 2000, 3000, or 4000 Hz in either ear constitutes an STS.
- Do not apply the National Institute for Occupational Safety and Health (NIOSH) age corrections when determining STS.
- Follow-up audiograms must be conducted when an individual's audiogram shows an STS relative to the current reference audiogram in either ear. When a positive STS (decrease in hearing threshold) is noted, two 14-hour noise-free follow-up tests must be administered to confirm that the decrease in hearing is permanent. When a negative STS (improvement in hearing) is noted, one 14-hour noise-free follow-up tests must be administered.
- Medical evaluation is required to validate the existence of a permanent noise-induced threshold shift and/or to determine if further medical referral is required. That evaluation must be performed by an audiologist, and otolaryngologist, or other knowledgeable physician.
- If, compared with the current reference audiogram, a loss of hearing of $\geq$ 35 dB in either ear at one or more of the speech frequencies (500, 1,000, 2000, or 3000 Hz) is noted , the employee must be medically removed from further workplace exposure.
- If the patient is on multiple monitoring protocols, ensure each unique item is completed. However, it is not necessary to duplicate tests and forms.

FIGURE 12-C-7

Date:	Unit:	OPFAC:	Unit POC:
Patient name:		SSN:	Unit Phone:
Exam type: ☐ Initial/Baseline ☐ Periodic ☐ Exit/Separation ☐ Acute exposure ☐ Other _____			

Examination Protocol for Exposure to

Pesticides

IF EXAM TYPE IS	✓	DO or COMPLETE THESE ITEMS
Initial/baseline	____	CG-5447 History and Report of OMSEP Examination
	____	DD-2808/DD-2807-1
	____	Blood cholinesterase level, two specimens at least 24 hrs. apart
Periodic/ Separation or Acute Exposure	____	Blood cholinesterase level, if current exposure involves organophosphate or carbamate pesticides
	____	CG 5447 (update)
All types	____	Pulmonary function tests (FVC & FEV_1).
All types except acute exposure	____	CBC and differential, with platelet count and RBC indices (MCV, MCH, MCHC)
All types except acute exposure	____	Multichemistry panel (includes glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, LDH, alkaline phosphatase)
All types except acute exposure	____	U/A with microscopic
Acute Exposure	____	Acute Exposure Form
All types	____	Physician's notification regarding examination results. (Final action.)

To the examining medical officer:

- You must follow-up any significant abnormality through to a physical diagnosis. Provide ICD codes.
- Ensure that the patient is questioned about the following history or symptoms: past and current exposures to pesticides, smoking and alcohol use history; eye, nose or throat irritation; cough; nausea, vomiting, diarrhea or abdominal pain; irritability, anxiety, difficulty concentrating, impaired short-term memory, fatigue, or seizures; numbness, tingling, or weakness in the extremities; allergic skin conditions or dermatitis.
- Ensure the patient is examined for the following possible signs: dermatitis, meiosis, rhinitis, mental status changes. Pulmonary system must be examined if respiratory protection is used.
- If the cholinesterase level is at or below 50% of the pre-exposure baseline, the employee must be medically removed from any further workplace exposure.
- Organophosphates and carbamates are inhibitors of the enzyme acetylcholinesterase. They cause parasympathetic nervous system hyperactivity, neuromuscular paralysis, CNS dysfunction, peripheral neuropathy, and depression of RBC cholinesterase activity. Chlorophenoxyacetic acid herbicides cause skin, eye, and respiratory tract irritation, cough, nausea, vomiting, diarrhea, abdominal pain, and peripheral neuropathy.
- If the patient is on multiple monitoring protocols, ensure each unique item is completed. However, it is not necessary to duplicate tests and forms.

FIGURE 12-C-8

Date:	Unit:	OPFAC:	Unit POC:
Patient name:		SSN:	Unit Phone:
Exam type: ☐ Initial/Baseline ☐ Periodic ☐ Exit/Separation ☐ Other _____			

Examination Protocol for Exposure to

Respirator Wear

IF EXAM TYPE IS	✓	DO or COMPLETE THESE ITEMS
Initial/Baseline	____	OSHA Respiratory Medical Evaluation Questionnaire
Periodic/Exit/Separation	____	OSHA Respiratory Medical Evaluation Questionnaire (update).
All types	____	Physician's notification regarding examination results. (Final action.)

