

HEADQUARTERS UNITED STATES CENTRAL COMMAND
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REGULATION
220-1

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Deployment Health
DEPLOYMENT HEALTH SURVEILLANCE AND FORCE HEALTH PROTECTION

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Chapter 1 GENERAL

1-1. PURPOSE. This regulation implements policies and prescribes procedures for deployment health activities for Joint and Service-specific deployments and exercises to monitor, assess, and prevent Disease and Injury (D&I); to control or reduce Occupational and Environmental Health (OEH) risks; to document and link OEH exposures with deployed personnel, including exposures to Chemical, Biological, Radiological, Nuclear (CBRN) warfare agents and toxic industrial chemicals, and establish procedures and reporting requirements for disease surveillance.

1-2. APPLICABILITY

a. This regulation applies to all United States Central Command (USCENTCOM) Service Components, Combined and other Joint Task Forces (CJTFs/JTFs), and all other United States military forces operating within the geographic area of responsibility (AOR) assigned to USCENTCOM by the Command Plan as well as Department of Defense (DoD) civilian employees and DoD contractor personnel deploying with United States (U.S.) forces (hereafter referred to as “DoD personnel”) consistent with DoD and Service-specific guidance. DoD contractor personnel are addressed per applicable contracts and DoDI 3020.41 (Reference 2), and/or applicable Service policy.

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

(1) Pre-Deployment. USCENTCOM, through deployment orders and separate instructions, requires the supporting Services and JTFs to accomplish the pre-deployment activities described in MCM 0028-07 and DoDI 6490.03 (References 3 and 4), individual medical readiness requirements in DODI 6025.19 (Reference 5), and meet pre-deployment requirements stipulated in USCENTCOM’s Individual and Individual/Unit Deployment Policy. Components and JTFs will incorporate OEHS requirements into contingency and crisis action planning.

(2) Post-Deployment. Post-deployment health activities are described in Reference 4, and are a Service responsibility.

c. For OCONUS deployments greater than 30 days with non-fixed U.S. MTFs, all of the deployment health activities described by this regulation apply. For OCONUS deployment of 30 days or less, and OCONUS deployment with fixed U.S. MTFs, deployment health activities are based on the health threats identified during the deployment, health risk assessments, and the decisions of the COCOM commander, Service component commander, or commander exercising operational control.

d. For information related to the environmental criteria for establishing, operating, maintaining, closing and/or transferring base camps as part of USCENTCOM contingency operations, refer to USCENTCOM Regulation (CCR) 415-1: Construction and Base Camp Development in the USCENTCOM AOR; The Sand Book (Reference 23); CCR 200-1: Protection and Enhancement of

Environmental Assets (Reference 26); and CCR 200-2: CENTCOM Contingency Environmental Guidance (Reference 25). CCR 200-1 also details the requirements for environmental surveys and reports, including the Environmental Baseline Survey (EBS), the Environmental Conditions Report (ECR), and the Environmental Site Closure Survey (ESCS).

1-3. REFERENCES. See Appendix A.

1-4. TERMS and DEFINITIONS. Terms used in the regulation not found in Joint Publication 1-02 (Reference 7) are defined in Appendix B.

1-5. POLICY. It is USCENTCOM policy to effectively anticipate, recognize, evaluate, control, and mitigate health threats to deployed forces in the USCENTCOM AOR, and to maximize electronic reporting and archiving of Force Health Protection surveillance activities.

Chapter 2 RESPONSIBILITIES

2-1. COMMANDER, USCENTCOM (CDRUSCENTCOM)

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

2-2. DEPUTY COMMANDER, USCENTCOM (DCDRUSCENTCOM)

- a. Provide Command deployment health surveillance guidance and direction to USCENTCOM Command Surgeon.

(1) Oversee staff coordination of deployment health surveillance issues within the USCENTCOM AOR.

(2) Meet reporting requirements IAW this regulation and DoD policy.

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

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

2-4. USCENTCOM DIRECTOR OF INTELLIGENCE (CCJ2)

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

2-5. USCENTCOM DIRECTOR FOR OPERATIONS (CCJ3)

a. Assist USCENTCOM Director for Strategic Planning and Policy (J5) in ensuring deliberate and crisis action plans address force health protection and deployment health surveillance requirements.

b. Provide the Command Surgeon and Service Health Surveillance Centers known forward operating base locations for OEHS and medical intelligence preparation of the operational environment (MIPOE) and intelligence preparation of the battle space (IPB) assessments.

c. Coordinate with the USCENTCOM Command Surgeon regarding suspected and confirmed OEH/CBRN incident exposures to facilitate personnel tracking of exposed or potentially exposed personnel, such as SIGACT numbers to facilitate updates to the designated CENTCOM SIGACT Database (e.g. combined information data network exchange (CIDNE) supported BUA SIGACT Events Database) and push information to Level IV medical assets.

2-6. USCENTCOM DIRECTOR OF LOGISTICS (CCJ4)

a. Factor preventive medicine personnel and equipment requirements into time-phased force and deployment data (TPFDD) planning in support of deployment health surveillance and force health protection.

b. Coordinate with the USCENTCOM Surgeon to field qualified personnel or teams to perform Environmental Baseline Surveys (EBSs), Occupational and Environmental Health Site Assessments (OEHSAs) and/or other environmental surveys related to infrastructure, construction or demolition projects and base camp closures/transfers.

c. Upon request, provide base camp location and other available relevant information to support Force Health Protection mission planning.

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

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

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

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

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

2-9. USCENTCOM COMMAND SURGEON (CCSG)

- a. Monitor the implementation of this regulation for the USCENTCOM AOR.
- b. Specify reporting requirements for Disease and Injury (D&I), Reportable Medical Events (RMEs), Occupational and Environmental Health Site Assessments (OEHSAs), Periodic Occupational and Environmental Monitoring Summaries (POEMS), and OEH/CBRN incident documentation and reporting requirements in Contingency and Operational Plans and Orders, as applicable.
- c. Identify USCENTCOM OEHS program critical shortfalls and assist Service Components and JTFs with developing solutions to meet compliance.
- d. Establish a Joint CENTCOM FHP working group to meet at least annually to review current deployment health surveillance guidance. In addition, the group will review OEHS lessons learned and after action report (AAR) items from past deployments and exercises highlighting successes, problems, and solutions. The group will develop and recommend changes to this regulation, as appropriate.
- e. Develop, implement, monitor, and assess the USCENTCOM OEHS Program.
- f. Provide guidance and direction concerning the FHP and OEHS program to separate DOD agencies and their contractors located within the USCENTCOM AOR that do not report directly to a higher DOD authority within the USCENTCOM AOR.
- g. Work with the Public Affairs, Strategic Communications, and/or Communications Integration Office(s), as applicable, to identify appropriate communications channels, develop messages, and implement media plans supporting health risk communication efforts.
- h. In coordination with J3, J4, and J5, ensure that deliberate and crisis action plans address FHP and OEHS (including risk communication) requirements.
- i. In the event of an exposure incident that involves weapons of mass destruction (WMD), to include CBRN agents or toxic industrial chemicals or materials (TICs/TIMs), coordinate with J3 and ensure the proper documentation and dissemination of information (per Appendices H and I) as quickly as possible and facilitate tracking casualties to final disposition. Ensure use of SIGACT numbers from the designated CENTCOM SIGACT Database (e.g. CIDNE supported BUA SIGACT Events Database).
- j. Provide final approval for Periodic Occupational and Environmental Monitoring Summaries, or delegate approval authority in writing to Service Component/JTF Surgeons.
- k. Implement and submit changes to medical travel restrictions to the DOD Foreign Clearance Guide through HQ United States Air Force as needed, at fcg@pentagon.af.mil.

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

- a. Integrate OEHS requirements into deployment plans, orders, and exercises.
- b. Ensure subordinate commands and units (battalion/squadron/ship size or larger) appoint an individual responsible for administering the OEHS program for deployments.
- c. Ensure requirements are accomplished according to this regulation.

2-11. CJTF AND SERVICE COMPONENT COMMAND SURGEONS

a. Ensure compliance with and execution of deployment health surveillance and FHP requirements for all operations and contingencies. Direct medical and OEH surveillance activities identified in Appendix C of this regulation. Specifically:

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

(2) Assess and manage medical threats and health risks within the area of responsibility IAW established military risk assessment and risk management doctrine. See Appendix D for further details regarding OEH operational risk assessment and management methodology.

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

b. Institute appropriate OEHS measures and provide PVNTMD support for identified hazards consistent with level of risk, mission and available resources.

c. Submit and Monitor health surveillance reports, to include RMEs, Medical Situational Awareness Tool (MSAT)/Joint Medical Workstation (JMeWS), Disease Reporting System Internet (DRSi) and other Service-specific health surveillance activities. See Appendices C-J for further details.

d. Institute appropriate OEHS measures and provide PVNTMED support for health risk assessment of residual hazards during decontamination of CBRN contaminated equipment and human remains before they leave the CJTF JOA.

e. Identify critical shortfalls and capability gaps required to meet the requirements of this regulation. Verify that PVNTMED/FHP units are staffed, equipped, and trained to execute USCENTCOM FHP policy. Provide the USCENTCOM Surgeon with situational awareness of critical shortfalls and gaps.

f. Include OEHS lessons learned into the after action reporting process. Identify and document

deficiencies in doctrine, organization, training, education, budgeting, risk communication processes, and/or equipment. When applicable, forward after action reports (AARs) through the Combatant Command for inclusion into Joint Lessons Learned, and include Service component Lessons Learned Centers. Send informational copies to USCENTCOM, Service Public Health Centers, and OSD HA (FHP&R).

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

(1) Oversight of and compliance with the OEHS program and reporting/record keeping requirements in this regulation.

(2) Coordination and liaison with the USCENTCOM FHP Officer.

(3) Implementing procedures to develop and document and track OEHSAs for all camps, sites, forward operating base locations within the respective AOR. Coordinate with Service Public Health Centers for reach back assistance and technical support. See Appendix E for additional details.

(4) Submission of a monthly OEHSA completion status report to the CENTCOM FHP Officer. Minimum Requirements for reporting are identified in Appendix E.

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

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

(7) Tracking, staffing, and coordination of Incident Reports and associated documentation required for all OEH exposure incidents as described in Appendix I.

(8) Membership support to the CENTCOM Joint Force Health Protection Working Group.

h. Ensure subordinate Preventive Medicine (PVNTMD) units and FHP Officers help develop OEHS plans for each assigned unit within their area of responsibility before deployment. Requirements during deployment include:

(1) Enter into DOEHRS or submit OEH monitoring data, food/water, PVNTMED and Veterinary Service survey and inspection reports, OEHSA, and POEMS in accordance with the references and guidance listed in Appendices C, E, F and J.

(2) Provide weekly D&I reports and daily RMEs to the Service Component/JTF Surgeon, and USCENTCOM Command Surgeon IAW procedures identified in Appendices G and H. Per Appendix H, Tri-Service RMEs are reported electronically, within 24 hours through the Service-specific reporting systems, and Disease Reporting System Internet (DRSi). Conditions that represent a potential significant threat to public health, including highly communicable disease and bioterror agents, should be reported to the Service Component/JTF Surgeon and USCENTCOM Command

Surgeon immediately. Report all unique RMEs, such as diagnosis or treatment resulting from a CBRN/TIC/TIM exposure, to USCENTCOM Command Surgeon as soon as possible following diagnosis.

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

(4) Update applicable documents and medical countermeasures as new information becomes available.

(5) Develop and implement health risk communication plans. This includes use of Medical Threat Briefs (MTBs) and other products such as facts sheets, or information cards that describe the CENTCOM country, and when applicable, area or base camp-specific health threats/medical risks and associated countermeasures. Coordinate with Service-specific public health activities/centers for assistance with products. See Appendix C for links to available resources.

Chapter 3 PROCEDURES

3-1. **SCOPE.** This regulation focuses on deployment health activities that are required during deployment operations. A summary of the procedures for the key required activities are described below. Additional details regarding the associated documents and reporting responsibilities are summarized in Appendix C. Detailed guidance is also provided in Appendices D (Risk Management), E (OEHSA), F (POEMS), G (D&I), H (RME), I (OEH/CBRN Incident reporting), J (DOEHR), and K (Animal Bite Reporting).

