



DEPARTMENT OF THE NAVY  
BUREAU OF MEDICINE AND SURGERY  
7700 ARLINGTON BOULEVARD  
FALLS CHURCH VA 22042

IN REPLY REFER TO  
BUMEDINST 6224.8C  
BUMED-M3  
25 Apr 2018

BUMED INSTRUCTION 6224.8C

From: Chief, Bureau of Medicine and Surgery

Subj: TUBERCULOSIS SURVEILLANCE AND CONTROL PROGRAM

Ref: (a) NMCPHC-TM OM 6260  
(b) BUMEDINST 6220.12C

Encl: (1) Tuberculosis Screening and Testing  
(2) Evaluation and Management of New Positive Tests for Latent Tuberculosis Infection  
(3) Tuberculosis Contact Investigation, Initial Tuberculosis Patient Management, and Required Reports  
(4) List of Tuberculosis Consultants

1. Purpose. To provide policy and procedures for screening, testing, treating, documenting, and tracking Department of the Navy (DON) military personnel and Military Sealift Command civilian mariners (CIVMAR) at risk for tuberculosis (TB). TB control efforts for other populations (e.g., healthcare workers, DON civilians, DON contractors, eligible beneficiaries, inmates of detention and confinement facilities, child development center workers, etc.) are to be guided by and consistent with current Centers for Disease Control and Prevention (CDC) guidance, Occupational Safety and Health Administration (OSHA) regulations, applicable federal laws, and reference (a), available at <https://nmcpeh-simweb.med.navy.mil/Content/medMatrix/MedicalMatrix.pdf>. This instruction is a complete revision and should be reviewed in its entirety.

2. Cancellation. BUMEDINST 6224.8B.

3. Scope. This instruction applies to all ships and stations with Medical Department personnel.

4. Background. Although the current TB case burden is low, the threat of TB remains a public health concern within the DON. While being a military member or CIVMAR is not in itself a risk factor for TB, particular situations imposed by military service may present an increased risk of infection. Close working and living quarters in military and shipboard operations demand vigilant public health measures to prevent the acquisition, activation, and spread of TB. Prompt recognition and respiratory isolation of persons with active pulmonary TB significantly reduces the chance that infection will spread to others. Early detection and treatment of latent TB infection (LTBI) reduces the risk of progression to active disease.

5. Program Summary. The strategy to control TB is:

a. To promptly detect, isolate, treat, and report persons who have developed clinically active (infectious) TB.

b. To protect persons in close contact with patients diagnosed with infectious TB.

c. To prevent TB disease in military personnel and CIVMARs through implementing accession testing followed by targeted testing and effective treatment for LTBI, as described in enclosures (1) through (3). Active and Reserve Component personnel and CIVMARs will be tested for LTBI only when they have high-risk exposures, high-risk occupations, or clinical conditions that increase the risk of progression from LTBI to active TB disease.

d. To conduct TB screening and targeted testing in non-military occupational populations based on the medical certification guidance contained in reference (a).

e. To assure through contracting oversight that DON contractors, especially in the deployment setting, are evaluated for TB infection. Contracts for healthcare workers must contain language that specifies screening for risk of exposure to TB.

6. Record Keeping. Relevant forms include: NAVMED 6224/7 Initial Tuberculosis Exposure Risk Assessment; NAVMED 6224/8 Tuberculosis Exposure Risk Assessment; NAVMED 6224/9 Monthly Evaluation for Patients Receiving Treatment for Latent Tuberculosis Infection (LTBI); and DD Form 2766 Adult Preventive and Chronic Care Flowsheet. These forms will constitute part of the patient's medical record.

7. Responsibilities

a. Fleet and Fleet Marine Force Surgeons will:

(1) Control TB in their supported populations by managing local control efforts per this instruction and current CDC guidelines. OSHA guidance, federal law, state law, and local ordinance may be considered when establishing local control efforts.