To the examining medical officer**:**

- You must follow-up any significant abnormality through to a physical diagnosis. Provide ICD codes.
- This protocol applies to all employees required to wear a respirator in the course of their work.
- Ensure that the patient is questioned about the following history or symptoms: past and current exposures to hazardous chemicals, fumes, and dusts; smoking and alcohol use history; any history of claustrophobia, asthma, angina, syncope, and other respiratory or cardiovascular disease.
- Ensure the patient is examined for the following possible signs: wheezing or other abnormal breath **sounds,** clubbing, and cardiac arrhythmias**.**
- You must address whether the employee as any detected medical conditions which would place him or her at increased risk of material health impairment from the required respirator use. Consider whether the employee's health will allow him or her to tolerate respirator wear.
    - ∗ Note: There currently exists no consensus standard by which physicians may assess a worker's ability to wear a respirator. As a general rule, however, anyone with documented respiratory impairment of moderate to severe degree (FEV1 or FVC <70% of predicted) should not be routinely approved to wear a respirator. Asthmatics with normal or mildly impaired lung function should be evaluated based on the job requirements, but disapproval should be strongly considered for asthmatics that require regular medications to maintain airflow, or who have a history of airway reactivity or sensitization to extrinsic materials (dusts, fumes, vapors, or cold).
- If the patient is on multiple monitoring protocols, ensure each unique item is completed. However, it is not necessary to duplicate tests and forms.

FIGURE 12-C-9

Date:	Unit:	OPFAC:	Unit POC:
Patient name:		SSN:	Unit Phone:
Exam type: ☐ Initial/Baseline ☐ Periodic ☐ Exit/Separation ☐ Acute exposure ☐ Other _____			

Examination Protocol for Exposure to

Respiratory Sensitizers

IF EXAM TYPE IS	✓	DO or COMPLETE THESE ITEMS
Initial/Baseline	____ ____	CG-5447 History and Report of OMSEP Examination DD-2808/DD-2807-1
Periodic/Exit/Acute Exposure	____	CG 5447 (update)
All types	____	Pulmonary function tests (FVC & FEV_1).
All types except acute exposure	____	CBC (complete blood count)
All types except acute exposure	____	Multichemistry panel (includes glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, LDH, alkaline phosphatase)
All types except acute exposure	____	U/A (dipstick sufficient)
Acute Exposure	____	Acute Exposure Form
All types	____	Physician's notification regarding examination results. (Final action.)

To the examining medical officer:

- You must follow-up any significant abnormality through to a physical diagnosis. Provide ICD codes.
- Ensure that the patient is questioned about the following history or symptoms: past and current exposures to respiratory sensitizers, smoking history; eye, nose or throat irritation; cough; asthma or other chronic airway problems; allergic skin conditions or dermatitis.
- In the event that the employee is not required to wear a respirator, and the history and routine laboratory tests are unremarkable, the medical officer may determine that a complete physical examination is not required. Otherwise, at a minimum, a directed physical examination with attention to the respiratory system must be completed. Pulmonary status must be evaluated if respiratory protection is used.
- Respiratory sensitizers include numerous compounds which cause both occupational asthma and/or hypersensitivity pneumonitis (extrinsic allergic alveolitis). Respiratory sensitizers include vegetable dusts and woods, molds and spores, animal danders, metals (platinum, chromium, nickel, cobalt, vanadium), and chemicals (isocyanates, formaldehyde, trimellitic anhydride).
- In the Coast Guard, exposure to respiratory sensitizers is primarily associated with industrial operations, though some marine inspection activities may also lead to exposures.
- If the patient is on multiple monitoring protocols, ensure each unique item is completed. However, it is not necessary to duplicate tests and forms.

FIGURE 12-C-10

Date:	Unit:	OPFAC:	Unit POC:
Patient name:		SSN:	Unit Phone:
Exam type: ☐ Initial/Baseline ☐ Periodic ☐ Exit/Separation ☐ Acute exposure ☐ Other _____			

Examination Protocol for Exposure to

Solvents

IF EXAM TYPE IS	✓	DO or COMPLETE THESE ITEMS
Initial/Baseline	____ ____	CG-5447 History and Report of OMSEP Examination DD-2808/DD-2807-1
All types	____	Pulmonary function tests (FVC & FEV_1).
All types except acute exposure	____	CBC and differential, with platelet count and RBC indices (MCV, MCH, MCHC)
Periodic/Exit/Acute Exposure	____	CG 5447 (update)
All types except acute exposure	____	Multichemistry panel (includes glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, LDH, alkaline phosphatase)
All types except acute exposure	____	U/A with microscopic
Acute exposure	____	Acute Exposure Form
All types	____	Physician's notification regarding examination results. (Final action.)