3-2. **PREDEPLOYMENT AND BASELINE DOCUMENTS.** Deployment health activities are based on the pre-deployment and baseline health threat and risk assessment documents for the area or areas of operations and the specific deployment location. These documents, and early site reconnaissance should be reviewed by incoming site PVNTMD personnel and updated as the deployment proceeds.

a. Pre deployment threat assessment information is documented in the IPB/MIPOE and Preliminary Health Assessments/Phase 1 reports.

b. OEHSAs, site reconnaissance, EBAs and EBSs, food and water vulnerability assessments and surveys are conducted to identify and assess actual or potential health threats, evaluate and identify completed exposure pathways, and determine courses of action and countermeasures to control or reduce the health threats and protect the health of deployed personnel. These documents, especially the OEHSA, are critical baseline documents that establish a conceptual site model that identifies key hazards and affected populations. The OEHSAs for the CENTCOM AOR are the responsibility of, and finalized under, the authority of CJTF and Service Component designated FHP personnel. They may be drafted in coordination with USAPHC, USAFSAM, or NMCPHC with assistance from preventive medicine assets/units in theater. The designated FHP personnel should use OEHSAs to direct and prioritize follow-on OEH activities such as routine sampling/monitoring, or focused sampling of a specific hazard or high risk areas, or to address significant information data gaps. Information based on follow-on and incident-driven monitoring and sampling and health risk assessments must be submitted to the applicable DOD-approved system of record listed in Appendix C. This information also serves as much of the source data from which POEMS are generated.

c. At established base camps, review previously published public health related documents for potential use and familiarity with that location's documented health hazards, to include base camp OEHSAs, POEMS, deployment specific hazard and incident factsheets, Deployment health Guide trifold, and risk communication documents such as medical threat assessments. Table C-1 provides links to useful sources.

3-3. **RISK COMMUNICATION PLANS AND TOOLS.** It is critical that personnel be provided hazard and countermeasure information prior to deployment to an area, during the deployment, and also be made aware of information he/she can access post deployment regarding potential site hazards/exposures. Information should be accurate, appropriate for the audience and cleared through appropriate technical and command channels to include Public Affairs, STRATCOM, and/or Communications Integration when applicable. See Appendices C and D.

3-4. ROUTINE OEH MONITORING DOCUMENTS. OEH surveillance includes monitoring and assessment of air, water, soil, food, vectors, noise, heat/cold and other potential hazards/exposures that can affect the short or long term health of troops. Routine monitoring and many individual surveys and reports are necessary to comprise a complete and effective OEHS program. OEHS related documents will be sent by the completing unit IAW DoD guidance for archiving to the DOD-approved system of record listed in Appendix C or entered into DOEHRS in accordance with Appendix J.

3-5. MEDICAL DATA SUPPORTING DOCUMENTATION

a. D&I surveillance shall be collected, reported, distributed, and archived within MSAT/JMEWS and per Appendices G and H.

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

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

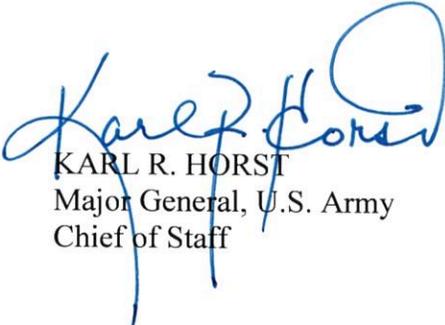
d. Once-Daily Location Tracking of Personnel. During deployments, service components and JTFs ensure once-daily individual service member locations are recorded and reported through Service-specific personnel reporting systems to the Defense Manpower Data Center (DMDC).

Chapter 4
PROPONENT PAGE

4-1. PROPONENT. The proponent for this regulation is the Command Surgeon (CCSG). Units are invited to submit comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) directly to HQ USCENTCOM Attn: CCSG, 7115 SOUTH BOUNDARY BOULEVARD, MacDill AFB, FLORIDA 33621-5101.

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“SUMMARY OF CHANGES”

CCR 220-1 has been revised to address advances in occupational and environmental health surveillance reporting and documentation via electronic data systems. These new electronic reporting capabilities and requirements are addressed through multiple changes to existing Appendices, and the addition of Appendix J – Defense Occupational and Environmental Health Readiness System (DOEHRS). This regulation has also been updated to address animal bite reporting procedures in the CENTCOM AOR, with the addition of Appendix K. Other updates include changes to Occupational/Environmental exposure incident reporting in Appendix I, and the addition of annual review and update requirements for Occupational and Environmental Health Site Assessments in the CENTCOM AOR.

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Appendix A
REFERENCES

1. DODI 1100.22, "Policy and Procedures for Determining Workforce Mix", April 12, 2010
2. DODI 3020.41, Contractor Personnel Authorized to Accompany the US Armed Forces, December 20, 2011
3. MCM 0028-07, Procedures for Deployment Health Surveillance, 2 November 2007
4. DODI 6490.03, Deployment Health, 11 August 2006
5. DODI 6025.19, Individual Medical Readiness (IMR), 3 January 2006
6. Modification 11 to United States Central Command Individual Protection and Individual, Unit Deployment Policy, 2 December 2011
7. Joint Pub 1-02, Department of Defense Dictionary of Military & Associated Terms, 8 November 2010 (As amended through 15 March 2012)
8. MCM 0026-02, Chemical Warfare (CW) Agent Exposure Planning Guidance, 29 April 2002
9. DODD 6490.02E, Comprehensive Health Surveillance, 08 February 2012
10. DODI 6055.05, Occupational and Environmental Health, 11 November 2008
11. DODD 8320.2, Data Sharing in Net-Centric Department of Defense, 2, December 2004
12. DODD 6200.04, Force Health Protection, certified current as of 23 April 2007
13. FM 3-11.19, Multiservice Tactics, Techniques, and Procedures for Nuclear, Biological, and Chemical Reconnaissance, 30 July 2004
14. Tri-Service Reportable Events Guidelines & Case Definitions, Armed Forces Health Surveillance Center (AFHSC), June 2009
15. Assistant Secretary of Defense for Health Affairs, Policy Memorandum – Implementation of the Post-Deployment Health Clinical Practice Guidelines, April 2002
16. DODI 4150.07, DoD Pest Management Program, 29 May 2008
17. U.S. Army Center for Health Promotion and Preventive Medicine (USACHPPM) Technical Guide (TG) 188, US Army Food and Water Vulnerability Assessment Guide, July 2008
18. USACHPPM TG 195 Safety and Health Guidance for Mortuary Affairs Operations: Infectious Materials and CBRN Handling, July 2009

19. USAPHC (Provisional) TG 230, Environmental Health Risk Assessment and Chemical Exposure Guidelines for Deployed Military Personnel, June 2010
20. USACHPPM TG 244, Medical CBRN Battle book, October 2008
21. USACHPPM TG 248, Guide for Deployed Preventive Medicine on Health Risk Assessment August 2001
22. Assistant Secretary of Defense for Health Affairs, Policy Memorandum – Human Rabies Prevention During and After Deployment, 23 September 2011
23. USCENTCOM Regulation (CCR) 415.1, Construction and Base Camp Development in the USCENTCOM AOR - The Sand Book, 17 October 2011
24. Field Manual (FM) 3-100.12, Risk Management, February 2001
25. USCENTCOM Regulation (CCR) 200-2, Contingency Environmental Guidance, 26 March 2012.
26. USCENTCOM Regulation (CCR) 200-1, Protection and Enhancement of Environmental Assets, 1 December 2011.

Appendix B TERMS and DEFINITIONS

1. **Health Risk** – Potential for adverse health impact to an exposed population or individuals – the consequences associated with military actions and resources. The risk may be due to acute health effects or chronic long-term health effects. See specific risk level definitions in Appendix E of this document.
2. **Health Risk Communication Plan** - A specific plan that documents means of delivery and development of key messages on deployment health threats and risks (including actual and potential exposures), associated countermeasures, and any necessary medical follow-up for deployed personnel. The plan should document how OEHS data and IHA information will be used to develop appropriate written and oral materials to communicate deployment health risks. The plan should identify how health risk communications will be updated as new information about health risks becomes available.
3. **Health Surveillance** - The regular or repeated collection, analysis, and interpretation of health-related data and the dissemination of information to monitor the health of a population and to identify potential health risks, thereby enabling timely interventions to prevent, treat, reduce, or control disease and injury. It includes occupational and environmental health surveillance and medical surveillance subcomponents.
4. **Health Threat** - A composite of ongoing or potential enemy actions; adverse environmental, occupational, and geographic and meteorological conditions; endemic diseases; and employment of nuclear, biological, and chemical weapons (to include weapons of mass destruction) that have the potential to affect the short- or long-term health (including psychological impact) of personnel.
5. **Industrial Hazard Assessments** – Reports developed by the intelligence community (i.e., National Center for Medical Intelligence) that identify potential local industrial operations and the hazards normally associated with those operations.
6. **Low Level Exposures** - Low-level exposures are occupational and environmental health exposures that do not produce acute health effects of significant clinical or physiological impact and, thus, will not pose significant operational (mission) impact. This involves a range of exposures and points along a hazard's dose-response continuum to include a) potential for mild non-impairing, minimally noticeable reversible acute effects and, b) for certain hazards, some limited possibility of latent (post-deployment onset) and/or non-clinical effects (reversible or non-reversible), and c) levels associated with no anticipated effects of any kind. Low-level exposures are generally assigned a negligible hazard severity.
7. **Medical Surveillance** - The ongoing, systematic collection, analysis, and interpretation of data derived from instances of medical care or medical evaluation, and the reporting of population-based information for characterizing and countering threats to a population's health, well-being, and performance.

8. Occupational and Environmental Health (OEH)/Exposure Incident – In general may be defined as an unexpected significant OEH (to include CBRN) exposure event that results in an acute illness or that has the potential to cause latent illness to those individuals affected or possibly exposed. Several variables, including event perception and data confidence limitations, may factor into the determination of whether an event constitutes an ‘incident’. See Appendix I of this document for more details.

9. Occupational and Environmental Health Risks – The likelihood of health risks associated with:

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

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

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

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

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

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

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

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

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

(1) The use of facilities with substantial friable asbestos as the official (1-year) living/working quarters for a deployed unit may be a “Low risk” relative to the acute impacts to the mission. However, the asbestos exposure could be deemed significant if toxicological and or epidemiological

scientific evidence supports High confidence exposures of similar magnitude and duration are strongly associated with the development of disease (e.g., asbestosis or mesothelioma).

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

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

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

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

14. Periodic Occupational and Environmental Monitoring Summary (POEMS) – A POEMS is a document that summarizes the DoD medical interpretation of existing occupational and environmental health (OEH) exposure information/data for deployment sites (e.g. base camps). Specifically, a POEMS describe the types of exposure hazards identified at a site (e.g., airborne pollutants, water pollutants, infectious disease, noise, heat/cold), summarizes data/information collected about those hazards, assesses mitigation measures that have been implemented to address the hazard, and then provides an assessment of the significance of any known or anticipated potential acute (short term) and long-term (post deployment) health effects to the personnel population deployed to the site. The POEMS concludes with a summary of the key acute and chronic hazards/risks. If a specific recommendation for follow-up is indicated, this must be coordinated with a health care provider before inclusion to the POEMS (Appendix F).

15. Reportable Medical Event (RME) - An event that meets the following criteria. In addition, a reportable medical event may be defined by the supported combatant command or subordinate organization (e.g., JTF).

a. There must be a clear case definition and a single standard code (from the International Classification of Diseases, 9th revision).

b. An intervention must be available and/or a public health response indicated.

- c. A sufficient, timely source of the required information must not already exist.
- d. The condition/event must also meet one of the following criteria:

(1) It represents an inherent, significant threat to public health by having the potential to affect large numbers of people, to be widely transmitted within a population, or to have severe/life threatening clinical manifestations.

(2) It represents a significant military operational threat by having the potential to disrupt military training, deployment, or operations.

(3) It is commonly reportable by state or federal laws, regulations, or guidelines.

(4) Tri-Service Reportable Events Guidelines and Case Definitions are available at <http://afhsc.army.mil/> under "Policy/References" heading and then under "AFHSC" Heading.

(5) Is identified a CBRN incident related exposure or CENTCOM specified event of interest as described in Appendix H of this regulation.