(2) Assist Navy Environmental and Preventive Medicine Units (NAVENPVNTMEDU) in the conduct, completion, and reporting of TB contact investigations.

b. Navy Medicine Regional Commanders. Must ensure subordinate medical treatment facilities (MTF) maintain an effective TB surveillance and control program and conduct ongoing evaluations of the risk for TB transmission, per the CDC's *Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health-Care Settings*, available at <https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5417a1.htm>.

c. Commanding Officers and Officers in Charge of MTFs will:

(1) Control TB in their supported populations by managing local control efforts per this instruction and current CDC guidelines. OSHA guidance, federal law, state law, and local ordinance may be considered when establishing local control efforts. As agencies of the Federal Government, MTFs are obliged to conform to federal law but are not obliged to comply with state law or local ordinance if these conflict with federal law, Department of Defense (DoD) directives, or Navy Medicine directives.

(2) Assist NAVENPVNTMEDUs in the conduct, completion, and reporting of TB contact investigations.

d. Commanding Officer, Navy and Marine Corps Public Health Center (NAVMCPUBHLHCEN) will:

(1) Ensure NAVENPVNTMEDUs provide TB surveillance and control technical support as needed to all Navy and Marine Corp units in their geographic area of responsibility.

(2) Ensure NAVENPVNTMEDUs conduct or facilitate contact investigations of all active TB cases within the DON in their area of responsibility.

8. Consultants. TB consultations can be obtained from the NAVENPVNTMEDUs or the Infectious Disease or Pulmonary Divisions at Walter Reed National Military Medical Center, Naval Medical Center Portsmouth, or Naval Medical Center San Diego as listed in enclosure (4).

9. Records Management. Records created as a result of this instruction, regardless of media and format, must be managed per Secretary of the Navy Manual 5210.1 of January 2012.

10. Review and Effective Date. Per OPNAVINST 5215.17A, Bureau of Medicine and Surgery (BUMED), Healthcare Operations (BUMED-M3) will review this instruction annually on the anniversary of its effective date to ensure applicability, currency, and consistency with Federal, DoD, Secretary of the Navy, and Navy policy and statutory authority using OPNAV 5215/40 Review of Instruction.

11. Forms and Information Management Control

a. DD Form 2766 Adult Preventive and Chronic Care Flowsheet, is available at <http://www.dtic.mil/whs/directives/forms/index.htm>.

b. The following forms are available for download from the Naval Forms Online Web site at <https://navalforms.documentservices.dla.mil>.

- (1) NAVMED 6224/7 Initial Tuberculosis Exposure Risk Assessment.
- (2) NAVMED 6224/8 Tuberculosis Exposure Risk Assessment.
- (3) NAVMED 6224/9 Monthly Evaluation for Patients Receiving Treatment for Latent Tuberculosis Infection (LTBI).
- (4) NAVMED 6230/4 Adult Immunizations Record.
- (5) NAVMED 6230/5 Child Immunizations Record.

c. Information Management Control. The medical event reporting requirements contained in this instruction are covered under the report control symbol established in reference (b).



C. FORREST FAISON III

Releasability and distribution:

This instruction is cleared for public release and is available electronically only via the Navy Medicine Web site at, <http://www.med.navy.mil/directives/Pages/BUMEDInstructions.aspx>.

## TUBERCULOSIS SCREENING AND TESTING

1. Testing for LTBI on Entry into Naval Service. Skin and blood tests are available for identifying individuals asymptomatically infected with the *Mycobacterium tuberculosis* complex bacteria that cause TB. Appropriate testing identifies persons with LTBI. These individuals are at increased risk for developing active TB, and should be treated to reduce their risk for developing active disease and transmitting TB infection to others.

a. All Navy and Marine Corps accessions, and all individuals beginning employment as CIVMARs, must be tested for LTBI unless there is documentation of previous TB infection as described below.

b. Individuals with a history of active TB, a positive Tuberculin Skin Test (TST) or Interferon Gamma Release Assay (IGRA), or treatment for LTBI must provide medical documentation of clinical evaluations, hospitalizations, diagnoses, and treatments. Documentation includes copies of pertinent medical records, treatment records, or a physician's statement on letterhead stationery. Pertinent information should be transcribed into the medical record. If such documentation is not available, test for LTBI.