To the examining medical officer:

- You must follow-up any significant abnormality through to a physical diagnosis. Provide ICD codes.
- Ensure that the patient is questioned about the following history or symptoms: past and current exposures to solvents, smoking and alcohol use history; allergic skin conditions, dry skin, or dermatitis ; eye, nose or throat irritation; headache, nausea, vomiting, dizziness, vertigo; fatigue, weakness, irritability, depression, difficulty concentrating, or impaired short-term memory; and numbness, tingling, or weakness in the extremities.
- Ensure the patient is examined for the following possible signs: dermatitis, peripheral neuropathy, cognitive dysfunction, and mental status changes.
- If the particular solvent exposure is well characterized and specific laboratory tests are available, biological monitoring should be considered.
- Make a recommendation as to when the next OMSEP examination for this employee should take place. The default interval is 1 year, but you may recommend a longer period of 18 or 24 months, if exposures are limited and there is no evidence of occupationally significant illness.
- There are over 30,000 industrial solvents. This protocol is designed to survey for the most frequent health effects of solvents when taken as a broad group. These effects are skin disorders, and acute and chronic CNS effects. Some other less frequent effects of solvents involve the hematopoietic, hepatic, peripheral nervous system, renal, reproductive, and respiratory systems. Most solvents are **not** carcinogenic in humans; benzene being a notable exception.
- In the Coast Guard, exposure to solvents is primarily associated with industrial and maintenance operations (e.g., painting).
- If the patient is on multiple monitoring protocols, ensure each unique item is completed. However, it is not necessary to duplicate tests and forms.

FIGURE 12-C-11

Date:	Unit:	OPFAC:	Unit POC:
Patient name:		SSN:	Unit Phone:
Exam type: ☐ Initial/Baseline ☐ Periodic ☐ Exit/Separation ☐ Acute exposure ☐ Other _____			

Examination Protocol for Exposure to

Tuberculosis

IF EXAM TYPE IS	✓	DO or COMPLETE THESE ITEMS
Initial/Baseline	____ ____	CG-5447 History and report of OMSEP Examination DD-2808/DD-2807-1
All types, **no** history of prior reactive skin test	____	Mantoux tuberculin skin test (TST) Enter results on SF 601 and PHS 731
All types, history of prior reactive skin test	____	SF 600 entry
Follow-up on newly reactive TST	____ ____	CG-5447 (update) CXR (only if TST is newly reactive)
All types	____	Physician's notification regarding examination results. (Final action.)

To the examining medical officer:

- You must follow-up any significant abnormality through to a physical diagnosis. Provide ICD codes.
- For personnel with a prior history of a reactive TST, ensure the patient is questioned about the following symptoms of active TB: fever, night sweats, weight loss, cough, and hemoptysis. This questioning may be completed by a nurse or health services technician.
- See section 7-D of the Medical Manual for full information on the tuberculosis control program.
- Forward a copy of all test results to the unit OMSEP coordinator.
- If the patient is on multiple monitoring protocols, ensure each unique item is completed. However, it is not necessary to duplicate tests and forms.

FIGURE 12-C-12

Date:	Unit:	OPFAC:	Unit POC:
Patient name:		SSN:	Unit Phone:
Exam type: ☐ Initial/Baseline ☐ Periodic ☐ Exit/Separation ☐ Acute exposure ☐ Other _____			

Examination Protocol for Exposure to

Unspecified

IF EXAM TYPE IS	✓	DO or COMPLETE THESE ITEMS
Initial/Baseline	____ ____	CG-5447 History and Report of OMSEP Examination DD-2808/DD-2807-1
All types	____	CBC (complete blood count)
All types	____	Multichemistry panel (includes glucose, BUN, creatinine, total protein, total bilirubin, AST, ALT, LDH, alkaline phosphatase)
Periodic/Exit/Acute Exposure	____	CG 5447 (update)
All types	____	U/A (dipstick)
Acute exposure	____	Acute Exposure Form
All types	____	Physician's notification regarding examination results. (Final action.)