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

17. Military Exposure Surveillance Library (MESL). The Army maintained DoD informatics system for submitting, searching, viewing and downloading OEHS related documents. The MESL exists in both the unclassified [MESL: <https://mesl.apgea.army.mil/mesl>] and classified [MESL-S: <https://mesl.csd.disa.smil.mil/mesl/>] environments. The user interface in both the MESL and MESL-S functions identically, however accounts and passwords are independent. All OEHS related documents should be submitted directly to the appropriate application based on the document classification. However, if connectivity to the MESL application is not available, unclassified documents should be sent to oehs.data@us.army.mil and classified documents should be sent to oehs@usachppm.army.smil.mil. Help resources and a MESL user guide are publicly available on both web sites. Unclassified documents are routinely transferred to the classified system, so there is no need to submit to both systems. Documents previously submitted to the archive can be disposed of in accordance with DoD or agency guidance. The MESL also includes a DOEHS resources page [<https://mesl.apgea.army.mil/mesl/doehrsResources/initialize.do>] containing Adobe versions of various DOEHS sample and survey forms as well as DOEHS training materials.

18. Defense Occupational and Environmental Health Readiness System (DOEHRS). The DoD Military Health System's (MHS's) maintained informatics system for entering standardized sample and survey collection forms and reporting associated sample laboratory results and survey data. The

DOEHRS system has multiple modules which include: Industrial Hygiene (IH); Environmental Health (EH); Radiation (R); and Incident Reporting (IR). Access to each of these modules is managed by an individual's roles within the system. DOEHRS also provides the ability to search and report across all data entered. DOEHRS is the foundation for the Longitudinal Exposure Record (LER).

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Appendix C

SUMMARY OF DEPLOYMENT HEALTH ACTIVITIES AND REPORTING REQUIREMENTS

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

Table C-1. Summary of Key Deployment Health Surveillance Activities* (per DoDI 6490.03, Section E4.A2.1.)	
Activity Description	Key Applicable/Required Forms, Reports, Documents
Ensure site OEH baseline documents are complete, reviewed and accurate; update as appropriate*	<ul style="list-style-type: none"> • Preliminary Hazard Assessment (PLHA)/Phase I Deployment OEH Site Assessment (MCM 0028-07) • Environmental Baseline Survey (EBS) (Environmental Baseline Survey Handbook) • Occupational Environmental Health Site Assessment (OEHSA) (Appendix E)
Implement health risk communication plans Conduct risk communication *	<ul style="list-style-type: none"> • Medical Threat Briefings (MTB) http://phc.amedd.army.mil/topics/envirohealth/fpm/Pages/MTB.aspx • Deployment Health Guides (DHG) http://phc.amedd.army.mil/topics/envirohealth/fpm/Pages/MTB.aspx • Deployment Incident and Hazard-Specific factsheets https://mesl.apgea.army.mil/mesl/ • Other factsheets/info cards http://usaphcapps.amedd.army.mil/HIOShoppingCart/ • Published base camp POEMS and previous reports https://mesl.apgea.army.mil/mesl/
Perform continuous health surveillance/monitoring activities to identify potential health hazards and detect trends in the health of deployed personnel or identify health conditions Ensure appropriate reports are created, updated, and submitted for archival in accordance with listed references. *	<ul style="list-style-type: none"> • Base Camp Assessments -periodic preventive medicine assessment of all facilities/services for a site (<i>A standardized form is still in development with USAPHC as of the date of this publication</i>) • D&I reporting (see Appendix G) • Field Data Sheets for environmental sample collection (sampling conditions and parameters for air, soil, water samples intended for advanced laboratory analyses) (See Appendix E and the MESL website: https://mesl.apgea.army.mil/mesl/doehrsResources/initialize.do) • Deployment Occupational and Environmental Health Risk Characterization Assessment (documents/reports/analytical data and summaries resulting from advanced laboratory analyses) • PVNTMD Field Surveys/Assessments (e.g. field water, food, sanitation, facilities, etc.) (See standardized applicable medical references, i.e. TB Med 577, TB MED 530, local forms) • Pest Management Records (DD Form 1532-1) (DoDI 4150.07) • Industrial Hygiene Surveys (AR 40-5) • Veterinary Service Reports and Data: food and bottled water sanitation audit reports; veterinary laboratory food, bottled water, and zoonotic disease test results; veterinary medicine zoonotic disease data (AR 40-905) • Vector Surveillance Reports (e.g. adult/larvae monitoring surveys) • Other: <ul style="list-style-type: none"> ○ Preventive medicine unit and situation reports ○ Occupational Noise Hazards ○ Occupational Radiation Safety • Periodic Occupational and Environmental Monitoring Summaries (POEMS) (See the MESL website and Appendix F)
Record and report once-daily locations (all personnel)	<ul style="list-style-type: none"> • DMDC/Service-Based Personnel Reporting Systems

Table C-2

Coordinating Elements for Deployment Health Surveillance Activities

Activity Description*	Activity Responsibilities										
	CENTCOM Commander	CENTCOM Deputy Commander	CENTCOM J1	CENTCOM J2	CENTCOM J3	CENTCOM J4	CENTCOM J5	CENTCOM J6	CENTCOM Surgeon	CENTCOM Service Component & JTF Commanders & Directors	CJTF & Service Component Command Surgeons
Activity 1 - Ensure site OEH baseline documents are completed and accurate; provide updates as appropriate.*				X	X	X			X	X	X
Activity 2 - Implement health risk communication plans/conduct risk communication.*	X				X				X	X	X
Activity 3 - Perform continuous health surveillance activities to identify potential health hazards and detect trends in the health of deployed personnel or identify health conditions; ensure appropriate reports are created, updated, and submitted through appropriate channels for archiving.	X	X		X	X	X			X	X	X
Activity 4 – Record/report daily locations (all deployed personnel).		X	X		X						
Activity 5 - Investigate, report and document all OEH and CBRN exposure incidents.*	X				X				X	X	X
Activity 6 - Document patient encounters via SF 600. Document any specified OEH/CBRN related exposures and use specified ICD-9 codes; file in the deployment health record (DD Form 2766) or equivalent.	X				X				X	X	X

Activity	Key Applicable / Required Forms, Reports, Documents*	Documentation Responsibilities										
		Component / JTF Combat Units	Component/JTF Combat Spt. Units	Component /JTF Combat Svc. Spt	Health Surveillance Ctrs/ Reachback Units	Component/ JTF Medical Units	Component & JTF Engr Units	Component/JTF PM/Vet Units	CENTCOM Surgeon/FHP	CENTCOM Staff (J1,J2,J3,J4,J5,J6)	Component /JTF SG/FHP Officer	CJTF & Svc Component Staff (J1,J2,J3,J4,J5,J6)
Activity 1	Annex Q	UI	UI	UI	UE			UE	UE D	CP AU E	UE D	CPA UE
	Preliminary Hazard Assessment (PLHA)/Phase I Deployment OEH Site Assessment	UI	UI	UI	CPA UE	UI		UE	UE D	EI	UE D	E
	Environmental Baseline Survey (EBS)				ES		C P A U E	UE	ED	E	ED	E
	Occupational and Environmental Health Site Assessment (OEHS)	I	I	U	CPB AUE S			CPB AU E	ED	E	ED	E
Activity 2	Country/site specific: Medical Threat Briefings (MTB)	UI	UI	UI	P	U I	U	PU	ED	U	ED	U
	Country/site specific: Deployment Health Guides (DHG)	UI	UI	UI	P	U	U	PU	ED	U	ED	U
	Country/site specific: Other factsheets/info cards	UI	UI	UI	P	U	U	PU	ED	U	ED	U
Activity 3	D&I reporting				E	PS		PSU E	ED		ED	
	Field Data Sheets for environmental sample collection (parameters for air, soil, water samples, advanced laboratory analyses)				ES			CPB AUE	ED		ED	
	Deployment Occupational and Environmental Health Risk Characterization Assessments (documents/reports/analytical data and summaries resulting from advanced laboratory analyses)	I	I	I	PAES	U DI		CUD I	ED		ED	
	PVNTMD Field Surveys/Assessments (e.g. field water, food, sanitation, facilities, etc.)	I	I	I	ES	U DI		CPB AUE SDI	ED		ED	
	Pest Management Records	P A	P A	P A	ES			CPA UES	ED		ED	

Activity 3 (continued)	Industrial Hygiene Surveys (e.g., chemical, noise, etc.)	I	I	I	CPB AUE S			CPB AUE SDI	ED		ED		
	Veterinary service reports and data: food and bottled water sanitation audit reports; veterinary laboratory food, bottled water, and zoonotic disease test results; veterinary medicine zoonotic disease data, animal bite reporting	I	I	I	ES			¹ CPA UES DI	ED		ED		
	Vector Surveillance Reports	I	I	I	ES			CPB AUE SDI	ED		ED		
	Other: Preventive medicine unit and situation reports	UI	UI	UI	ES			CPA UES	ED		ED		
	Periodic Occupational and Environmental Monitoring Summaries (POEMS) [#]	UI	UI	UI	CPA UES			CPA UES	ED		ED		
Activity 4	Location Report	CP A	C P A	C P A	UES				U		U		
Activity 5	Reportable Medical Event (RME)	CP AU E	CP AU E	CP AU E	UES	CP AU E		E	ED	UE	ED	UE	
	Significant Action Report (SIGACTS) (e.g. CIDNE/TIGR) and associated reports related to incident exposures	CP AS	C P A S	C P A S	UES	U		E	AE D	UE	AE D	UE	
	NBC reports (e.g. EOD reports)	CP AS	C P A S	C P A S	UES				AE D	UE	AE D	UE	
	• Initial Field Account (IFA)	PS	PS	PS	UES	PU E		CPB AUE S	AE D	UE	AE D	UE	
Activity 6	• SF 600					PA							
	• DD Form 2766					PA							

Table C-3 Legend
Responsibilities for Key Deployment Health Surveillance Report/Documents

Requirements Source: DoDI 6490.03, Section E4.A2.1

* Required for all >30 day deployments; for <30 day deployments the asterisk* activities are not required though recommended if feasible (Commander determined)

! Veterinary Medicine Units

POEMS are approved by CENTCOM Command Surgeon/FHP Officer or designated Component/JTF Surgeon/FHP Officer

NOTE: Reports will usually go through the respective organizational chain of command

Specific Action Legend

C – Coordinate

P – Prepare Document

B- Enter data into DOEHRS (If entered into DOEHRS, OEHS data does NOT need to be sent to the MESL)

A – Submit to Military Exposure Surveillance Library (MESL)(For SF 600 & DD 2766 submit to Individual Medical Record. For Location report submit through Service-Specific Personnel Reporting System to DMDC)

S – Submit to FHP Officer/Command Surgeon

U – Use/Take Action

E – Evaluation of trends, Follow-up of issues, Determine if recommendations implemented, Recommend appropriate countermeasures, etc.

D – Develop appropriate policy/guidance if needed.

I – Implement Recommendations as appropriate

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Appendix D MILITARY RISK MANAGEMENT PROCESS APPLIED TO HEALTH HAZARDS

1. Background

a. Commanders are responsible for protecting and preserving personnel and equipment against injury, damage, or loss that may impact the military mission and force readiness. Risk is an expression of the possible mission impacts (either tactical or strategic) that a hazard may have in terms of both the consequences of its occurrence (severity) and the probability effects may occur. The determination as to whether a risk is acceptable or not for military operations is an iterative process that requires evaluation of changing conditions and multiple kinds of hazards and risks. This is an *all-hazards* approach to risk management.

b. The process used to identify and control hazards across the full spectrum of military missions, functions, operations, and activities described in multiservice doctrine (*Operational Risk Management* - FM 3-100.12) as well as service specific doctrine (e.g., *Army's Composite Risk Management* - FM 5-19). The matrix shown in Table D-1 is the qualitative ranking tool described by military doctrine. Use of this standardized matrix is to characterize all types of risk facilitates comparison of different risks and supports balanced decision-making.

c. To determine a risk estimate, first, a hazard must be identified, then the hazard severity is assessed, then the hazard probability assessed. The Hazard severity and probability are converted into the specified risk estimate levels shown in the matrix shown in Table D-1.

