CHANGE 120
Manual of the Medical Department
U.S. Navy
NAVMED P-117

10 Jan 2005

To: Holders of the Manual of the Medical Department

1. **This Change**

a. Incorporates revisions to SECNAVINST 1850.4E, Navy Disability Evaluation Manual.

b. Aggregates guidance on removal from full duty for medical reasons, including sick in quarters (SIQ), convalescent leave, light duty, and limited duty.

c. Incorporates Headquarters, Marine Corps (HQMC) and Chief, Bureau of Naval Personnel (BUPERS) changes to limited duty (LIMDU) initiation and reflects HQMC and BUPERS mandated changes in maximum time allowed for LIMDU.

d. Clarifies confusing and often-misapplied language regarding definitions of a "medical board," affording synchronized terminology among Navy Medicine, PERS, MMSR-4, and the Physical Evaluation Board (PEB).

e. Reflects changes in the permissible time period for submission of cases to the PEB (derived in conjunction with PEB following naval audit study) from the previous "30 days from the date of the attending physician's decision to dictate an Medical Evaluation Board Report (MEBR)" to the new standard of "30 days from date of dictation by the attending physician of an MEBR."

f. Updates procedures for submitting "Death Imminent" MEBRs to the PEB.

g. Revises the NAVMED 6100/5, Abbreviated Limited Duty Medical Board Report, to enhance medical documentation and provide increased accountability of personnel on LIMDU.

h. Clarifies whom in Navy Medicine has convening authority (CA) for initiating medical evaluation board (MEB) actions, specifically prohibiting medical treatment facilities (MTFs) without CA from unilaterally effecting MEBs, yet providing MTF commanders with CA an opportunity to allow initial MEB preparation at their respective branch medical clinics as they determine appropriate.

i. Provides expanded information of unique cases involving recruits, reservists, and General, Flag, and Medical Corps officers relative to PEB submissions.

j. Emphasizes protection of patient information privacy in the advent of HIPAA.

k. Delineates training responsibilities and suggested topics for providers, medical boards staff, and patients involved with MEBs.

l. Incorporates guidance emanating from DOD Instruction 6025.15 for reporting applicable cases to the Defense Practitioner Data Bank (DPDB).

m. Provides guidance on determining "end of career" MEB actions and elective medical care, including the definition of "fitness to separate" relative to separation physical examinations.

n. Provides enhanced references for additional research.

2. **Cancellation**. The following forms and reports are cancelled:

a. NAVMED 6100/1 (Rev. 10-83), Medical Board Report Cover Sheet, S/N 0105-LF-982-3800 and S/N 0105-LF-206-1006.

b. NAVMED 6100/2 (Rev. 1-74), Medical Board Statement of Patient, S/N 0105-LF-206-1010.

c. NAVMED 6100/3 (Rev. 3-75), Medical Board Certificate Relative to a PEB Hearing, S/N 0105-LF-206-1015.

d. NAVMED 6100/4 (11-86), Medical Board Certificate Relative to Counselling on Refusal of Surgery and/or Treatment (per NAVMEDCOMINST 6320.3B form was available from COMNAVMEDCOM (MEDCOM-33)).

e. NAVMED 6100/5 (10-89), Abbreviated Temporary Limited Duty (TLD) Medical Board Report, S/N 0105-LF-008-2800.

f. MED 6100-1 (10-83), Medical Board Report.

g. MED 6100-2 (1-80), Medical Board Report.

3. **Forms**

a. SF 600 (REV. 6-97), Chronological Record of Medical Care is available electronically at: http://contacts.gsa.gov/webforms.nsf/0/4951AF308C046D9785256A3F0005BE96/$file/sf600.pdf.

b. DD 2766 (Rev. 01-00), Adult Preventive and Chronic Care Flowsheet, S/N 0102-LF-984-8400, is available at: http://forms.daps.dla.mil/order/. This form will be used for all non-active duty outpatient records.

c. NAVMED O/P 6150/43 (3-2004), Deployment Health Record, stock number 0102-LF-128-8100, will be available through normal supply channels soon.

d. The following forms are available in the MedBOLTT software and electronically at: http://navymedicine.med.navy.mil/default.cfm?selTab=Directives at the "Forms" tab:

(1) NAVMED 6100/1 (Rev. 8-2004), Medical Board Report Cover Sheet.

(2) NAVMED 6100/2 (Rev. 8-2004), Medical Board Statement of Patient.

(3) NAVMED 6100/4 (Rev. 8-2004), Medical Board Certificate Relative to Counselling on Refusal of Surgery and/or Treatment.

(4) NAVMED 6100/5 (Rev. 8-2004), Abbreviated Medical Evaluation Board Report.

(5) NAVMED 6100/6 (8-2004), Return of a Patient to Medically Unrestricted Duty from Limited Duty.

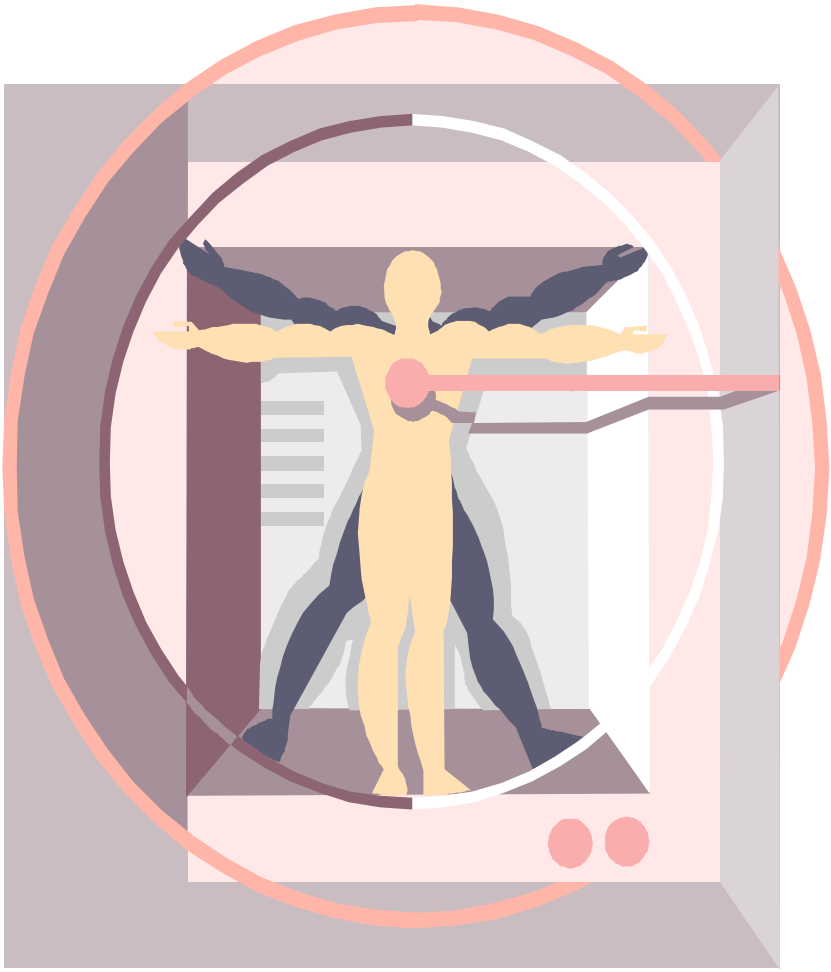
e. The Patient Information Sheet, Sample Format, is available electronically at: http://navymedicine.med.navy.mil/default.cfm?selTab=Directives at the "Sample Format" tab.