To the examining medical officer:

- You must follow-up any significant abnormality through to a physical diagnosis. Provide ICD codes.
- Ensure that the patient is questioned about his or her general medical and work history, including: past and current exposure to chemical and physical hazards, smoking history and alcohol use, and a complete review of systems.
- Ensure the patient is receives a complete physical examination of all systems, with attention to any organ systems with a significant history or current systems.
- Make a recommendation as to when the next OMSEP examination for this employee should take place. The default interval is 1 year, but you may recommend a longer period of 18 or 24 months, if exposures are limited and there is no evidence of occupationally significant illness.
- Individuals under going surveillance in this protocol have exposures to hazards which are not included in any of the other protocols.
- If the patient is on multiple monitoring protocols, ensure each unique item is completed. However, it is not necessary to duplicate tests and forms.

CHAPTER 14

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CHAPTER 14. MEDICAL INFORMATION SYSTEMS (MIS) PROGRAM

Section A - Medical Information Systems (MIS) Plan.

1. Purpose.

   a. The Medical Information System (MIS) program described here follows the policy established by the Office of Health Services, outlines systems and assigns responsibility for the administration of the MIS. The MIS is a key component for the overall management of Coast Guard clinics and sickbays. MIS is a dynamic tool, which will provide a comprehensive electronic solution for tracking operational medical readiness, health systems management, and patient access to care. The Health and Safety Directorate, Maintenance and Logistics Commands, unit Commanding Officers, and health care providers are responsible for ensuring successful implementation of the Coast Guard Medical Information Systems.

2. Background.

   a. There is an ongoing need for Commandant, Area Commanders, and field level Commanding Officers to assess medical operational readiness. Additionally, the Coast Guard Health Services program needs to accurately capture workload, performance, and productivity through standardized methodology. Proper analysis of health care data provides the ability to realign assets where they are most needed to deliver timely quality health care. The **full** implementation of the Composite Health Care System I/II (CHCS), Shipboard Automated Medical System (SAMS), Dental Common Access System (DENCAS), and Third Party Collections Program (TPC) will significantly enhance our ability to provide this information as needed.

   b. Federal statutes impose strict requirements for managing government information. The most pertinent Federal statutes that govern information include:

      (1) **Federal Records Act (Public Law 81-754):** Sets policy for and mandates establishment of agency programs for the management of Federal records.

      (2) **Freedom of Information Act (Public Law 90-23):** Provides policy to ensure public access to Federal government information.

      (3) **Paperwork Reduction Act (Public Law 96-511):** Recognizes information as a Federal resource and directs agencies to establish specific programs for management of the resource and associated elements.

      (4) **Paperwork Reduction Reauthorization Act (Public Law 99-500):** Defines information resources management and directs further program management requirements.

(5) **Privacy Act (Public Law 93-579):** Provides policy and safeguards to protect privacy of individuals.

(6) **Health Insurance Portability and Accountability Act (HIPAA), (Public Law 104-191):** Requires health plans to assure the security and privacy of individually identifiable health information, and to use specified standards and code sets for electronic transactions involving medical information.

3. Coast Guard policy concerning the privacy rights of individuals and the Coast Guard's responsibilities for compliance with operational requirements established by the The Coast Guard Freedom of Information Acts Manual, COMDTINST 5260.3, Privacy Act and HIPAA are as follows:

   a. Protect, as required by the Privacy Act of 1974, as amended, and HIPAA, the privacy of individuals from unwarranted intrusion. Individuals covered by this protection are living citizens of the United States and aliens lawfully admitted for permanent residence.

   b. Collect only the personal information about an individual that is legally authorized and necessary to support Coast Guard operations. Disclose this information only as authorized by the Privacy Act and HIPAA, and described in Chapter 4 of this Manual.

   c. Keep only personal information that is timely, accurate, complete, and relevant to the purpose for which it was collected.

   d. Safeguard personal information to prevent unauthorized use, access, disclosure, alteration, or destruction.

   e. Let individuals know what records the Coast Guard keeps on them and let them review or get copies of these records, subject to exemptions authorized by law.

   f. Permit individuals to amend records about themselves contained in Coast Guard systems of records, as authorized by HIPAA, which they can prove are factually in error, not up-to-date, not complete, or not relevant.

   g. Allow individuals to ask for an administrative review of decisions that deny them access to or the right to amend their records.

   h. Maintain only information about an individual that is relevant and necessary for Coast Guard purposes, as required to be accomplished by statute or Executive Order.

   i. Act on all requests promptly, accurately, and fairly.