HAZARD SEVERITY	HAZARD PROBABILITY				
	Frequent (A)	Likely (B)	Occasional (C)	Seldom (D)	Unlikely (E)
Catastrophic (I)	Extremely High	Extremely High	High	High	Moderate
Critical (II)	Extremely High	High	High	Moderate	Low
Marginal (III)	High	Moderate	Moderate	Low	Low
Negligible (IV)	Moderate	Low	Low	Low	Low

Table D-1 Military Risk Management Matrix (FM 3-100.12, FM 4-02, & FM 5-19)

2. Using Military Risk Management to Estimate Health Risks from OEH Exposures

a. Current DoDI and Joint Staff policy requires this process to be used to estimate risks of both the acute and chronic health effects to military personnel that could occur from OEH exposures during deployments. Since the types of risks and impacts caused by acute health effects versus those of long term/chronic health effects are different (e.g. tactical relevance versus strategic life-cycle impact), OEH exposures must be evaluated as two separate types of risk - short-term (tactical) and

long term (strategic life-cycle). The general approach and definitions to be used to assess severity and probability of OEH health hazards IAW current DOD and Joint policy is described in following paragraphs.

b. The process of assessing and characterizing deployment-related risks from OEH exposures inherently involves significant data limitations, uncertainty, variability, and professional judgment. The guidance in this regulation provides the general framework and definitions to be used by personnel who develop OEH risk estimates for deployed personnel. Note, however, that the application of this process requires certain assumptions and interpretations that go beyond those explicitly provided by existing policy or doctrine. Hazard specific assessment tools, such as USACHPPM's Technical Guide 230, *Environmental Health Risk Assessment and Chemical Exposure Guidelines for Deployed Military Personnel*, should be used to assess unique hazard types. Use this guidance with site-specific exposure information, sampling and field data to develop risk estimates for those specific types of hazards.

3. Identifying the OEH Hazard

a. A deployment-related OEH hazard exists when a substance/material is present at a level and in a form that might be associated with either an acute and/or a chronic adverse health outcome in an exposed population.

b. The mere presence or detection of a substance/material does not mean it is an OEH hazard. A substance/material is only considered a potential problem if it is determined to be present in a form/in media where personnel could plausibly be exposed for sufficient periods of time at concentrations that could be associated with either acute or chronic health effects. Hazard specific guidance tools should be consulted to help determine whether a specific OEH hazard exists.

4. Assessing and Ranking OEH Hazard Severity

a. The Hazard Severity of any given deployment-related OEH exposure refers to the extent and severity of potential acute and/or chronic (long-term/latent) injury, illness, disease, or other adverse health effects within the population under assumed exposure conditions.

b. The extent and the severity of effects are presented in terms of significance to military operations and anticipated medical response needs. The significance of the potential health outcomes are ranked differently for tactical versus strategic hazards. Current military policy as articulated by the Office of the Chairman of The Joint Chiefs of Staff (MCM 2007) provides distinct and separate health-based hazard severity level definitions for acute and chronic (long-term/latent) health effects. While the severity categories (e.g., Catastrophic, Critical, Marginal, and Negligible) correspond to the four hazard severity levels established by the doctrinal risk matrix in Table D-1, the Joint policy definitions provide the interpretations of these levels as they specifically apply to acute and chronic (long-term) health effects. The policy definitions from the Joint Staff memorandum (MCM 2007) are presented in Table D-2. The difference between "acute" and "chronic" health effects as it pertains to the military risk assessment process is described below.

5. Acute Health Effects. These are health effects that develop immediately or shortly after an exposure. Generally speaking, acute/short term effects occur after single relatively brief or short

term exposures (minutes to days). Acute health effects can degrade personnel ability to conduct real-time deployment required mission tasks and thus have direct/real-time (tactical) consequences to military operations and force readiness. Overall consequences to be considered include direct impacts on soldier/unit capability as well as any associated impacts on medical or preventive medicine resources required to address the health effects during the specific deployment operation. This is akin to 'traditional' military risk management.

6. Chronic (Long-Term/Latent) Health Effects. These are health effects that develop post-deployment (e.g. months or years later). Chronic, long-term, or latent health effects are generally associated with continuous or repeated chronic or long-term exposures (e.g. many months or more). However, it is also possible for certain single, short-term exposures to result in a latent health effect (e.g., permanent damage to lung tissue leading to long term respiratory disease). Chronic health effects can have strategic life-cycle consequences for military operations and force readiness. The full force readiness 'life cycle' includes personnel accession through retirement or separation and beyond. Impacts to overall DoD resources and readiness are inherently tied to medical documentation, surveillance, and potentially the follow-up of personnel if at risk of long-term illness associated with exposures encountered during deployments. While such effects do not have tactical impact, in accordance with the current policy, Commanders must consider these future medical risks during operational as well as strategic decision-making.

Negligible Severity	Marginal Severity	Critical Severity	Catastrophic Severity
<p><u>Acute Effects</u> Few exposed personnel (if any) are expected to have noticeable health effects during mission. Exposed personnel are expected to be able to effectively perform all critical tasks during mission operations. Minimal to no degradation of abilities to conduct complex tasks are expected.</p>	<p><u>Acute Effects</u> Many exposed persons are expected to have noticeable but not incapacitating health effects. Observable effects require minimal if any medical attention but may reduce some individual physical capabilities and/or may enhance stress-related casualties. Exposed personnel able to perform most critical tasks. Note: Ability to accomplish complex tasks may be degraded.</p>	<p><u>Acute Effects</u> Personnel are expected to have incapacitating health effects requiring immediate medical treatment or support (e.g., are considered 'casualties'.) There may be limited numbers of fatalities. Personnel not experiencing more serious effects are expected to have at least noticeable, but not incapacitating health effects. Exposed personnel will have limited ability to perform most critical tasks. Note: Ability to accomplish complex tasks likely to be degraded.</p>	<p><u>Acute Effects</u> Casualties with severe incapacitating effects requiring immediate and significant medical attention and/or additional support for survival. Increasing number of fatalities are expected. Exposed personnel unable to perform critical tasks.</p>
and/or	and/or	and/or	not a driver
<p><u>Chronic Effects</u> Few exposed personnel (if any) are expected to develop delayed onset, irreversible effects</p>	<p><u>Chronic Effects</u> Many exposed personnel are plausibly expected to develop delayed onset, irreversible effects. While this may not affect the immediate physiological capabilities of individuals, commanders must consider long-term implications and appropriately communicate the potential risks. Operational stress related implications may adversely impact operations particularly over extended operational periods.</p>	<p><u>Chronic Effects</u> Majority to all exposed personnel are plausibly expected to develop delayed onset, irreversible effects due to the specified exposure. This may not affect the immediate physiological capabilities of individuals, but commanders must consider long-term implications and communicate the potential risks. Psychological implications may adversely impact operations particularly over extended operational periods.</p>	<p><u>Chronic Effects</u> This level of hazard severity is reserved for the most serious of conditions where immediate survivability against acute effects is the priority. Those that survive may be at increased risk for certain chronic effects.</p>

Table D-2, Health Effects Descriptions for Each Hazard Severity Category (MCM 2007)*

This matrix applies to all health hazards encountered during deployment. Health effects associated with chemical exposures are typically either acute or chronic, but in some cases may be both. In general, short-term one-time chemical exposures are primarily associated with acute effects, while repeated long-term exposures are associated with chronic effects.* Format modified from MCM version for ease of presentation, to include the elimination of the 'no effects' category.

7. Assessing and Ranking OEH Hazard Probability

a. The Hazard Probability of an identified OEH hazard represents the likelihood that the population exposure will result in the hazard severity outcome.

b. OEH hazard probability is generally ranked after hazard severity is ranked. There are five doctrinal levels of hazard probability. Definitions applicable to OEH hazard assessment are described in Table D-3. Determination of the probability level is based on a variety of exposure factor considerations - to include frequency, duration, and rate of exposure as well as degree or extent of population exposed.

Rank	OEH HAZARD PROBABILITY DEFINITION
Frequent	Personnel will continuously experience exposures that are greater than that required to produce the health effect outcomes associated with the hazard severity level.
Likely	Personnel will commonly experience exposures that are greater than that required to produce the health effect outcomes associated with the hazard severity level.
Occasional	Personnel will occasionally experience exposures that are greater than that required to produce the health effect outcomes associated with the hazard severity level.
Seldom	Personnel will rarely experience exposures that are greater than that required to produce the health effect outcomes associated with the hazard severity level.
Unlikely	Personnel are unlikely to experience any exposures that are greater than that required to produce the health effect outcomes associated with the hazard severity level.

Table D-3 OEH Hazard Probability Definitions*

* Derived from FM 4-02, MCM Memorandum 0028-07 (MCM 2007), FM 3-100.12

8. Estimating the OEH Risk. As previously indicated, the previously described steps are used to determine two different kinds of risk: risk of acute health effects (tactical or short-term risk) and then risk of chronic health effects (strategic/life-cycle long-term risks). Specifically, the acute and chronic hazard severity levels and probability ranks are compared with the risk matrix (Table D-1) to determine a risk level. The risk levels have specific definitions depending on type of health effects (e.g., tactical risks and strategic lifecycle risks). These are explained below.

9. Tactical risk associated with acute health effects from OEH hazards. Acute health effects may result in tactical risk to ongoing mission and thus are described as a short-term health or medical risk. Current doctrinal risk definitions are presented in Table D-4 along with the possible types/degree of real-time (in-theater) medical risk management responses that may be anticipated (noted in italics). In addition to the medical resources needed to treat and document acute effects, certain exposures that result in acute health effects may also be associated with effects that require post-deployment medical surveillance/follow-up. The potential for any post-deployment medical

follow-up and surveillance should be addressed as part of the long-term health risk estimate as discussed below.

10. Strategic/lifecycle risk associated with chronic health effects from OEH hazards. Strategic risk estimates reflect long-term medical risks to Force Readiness and are described in terms of the degree of impact to the medical support system following deployment. Risk definitions are presented in Table D-5 below along with possible risk management responses for preventive medicine and medical assets (in italics). While the risk/consequences represented are less oriented on treatment/countermeasures than those associated with acute health risks, they can reflect significantly broad long-term resource responsibilities to the military medical system and overall force readiness.

Risk Level	Tactical Consequences to Military Operations and Force Readiness ^{1, 2, 3, 4}
Extremely High	Loss of ability to accomplish the mission if hazards occur during mission. <i>Notable in-theater medical countermeasures and resources anticipated. For example, protection, treatment, and exposure documentation.</i>
High	Significant degradation of mission capabilities in terms of the required mission standard, inability to accomplish all parts of the mission, or inability to complete the mission to standard if hazards occur during the mission. <i>Some in-theater medical countermeasures and resources anticipated. For example, protection, treatment, and exposure documentation.</i>
Moderate	Expected degraded mission capabilities in terms of the required mission standard and will result in reduced mission capability if hazards occur during the mission. <i>Limited in-theater medical countermeasures and resources anticipated. For example, protection, treatment, and exposure documentation.</i>
Low	Expected losses have little or no impact on accomplishing the mission. <i>Little to no in-theater medical resources anticipated for protection and treatment. However, a summary of any negative or low level sampling results should be documented and archived particularly if some personnel express concerns.</i>

Table D-4 OEH Tactical Risk Definitions and Possible Medical Responses Associated with Real-Time or “Acute” Health Effects

¹ The italicized phrases are not part of the doctrinal definitions (FM 3-100.12) but are the types of anticipated medical and preventive medicine responses associated with the expected health outcomes associated with these risk levels.

² In addition to the medical resources needed to treat and document acute effects, certain exposures that result in acute health effects may also be associated with effects that require post-deployment medical surveillance/follow-up. The potential for any post-deployment medical follow-up and surveillance should be addressed as part of the “chronic” risk estimate.

³ For certain OEH exposures the risk outcomes may be especially pronounced in certain individuals who have underlying traits or behaviors that make them more susceptible to developing effects. For example, moderate risk exposures to the chemical sulfur dioxide may be irritating to most personnel and cause some mild impairment, but may significantly exacerbate the condition of asthmatics and require medical countermeasures. Individuals who smoke may also be more likely to demonstrate exacerbated adverse health effects.

⁴ Per DoDI 6490.03, exposure documentation includes any applicable medical treatment documentation (e.g. SF 600) as well as exposure data incident information (to include field data and incident descriptions). In addition to required in-theater reporting channels; unclassified documentation should be submitted directly to Military Exposure Surveillance Library [MESL] <https://mesl.apgea.army.mil/mesl>. If access to the MESL is not available documents should be sent to oehs.data@us.army.mil. Classified documentation should be submitted directly to Military Exposure Surveillance Library - SIPR [MESL-S] <https://mesl.csd.disa.smil.mil/mesl/>. If access to the MESL-S is not available documents should be sent to oehs@usachppm.army.smil.mil.