4. **Action**. Remove entire chapter and replace with this change.

D. C. ARTHUR
Chief, Bureau of
Medicine and Surgery

Chapter 18

Medical Evaluation Boards



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Chapter 18

CURRENT VS. REVISED CONTENTS

Old Article	Title	New Article	Title
18-1	Purpose	18-1	Overview, and Definition of MEBs and MEBRs
18-2	Convening Authority	18-3	MTF Convening Authority Definition and Responsibilities
18-3	Responsibilities of the Convening Authority	18-3	MTF Convening Authority Definition and Responsibilities
18-4	Composition	18-6	Medical Evaluation Board (MEB) Composition
18-5	Convening of a Medical Board	18-4 and 18-5	Conditions and Circumstances Requiring the Convening of an MEB and Medical Conditions Not Meriting an MEB Being Convened; Administrative Redress; and Cases Involving Legal and/or Administrative Action
18-6	Health Record Entity	18-8	Health Record Entries, Record Keeping Requirements, and TMU Inspections
18-7	Medical Board Report Preparations	18-12 through 18-14	*Various Sections,* regarding MEBR preparation to PEB, for LIMDU, and under Death Imminent conditions
18-8	Medical Board Report Cover Sheet (NAVMED 6100/1)	18-9	Gathering Patient Data and Completing the Patient Information Sheet
18-9	Convening Authority Actions	18-3	MTF Convening Authority Definition and Responsibilities
18-10	Counseling the Member and Subsequent Processing	18-7	Notifying and Counseling the Patient of the Decision to Convene an MEB. *(Also see article 18-28)*

Old Article	Title	New Article	Title
18-11	Notification of Parent Command	18-10 and 18-15 through 18-17 and 18-28	*Multiple Sections,* discussing various types of MEBRs including LIMDU and PEB cases, Non-Medical Assessments, and Cancellation of Cases at PEB
18-12	Report Routing and Disposition	18-10 through 18-18	*Multiple Sections,* discussing various types of MEBRs including LIMDU and PEB Cases, Non-Medical Assessments, and Cancellation of Cases at PEB. *(Also see article 18-3)*
18-13	Processing Time	18-19	Definition of, and Processes for Complying With, Mandated Timeframes for Completion and Submission of MEBRs
18-14	Automatic Data	18-27	The Medical Board OnLine Triservice Tracking (MedBOLTT) System
18-15	Departmental Review	18-14	Format of the MEBR prepared for Placement on Limited Duty or for Referral to Service Headquarters Requesting Limited Duty (i.e., "Departmental Review")
18-16	Medical Boards on Officers	18-10 through 18-14 and 18-24	*Multiple Sections,* discussing LIMDU and PEB Cases, and special consideration in Flag, General, and Medical Corps Officers
18-17	Recruit Evaluation Unit	18-21	Recruits: Removal from "Full Duty" Status; MEBs on Recruits and Members Within First 180 Days of Service
18-18	Determination of Fitness for Recruits for Service	18-21	Recruits: Removal from "Full Duty" Status; MEBs on Recruits and Members Within First 180 Days of Service
18-19	Medical Boards on Recruits	18-21	Recruits: Removal from "Full Duty" Status; MEBs on Recruits and Members Within First 180 Days of Service

Old Article	Title	New Article	Title
18-20	Medical Boards on Reservists	18-23	Reservists: Physical Disqualification and Referral to the PEB
18-21	Return to Duty-Aviation, Submarine, and Other Special Duty Personnel	18-1 and 18-10	Overview and Definition of MEBs and MEBRs and Limited Duty
18-22	Members Who Refuse Medical, Dental, or Surgical Treatment	18-11	Determining Disability Cases to be Referred to the DON PEB
18-23	Board With Disciplinary or Punitive/Misconduct Administrative Action	18-5	Medical Conditions Not Meriting an MEB Being Convened; Administrative Redress; and Cases Involving Legal and/or Administrative Action
18-24	Medical Boards Involving Waivers of Entry Standards	18-21	Recruits: Removal from "Full Duty" Status; MEBs on Recruits and Members Within First 180 Days of Service
18-25	Conditions Not Considered A Physical Disability	18-5	Medical Conditions Not Meriting an MEB Being Convened; Administrative Redress; and Cases Involving Legal and/or Administrative Action
18-26	Medical Boards for Members Medically Waived from the Physical Readiness Test	18-5	Medical Conditions Not Meriting an MEB Being Convened; Administrative Redress; and Cases Involving Legal and/or Administrative Action
18-27	EPTE Physical Defects	18-21	Recruits: Removal from "Full Duty" Status; MEBs on Recruits and Members Within First 180 Days of Service
18-28	Mental Competency and Incapacitation	18-6 and 18-7	MEB Composition and Notifying and Counseling the Patient of the Decision to Convene an MEB
18-29	Temporary Limited Duty (TLD) Medical Boards	18-10	Limited Duty

Old Article	Title	New Article	Title
18-30	Light Duty	18-2	Removal from Duty for Medical Reasons: Sick in Quarters (SIQ), Convalescent Leave, Light Duty, Limited Duty
18-31	Triservice Medical Boards	18-3	MTF Convening Authority Definition and Responsibilities
18-32	Medical Boards from Other than DOD Sources	18-3	MTF Convening Authority Definition Responsibilities
18-33	Providing Additional Medical Information and Line of Duty and Misconduct Investigation	18-15 and 18-16	Non-Medical Assessment (NMA); and Line of Duty/Misconduct (LOD/M) Determination
18-34	Surgical Procedures on Member in the Disability Evaluation System	18-25	Care at the End of Active Duty, Medical Care Subsequent to Submission of a Case to the PEB, and Fitness to Separate
18-35	Withdrawing a Medical Board from the DES	18-28	Rejection, Suspension, or Termination of Cases at PEB
18-36	Medical Board Quality Control Checklist	18-26	Checklist Elements for MEBR Being Submitted to the PEB
18-37	Cognizant MTFs for Triservice Medical Boards	18-3	MTF Convening Authority Definition and Responsibilities
18-38	Acronyms	N/A	Incorporated in the body of the chapter
	NEW ARTICLES		
18-20	Transmission Methods, HIPAA, and Privacy Maintenance	N/A	New Article
18-22	Students and Midshipmen	N/A	New Article
18-29	Training for MTF Staff, Patient Counseling, and the Role of the PEBLOs	N/A	New Article
18-30	Reference Listing	N/A	New Article

Chapter 18
TABLE OF CONTENTS

Section I
OVERVIEW

18-1 Overview and Definition of Medical Evaluation Boards (MEBs) and Medical Evaluation Board Reports (MEBRs)

(1) ***This chapter of the MANMED***

(a) Reiterates that MEB and MEBR operations are significant and vital components of appropriate patient care, as well as compelling readiness issues whose appropriate execution serves as a tangible force multiplier.