4. Applicability and Scope.

a. All health care facilities (clinics, super sickbays, and sickbays) shall comply with the MIS operating guidelines as set forth. The MIS program described here contains the essential elements required at all Coast Guard facilities with medical personnel assigned and assigns responsibilities for the program's initiatives. The Chief of Health Services shall ensure all healthcare providers and support staff; which include Medical Officers, Dental Officers, Pharmacy Officers, Clinic Administrators, HS's; HSD's and Medical and Dental contractors; shall participate. Information technology is not static in nature but rapidly changing and dynamic, and requires the diligence of all concerned to create and maintain a sound program.

5. Objectives.

a. The Director of Health and Safety has established a MIS that provides necessary tools and capabilities to assist in making sound business decisions for those Commands having healthcare facilities.

b. Identify and justify resources required to maintain a quality MIS.

c. Establish access and connectivity for Coast-Guard wide comprehensive utilization of CHCS, continuing local DoD host site affiliation for electronic referrals and consultations.

d. Establish and maintain clinic and sickbay Microcomputer Allowance Lists (MAL) that provide appropriate access to medical information systems for managing clinical and administrative operations.

e. Establish a standardized equipment list for peripherals. (i.e. pharmacy printers, Local Area Network Interface Unit (LIU) devices, etc.)

f. Identify systems training requirements and ensure required education and training standards are established and maintained.

g. Provide direction as new adjuncts to existing programs are developed and deployed. (i.e. CHCS II, Theatre Medical Information Program (TMIP), etc.)

h. Participate in DoD sponsored software and product development for use in the medical arena.

6. Definitions.

a. Intranet: A privately owned network based on the Transmission Control Protocol/Internet Protocol (TCP/IP) suite.

b. Internet: A voluntary interconnected global network of computers based upon the TCP/IP protocol suite, originally developed by the U.S. Department of Defense Advanced Research Projects Agency.

c. NIPERNET: Non-Classified Internet Protocol Routing Network. The Defense Information Systems network (DISN) Internet line for unclassified DoD and federal agency Internet traffic.

d. CGDN+: Coast Guard Data Network Plus. Secure closed Coast Guard wide area network (WAN).

e. Firewall: Security measure which blocks unwanted/unauthorized entry to computer systems from outside the internal system.

f. Host (site): Medical facility where a CHCS server platform resides.

g. TelNet: Telecommunications Network. A protocol that facilitates remote logins to host site server and functions via the Internet.

h. IP address: Internet Provider address. An assignable 32 bit numeric identifier, which designates a device's location on an intranet network or on the Internet.

i. LIU: Local Area Network Interface Unit. Device designed to provide external access and interface with the local area network (LAN).

7. Organizational Responsibilities.

a. Chief, Office of Health Services.

(1) Establish a comprehensive MIS using the DoD Composite Health Care System (CHCS) and Dental Common Access System (DENCAS) at all Coast Guard health care facilities ashore and afloat.

(2) Establish and promulgate MIS policy, including performance standards for use of all systems/applications contained within the program.

(3) Develop and promulgate MIS operation guidance detailing the various functional/operational requirements and adjuncts of the MIS program.

(4) Identify education and training requirements, and ensure satisfactory standards are established.

(5) Establish and maintain a Third Party Collection system for the recovery of reimbursable medical costs through Other Health Insurance (OHI).

b. Maintenance and Logistics Commands.

(1) Ensure the Health and Safety Directorate's MIS is executed at the field level.

(2) Provide technical and professional advice regarding medical information systems, software, and hardware to units as required.

(3) Coordinate professional training for MIS and health services personnel.

c. Commanding Officers.

(1) Ensure the unit actively pursues implementation and compliance with the health service MIS standards.

d. Chief, Health Services Division.

(1) Designate in writing an individual to serve as Health Services MIS Unit Site Manager for the Health and Safety Directorate's MIS.

(2) Implement and adhere locally to the Health and Safety Directorate's MIS policy.

(3) Ensure all health care facility personnel as prescribed, are in compliance of all provisions contained in this chapter.

e. MIS Unit Site Manager.

(1) Provide local level oversight of the Health and Safety Directorate's MIS.

(2) Coordinate and provide MIS training to health care facility staff.

(3) Coordinate and provide local systems hardware and software support.

(4) Coordinate with the cognizant Maintenance and Logistics Command (MLC) regarding hardware/software support issues beyond their ability to resolve.