### 2. LTBI Screening at Times Other than Service Entry

a. Screen all Active and Reserve Component military personnel annually using form NAVMED 6224/8 to determine their TB exposure history and risk of acquiring TB. This screening may take place in conjunction with the periodic health assessment. Individuals answering "yes" to one or more questions on this form may be at increased risk and require medical evaluation. CIVMAR screening will be performed per relevant Military Sealift Command policy.

b. Additional TB exposure risk screening and targeted LTBI testing will be performed if directed by a Combatant Command Surgeon or recommended by the cognizant NAVENPVNTMEDU during a TB contact investigation.

3. LTBI Testing Guidance. The purpose of LTBI testing is to identify those who require prophylactic therapy. Either TST or IGRA should be performed, not both.

#### a. TST

(1) Tuberculin, Purified Protein Derivative (PPD). The approved TST material for the routine Mantoux test is the Tween-80-stabilized intermediate strength PPD (5 tuberculin unit equivalent) available as NSN 6505-00-105-0102. Administer the TST per the procedures described in the CDC's *Core Curriculum on Tuberculosis: What the Clinician Should Know*, sixth edition, 2013 available at <https://www.cdc.gov/tb/education/corecurr/index.htm>. Per the

Assistant Secretary of Defense (Health Affairs) policy memorandum 08-012 of 29 September 2008, (<https://health.mil/Reference-Center/Policies?daterange=2005-2009&query=08-012>), the preferred product is Tubersol<sup>®</sup> from Sanofi Pasteur vice Aplisol<sup>®</sup> from JHP Pharmaceuticals. However, Aplisol<sup>®</sup> may be used when Tubersol<sup>®</sup> is not available.

(2) Recording Administration. Enter the date administered, type and strength of tuberculin, manufacturer, lot number, and route of administration into an approved electronic data system and in the Service member's health record.

(3) Measurement. The TST reaction must be read within 48 to 72 hours after PPD administration. Measure induration to the nearest whole millimeter (mm). If a person returns more than 72 hours after TST placement, record the result as "Not Read" and apply a TST on the opposite forearm. If the person does not return at all, enter "Not Read" on the appropriate forms, recall the person, and administer another TST.

(4) Recording Result. Enter TST result in mm of induration on NAVMED 6230/4 Adult Immunizations Record or NAVMED 6230/5 Child Immunizations Record and enter into the authorized electronic medical information system. If there is no induration, record result as "zero mm." A TST record is not complete without clear documentation of all required data elements and entry into an authorized electronic immunization tracking system for electronic data storage and reporting.

b. IGRA

(1) Assays. Three U.S. Food and Drug Administration approved IGRAs, QuantiFERON<sup>®</sup>-TB Gold (QFT), QuantiFERON<sup>®</sup>-TB Gold Plus (QFT-Plus), and T-SPOT<sup>®</sup>.TB (T-SPOT), are available for LTBI testing. Guidance on LTBI test selection and interpretation of IGRA results is available in the following documents: the CDC's *Updated Guidelines for Using Interferon Gamma Release Assays to Detect Mycobacterium Tuberculosis Infection – United States, 2010*, available at <https://www.cdc.gov/mmwr/pdf/rr/rr5905.pdf>; and the *Official American Thoracic Society/Infectious Diseases Society of America/Centers for Disease Control and Prevention Clinical Practice Guidelines: Diagnosis of Tuberculosis in Adults and Children, Clinical Infectious Diseases*, available at <https://academic.oup.com/cid/article/64/2/e1/2629583>.

(2) Recording Result. As with the TST, QFT, QFT-Plus, and T-SPOT results must be recorded in detail in the medical record. Include the date of the blood draw, quantitative assay measurements in specific units (e.g., international units per milliliter or number of spots to nil), and the qualitative test interpretation (e.g., positive, negative, borderline, or indeterminate).