(b) Defines the processes by which Navy and Marine Corps members are removed from full duty for medical reasons, including "light duty" and "limited duty (LIMDU)."

(c) Delineates the operations, responsibilities, and composition of MEBs.

(d) Identifies unique parameters of MEB evaluation of cases of recruits, reservists, and students in certain programs leading to a commission, Midshipmen, Flag and general officers, physicians, and personnel facing high year tenure or other mandatory separation or retirement proceedings.

(e) Provides processes for referral of MEB cases into the Navy Disability Evaluation System (DES), including MTF processing responsibilities, and conditions not meriting referral to the DES.

(f) Provides key references for additional research.

(2) ***Overview and Definition.*** Navy Medicine will evaluate each instance in the career of a Navy and Marine Corps active duty service member (ADSM) in which a medical condition will be responsible for the member's inability to operate in a medically unrestricted duty status. Periods of "light duty" (as defined in article 18-2(4)) may be sufficient to allow a return to duty status; failing this, Navy Medicine will conduct MEBs to determine whether the member will be placed on temporary LIMDU and/or referred into the DES. For the purpose of determining cases to be referred to MEBs, "medically unrestricted duty status" signifies that there is no medical condition prohibiting the member's ability to fully execute the duties and responsibilities of their rank, rate, specialty, or office including operational/worldwide assignability. (Pregnancy does not, by governing directive definition, automatically equate to "medically restricted duty status" for purposes of MEB referral; directives issued by the respective Service headquarters on the management of pregnant servicewomen (see OPNAVINST 6000.1 series and Marine Corps Order (MCO) P3000.13 series) should be consulted for the appropriate protocols for those patients.)

(3) ***Medical Evaluation Board (MEB).*** An MEB is a panel of providers attached to one of the medical treatment facilities (MTFs) whose commander or commanding officer (CO) has been expressly designated to hold "convening authority" (CA) for MEBs. (MANMED article 18-3 describes CA in detail; article 18-6 details MEB composition.)

(4) ***Medical Evaluation Board Report (MEBR).*** The deliberations of an MEB will result in a document of findings known as the MEBR. The MEBR will either:

(a) Recommend placement of an active duty service member on a period of temporary LIMDU.

(b) Verify that the member is "fit for duty," after being cleared from LIMDU, and should be able to execute the duties of their respective office.

(c) Refer the case to the Department of the Navy (DON) Physical Evaluation Board (PEB) for disability adjudication and determination of fitness for continued service, in accordance with SECNAVINST 1850.4 series, "Department of the Navy Disability Evaluation Manual."

(5) ***Distinguishing "Fit for Duty" from "Fitness for Continued Naval Service"***

(a) ***"Fit for Duty"*** refers to a pronouncement by a physician or by an MEB that a patient previously on light or LIMDU has healed from the injury or illness that necessitated the member's serving in a medically restricted duty status.

(b) ***"Fitness for Continued Naval Service"*** is a finding made *exclusively* by the DON PEB in determining an ADSM's ability to continue serving in the Navy or Marine Corps. This topic is explained in detail in this chapter in article 18-10 regarding LIMDU and in article 18-11 regarding referral of cases to the DON PEB.

(6) ***Distinguishing MEBs from MEBRs.*** There has historically been imprecision as to the meaning of the term "medical board." To remove the ambiguity inherent in this term, it will be superceded by the terms "Medical Evaluation Board " and "Medical Evaluation Board Report." It is imperative to distinguish between an MEB–the providers evaluating a patient, and an MEBR–the MEB's product. "Medical boards" are most appropriately referred to as MEBs, and will be identified as such throughout the remainder of this chapter and in the operations of Navy Medicine.

(7) ***Coordination.*** This chapter has been coordinated by the Bureau of Medicine and Surgery (BUMED) through the Office of the Chief of Naval Operations (OPNAV) (particularly N-1) and Headquarters, United States Marine Corps (USMC). This chapter is maintained by the BUMED Patient Administration and TRICARE Operations Branch; 2300 E Street, NW, Washington DC 20372-5300. All inquiries on, or proposed changes to, the content of this chapter should be directed to that branch. Additionally, information on "best practices" that MTF officials and other stakeholders wish to share with others to enhance the efficacy of the enterprisewide MEB operation are actively solicited by the BUMED Patient Administration and TRICARE Operations Branch for distribution to the field.

Note: The optimal use of this chapter will be derived by reading it in its entirety, and by comprehensively reading the resources referenced within. However, owing to the complexity of the subject matter, topics have been presented in sufficient detail that the articles of the chapter can "stand alone" for those requiring rapid information on a specific topic. Accordingly, much of the information in the chapter is repeated, intentionally, in a number of the articles, and information from the references is liberally imported, so that readers can still derive benefit by reference to particular articles (as depicted in the Table of Contents) if a comprehensive read of the chapter and additional references is not possible.

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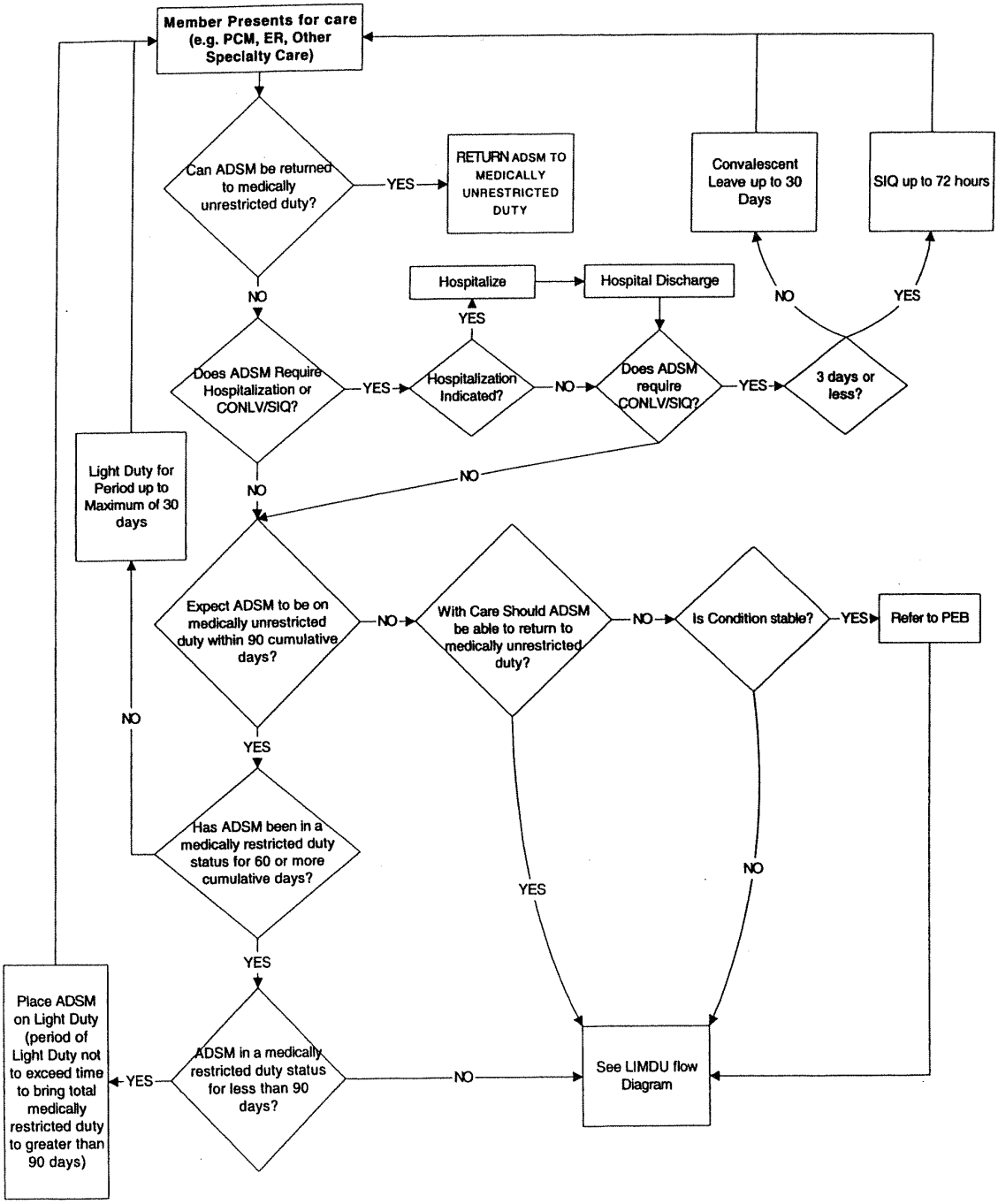
REMOVAL FROM DUTY FOR MEDICAL REASONS:
SICK IN QUARTERS (SIQ), CONVALESCENT LEAVE, LIGHT DUTY, LIMITED DUTY