(5) Establish liaison with medical appointment referral DoD Medical Treatment Facility (MTF) for MIS issues.

Section B - Medical Information System.

1. Background.

   a. Information technology is not static in nature but dynamic and rapidly changing. Commandant (G-WKH) is responsible for ensuring that the Health and Safety Directorate's MIS continues to evolve. The MIS has evolved from manual data collection systems of old, such as the old Daily Dental Workload sheets, to the Clinic Automated Management System (CLAMS) in the early 1990's. The late 1980's brought the DoD deployment of a hospital-based medical information system, the Composite Health Care System (CHCS). Concurrently, as the old Convergent Technology Operating System (CTOS) was phased out of the Coast Guard in the mid 1990's, CLAMS II was developed internally and deployed to Coast Guard clinics. The advent of TRICARE in the mid 1990's has necessitated integration of Coast Guard health care information with that of DoD's medical information infrastructure.

2. Systems. The following outlines current automated information systems, applications and program components that come under the Coast Guard MIS program.

   a. Composite Health Care System (CHCS) I & II.

      (1) CHCS is the primary clinic/hospital based automated medical information system for DoD and is the legacy system, which will eventually transition to CHCS II. Major DoD commands generally act as host sites within their AOR. A "host" site is where the CHCS servers and database reside. Access to the functionality and modules of CHCS are accomplished through several options such as a closed internal network, through web based applications (i.e. Persona) or TelNet protocols . With the deployment of CHCS II, over 40 legacy and migration systems will integrate into a seamless clinical information system which will support readiness of forces, provide clinical data to enable health care providers to deliver quality managed care, and capitalize on technological advances to make a computer-based patient record (CPR) a reality. CHCS II will be the primary automated information system supporting the clinical business area within the DoD Health Affairs program.

      (2) Definitions.

         (a) **Modules:** Particular functional features of the CHCS system.

         (b) **Keys:** Security access tokens allowing access to modules within CHCS programs.

      (3) Modules.

(a) **PHR:** Pharmacy. This module is used to input and process inpatient and outpatient medication orders and prescriptions. It is also used to maintain and record formulary files, bulk and clinic issues.

(b) **MCP:** Managed Care Program. This module is used to perform patient enrollment, manage appointment referrals, perform provider searches, and to create and book appointments for enrolled and non-enrolled patients.

(c) **ORE:** Order Entry. This module allows providers to enter orders that are immediately transmitted to other health care workers for implementation. Providers can create, modify sign, or counter-sign orders. Additionally, order information for individual patients can be retrieved for review.

(d) **ERT:** Electronic Referral Tracking. This module allows providers to track the status and progress of patient referrals

(e) **LAB:** Laboratory. This module allows health care professions to enter lab test orders, access test status, access test results, receive notification of problems running a test, and track patient test history.

(f) **RAD:** Radiology. This module allows users to enter or modify radiological orders, view order status, and review the radiological impression.

(g) **ADM:** Ambulatory Data Module. This module is used to track provider workload statistics, patient disposition, and patient diagnosis and procedure history.

b. SNAP Automated Medical System (SAMS).

(1) The U.S. Navy's primary shipboard and sickbay medical information system program is SAMS. This application provides a user-friendly product that allows the Independent Duty Technician (IDT) to document all facets of health care; including patient encounters, medical and dental tickler system, and immunization tracking. SAMS functionality also offers users tools to produce binnacle lists, document shipboard training, and monitor environmental health issues such as heat stress and potable water testing. The fully functional tickler system flags crewmembers in need or past due for items such as physical examinations and immunizations, greatly enhancing operational readiness. Currently, SAMS functionality resides at the Headquarters/MLC level to track members in the anthrax immunization program and is set for deployment to the entire Coast Guard IDT community.

(2) Definitions.

(a) **Modules:** Particular functional features of the SAMS system.

(b) **AMMAL:** Authorized Minimum Medical Allowance Level. This is analogous to the medical portion of the Health Services Allowance List.

(c) **AMDAL:** Authorized Minimum Dental Allowance Level. This is analogous to the dental portion of the Health Services Allowance List.

(3) Modules.

(a) **Master Tickler:** This module is used to document, update, report and transfer medical information on a crewmember. This module tracks demographic, physical examinations (routine, occupational and special duty), women's health maintenance examinations, allergies, immunization tracking, vision, hearing, dental readiness tracking, laboratory results, and sexually transmitted diseases.