4. Special Situations

a. Previous Bacillus Calmette Guérin (BCG) Immunization. TST results in persons vaccinated with BCG immunization will be interpreted and treated using the same criteria for those not BCG vaccinated.

b. Previous Positive LTBI Test

(1) If a person gives an undocumented history of a positive IGRA or TST without documentation of an adequate course of treatment for LTBI or active TB, perform an IGRA or TST. If the person's IGRA is positive or if the TST reaction is  $\geq 5$  mm of induration, manage per enclosure (3).

(2) If a person has a credible documented past positive TST or IGRA, do not perform another LTBI test. Document whether the individual received an adequate course of treatment for LTBI or active TB. If the individual did not receive an adequate course of treatment for LTBI, manage per enclosure (3).

c. Targeted Testing of Contractors. Contracting officers and their representatives will include requirements in all contracts to ensure that contractors and their employees undergo TB screening and targeted testing whenever said employees are working in an environment in which DON employees would normally be required to undergo this testing. TB screening, targeted testing, and treatment will be paid for by the contractor.

EVALUATION AND MANAGEMENT OF NEW POSITIVE TESTS  
FOR LATENT TUBERCULOSIS INFECTION

1. **TST Interpretation.** Evaluate all individuals with a TST induration  $\geq 5$  mm to determine if their test is positive based on the risk factors outlined in Table 1 and discussed the CDC's *Targeted Tuberculin Testing and Treatment of Latent Tuberculosis Infection*, available at <https://www.cdc.gov/mmwr/PDF/rr/rr4906.pdf>. In addition, an increase in reaction size of 10 mm or more, within a 2-year period, is considered a positive test. Service accessions without exposure or clinical risk factors for acquiring TB are the low risk group in Table 1, so their TST is considered positive only for indurations  $\geq 15$  mm.

**TABLE 1  
Criteria for Determining a Positive TST Reaction**

<u>High Risk</u> Reaction $\geq 5$ mm of induration is considered positive in:	<u>Medium Risk</u> Reaction $\geq 10$ mm of induration is considered positive in:	<u>Low Risk</u> Reaction $\geq 15$ mm of induration is considered positive in:
<p>Recent close contacts of active (infectious) TB disease patients.</p> <p>Persons with fibrotic or other changes on chest radiograph consistent with prior TB.</p> <p>Patients suspected of having active TB disease.</p>	<p>Recent immigrants (within the last 5 years) from high TB prevalence areas, e.g., Africa, Asia, Eastern Europe, Latin America, and Russia.</p> <p>Healthcare workers and others at risk of occupational exposure to TB.</p> <p>Persons with clinical conditions that place them at increased risk for TB disease progression.</p>	<p>Persons with no risk factors for TB.</p>

2. **IGRA Interpretation.** Interpret IGRA results per the assay manufacturer's package insert and the guidelines found in the CDC's *Updated Guidelines for Using Interferon Gamma Release Assays to Detect Mycobacterium Tuberculosis Infection – United States, 2010*, available at <https://www.cdc.gov/mmwr/pdf/rr/rr5905.pdf>.

3. **Initial Evaluation: Persons with Positive IGRA or TST.** Ensure all persons newly identified as having a positive IGRA or a positive TST are evaluated by a medical officer, nurse practitioner, physician's assistant, or Independent Duty Corpsman to rule out active TB disease.



A person with suspected active TB should be masked and isolated immediately and then referred to an appropriate provider at an MTF for evaluation, diagnosis, and initial treatment. The evaluation of positive tests must include:

- a. Physical Examination and Medical History. Document history on NAVMED 6224/7 Initial Tuberculosis Exposure Risk Assessment, or other form or electronic record system that captures same information.
- b. Chest Radiograph. Examine chest radiographs for fibrotic changes consistent with old TB infection and for any signs of active pulmonary TB.
- c. Sputum Examination. Submit sputa for acid fast bacilli smear microscopy, diagnostic nucleic acid amplification testing, and culture when radiographic signs of active TB or symptoms suggestive of TB disease are present.