18-2 Removal from Duty for Medical Reasons: Sick In Quarters (SIQ), Convalescent Leave, Light Duty, or Limited Duty

(1) ***MTF Responsibilities***. Navy MTFs will recommend Navy and Marine Corps members for periods of medically restricted duty when this is deemed clinically appropriate by properly credentialled Department of Defense (DOD) health care providers. MTF leadership will ensure an appropriate mechanism exists within their respective MTFs to notify the patient, the patient's parent command, and when possible, the patient's personnel support detachment (PSD) or administrative office, of the timeframe of this medically restricted duty period, and of the restrictions from duty recommended for the service member in each case. The following paragraphs present the categories of potential "medically restricted duty" status for Navy and Marine Corps members.

(2) ***Sick In Quarters (SIQ).*** A properly credentialled DOD health care provider may recommend a member for SIQ status following medical treatment or for the purpose of "medically directed self treatment." "SIQ," as implied in the name, is a status in which the military member is relieved of all military duties with the expectation that the member will be in his or her residence recuperating until the expiration of the SIQ period. Providers recommending members for SIQ do so in full anticipation that the member will return to a medically unrestricted duty status at the conclusion of the SIQ period. SIQ status should usually not exceed 72 hours. (MILPERSMAN articles in the 1050 series and MCO P1900.16 series may be consulted for additional information in those rare instances in which extensions of SIQ status (potentially up to 14 days) emerge as medically indicated. Respective Service headquarters instructions on the management of pregnant servicewomen should be consulted for special categories of SIQ, e.g., "OB Quarters," that may be appropriate in caring for these patients.)

(a) Health care providers recommending a service member for SIQ are responsible for ensuring, in concert with the ADSM's parent command, that the facilities to accommodate the patient's condition, and the availability of any necessary auxiliary caregivers at the member's "quarters," are entirely clinically compatible with the condition for which the member is being placed SIQ.

(b) Providers are also responsible for ensuring the patient in an SIQ status fully understands any follow-on evaluation and care requirements during and following the SIQ period.

(c) Appropriate clinical judgment is critical in successfully evaluating a patient for SIQ status, and any doubt as to the appropriateness of an SIQ placement will be resolved by foregoing SIQ status in lieu of a more comprehensive treatment protocol.

(d) The recommendation to place a member on SIQ must be communicated by the senior medical department representative or MTF to the appropriate level of the member's parent command for concurrence. MTF commanders and senior medical department representatives shall ensure an appropriate notification process exists for timely notification to an ADSM's parent command of any SIQ recommendation; a critical component of this process is verifying the timely receipt of information by the parent command. MTF business practices in this regard must carefully balance the undeniable need to provide information to the parent command with the need to protect the patient against further aggravation or discomfort from the condition that has resulted in the SIQ recommendation. In some cases, requiring the patient to physically return to his or her parent command to present an "SIQ chit" for approval may be clinically contraindicated. Here, the provider and MTF leadership need to rely on other appropriate communication methods that satisfy both the health care needs of the patient and the operational and administrative control needs of the parent command (e.g., if the patient's return to the parent command is contraindicated, the provider or another appropriate MTF official might call the patient's division officer for official notification; this would be followed by the patient's delivering the SIQ paperwork to the division officer upon the patient's return to duty).

(1) In the event of a conflict between the MTF's SIQ recommendation and the parent command's willingness to grant SIQ status, the matter should be elevated to such a level in the chain of command of the respective MTF and the parent command that an appropriate compromise is achieved

that preserves both the parent command's mission readiness posture and the patient's well-being. As in all endeavors, the member's CO bears overall and final responsibility for the well-being of the member; Navy Medicine must ensure that appropriate information is conveyed that allows COs to exactingly carry out this responsibility in medical matters.

(2) Placing a member on SIQ does not require the convening of an MEB.

(3) ***Convalescent Leave.*** A properly credentialed DOD health care provider may recommend a member be placed in convalescent leave (often referred to as "con leave") status following significant medical treatment and/or a period of inpatient hospitalization. "Convalescent leave" is a period when the member is relieved of all military duties and is in a leave status until the expiration of the leave period. (Convalescent leave is not charged as regular leave; if given medical clearance members may travel, usually at their own expense, to a location other than their residence during a convalescent leave period. Some convalescent leave travel for members medically evacuated (MEDEVAC'd) from a war zone may qualify for reimbursement.) Every health care provider recommending convalescent leave on any patient will be familiar with the provisions of, and have ready access through their patient administration officer to, MILPERSMAN article 1050-180, MCO P1900.16 series, and NAVMEDCOMINST 6320.3B, section A-4d (as modified by BUMED Notice 1300 of 3 May 1991) which detail convalescent leave policies. Providers must pay particular attention to factors such as length of convalescent leave periods and requirements for medical evaluation during and at the conclusion of convalescent leave.

Note: Convalescent leave periods are not to exceed 30 days (with the exception of post-delivery maternity cases in which 42 days of convalescent leave may be recommended). Questions on any aspect of the convalescent leave program are to be referred to the MTF's patient administration officer.

(a) Health care providers recommending convalescent leave are responsible for ascertaining from the patient that the facilities to accommodate the patient's condition, and the availability of any necessary auxiliary caregivers at the member's proposed convalescent leave site, are entirely clinically compatible with the patient's condition.

(b) Appropriate clinical judgment is critical in successfully evaluating a patient for convalescent leave status, and any doubt as to the appropriateness of a convalescent leave recommendation will be resolved by foregoing the leave in lieu of a more comprehensive treatment protocol.