(b) **Medical Encounters:** This module is used to document and report health care encounters with the medical department. Specific encounters include routine sick call using the SOAP format, vital sign monitoring/tracking, follow-up examinations/visits, consultations and referrals, patient disposition accident and injury reporting.

(c) **Occupational/Environmental Health:** This module documents environmental conditions that may affect the health of Coast Guard personnel. This module includes heat stress monitoring, potable water testing, and pest control.

(d) **Supply Management:** This module supports the inventory management of medical material and pharmaceuticals. Support is provided for AMMAL and AMDAL inventory management. Users can requisition, store, distribute, and track all medical materials. The module produces a variety of inventory reports and maintains the Operating Target (OPTAR) log. The Coast Guard version of SAMS will utilize the Heath Services Allowance List.

(e) **Training Management:** This module tracks both crew and medical department personnel training. The module can be customized by the user to suit the needs of the unit.

(f) **Periodic Duties:** This module provides supervisory personnel with a method to schedule, assign and track the completion of assigned tasks.

(g) **System Management:** This module maintains unit specific information, user table maintenance, and system utilities.

c. Dental Common Access System (DENCAS).

(1) The Dental Common Access System is an enterprise-wide, world class e-business system that functions seamlessly between ship and shore to provide a complete picture of Navy and Coast Guard personnel dental readiness. DENCAS also provides an accurate, real-time, comprehensive administrative reporting system. The dental data is centralized in a single database for query by authorized staff over the NIPRNET. The DENCAS system is designed with security features that prevent unauthorized access, data transmission interception, and alteration. Navy Dental Treatment Facilities (DTF) and Coast Guard dental clinics are able to access dental data on individual active duty members from either service. However, summary dental data for each clinic is only available to their respective commands.

(2) Definitions.

(a) **Modules:** Particular functional features of the DENCAS system.

(b) **DIRS:** Dental Information Retrieval System. This system collects dental procedure codes.

(c) **NMIMC:** Naval Medical Information Management Center. Responsible for DENCAS application support.

(3) Modules.

(a) **DTF User:** This module maintains patient dental records. It automatically updates Dental Class status, recall appointment intervals, documents dental treatment needs, allows for the transfer of patient dental data, tracks dental provider information, and records DIRS (dental productivity) data. Additionally, this module can generate a variety of dental reports.

(b) **Command User:** Command User functions are designed for use by dental officers to review dental information on active duty members within their respective geographic areas of responsibility (AOR). This module displays the current dental readiness and dental health statistics for each command within their AOR. Command Users have access to the reports concerning individual patient dental class, recall appointments,

and treatment needs. In addition, DIRS data for each provider and the Command User's dental clinic is available.

(c) **Corporate User:** This module provides patient and DIRS reports for all Coast Guard active duty members and Coast Guard dental clinics to the Coast Guard Maintenance and Logistics Commands and Office of Health Services.

(d) **External User:** This module provides access to a number of useful reports on the real-time status of dental health within the External User's own command. When an External User first logs on to DENCAS, the Home Page displays the current status of dental readiness and dental health for the External User's own customer command. With a click on any of the report links on the page, the External User can view reports summarizing dental class, exam recall, members requiring routine dental care, and members requiring urgent dental care.

(e) **System Management:** This module provides for system setup, table maintenance, and maintains system-related information such as user access, password configuration, and the access log. Responsibility for this module is shared between NMIMC and the Coast Guard Office of Health Services.

d. Third Party Collections Program: Other Health Insurance (OHI).

(1) The United States Coast Guard is required by law to collect money from all third party insurance payers for the cost of medical services provided to military beneficiaries. This requirement, under Title 10 of the United States Code, Section 1095 is known as the Third Party Collection Program (TPC).

(2) This program applies to family members and retirees who have health insurance coverage other than TRICARE, Medicare or Medicaid. Commanding Officers and Chiefs of Health Services will ensure that clinic staffs market the program and educate eligible beneficiaries based on guidelines provided by the G-WKH program manager.

(3) Each CG clinic will follow guidelines established by the Office of Health Services for documenting in CHCS any Other Health Insurance information non-active beneficiaries may have and facilitate the recovery of health care costs by adhering to guidelines provided by the G-WKH program manager.

Section C - Medical Readiness System (MRS).

To be developed pending implementation of a functional system.