4. LTBI Treatment and Management. Once active TB is ruled out, LTBI treatment should be initiated unless medically contraindicated. Treatment regimens for LTBI therapy are listed in Table 5.3 of the CDC's *Core Curriculum on Tuberculosis: What the Clinician Should Know*, sixth edition, 2013 and Table 2 of the CDC's *Latent Tuberculosis Infection: A Guide for Primary Health Care Providers*, available at <https://www.cdc.gov/tb/publications/ltbi/pdf/targetedltbi.pdf>. Shorter regimens for treating LTBI are more likely to be completed.

- a. Baseline Laboratory Testing. Baseline laboratory testing is not routinely indicated for patients at the start of treatment for LTBI. Baseline hepatic measurements of serum aspartate aminotransferase ((AST); also known as serum glutamic oxaloacetic transaminase (SGOT)), alanine aminotransferase ((ALT); also known as serum glutamate-pyruvate transaminase (SGPT)), and bilirubin are indicated for patients whose initial evaluation suggests an elevated risk for a liver disorder, such as persons who use alcohol regularly.
- b. Laboratory Monitoring. Routine laboratory monitoring during treatment for LTBI is recommended for persons who had abnormal initial results and for other persons at risk for hepatic disease. Consider withholding medication if a patient's transaminase levels exceed three times the upper limit of normal if associated with symptoms, or five times the upper limit of normal if the patient is asymptomatic.
- c. Clinical Monitoring. Monthly follow up of individuals receiving treatment for LTBI must be conducted until treatment is completed. The healthcare provider should evaluate patient compliance, possible side effects, and indications of active TB and document monthly evaluations on NAVMED 6224/9 Monthly Evaluation of Patients Receiving Therapy for Latent Tuberculosis Infection (LTBI), or equivalent. Those creating encounter templates in an electronic medical record should use NAVMED 6224/9 as a guide and select the appropriate LTBI International Classification of Diseases (ICD) diagnosis code.

d. Directly Observed Therapy. The CDC recommends directly observed therapy for the 12-dose treatment regimen or other intermittent regimens. The CDC provides recommendations on using directly observed therapy to improve LTBI treatment completion rates in their *Guidelines for the Investigation of Contacts of Persons with Infectious Tuberculosis*, available at <https://www.cdc.gov/mmwr/pdf/rr/rr5415.pdf>.

5. Patient Education. Patients must be educated about the implications of their positive IGRA or TST results, the benefits and risks of LTBI treatment, and the potential signs of an adverse drug effect. The necessity for strict adherence to the prescribed course of treatment in the absence of untoward side effects must be strongly emphasized throughout the course of treatment. Document patient education and counseling in the patient's medical record.

6. Completion of Treatment for LTBI. Document successful completion of the LTBI treatment regimen in the medical record. No additional LTBI testing or chest radiograph is required unless otherwise indicated.

7. Adherence to LTBI Treatment. The CDC's *Core Curriculum on Tuberculosis: What the Clinician Should Know*, sixth edition, 2013, discusses missed medication doses and strategies to improve patient adherence to LTBI treatment regimens. Consultants listed in enclosure (4) can provide management guidance when LTBI treatment has been interrupted prior to completion of an adequate treatment course.

8. Continuity of Care for LTBI. Personnel who transfer from the treating healthcare facility or leave the military Service before completing a course of treatment for LTBI must be counseled on the need for continued treatment, and counseling must be documented on NAVMED 6224/9.

a. The treating medical department will contact the gaining medical departments about all transferring members currently receiving treatment for LTBI.

b. The transferring medical department must ensure the member has enough medication to continue LTBI treatment enroute to the gaining medical department. Gaining medical departments must continue therapy initiated as outlined in paragraph 4 of this enclosure.

c. Members leaving active Service are eligible for continued LTBI treatment and can schedule follow up care at the Department of Veterans Affairs (VA) facilities by calling the local VA prior to separation or discharge. Providers will make initial arrangements for the member's follow up, either at a military facility (if member is still eligible for care), at the VA facility closest to their home, or through alternative options such as local health departments or private providers.