Risk Level	Strategic Consequences to Military Operations and Force Readiness ^{1,2}
Extremely High	Significant future medical surveillance activities and medical provider resources anticipated. <i>Documentation of exposure data in designated DoD archive and designate a registry to actively track the exposed personnel. Conduct specific active surveillance and/or medical follow-up procedures for life-cycle of identified group.</i>
High	Notable future medical surveillance activities and related resources anticipated. <i>Documentation of exposure data in designated DoD archive. Specific identification and documentation of the exposed personnel. Possible passive medical surveillance related activities.</i>
Moderate	Limited future medical surveillance activities and related resources anticipated. <i>Documentation of exposure data in designated DoD archive. Consider documenting exposed groups or personnel of surveillance interest.</i>
Low	No specific medical action required. <i>Documentation of exposure in designated DoD archive.</i>

Table D-5 OEHL Strategic (Lifecycle) Risk Definitions and Medical Responses Associated with Post-Deployment “Chronic” Health Effects

¹ The definitions reflect the objectives of current DoD and Joint Staff policies and requirements. The italicized phrases are the types of anticipated medical and preventive medicine responses associated with the expected health outcomes associated with these risk levels.

² Per DoDI 6490.03, unclassified exposure data should be submitted directly to Military Exposure Surveillance Library [MESL] <https://mesl.apgea.army.mil/mesl>. If access to the MESL is not available, send the data to oehs.data@us.army.mil. Classified exposure data should be submitted directly to Military Exposure Surveillance Library - SIPR [MESL-S] <https://mesl.csd.disa.smil.mil/mesl/>. If access to the MESL-S is not available send data to oehs@usachppm.army.smil.mil.

11. Estimating the Degree of Confidence in the OEHL Risk Estimate

a. The best decisions are made based on obtaining the best data, and considering the uncertainties associated with that data. Data quality, including both sampling data and information that informs exposure parameters, will have a direct impact on the confidence in the risk assessment.

b. Some considerations in determining the confidence in the assigned risk are presented below. While some guidelines are presented, there is no “standard” definition of the level of confidence.

The risk assessor should consider all the information at hand, and communicate to the decision maker the level of confidence they have in the risk level being presented. Indicators of confidence are given in Table D-6.

(1) **High Confidence.** High confidence in a risk level implies significant understanding of all the variables used to determine the risk. It results from sampling data that is adequate to characterize typical exposures and the range of those types of exposures, as well as a good understanding of the exposure patterns of the population being characterized.

(2) **Medium Confidence.** Medium confidence in a risk level implies some understanding of most of the variables used to determine the risk. It results from sampling data that is plausibly adequate to characterize typical exposures and the range of those types of exposures.

(3) **Low Confidence.** Low confidence is assigned when sampling data may not be adequate to characterize the situation, and when the assessor is making a best scientific assessment in the absence of complete information.

Confidence	Criteria
High	<ul style="list-style-type: none"> - Field Sampling data quality is very good – substantial samples over time/space. - Field activity patterns are well known. - True exposures are reasonably approximated. - No important missing information. - The predicted health outcomes are highly plausible (strong toxicological weight of evidence/human data) or already demonstrated.
Medium	<ul style="list-style-type: none"> - Field data quality is relatively good. - Estimates of field exposure are likely to be greater than true exposures due to incomplete data coverage relative to actual exposure durations. - Detailed information is lacking regarding true personnel activity patterns in the field. - Predicted health outcomes are plausible but there is toxicological data but limited weight of evidence/human data is lacking.
Low	<ul style="list-style-type: none"> - Important data gaps and/or inconsistencies exist. - Exposure conditions are not well defined. - Field personnel activity patterns are basically unknown. - Predicted health outcomes are not plausible because it is not consistent with real-world events/experience.

Table D-6 Example Criteria for Assigning Confidence Levels

Appendix E
OCCUPATIONAL AND ENVIRONMENTAL HEALTH SITE ASSESSMENT (OEHSA)

1. The OEHSA provides a comprehensive assessment of both occupational and environmental health hazards associated with deployment locations as described in paragraph 11 of Appendix B, and the activities and missions that occur there. The template can be found at the following web link, under the drop down menu for 'Survey Forms':
<https://mesl.apgea.army.mil/mesl/doehrsResources/initialize.do>

2. OEHSAs will be initiated within 30 days of date of establishment and completed within 3 months for all permanent and semi-permanent base camps, whenever feasible. When completion within 3 months of establishment is not feasible, the issues affecting OEHSA progress and completion will be submitted with the monthly reporting requirement per paragraph 5. Review OEHSAs annually to ensure they are current, and update anytime a change in operations may have either a negative or positive impact upon the occupational or environmental setting IAW References 3 and 4.

3. OEHSAs are conducted to validate actual or potential health threats, evaluate exposure pathways, and determine courses of action and countermeasures to control or reduce the health threats and protect the health of deployed personnel.

4. OEHSA-related documents will be sent by the completing unit through the designated CJTF PM/FHP officer for review and submitted directly to MESL <https://mesl.apgea.army.mil/mesl>. If the MESL is not available, email the document to oehs.data@us.army.mil. Classified exposure data should be submitted directly to MESL-S <https://mesl.csd.disa.smil.mil/mesl/>. If access to the MESL-S is not available, email the document to oehs@usachppm.army.smil.mil. *Important note: If sent via email, do not digitally sign or encrypt the email. These two email features interfere with the processing of email submissions. To disable these features in MS Outlook 07, click the 'Sign' and/or 'Encrypt' buttons on the outgoing message ribbon toolbar. The buttons will appear grayed once the features are disabled.*

5. Service Components and JTFs are responsible for approving OEHSA completion and will submit a monthly OEHSA status report to the CENTCOM PM/FHP Officer, by no later than the 5th of each month. The minimum submission metric for OEHSAs is: Percent of currently operational contingency operating bases and sites, by country, which have current OEHSAs (either completed or reviewed/updated for currency within the past year). This metric is to be calculated as:

$$\left[\frac{\text{(Number currently operational contingency operating bases and sites with completed/reviewed/updated OEHSAs (that have been submitted to MESL (OEHSAs pending sampling results may be included in this calculation))}}{\text{(Number currently operational contingency operating bases and sites within the operating area)}} \right] \times 100\%$$

6. U.S. Army Public Health Command uploads OEHSAs that have been submitted to a classified website. The archive of completed OEHSAs is available at the following SIPR website:
<https://phc.army.smil.mil/Pages/OccupationalEnvironmentalHealthSiteAssessments.aspx>.

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Appendix F

PERIODIC OCCUPATIONAL AND ENVIRONMENTAL MONITORING SUMMARY (POEMS)

1. The POEMS are the official DoD approved documents that summarize health risks and associated medical implications resulting from occupational and environmental health (OEH) exposures identified at major deployment sites (e.g. base camps). Specifically, POEMS describe the types of exposure hazards (e.g., airborne pollutants, water pollutants, infectious disease, noise, heat/cold), summarize site data/information collected, and provide an assessment of the significance of any known or potential short term (during deployment) and long-term (post deployment) health risks to the personnel population deployed to the site.
2. The POEMS have been developed to address requirements of DoDIs 6490.03 and 6055.05, and JCSM (MCM) 0028-07, *Procedures for Deployment Health Surveillance*, 2007. The POEMS satisfies the DoDI requirement to prepare “periodic occupational and environmental monitoring summaries on a SF 600 for each permanent or semi-permanent basing location.” POEMS are to be created and validated/updated for every major deployment site as soon as sufficient site data is available, but no later than one year after occupation. In general, POEMS should reflect data and information collected from a year or more time at a site in order to adequately evaluate potential risks from long term exposures. POEMS should be reevaluated as data indicates exposure conditions have changed.
3. The CJTF or Component PM/FHP Officer is responsible for verification of certain information by designated field PVNTMD personnel and ensuring the POEMS in the AOR are completed and approved. However, requests may be submitted to specialized technical support (e.g. specialized deployable teams/units, USAPHC, NMCPHC, USAFSAM) for drafting elements of the POEMS, especially for description of long-term health risks.
4. The primary audience of the POEMS is military public health personnel and health care providers (military, VA, as well as private sector). To the extent that the available data allows, the POEMS describes the general ambient conditions at the deployment site and surrounding area, and characterizes the risks at the *population-level*. While useful to inform providers and others of potential health effects and associated medical implications, it *does not* represent an individual exposure profile. Actual individual exposures and specific resulting health effects depend on many variables and should be addressed in individual medical records by providers as appropriate at the time of an evaluation of a unique exposure. The intent of POEMS is to satisfy the need for such population-level health surveillance information to be available, should service personnel have OEH exposure-related concerns. For additional assessment of potential individual exposures, Service members are also required to complete pre- and post- deployment questionnaires regarding their individual health status and any occupational or environmental exposures that they believe that they experienced while deployed.
5. The template for the POEMS is located at:
<https://mesl.apgea.army.mil/mesl/healthSummary.jsp>.
 - a. Completed approved POEMS are available via NIPRNET on the MESL at <https://mesl.apgea.army.mil/mesl/>. *Note: As of this regulation’s publication date, access to the*

POEMS requires an individual to have established an account through the MESL. However, OSD Health Affairs has been coordinating to allow posting of POEMS on a website accessible to the public.

b. Approved POEMS are also available at the following SIPRNET website: <https://phc.army.smil.mil/Pages/PeriodicOccupationalEnvironmentalMonitoring.aspx>.

Appendix G
DISEASE AND INJURY (D&I) SURVEILLANCE

1. Purpose and Processes for D&I surveillance

a. D&I (formerly known as disease and non-battle injury [DNBI]) surveillance, as required by Reference 3, can reveal abnormal patterns and trends that may signal a serious, widespread health problem that could negatively impact the mission. The causes of these types of health problems include environmental health threats, inadequate sanitation and hygiene and monitoring programs, inadequate use of preventive and/or protective measures, and unhealthy behaviors and practices.

b. The purpose of D&I surveillance is to promote and maintain the health and fitness of deployed forces and maximize force health protection through monitoring illness and injury rates, and instituting interventions as required. Specific objectives include:

(1) Communicable disease outbreak detection.

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

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

c. D&I surveillance is based on information from healthcare visits at every level of the combat healthcare system. In locations where an electronic medical record is used, the bulk of information flows automatically from the NIPRNET-based health information system to Medical Situational Awareness Tool (MSAT) a SIPRNET-based application that facilitates monitoring of D&I trends throughout the AOR (<https://msat.fhp.smil.mil/portal>). The JMeWS tab within MSAT allows users to monitor trends over time and compare D&I rates across geographic and command levels in order to survey for potential problems.

(1) Sites operating without NIPRNET in their healthcare areas must maintain a spreadsheet containing the counts of their local healthcare visits IAW Reference 3.

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

d. The weekly D&I report through MSAT/JMeWS indicates the number of cases of disease or injury (as defined by Reference 3) along with the size of the population at that location.

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

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

e. Using MSAT/JMeWS, FHP personnel aggregate weekly reports by UIC (or a similar location-specific code) in order to survey their specific AOR.

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

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

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

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

2. Specific Procedures.

a. Reference 3 contains the latest requirements for conducting D&I surveillance. Additional procedures designed to enhance D&I surveillance in USCENTCOM are provided below.

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

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

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

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

c. Ensure that reports conform to the established methods for counting cases. It is critical that D&I surveillance at all levels follows the established case definitions. FHP personnel and surgeons

are responsible for distributing copies of the JSC memo throughout their AORs and conducting local training, as needed.

Example DNBI rate calculation:

$$DNBI (\%) = \left(\frac{\# Patients}{\# Troops} \right) \times 100$$

$$DNBI_{derm} (\%) = \left(\frac{20}{500} \right) \times 100$$

$$DNBI_{derm} (\%) = (0.04) \times 100$$

$$DNBI_{derm} (\%) = 4\%$$

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Appendix H CENTCOM REPORTABLE MEDICAL EVENT (RME) DATA PROCEDURES

1. Purpose and Process for RME reporting.

a. RMEs are those diseases and conditions defined by Reference 14 that represent a special concern to the military leadership and public health authorities because they carry with them the potential for infectious disease outbreaks, or they may constitute sentinel events that indicate the failure of force health protection measures. Many are consistent with conditions that are reportable under U.S. federal or individual state laws.

b. Central reporting of Reportable Medical Events ensures that commanders have timely visibility of medical situations that threaten the health of the force. Centralized reporting retains historical data, supports disease mapping, and enhances public awareness, treatment options and vector mitigation. Medical providers at all levels are responsible for knowing the list of RMEs, reporting via service specific RME reporting systems as well as Disease Reporting System Internet (DRSi), informing FHP personnel of the occurrence within 24 hours of diagnosis, and assisting in epidemiological investigations, as necessary.