(c) The decision to place a member on convalescent leave generally requires concurrence of the member's parent command. (In instances where the member's parent command is geographically removed from the MTF recommending convalescent leave, the MTF CO or their designee can approve the convalescent leave without approval of the parent command.) Parent command concurrence on a convalescent leave recommendation is often obtained by having the member deliver the convalescent leave request, after medical endorsement from the provider, to the parent command. There may be cases however, in which directing the patient back to the parent command is logistically difficult or clinically contraindicated based on the condition that resulted in the convalescent leave recommendation. In these instances, MTF business practices must carefully balance the undeniable need to provide information to the parent command with the need to protect the patient against further aggravation or discomfort from the condition that has resulted in the convalescent leave recommendation. In such cases, the provider and MTF leadership need to rely on other appropriate communication methods that satisfy both the health care needs of the patient and the operational and administrative control needs of the parent command (e.g., if the patient's return to the parent command prior to starting convalescent leave is clinically contraindicated, the provider or another appropriate MTF official might call the patient's division officer for official notification; this would be followed by the patient's delivering to the division officer the convalescent leave paperwork upon the patient's return to duty. Moreover, the convalescent leave notification can be conveyed in the message traffic sent by MTFs to parent commands advising them when command members are discharged from an inpatient hospitalization.).

(d) In the event of a conflict between the MTF's convalescent leave recommendation and the parent command's granting convalescent leave, the matter should be elevated to such a level in the chain of command of the respective MTF and parent command that an appropriate compromise is achieved

that preserves both the parent command's mission readiness posture and the patient's well-being. As in all endeavors, the member's CO bears overall and final responsibility for the well-being of the member; Navy Medicine must ensure that appropriate information is conveyed that allows COs to exactingly carry out this responsibility in medical matters.

(e) Placing a member on convalescent leave does not of itself require the convening of an MEB.

(4) ***Light Duty.*** A properly credentialed DOD health care provider may recommend a Navy or Marine Corps member for light duty to evaluate the affect that an illness, injury, or disease process has on the member's ability to be in a medically unrestricted duty status. "Light duty" is a period when the member reports to their work space, but during the period the member is excused from the performance of certain aspects of military duties, as defined in their individual light duty write-up. The goal of light duty is to allow for appropriate clinical evaluation without causing further damage to the patient during the evaluation period. A provider placing a member on light duty does so only with the expectation that the member will be able to return to medically unrestricted duty status at the end of the light duty period; care must be exercised to ensure that light duty is not abused or used as an inappropriate substitute for MEB overview of a case. Accordingly, when a diagnosis is initially made of a new condition for which the provider feels light duty is appropriate, light duty is permitted. (This criterion of a "new condition" does not preclude multiple "light duty" periods over the course of a member's career; it does however preclude excessive periods of light duty consecutively for the same condition.) Light duty presumes frequent provider and patient interaction to determine whether return to medically unrestricted duty status or more intensive therapeutic intervention is appropriate in any given case. Therefore, light duty will be ordered in periods not to exceed 30 days to ensure appropriate patient clinical oversight. Consecutive light duty for any "new condition" up to 90 days may be ordered by the provider (in maximum 30-day periods), but in no case will light duty exceed 90 consecutive days, inclusive of any convalescent leave periods. At the end of the light duty period, the member will either be immediately returned to medically unrestricted duty or will be referred to an MEB.

(a) The MEB will prepare an MEBR for placing the member on temporary LIMDU and/or referring the member to the PEB for DES processing. In no case will a member reach the 90th day of light duty without the MTF having submitted an MEBR either placing the ADSM on LIMDU or referring the patient to the PEB for DES adjudication.

(b) A provider recommending a member for a light duty status will complete NAVMED 6310/1 (11-2004), Individual Sick Slip. The provider will clearly annotate the restrictions and limitations imposed upon the member's duty, as well as the time period required in a light duty status. The provider will ensure that the NAVMED 6310/1 is placed in the member's health record and that copies are provided to the member for the member to deliver to the parent command.

(c) If there is a question that the medical condition necessitating light duty is due to an injury, thereby requiring line of duty/misconduct (LOD/M) determination, the provider will ensure the member is directed to the MTF's patient administration department immediately following the determination that light duty is clinically indicated. The patient administration or medical boards office will launch (via naval message traffic) the request to the parent command for a line of duty determination/investigation (LODD/I). LOD/M determinations are discussed in more detail in article 18-16.

(d) The decision to place a member on light duty requires concurrence of the member's parent command. As light duty placement, by definition, will usually return the patient to the parent command throughout the light duty period, parent command concurrence for a light duty recommendation is most often obtained by having the member deliver the light duty recommendation to the parent command. MTF commanders shall ensure an appropriate notification process exists by which the MTF makes timely notification to the parent command of any Navy or Marine member recommended for light duty; a critical component of this process is a mechanism for positively verifying the timely receipt of information by the parent command.

(e) MTF providers and patient administration officers must maintain close liaison with parent commands of members placed on light duty, and remain mindful of the burdens placed on a command when

its members are medically restricted from performing aspects of their duty. In the event of a conflict between the MTF's light duty recommendation and the parent command's granting light duty, the matter should be elevated to such a level in the chain of command, of the respective MTF and parent command, that an appropriate compromise is achieved that preserves both the parent command's mission readiness posture and the patient's well-being. However, if a parent command indicates that it is incapable of accommodating a proposed light duty placement for a member, and the provider has conclusive clinical indications that denial of light duty will cause further harm to the patient, the provider should immediately initiate MEB proceedings for an MEBR leading to the patient's placement on temporary LIMDU. As in all endeavors, the member's CO bears overall and final responsibility for the well-being of the member; Navy Medicine must ensure that appropriate information is conveyed that allows COs to exactingly carry out this responsibility in medical matters.

(f) Placing a member on light duty does not require the convening of an MEB.

(5) ***Limited Duty.*** A properly convened MEB at an MTF may recommend that a member be placed on a documented period of medically restricted duty as a result of illness, injury, or disease process. LIMDU is a period when the member reports to their work space, but during the period the member is excused from the performance of certain aspects of military duties as defined in their individual LIMDU write-up. For this chapter, and in the actions of all MEBs throughout Navy Medicine, "limited duty" will refer to temporary limited duty (as opposed to permanent limited duty). Temporary limited duty is also known as LIMDU and or TLD; these terms are used interchangeably throughout this chapter.

(a) LIMDU is similar in many respects to light duty; major differences between the two are that, in comparison to light duty, LIMDU periods:

(1) Last longer than light duty periods.

(2) Require notification to not only the parent command, but to respective service headquarters and the servicing PSD of the member's status.

(3) May necessitate the transfer of the member from the parent command if it is a deployable unit.

(4) Do not necessarily require the consent of the member's parent command, or of the respective service headquarters. MTF commanders possessing "Convening Authority" allowing them to empanel MEBs must ensure appropriate business practices to alleviate undue burden on both the patient and the patient's parent command, and must include in all LIMDU cases appropriate notification to the patient's parent command servicing personnel/administrative office, and the respective service headquarters personnel office.

(b) Continuing care, recovery, and rehabilitation are conducted during LIMDU in an effort to return the member to medically unrestricted duty status.