TUBERCULOSIS CONTACT INVESTIGATION, INITIAL TUBERCULOSIS  
PATIENT MANAGEMENT, AND REQUIRED REPORTS

1. Contact Investigation Summary. Upon discovery of a suspected or confirmed case of active (infectious) TB in a beneficiary diagnosed at a Navy MTF or in a Service member assigned to Navy or Marine Corps operating forces, the responsible medical department representative must notify the cognizant NAVENPVNTMEDU (see enclosure (4)) and the local health department as soon as possible. The cognizant NAVENPVNTMEDU will conduct or facilitate a TB contact investigation, assisted by command medical personnel, based on the CDC's *Guidelines for the Investigation of Contacts of Persons with Infectious Tuberculosis*. Upon completion of the TB contact investigation, the NAVENPVNTMEDU will provide an investigation report to the member's Command, cognizant Fleet or Type Commander Surgeon, and NAVMCPUBHLHCEN.

2. Contact Investigation Responsibilities. The medical department representative for the individual diagnosed with active TB disease is responsible for ensuring the contact investigation is initiated rapidly and command support for the NAVENPVNTMEDU public health interventions is maintained until the investigation is completed. The commanding officer or officer in charge is responsible for the continuation and completion of contact investigations initiated among personnel assigned to or transferred from their command. Personnel transferring from the command during the course of a contact investigation must have appropriate documentation in their medical record, and the receiving command must be notified of their status. Personnel who are enrolled in a contact investigation but are separating from the Service before the 8-10 week repeat test for TB infection, must be identified to the local public health department for follow-up testing.

3. Protection of Non-Infected Persons in Spaces Occupied by Patients with Infectious TB Disease. Surgical masks are designed to prevent respiratory secretions of the person wearing the mask from entering the air. Particulate respirators (i.e., N95) are designed to filter air before it is inhaled by the person wearing the respirator. Patients with suspected or known active TB should wear surgical masks, when indicated, to minimize aerosolization of respiratory secretions. They should not wear a particulate respirator, with or without an exhalation valve. Precautions for pre-MTF or shipboard management of persons with known or suspected active TB include:

- a. Unless being treated in home isolation or special isolation quarters, transfer persons with known or suspected active TB to an MTF as soon as practicable.
- b. Before and during transfer, persons with known or suspected active TB should wear a surgical mask at all times. Every attempt should be made to remove a potentially active TB case from shared berthing spaces or medical wards until the individual can be transferred to an MTF.
- c. Medical department personnel must wear particulate respirators (N95 minimum) when working in rooms or spaces containing a person with known or suspected active TB.

d. Visitors to rooms or spaces containing a person with known or suspected TB should wear a particulate respirator. When this is not possible, visitors should wear a surgical mask and minimize time spent in the room or space.

4. Reporting Requirements. Per reference (b), a Medical Event Report must be submitted within 24 hours for all known or suspected cases of active TB.