(1) FHP personnel responsible for monitoring RME reporting must use available health information systems to discover the occurrence of events that have not been reported by a provider. Such resources include (but are not limited to) MSAT/JMeWS, the Theater Medical Data System (TMDS), (DRSi), sick call logs or emergency room admission records. Such resources, where available, should be reviewed daily.

(2) FHP personnel will maintain a regional approach to ensure that all geographic and command AORs are covered for health surveillance and reporting of medical events. Where needed, FHP personnel will coordinate with each other to ensure coverage and reduce overlap.

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

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

(1) During initial site establishment, FHP personnel may also send forms directly to a reporting site at a fixed MTF in CONUS or OCONUS, but must coordinate with that site to ensure that it is capable of handling the additional workload. Such agreements must be approved by the Theater Surgeon.

(2) When external reporting locations are used to transmit RMEs for entry into disease reporting systems, FHP personnel will maintain careful records regarding the transmission of RMEs in order to ensure that cases are not missed and are properly updated when needed.

2. Specific procedures.

a. The Services maintain specific policies for the reporting of medical events, but all conform to the minimum requirements in Reference 14. For USCENTCOM, additional requirements and guidelines are provided as follows.

b. The CENTCOM Surgeon has identified the following additional medical conditions and exposures for reporting in the CENTCOM AOR.

(1) Chemical, Biological, Nuclear, and Radiological Exposure. If treatment is provided to personnel with effects from exposures to acutely toxic chemicals (warfare agents as well as commercial chemicals such as chlorine, ammonia, sulfur dioxide) or radiological exposures, these are considered CBRN/OEH exposure incidents that may require long-term medical surveillance and/or future epidemiologic/legal investigation. The FHP Officer is required to complete the CBRN/OEH incident technical summary reports (see Appendix I). To ensure complete incident documentation, individual medical treatment data is crucial. In these cases, the RME form should be completed with special attention to the section that requires a brief summary of the type of exposure. Because CBN incidents are not captured in all Service-specific RME systems, the RME form should be sent directly to the CENTCOM Surgeon/FHP Officer ccsg-pmo@centcom.smil.mil within 48 hours of treatment. Treatment records should include the appropriate code from below:

- (a) 987 Toxic effects of other gases, fumes, vapors
- (b) 987.6 Chlorine gas
- (c) 987.8 Mustard gas
- (d) E996.1 Radiation in war operations

(2) Pneumonia, code by organism, to include 518.3 Eosinophilic pneumonia.

(3) Acinetobacter infections, coded as a bacterial infection specific to an anatomical site, along with antibiotic sensitivities if available and recent travel history.

(4) Death or injury from failure of helmet or body armor, coded using E991.0-E991.5 or E997.8 (injuries due to war operations).

(5) 993.0 Acoustic trauma (otitic barotrauma).

(6) Traumatic loss or damage to vision or eye, coded as 870.3-871.6 (penetrating injury) or 918.1-918.9 (non-penetrating injury. Note if eye protection was worn.

c. MTF laboratory personnel should promptly notify the requesting provider and supporting FHP personnel of any positive laboratory test that confirms or supports the diagnosis of a RME, specifically for infectious/communicable diseases.

d. FHP personnel and surgeons will periodically monitor and review non-emergency RME reports from their AOR for patterns indicative of a public health problem. Additional time and resources may be necessary in order to determine the need for a specific public health intervention.

e. FHP personnel, surgeons and reporting providers are responsible for proper completion of all required data elements. The “Country” field should be used to indicate the country in which the Service Members is deployed. Travel history (Country 1 and 2) should include any other country relevant to the condition, including CONUS (if the patient was recently on leave, for instance). Travel to more than 3 countries can be added to the comments field.

CENTCOM REPORTABLE MEDICAL EVENT (RME) FORM

(U) PATIENT DATA:

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

(U) DISEASE DATA (complete as much as possible):

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

(U) FOR HEAT OR COLD INJURIES:

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

(U) FOR CBRN/OEH TIC/TIM EXPOSURE INCIDENTS:

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

(U) REPORTING SOURCE:

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

TRI-SERVICE AND CENTCOM RME DISEASE CODES**

006	Amebiasis	984	Lead Poisoning	090	Syphilis, congenital
022	Anthrax	482.84	Legionellosis	096	Syphilis, latent
E997.1	Biological Warfare Agent Exposure	085.4	Leishmaniasis, cutaneous	095	Syphilis, late (tertiary)
005.1	Botulism	085.5	Leishmaniasis, mucocutaneous	091	Syphilis, primary/secondary
023	Brucellosis	085.9	Leishmaniasis, unspecified	097.9	Syphilis, unspecified
008.43	Campylobacter	085	Leishmaniasis, visceral	037	Tetanus
986	Carbon Monoxide Poisoning	030	Leprosy	040.82	Toxic Shock Syndrome
989	Chemical Agent Exposure	100	Leptospirosis	124	Trichinosis
099.41	Chlamydia	027	Listeria	086	Trypanosomiasis
001	Cholera	088.81	Lyme disease	011	Tuberculosis, pulmonary
114	Coccidiomycosis	084	Malaria, falciparum	021	Tularemia
991.3	Cold Injury, Frostbite	084.2	Malaria, malariae	002	Typhoid fever
991.6	Cold Injury, Hypothermia	084.3	Malaria, ovale	080	Typhus fever
991.4	Cold Injury, Immersion Type	084.6	Malaria, unspecified	099.4	Urethritis, non-gonococcal
991.9	Cold Weather Injury, Unspecified	084.1	Malaria, vivax	979	Vaccine, adverse event
007.4	Cryptosporidiosis	055	Measles	052	Varicella, active duty only
007.5	Cyclospora	036	Meningococcal dis., Meningitis	066.4	West Nile Virus
061	Dengue fever	036.2	Meningococcal dis., Septicemia	060	Yellow Fever
032	Diphtheria	072	Mumps	Additional CENTCOM Reportable Conditions/Exposures ** 1. Chemical, Biological, Nuclear, Radiological (CBRN) and TIC/TIM OEH exposure: 987 Toxic Effects of Other Gases, Fumes, Vapors 987.6 Chlorine Gas 987.8 Mustard Gas E996.1 Radiation in War Operations 2. Pneumonia, code by organism, to include: 518.3 Eosiniphillic pneumonia 3. Acinetobacter infections. Report antibiotics sensitivities 4. Death or injury from failure of Helmet or Body Armor 5. Acoustic Trauma (Explosive) 6. Traumatic Loss or Damage to Vision or Eye (note if eye protection was worn).	
008.04	E. coli 0154:H7	008.63	Norovirus		
082.4	Ehrlichiosis	136.9	Outbreak (any pathogen)		
062	Encephalitis	033	Pertussis		
125	Filariasis	020	Plague		
007.1	Giardiasis	045	Poliomyelitis		
098	Gonorrhea	083	Q fever		
038.41	Haemophilus influenza, invasive	071	Rabies, human		
079.81	Hantavirus infection	087	Relapsing fever		
992.3	Heat exhaustion	390	Rheumatic fever, Acute		
992	Heat stroke	066.3	Rift Valley fever		
065	Hemorrhagic fever	082	Rocky Mountain Spotted fever		
070.1	Hepatitis A, Acute	056	Rubella		
070.3	Hepatitis B, Acute	003	Salmonellosis		
070.51	Hepatitis C, Acute	079.82	SARS		
487	Influenza	120	Schistosomiasis		
		004	Shigellosis		
		050	Smallpox		
		038	Streptococcus, Grp. A, invasive		

** Additional Guidelines for the TriService Reportable events can be found at : <http://afhsc.army.mil/reportableEvents>

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

CATEGORY CODES

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

PRIVACY ACT INFORMATION

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

Purpose: The purpose of this form is to compile relevant patient information concerning communicable diseases and injuries occurring among Department of Defense personnel and family members stationed or operating in Europe.

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

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

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

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Appendix I
OEH EXPOSURE INCIDENT DOCUMENTING AND REPORTING

1. PURPOSE

a. This appendix provides responsibilities and guidance related to OEH incident reporting.

(1) DoD and Joint Staff policies require documentation of exposure incidents from OEH contaminants resulting from a significant exposure to any deployed individual(s), to include exposures from CBRN agents and acutely toxic industrial chemicals. The DOEHRS-Incident reporting (IR) Module is the system of record for DoD exposure documentation. The DOEHRS-IR module provides an electronic system for users to directly complete data fields to document information surrounding exposure events. This requirement ensures an archived, completed record of the incident and corresponding assessment, as well as details of specific personnel, procedures, and data. Finally, it documents recommendations regarding any long term health concerns that require medical surveillance or follow-up.

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

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

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

b. Information Requirements: Specific information required ^{1,2} to be documented and archived includes:

- (1) Location, date, and time of incident
- (2) Unit rosters of all personnel involved (affected or possibly exposed)
- (3) Acute or known/anticipated latent health outcomes and any medical follow-up required.
- (4) Documentation of personal protective equipment (PPE) or countermeasures used, effectiveness of and compliance with countermeasures, and any other exposure incident response activities.
- (5) Results of environmental monitoring including hazard and exposure information (duration, frequency, field measurements and laboratory results)
- (6) Attachment or description of any health risk communication materials provided to health care providers, patients, or the population at risk

2. AUTHORITY. The process and documents described in this appendix meet current deployment health reporting requirements¹ for capturing, consolidating and archiving exposure incident information for OEH exposure incidents.

3. BACKGROUND

a. General. OEH exposure incident reports will be prepared for all exposure incidents meeting at least one of the thresholds listed in Table I-A-1 and submitted through medical channels in a timely and adequate manner.

b. Information Requirements. Timely and accurate data/information collection, transfer, and archival of actual or potential OEH exposures is necessary to address future investigation and or health surveillance of potentially exposed personnel.

c. Command Support: In situations involving non-routine or unanticipated exposures, medical or preventive medicine assets may not be immediately available for response. Commanders must ensure that in the interim, consultation occurs with subject matter experts in order to develop an accurate assessment, mitigation, and response.

4. PROCEDURES

a. General. OEH exposure event information is documented on the following forms:

¹ DoDI 6490.03, Deployment Health, 11 August 2006; DoDI 6055.05, Occupational and Environmental Health (OEH), 11 November 2008; Chairman of Joint Chiefs of Staff Memorandum (MCM) 0028-07, Procedures for Deployment Health Surveillance, 2 November 2007; FM 3.11.3, MTTP for CBRN Contamination Avoidance

- (1) Unit reporting. Initial Field Account (IFA)(see Annex A of this appendix) .
- (2) Clinical Reporting. CENTCOM Medical Reportable Medical Event (RME) documentation for CBRN/OEH Exposures (Appendix H).

(3) Public Health Reporting. The Incident Report (IR) is the preventive medicine/subject matter expert assessment of the event. The key purpose of the IR is to provide a completed record of the incident assessment, details of specific personnel, procedures, and data, and recommendations regarding medical surveillance or follow-up treatment. This report provides verification and interpretation of reference documents, to include any associated initial field accounts (IFAs) and field rosters, as well as SIGACT(s), RME documentation, equipment monitoring and/or sampling results, and risk communication products (Annex B of this appendix)². Whenever possible, the IR should be unclassified and serve as the official incident assessment for both personnel and providers.