(c) LIMDU may only be provided to a patient as the result of the actions of an MEB. LIMDU MEBs are addressed in detail in article 18-10.

(d) A patient whose case is referred to the PEB for DES adjudication, if the patient is not already in a LIMDU status, will be concurrently placed on LIMDU pending the PEB outcome. The Abbreviated Limited Duty Medical Evaluation Board Report detailed in article 18-17 may be used for this purpose.

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Section II
CONVENING MEDICAL EVALUATION BOARDS (MEBs)

18-3 MTF Convening Authority Definition and Responsibilities

(1) ***Convening Authority.*** Authority in Navy Medicine to convene MEBs is granted exclusively to the COs of naval medical centers, naval hospitals, naval medical clinics, and the naval ambulatory care centers. As such, these officers may order an MEB comprising providers under their respective command to evaluate any member of the Armed Forces. Only MTFs whose COs have "CA" can conduct MEBs. (This "authority" is not to be confused with court-martial CA pursuant to the Uniform Code of Military Justice (UCMJ).) Officers in charge (OICs) of branch medical clinics do not hold CA; neither do operational unit surgeons or ship medical officers. *Within DON, other than the MTF commanders identified in this paragraph, and those officers identified in article 18-3(2) below, no other command or officer may convene an MEB, or take unilateral action to place a member on LIMDU, or refer a member's case to the DON PEB.*

(2) ***Additional Officers Authorized to Order MEBs.*** The Chief of Naval Operations (CNO), the Commandant of the Marine Corps (CMC), the Fleet Commanders, the Chief of Naval Personnel (CHNAVPERS), the Commander, Naval Reserve Force (COMNAVRESFOR), the Chief, Bureau of Medicine and Surgery (BUMED), and the OIC, Military Medical Support Office (MMSO) may also initiate MEBs by ordering one of the CA officers identified in article 18-3(1) to convene an MEB.

(3) ***Delegation of CA Signatory Responsibility for Approving MEBRs.*** The COs defined as CAs in article 18-3(1) may delegate, in writing, signatory responsibility for acting in their behalf to approve or disapprove the findings and recommendations of an MEB convened at their respective MTFs. This delegation does not confer CA status; it allows appropriate senior clinical leaders at the MTFs to assist their MTF CA in the execution of his or her myriad responsibilities by reviewing and processing MEBRs. Deciding whether to delegate this signatory responsibility is entirely at the discretion of each MTF commander for his or her respective command. If the CA does award signatory responsibility, the following hierarchy will be followed: at Naval medical centers and naval hospitals, this signatory responsibility delegation may be granted to appropriate directors and clinical department heads; at naval medical clinics and naval ambulatory care centers, this delegation will not be granted below the level of the chief of clinical services.

(4) ***Branch Medical Clinics and Operational Units***

(a) In no circumstance will CA signatory responsibility be delegated to branch medical clinics.

(b) MTF commanders, may, however consider authorizing their respective branch clinic's clinical staffs to serve as MEB members and to initiate MEBRs which then must be forwarded to the MTF for processing and CA approval and signature before the MEBR findings or recommendations become effective. This initiative to "move paper, not patients" affords the opportunity to rapidly assess members, to assist in compliance with TRICARE access standards, and to potentially reduce travel difficulties and time away from the command for members whose conditions merit MEB referral. Evaluation of a branch medical clinic's capability to initiate MEBRs must be predicated on the availability (either internally or in conjunction with TRICARE partners) of clinically appropriate diagnostic resources and appropriate medical specialists. MTF commanders will personally render the decision on which of their respective branch clinics are authorized to initiate MEBRs, will communicate this policy in writing throughout their respective commands, and will ensure an appropriate evaluation process exists to monitor the efficacy of this program. This initiative is only available to branch medical clinics under the auspices of an MTF whose commander has CA.

(1) Shipboard and operational unit medical department representatives who are not under the direct chain of command of an MTF commander with CA, as defined in article 18-3(1) above, are not eligible to participate in this initiative and are prohibited from independently executing MEB actions and MEBRs.

(2) Similar prohibitions exist on providers who are permanently assigned under the direct chain of command of an MTF commander with CA, but who are temporarily rendering care at an operational unit (e.g., on temporary additional duty (TAD) or "circuit riding" to provide specialty care). Cases these providers determine to require consideration for LIMDU or for referral to the PEB must be referred for action to an MTF whose commander or CO holds CA. (As delineated in article 18-3(4)(b) above, MTF commanders may consider authorizing these providers to serve as MEB members and initiate MEBRs which then must be forwarded to the MTF for processing and CA approval and signature before their findings and/or recommendations become effective.) Accordingly, no provider can unilaterally place a member on LIMDU or otherwise execute MEB actions in the absence of deliberation by other MEB members and the approval of an MTF CA. For shipboard/operational personnel, it is likely that a condition significant enough to merit referral to an MEB is not compatible with continued shipboard/operational unit service; providers and patient administration officers must ensure close liaison with the parent command of members in this situation to effect appropriate transfer (e.g., temporary duty (TEMDU) orders on enlisted members or permanent change of station (PCS) orders on officer members) for treatment.

(5) ***Other Service and TRICARE Provider Involvement in Navy and Marine MEBs***

(a) Paperwork on the cases of all Navy and Marine members undergoing any MEB action must be processed through a Navy MTF, even if an MTF of another branch of the Armed Forces initiated the MEB or if TRICARE network providers were engaged in the preparation of the MEBR.

(b) Previous editions of this chapter provided detailed listings of which U.S. Army and U.S.Air Force MTFs should receive and send MEB cases to Navy MTFs. In this iteration, MTF commanders are allowed discretion in determining which MTFs they will work with regarding MEB actions. Of paramount importance is the establishment of positive working relationships between respective MTF medical board services, as significant aspects of this performance of MEBs (e.g., "profiles" in other services) differ among the branches of the Armed Forces. Navy MTFs receiving MEBs from other service MTFs on Navy and Marine personnel shall ensure that the patient administration department reviews all work being forwarded from the other services' MTF; at the conclusion of this verification, the patient administration/MEB officer shall append a Navy cover sheet, bearing all signatures and designations as required for processing any board originating within a Navy MTF, to the MEBR before forwarding it to the CA.

(6) ***Responsibilities of the CA***

(a) Ensuring that patients being evaluated by an MEB are thoroughly and appropriately counseled on the process. The CA will ensure as well that patients are, as appropriate, made thoroughly familiar with LIMDU, medical holding company operations, DES processing, and the role of the PEB liaison officers (PEBLOs). A critical part of this requirement for counseling is the provision of appropriate physical plant spaces in which patients meet with providers, MTF medical boards staff, and PEBLOs such that patient privacy is protected and confidential counseling can occur.

(b) Ensuring that patients being evaluated by an MEB are made thoroughly aware of the findings of the MEB, are provided a copy of the MEBR, are afforded the opportunity to discuss opinions and recommendations with each member of the MEB, and are afforded the opportunity to submit a statement on any portion of the MEBR, which then becomes a part of the official documentation of the MEBR. If the CA determines that revealing any of the information contained in the MEBR to the patient will be harmful, deleterious, or have adverse affect on the mental and physical health of the patient, or if the patient has been determined mentally incompetent or incapacitated to handle his or her own affairs, the CA will instead ensure that the legally appropriate next of kin (or legally appointed trustee) representing the patient is provided all information and afforded all rights described in this article (see SECNAVINST 1850.4 series, Navy Disability Evaluation Manual, that offers additional information on this topic).