LIST OF TUBERCULOSIS CONSULTANTS

<p>Navy Environmental Preventive Medicine Unit Number 2 1285 West D St, Building U238 Norfolk, VA 23511-3394 Defense Switched Network (DSN): 377-6600                      Commercial: (757) 953-6600 Facsimile (FAX) DSN: 377-7212                                      Commercial: (757) 953-7212 Plain Language Address (PLAD): NAVENPVNTMEDU TWO NORFOLK VA Web site: <a href="http://www.med.navy.mil/sites/nepmu2/">http://www.med.navy.mil/sites/nepmu2/</a> E-mail: <a href="mailto:usn.hampton-roads.navhospporsva.list.nepmu2norfolk@mail.mil">usn.hampton-roads.navhospporsva.list.nepmu2norfolk@mail.mil</a></p>
<p>Navy Environmental Preventive Medicine Unit Number 5 Naval Station Box 368143 3035 Albacore Alley San Diego, CA 92136-5199 DSN: 526-7070    Commercial: (619) 556-7070 FAX DSN: 526-7080    Commercial: (619) 556-7080 PLAD: NAVENPVNTMEDU FIVE SAN DIEGO CA Web site: <a href="http://www.med.navy.mil/sites/nepmu5/">http://www.med.navy.mil/sites/nepmu5/</a> E-mail: <a href="mailto:usn.san-diego.navenpvntmedufive.list.nepmu5-pao@mail.mil">usn.san-diego.navenpvntmedufive.list.nepmu5-pao@mail.mil</a></p>
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<p>Navy Environmental Preventive Medicine Unit Number 7 PSC 819 Box 67 FPO AE 09645-0085 DSN: 314-727-2230 PLAD: NAVENPVNTMEDU SEVEN Web site: <a href="http://www.med.navy.mil/sites/nmcphc/nepmu-7/Pages/default.aspx">http://www.med.navy.mil/sites/nmcphc/nepmu-7/Pages/default.aspx</a> E-mail: <a href="mailto:nepmu7@eu.navy.mil">nepmu7@eu.navy.mil</a></p>
<p>Navy and Marine Corps Public Health Center 620 John Paul Jones Circle Suite 1100 Portsmouth, VA 23708-2103 DSN: 377-0700    Commercial: (757) 953-0700 After hours: (757) 621-1967 FAX DSN: 377-0685    Commercial: (757) 953-0685 PLAD: NAVMCPUBHLTHCEN PORTSMOUTH VA Web site: <a href="http://www.med.navy.mil/sites/nmcphc/Pages/Home.aspx">http://www.med.navy.mil/sites/nmcphc/Pages/Home.aspx</a> E-mail: <a href="mailto:usn.hampton-roads.navmcpubhlthcenpors.list.nmcphc-threatassess@mail.mil">usn.hampton-roads.navmcpubhlthcenpors.list.nmcphc-threatassess@mail.mil</a></p>

<p>Walter Reed National Military Medical Center Infectious Diseases Division 8901 Wisconsin Avenue Bethesda, MD 20889-5600 DSN: 295-6400/6295                      Commercial: (301) 295-6400/6295 FAX DSN: 295-2988/2992                Commercial: (301) 295-2988/2992 Web site: <a href="http://www.wrnmmc.capmed.mil/Health%20Services/Medicine/Medicine/Infectious%20Diseases/SitePages/Home.aspx">http://www.wrnmmc.capmed.mil/Health%20Services/Medicine/Medicine/Infectious%20Diseases/SitePages/Home.aspx</a></p>
<p>Naval Medical Center Portsmouth Infectious Diseases Division 620 John Paul Jones Circle Portsmouth, VA 23708 DSN: 377-5179/7005                      Commercial: (757) 953-5179 FAX DSN: 377-5514                      Commercial: (757) 953-5514 Web site: <a href="http://www.med.navy.mil/sites/nmcp/SitePages/home.aspx">http://www.med.navy.mil/sites/nmcp/SitePages/home.aspx</a></p>
<p>Naval Medical Center San Diego Infectious Diseases Division 34800 Bob Wilson Drive Suite 201 San Diego, CA 92134-5000 DSN: 522-7475                            Commercial: (619) 532-7475 FAX DSN: 522-7478                      Commercial: (619) 532-7478 Web site: <a href="http://www.med.navy.mil/sites/nmcsc/Patients/Pages/InfectiousDiseaseClinic.aspx">http://www.med.navy.mil/sites/nmcsc/Patients/Pages/InfectiousDiseaseClinic.aspx</a></p>
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<p>Naval Medical Center Portsmouth Pulmonary Diseases Division 620 John Paul Jones Circle Portsmouth, VA 23708 DSN: 377-2075                            Commercial: (757) 953-2075 FAX DSN: 377-0832                      Commercial: (757) 953-0832 Web site: <a href="http://www.med.navy.mil/sites/nmcp/Dept/SitePages/PulmonaryClinic/default.aspx">http://www.med.navy.mil/sites/nmcp/Dept/SitePages/PulmonaryClinic/default.aspx</a></p>
<p>Naval Medical Center San Diego Pulmonary Diseases Division 34800 Bob Wilson Drive San Diego, CA 92134-5000 DSN: 522-5990                            Commercial: (619) 532-5990 FAX DSN: 522-7606/7025                Commercial: (619) 532-7625 Web site: <a href="http://www.med.navy.mil/sites/nmcsc/">http://www.med.navy.mil/sites/nmcsc/</a></p>