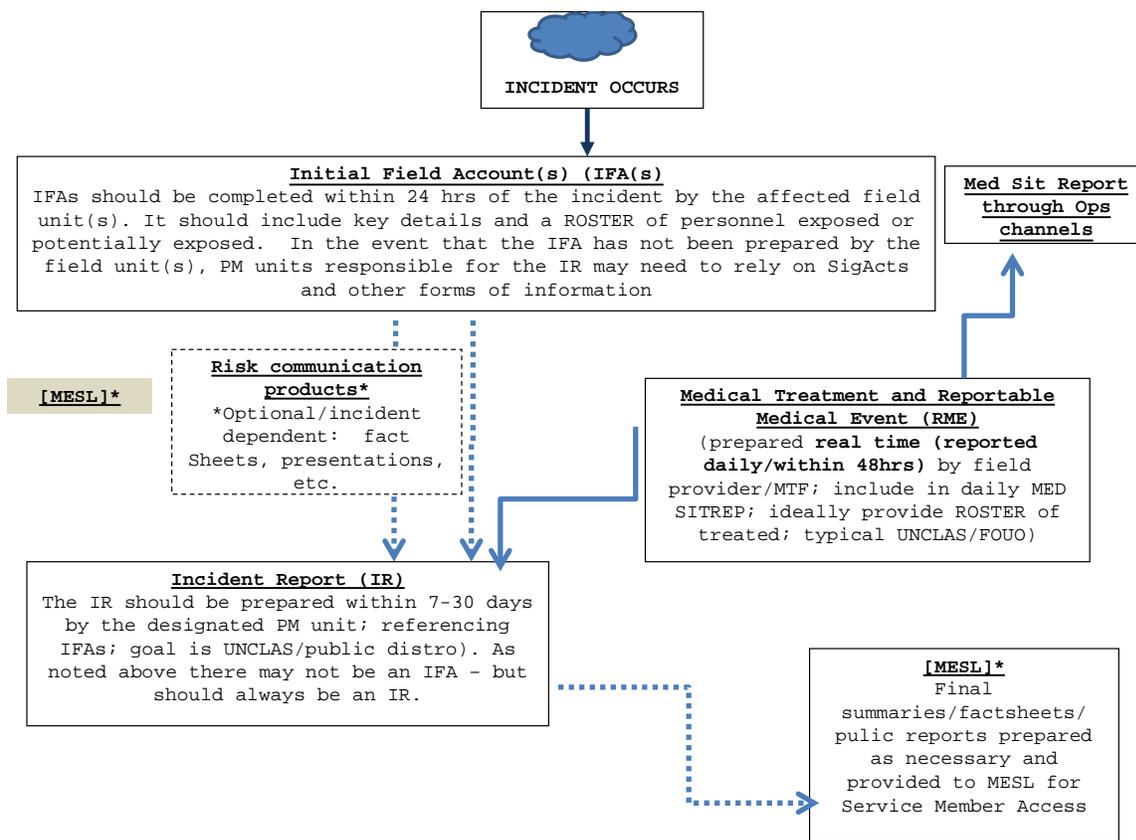


Figure I-1: OEI Incident Documentation and Reporting forms

b. Process Flow: Figure I-1 shows the Incident Reporting process, summarized in the following steps:

² All event documentation is to be forwarded to the Military Environmental Surveillance Library for analysis and archiving at <https://mesl.apgea.army.mil/mesl/>.

(1) Using the criteria at Table I-A-1, unit personnel identify an incident and initiate data collection and documentation.

(a) The IFA is the responsibility of the affected unit(s). There may or may not be PVTMD assets within the unit. The Commander ensures that someone is assigned to gather the documentation and forward it to the investigating PVTMD assets who will prepare the Incident Report. See example of IFA in Annex B of this appendix.

(b) The IFA or associated documentation must be transmitted within 24 hours of the incident to the Command Surgeon/FHP Officer.

(2) Document any personnel treated for exposures.

(a) Medical support personnel/MTFs that receive and treat persons for an exposure incident should document the exposure condition as a RME per the guidance and codes described in Appendix H of this regulation.

(b) Per Appendix H, for CBRN/acutely hazardous TICs/TIMs exposure incidents, a hardcopy RME report must be submitted to the Command Surgeon/FHP Officer within 72 hours of treating personnel and as part of the daily Medical SITREP reported through command reporting channels.

c. Consolidate, assess, and summarize overall incident information pertaining to personnel exposures and health effects.

(1) The Command Surgeon/FHP Officer will designate preventive medicine personnel to review any IFA(s), Medical SITREPS, CBRN RME reports, and any other pertinent documents (i.e. NBC reports, Sig Acts, Field Sampling/data reports) in order to complete the Incident Report (IR).

(2) Preventive Medicine personnel will consult with applicable Service Public Health Center(s) to ensure proper risk assessment (especially for potential chronic/long term health impacts) and follow-up recommendations in the IR. The IR is the final field documentation of the incident and associated health outcomes. It should be completed within 7 to 30 days of an incident.

(3) Once the IR is complete, submit the report and accompanying documents to the Component/Joint Task Force (JTF)/Combined Joint Task Force (CJTF) Surgeon or FHP Officer (as applicable) and provide a copy back to the original requesting Command Surgeon).

Service consultative assistance:

U.S. Army Public Health Command (USAPHC) Phone: (800) 222-9698 http://phc.amedd.army.mil	Navy and Marine Corps Public Health Center (NMCPHC) (formerly NEHC) Phone: (757) 953-0700 http://www-nehc.med.navy.mil	U.S. Air Force School of Aerospace Medicine (USAFSAM) Phone: (888) 232-3764 Email: esoh.service.center@WPAFB.af.mil http://www.brooks.af.mil/units/airforceinstituteforoperationalhealth/index.asp
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d. Determine if follow-on investigation and/or health surveillance is warranted.

(1) In coordination with the CENTCOM Surgeon, the Component/JTF/CJTF Surgeon reviews information in the IR and determines whether future medical surveillance is required.

(2) If the Component/JTF/CJTF Surgeon determines a need for follow-on investigation and/or health surveillance, he/she may submit a request for assistance (RFA) through the Service Component HQ, and/or request additional support through the CENTCOM Surgeon/FHP Officer.

Forward any hardcopy IFAs and IRs, as well as the accompanying documents, to the designated DOD OEHS data archive:

CLASSIFIED channels:

Secure e-mail: oehs@usachppm.army.smil.mil
 Secure phone/FAX: DSN: 312.584.4244; COMM: 410.436.4244
 Unclassified Mail: USAPHC; ATTN: MCHB-CS-OCP (OEHS Data Archive) 5158 Blackhawk Road, Building E1930; Aberdeen Proving Ground, MD 21010-5403

UNCLASSIFIED channels:

Unsecured e-mail: oehs.data@us.army.mil
 Unsecured phone: DSN: 312.584.4230
 COMM: 410.436.4230
 Unclassified Mail: USAPHC; ATTN: MCHB-TS-RDD; 5158 Blackhawk Road, Building E1675
 Aberdeen Proving Ground, MD 21010-5403

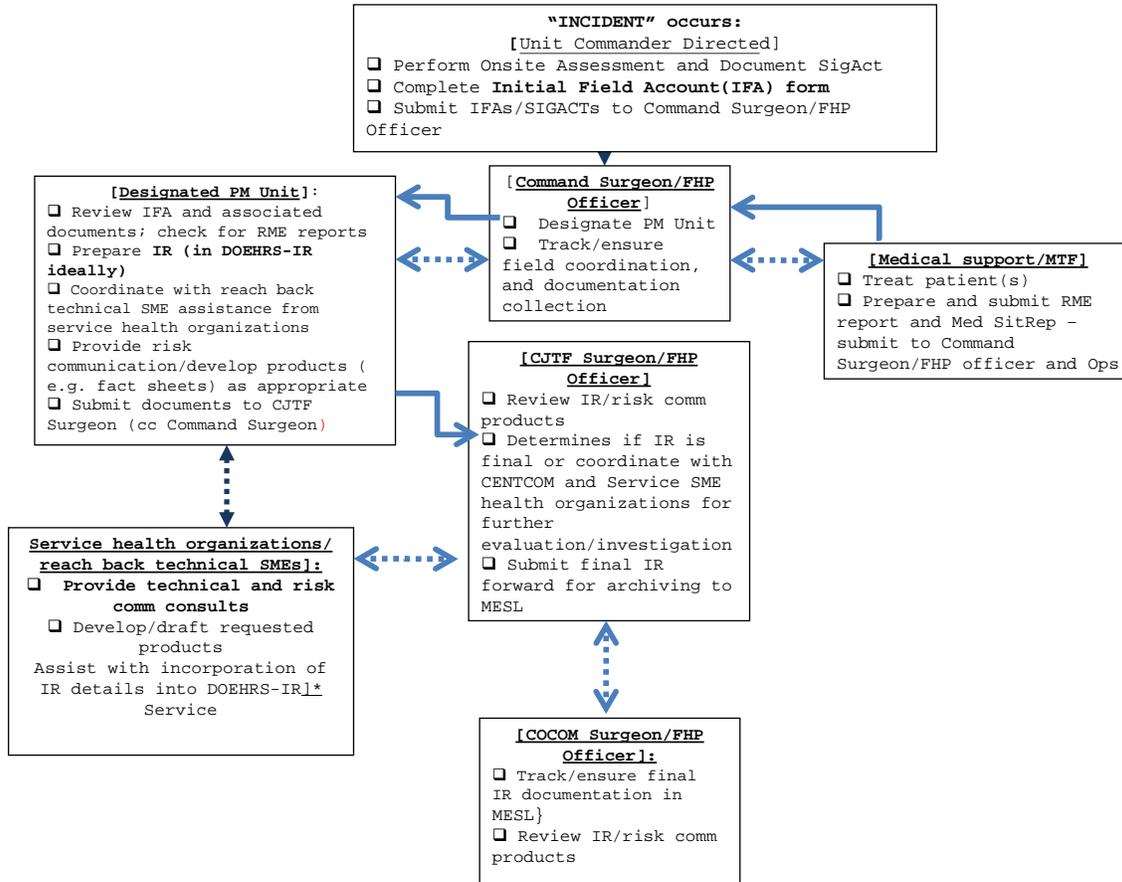


Figure I-2: CBRN and OEH Incident Documentation and Reporting Process

Appendix I - ANNEX A
SUMMARIZING AN OEH INCIDENT AND PREPARING THE INCIDENT REPORT (IR)

1. Purpose. The IR is a consolidated assessment of overall incident information pertaining to personnel exposures and any associated health effects. Completion of the IR ensures that the necessary information is consolidated and submitted to the MESL.
2. Responsibility. Preventive Medicine personnel designated by the Command Surgeon/FHP Officer will prepare the Incident Report.
3. Security Classification. While details in some of the underlying documents and reports (SIGACTS, IFA, and roster) may on occasion be classified, the IR should be completed at the lowest classification possible for the widest distribution.
4. Completion of the IR. The IR Form constitutes a series of data fields built into the DOEHRS-IR module. An authorized DOEHRS user can insert relevant data into the module to complete the report. In the absence of access to the DOEHRS-IR module, field PM personnel may utilize a hard copy version to collect data and provide the information to the Service public health centers (e.g. USAPHC), and they will assist with inserting the data in the DOEHRS-IR module for archival. PM personnel designated with responsibility of documenting an incident must ensure that all necessary information has been provided to the Service public health center.

(a) Source of Information. Most of the required elements listed on the IR form will be obtained from supporting documents. Supporting documents include the SIGACT, IFA(s), rosters, field and/or analytical data, and any risk communication information. These documents may be referenced as attachments. However, additional assessment/interpretation of the information may be necessary in the IR itself in order to provide a contextual summary of the required information. For example, PM personnel completing the IR should summarize the incident information and provide a qualitative risk estimate of the level of the acute health effects presented during the incident as well as a risk estimate of the potential for long term chronic health consequences of concern using the risk definitions in Tables I-1 and I-2. Especially for determination of long term health consequences and the medical implications, personnel may contact their Service Public Health Center for medical advisement. In addition, USAPHC Technical Guide 230 (available at <https://mesl.apgea.army.mil/mesl/>) provides detailed guidance on information regarding OEH risk estimation. Depending on the incident, risk communication products such as fact sheets, briefings, etc., may be prepared.

(b) Health Effects and Medical Information (Section II).

(1) Include reference to the roster that indicates those persons medically treated and their disposition. Provide any RME reports and any SF600 overlays.