(c) Ensuring that only appropriately trained providers are appointed to MEBs. In addition to requisite clinical training, appropriate training, at a minimum, consists of thorough familiarity with this document and with the SECNAVINST 1850.4 series. The CA will ensure that defined criteria for MEB membership are published for their respective commands, and will ensure development of verification methods to ensure that only fully trained providers are allowed to comprise MEBs.

(d) Ensuring that MEBs are comprised of the correct number and specialties (board certified or board eligible) of providers, appointed based on the condition and status of the patient being evaluated (e.g., psychiatrists on a mental incapacitation board, or reserve representation when a reservist is being evaluated by an MEB). Article 18-6 details MEB composition.

(e) Ensuring that MEB office and patient administration staff members are appropriately trained in supporting MEBs, including the compilation and processing of MEBRs. This training, at a minimum, consists of thorough familiarity with this document and with the SECNAVINST 1850.4 series, Navy Disability Evaluation Manual. Training must also be implemented at the MTF level to ensure that the patient administration staff who will be serving and counseling patients are adequately prepared for their vital roles. Article 18-29 details MEB training requirements.

(f) Ensuring inclusion of all indicated medical tests and examinations, including a complete physical examination (PE), conducted in accordance with the Manual of the Medical Department (MANMED)

chapter 15 and as required by the SECNAVINST 1850.4 series (attachment A to enclosure (8)) for those cases being referred to the PEB, with each MEBR, and ensuring that all appropriate annotations of MEB activity are incorporated into the patient's medical record.

(g) Ensuring compliance with processing timeframes stipulated in the SECNAVINST 1850.4 series, Navy Disability Evaluation Manual, and ensuring proper entry of MEBR information in the Medical Board OnLine Triservice Tracking (MedBOLTT) System, or systems that replace it, as installed in MTFs and operated under the aegis of Naval Medical Information Management Center (NMIMC).

(h) Ensuring that appropriate liaison is maintained with the Responsible Line Commander, parent commands, and servicing personnel support activities and detachments of patients undergoing MEB processing, as well as with the NAVPERS Transient Monitoring Unit (TMU). Critical among this liaison function is ensuring that monthly meetings held by the MTF for "LIMDU coordinators" representing all commands with patients on LIMDU occur as required by the MILPERSMAN. MTFs can significantly enhance their performance in this regard by ensuring appropriate interoperability exists between their MEB offices and their Operational Forces Medical Liaison Services Office.

(i) Ensuring, in conjunction with the PEB, that indicated cases are brought to the attention of the Chief, BUMED (BUMED Risk Management) for review and possible reporting to the National Practitioner Data Bank (DPDB) as delineated in section 5.2.9. of DOD Directive 6025.13 of 4 May 2004, Medical Quality Assurance (MQA) in the Military Health System.

18-4 Conditions and Circumstances Requiring the Convening of an MEB

(1) ***Proposals of MEBs***. An MEB evaluates a patient and produces an MEBR on that patient's condition. MTF CAs may convene an MEB to evaluate and prepare an MEBR on any member of the military. MEBRs are used for two purposes:

(a) Placing a patient on temporary limited duty (TLD or LIMDU).

(b) Referring a patient to the PEB for a determination of the patient's fitness for continued service. The DON PEB is not under the aegis of Navy Medicine, and reports directly to the Director, Secretary of the Navy Council of Review Boards (DIRSECNAVCORB) formerly DIRNCPB. Delegated by the Secretary of the Navy (SECNAV), the PEB, under DIRSECNAVCORB, has sole authority within the DON to determine a Navy or Marine member's fitness for continued Naval service for a condition which may constitute disability.

(2) ***Circumstances Indicating Need for an MEB.*** An MEB shall be initiated when a physician trained and certified for MEB membership by the MTF CA (as defined in articles 18-3(5) and 18-6) determines that:

(a) A member has a condition that appears to significantly interfere with performance of duties appropriate to the member's office, grade, rank, or rating.

(b) A member has a condition that will prohibit returning the patient to his or her parent command in a medically unrestricted duty status following appropriate light duty as defined in article 18-2(4). Special consideration must be exercised in cases involving members assigned to operational commands which may be unable to sustain the unplanned loss of ADSMs for significant light duty periods. For these ADSMs, placement of the member on LIMDU or in a medical holding company status

may be indicated to ensure the most appropriate personnel status of the unit and allow for the parent command to effect an "unplanned loss" replacement most expeditiously; MTF staff must be in close liaison with the patient's commands in these cases to determine appropriate actions.

(c) A member has a condition that may seriously compromise the member's health or well-being if the member were to remain in the military service (e.g., continued service would likely result in extended hospitalization(s), requirements for close medical supervision, or potential aggravations of the existing condition).

(d) A member has a condition that may prejudice the best interests of the Government if the member were to remain in the military service.

(e) A member has a condition that requires assignment limitations (e.g., geographic restraints or assignment near a particular MTF with specialty services, etc.).

(f) An inactive reservist incurs or aggravates an injury or illness during a period of active service and the period of required treatment, rehabilitation, or convalescence is expected to exceed 12 weeks or require retention beyond authorized active duty service orders.

(g) A member refuses reasonable medical or dental treatment (including surgery) and the member's ability to perform medically unrestricted duty is suspect. In these cases, the CA will determine the "reasonableness" of the member's refusal to accept indicated care, predicated on appropriate clinical standards of practice, availability of reliable care, (e.g., in an outside of the Continental United States (OCONUS) setting where care is not available at an MTF and MEDEVAC is clinically contraindicated), and other factors the CA deems appropriate.

(h) A member who has "self-referred" for elective care outside the direct Military Health System (MHS) (e.g., for organ donation or corrective laser eye surgery) who sustains an untoward outcome that calls into question the member's continued fitness for service as a result of that care will be referred by an MEB to the DON PEB. The PEB will determine the member's fitness for continued Naval service and concurrently will determine whether the patient is eligible for disability benefits. Parent commands and MTFs must perform specific counseling requirements; refer to SECNAVINST 1850.4, BUMEDINST 6320.72, and BUMEDINST 6300.8 series instructions.

(i) A member whose condition indicates the need to receive an organ transplant merits referral to an MEB; close coordination between the MTF and the PEB must occur in these cases, particularly if the member is being retained in an active duty status until the completion of the transplant; refer to SECNAVINST 1850.4 series, enclosure (8), attachment A, paragraph 2s.

(3) ***Conditions Indicating Need for an MEB.*** SECNAVINST 1850.4 series, enclosure (8), provides a listing of "Medical Conditions and Physical Defects Which Normally are Cause for Referral to the Physical Evaluation Board." While the primary consideration in determining whether an MEB should be convened is the professional judgment of the attending physician, this list should be consulted frequently by providers and patient administration staff.