(2) Describe overall types and severity of acute and chronic health effects and the 'risk levels' ranking assigned for each. *If none are identified, state "none identified or anticipated." If health effects/risk are unique to certain personnel/units, explain.* Risk levels to be used are described in the following Tables I-1 and I-2:

Table I-1. ACUTE RISK LEVELS (EFFECTS IN FIELD):	
(Note if there are different risk levels for different units)	Extremely High: Loss of ability to accomplish the mission if hazards occur during mission. <i>Notable in-theater medical countermeasures/resources were required (e.g. protection, treatment & exposure documentation).</i>
	High: Significant degradation of mission capabilities in terms of the required mission standard, inability to accomplish all parts of the mission, or inability to complete the mission to standard if hazards occur during the mission. <i>Some in-theater medical countermeasures/resources (e.g. protection, treatment and exposure documentation) were required.</i>
	Moderate: Expected degraded mission capabilities in terms of the required mission standard and will result in reduced mission capability if hazards occur during the mission. <i>Limited in-theater medical countermeasures/resources (e.g. protection, treatment & exposure documentation) were required,</i>
	Low: Expected losses have little or no impact on accomplishing the mission. <i>No in-theater medical resources required/anticipated other than documentation for Incident Report/etc.</i>

Table I-2. LATENT CHRONIC RISK LEVELS (LONG TERM/PERMANENT EFFECTS):	
(Note if there are different risk levels for different units)	Extremely High: Significant future medical surveillance activities and medical provider resources anticipated: <i>Document Incident Report and exposure data in designated DoD archive and designate a registry to actively track the identified personnel/group and conduct specific active surveillance and/or medical follow-up procedures for life cycle of identified group.</i>
	High: Notable future medical surveillance activities and related resources anticipated. <i>Document Incident Report and exposure data in designated DoD archive; specifically identified exposed personnel/group documented; possible passive medical surveillance activities for this group.</i>
	Moderate: Limited future medical surveillance activities and related resources anticipated. <i>Document Incident Report and exposure data in designated DoD archive; document potential groups/personnel of interest.</i>
	Low: No specific medical action required. <i>Document Incident Report and exposure data in designated DoD archive</i>

5. Consultative Assistance. When completing the IR, especially for assessing the degree of any potential long-term health risks of concern and/or follow-up medical surveillance, and preparing risk communication products (e.g., fact sheets, briefings, etc.) PM personnel should contact service SMEs for consultative assistance:

<p>U.S. Army Public Health Command (USAPHC) Phone: (800) 222-9698 http://phc.amedd.army.mil</p> <p><i>Or for direct medical support</i> Environmental Medicine Program & Clinical Consult Service at: 410-436-2714 (EST duty hours) or USAPHC-EMP@AMEDD.army.mil</p>	<p>Navy and Marine Corps Public Health Center (NMCPHC) (formerly NEHC) Phone: (757) 953-0700 http://www-nehc.med.navy.mil</p>	<p>U.S. Air Force School of Aerospace Medicine (USAFSAM) Phone: (888) 232-3764 Email: esoh.service.center@WPAFB.af.mil http://www.brooks.af.mil/units/airforceinstituteofoperations/health/index.asp</p>
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6. Submission of IR. When complete, the IR and all associated attachments/documents (including copies of the IFA, associated rosters, analytical data, medical treatment/RME information, and risk communication products (e.g., fact sheets, briefings, etc.) should be submitted to the Component/JTF/CJTF Surgeon/FHP Officer ultimately responsible for a final determination that the IR has been completed in the DOEHRS–IR module and that any long term health concern that would require medical surveillance or follow-up has been coordinated with the CENTCOM Surgeon and Service health organizations.

7. Follow-on assessment/surveillance determination. Additional technical SME evaluation/investigation may be requested via a request for assistance (RFA) through the Service Component Headquarters, or to the CENTCOM Surgeon/FHP Officer.

8. The IR described in this Regulation is available under the Survey Forms section at the following website: <https://mesl.apgea.army.mil/mesl/doehrsResources/initialize.do>, or through the DOEHRS-IR module. Service public health centers can provide assistance completing these forms. Completion must occur in the DOEHRS–IR module system in order for the official record of the event to be closed out.

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Appendix J DOEHRS

1. Purpose. Defense Occupational and Environmental Health Readiness System (DOEHRS) provides the ability to manage and report occupational and environmental health surveillance information. Information managed in DOEHRS includes site observation, field equipment results, and laboratory analysis supporting population and individual based OEH exposures. Occupational and environmental health operations conducted in CENTCOM should use DOEHRS forms whenever possible for data entry and archival.
 - a. DOEHRS is a CAC enabled web-based system (available via NIPR only) with multiple modules. The primary modules used for deployment OEHS are Industrial Hygiene (IH), Environmental Health (EH), Radiation (R) and Incident Reporting (IR). Access to different modules is granted on an individual basis.
 - b. DOEHRS contains a variety of preventive medicine surveys and sample categories. Survey categories include Occupational and Environmental Health Site Assessment (OEHSA), food sanitation, general sanitation, water, entomology and waste management. The OEHSA serves as the foundation document for which potential hazards are identified and future sampling and surveillance plans are developed. Other surveys and samples in DOEHRS document follow-on surveillance activities to define, monitor and control identified hazards on the OEHSA.
 - c. Sample types in DOEHRS include various air methods, water, soil and thermal stress. Samples and surveys may relate to another document within this system; DOEHRS provides the ability to associate samples to surveys (to include Radiation surveys and Incident Report surveys), as well as associate both samples and surveys to the OEHSA.
 - d. Various reporting functionalities reside in DOEHRS that enable the user to view current and historical data either discretely or collectively, including access to laboratory results related to samples collected in theater, that have been sent to rear-area support organizations (such as USAPHC).
2. Responsibility. Deploying PM Commanders will ensure that their unit is trained on DOEHRS and that DOEHRS is used whenever possible as a routine business practice of the health surveillance mission.
3. Procedure: Whenever possible enter data collected on DOEHRS forms. These forms are available at: <https://mesl.apgea.army.mil/mesl/doehrsResources/initialize.do>.
 - a. Field personnel will establish a DOEHRS account. Surveys and samples should be entered into DOEHRS whenever a CAC enabled NIPR computer with internet connectivity is available.
 - b. Unclassified portions of the OEHSA will be entered into DOEHRS. Any classified portions of the OEHSA will be sent to the MESL-S, including the associated Survey ID of the unclassified OEHSA entered in DOEHRS. The unclassified portion within DOEHRS can be exported as a document using the “Other Actions” tool within the OEHSA survey in DOEHRS. Classified

information can then be added to it, prior to submission to the MESL-S. A blank OEHSA survey can be downloaded from the DOEHRS resources page on the MESL <https://mesl.apgea.army.mil/mesl/doehrsResources/initialize.do>. OEHSAs will be updated as site conditions change, and reviewed at least annually.

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

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

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

(3) If possible, scan hardcopy FDS and load as an attached in the DOEHRS sample.

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

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

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

d. General Sanitation, Food Establishment, Water, and Waste Surveys will be conducted by field personnel in support of OEHS and entered in DOEHRS. The surveys can be downloaded from the DOEHRS resources page on the MESL.

[\[https://mesl.apgea.army.mil/mesl/doehrsResources/initialize.do\]](https://mesl.apgea.army.mil/mesl/doehrsResources/initialize.do) Field personnel should routinely notify USAPHC POCs of the surveys completed, and document issues as they arise to clarify the potential need to update an OEHSA or create an IR.

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

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

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

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

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

d. A training tutorial video can be found on the DCO website [<https://www.dco.dod.mil>]. An account must first be created before the tutorial can be found by searching the “Meeting/Recording Search” area for “PHC DOEHRS-EH OVERVIEW”.

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Appendix K
ANIMAL BITE REPORTING

1. Endemic animal rabies exists in many countries within the CENTCOM AOR. Apply a higher index of suspicion when considering whether an animal may be rabid. Components and CJTFs/JTFs will document and report all animal bites or instances of possible rabies exposure resulting from contact with wild, stray or feral animals.

a. Personnel whose normal duties expose them to a higher than normal risk of potential exposure to the rabies virus should receive rabies pre-exposure vaccination in accordance with guidance in Reference 6.

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

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

3. Document a rabies risk assessment for all potential rabies exposures.

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

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

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

4. Adhere to risk-based post-exposure rabies prophylaxis protocols in accordance with the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) guidance.

a. Treatment consists of appropriate wound care and, as indicated by the rabies risk assessment, complete CDC/ACIP rabies post-exposure prophylaxis. The CDC/ACIP rabies post-exposure prophylaxis schedule to be used depends upon the rabies immunization status and immunosuppression status of the individual. When rabies prophylaxis is initiated, measures will be in place to ensure the completion of the protocol without deviations.
(www.cdc.gov/rabies/resources/index.html)

5. All DD Form 2341s should be reviewed within 30 days of the initiation of each report for final disposition of the case. Each report/case will be reviewed by the Rabies Advisory Board for proper disposition. To the maximum extent possible, ensure that all necessary measures have been taken to reduce any risk of rabies.

6. Ensure documentation of rabies pre- and or post- exposure prophylaxis (including lot numbers) in Service immunization databases as well as the individual's electronic medical record.

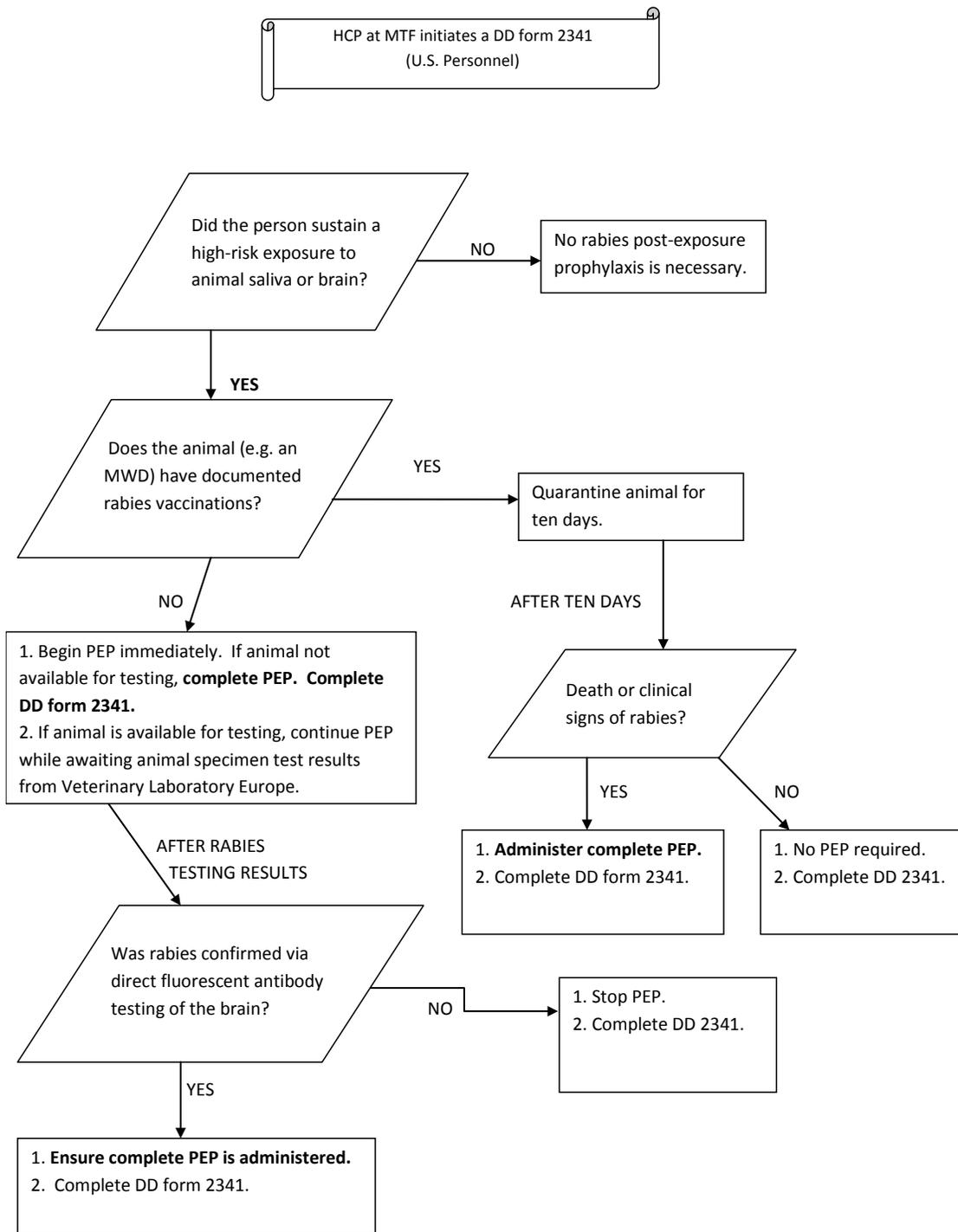


Figure K-1: Rabies Post-Exposure Treatment Flow Chart