(4) ***Referral of Patients to an MEB.*** Uniformity throughout Navy Medicine in referring patients to MEBs is a critical issue for our MTFs, our patients, and their parent commands. Issues beyond those implicit in the care of an individual patient, such as total force personnel strengths and the maintenance of a fit force, are key and vital considerations that must be addressed concurrently with the delivery of exactingly efficacious medical care. Accordingly, the criteria for convening MEBs and preparing MEBRs must be diligently applied throughout Navy Medicine. While each unique patient's case merits scrutiny for extenuating circumstances, the operating parameter for the overwhelming majority of our patients is that if an ADSM has a medical condition which will be responsible for their inability to operate in a medically unrestricted duty status for 90 days or greater duration, the patient must be referred to an MEB for placement in a TLD/LIMDU status and/or for referral to the DON PEB.

(5) ***Guidelines for Convening MEBs.*** The following provides guidelines for convening MEBs to place patients on TLD/LIMDU and/or refer patients to the PEB: (See next page for guidelines.)

MEB REQUIREMENTS

ACTION SOUGHT/MEMBER STATUS	MEB REQUIRED?	ROUTE MEB TO	OTHER REQUIRED ACTION
			Cases where "MEB Required?" = Yes: (1) Notify parent command via Naval Message traffic. (2) Input to MedBOLTT or replacement system. (3) Additional actions indicated below.
1st period TLD ≤6 months/ USN officer	Yes	NAVPERSCOM (PERS-4821)	Provide abbreviated MEBR.
1st period TLD ≤6 months/ USMC officer	Yes	HQMC (MMSR-4)	Provide abbreviated MEBR and NMA from parent command.
1st career period TLD ≤6 months/ USN enlisted	Yes	File in Health Record.	Provide abbreviated LIMDU MEBR.
1st career period TLD ≤6 months/ USMC enlisted	Yes	File in Health Record.	Provide abbreviated LIMDU MEBR.
2nd period TLD ≤6 months/ USN officer	Yes	NAVPERSCOM (PERS-4821)	Provide abbreviated MEBR.
2nd period TLD ≤6 months/ USMC officer	Yes	HQMC (MMSR-4)	Provide abbreviated MEBR and NMA from parent command.
2nd period TLD ≤6 months/ USN enlisted	Yes	Not Applicable	Provide abbreviated MEBR.
2nd period TLD ≤6 months/ USMC enlisted	Yes	HQMC (MMSR-4)	Provide abbreviated MEBR.
3rd subsequent period TLD/ USN officer or USN enlisted	Yes	NAVPERSCOM (PERS-4821)	(1) If the TLD is sought for the condition responsible for the first and/or second TLD periods, provide dictated MEBR, NMA from parent command, and MEBR cover sheet. (2) If the TLD is sought for a different condition than that responsible for the first and/or second TLD periods, provide the abbreviated MEBR.
3rd subsequent period TLD/ USMC officer or USMC enlisted	Yes	HQMC (MMSR-4)	(1) If the TLD is sought for the condition responsible for the first and/or second TLD periods, provide dictated MEBR, NMA from parent command, and MEBR cover sheet. (2) If the TLD is sought for a different condition than that responsible for the first and/or second TLD periods, provide the abbreviated MEBR.
Referral to PEB/USN officer	Yes	DON PEB	Ensure appropriate physical examination (PE), NMA from parent command, and LODD (as indicated).
Referral to PEB/USMC officer	Yes	DON PEB	Ensure appropriate PE, NMA, and LODD.
Referral to PEB/USN enlisted	Yes	DON PEB	Ensure appropriate PE, NMA, and LODD.
Referral to PEB/USMC enlisted	Yes	DON PEB	Ensure appropriate PE, NMA, and LODD.
Conditions described in article 18-5 as not meriting referral to the PEB	No	Not Applicable	Forward to parent command with copy in health record. Parent command to initiate appropriate administrative separation procedures.
Light Duty	No	Not Applicable	Forward to parent command with copy in health record. Ensure appropriate clinical followup and receipt of parent command concurrence.
Return to duty from LIMDU	No	Not Applicable	NAVMED 6100/6. Message traffic notification to parent command and PERS-4821 or MMSR-4. Ensure entry into MedBOLTT or replacement system.
Final findings from PEB	No	Not Applicable	Ensure entry into MedBOLTT or replacement system.

PEB Mailing Address: President, Physical Evaluation Board, Building 36, 720 Kennon Street, SE, Washington, DC 20374-5023.

18-5 Medical Conditions Not Meriting an MEB Being Convened; Administrative Redress; and Cases Involving Legal and/or Administrative Action

(1) MEBs convene to evaluate patients and produce MEBRs that either place a member on temporary LIMDU and/or refer a member to the PEB for disability evaluation. The Navy Disability Evaluation Manual, SECNAVINST 1850.4 series defines "disability" as "any impairment due to disease or injury, regardless of degree, that reduces or prevents an individual's actual or presumed ability to engage in gainful employment or normal activity."

(2) As stipulated in the Navy Disability Evaluation Manual *a "medical impairment or physical defect standing alone does not constitute a physical disability.* To constitute a physical disability, the medical impairment or physical defect must be of such a nature and degree of severity as to interfere with the member's ability to adequately perform his or her duties." The Navy Disability Evaluation Manual continues that "the term, "physical disability," includes mental disease, but not such inherent defects as behavioral disorders, adjustment disorders, personality disorders, and primary mental deficiencies."

(3) ***Conditions not meriting an MEB.*** *A*ccordingly, the mere presence of a physical or mental condition does not constitute a "disability" and therefore there are conditions and situations in which convening an MEB is neither appropriate nor desired. Certain conditions and defects of a developmental nature are not ratable in the absence of an underlying ratable causative disorder. These conditions, while not appropriate for MEB referral, may be referred for appropriate administrative action (for Navy, MILPERSMAN article 1900 series applies and for USMC, the Marine Corps Separation and Retirement Manual (MARCORSEPMAN), chapter 6, applies) and include, but are not limited to, the following, which are detailed in SECNAVINST 1840.4 series (in sections 2016 and 3202, and in attachment B to enclosure (8)):

(a) Enuresis.

(b) Sleepwalking and/or somnambulism.

(c) Dyslexia and other learning disorders.

(d) Attention deficit hyperactivity disorder.

(e) Stammering or stuttering.

(f) Incapacitating fear of flying confirmed by psychiatric evaluation.

(g) Airsickness, motion sickness, and/or travel sickness.

(h) Phobic fear of air, sea, and submarine modes of transportation.

(i) Uncomplicated alcoholism or other substance use disorder.

(j) Personality disorders.

(k) Mental retardation.

(l) Adjustment disorders.

(m) Impulse control disorders.

(n) Homosexuality.

(o) Sexual gender and identity disorders paraphilias.

(p) Sexual dysfunction.

(q) Factitious disorder.

(r) Obesity.

(s) Overheight.

(t) Psuedofolliculitis barbae of the face and/or neck.

(u) Medical contraindication to the administration of required immunizations.

(v) Significant allergic reaction to stinging insect venom.

(w) Unsanitary habits.

(x) Certain anemias, in the absence of unfitting sequelae, including G6PD deficiency, other inherited anemia trait, and Von Willebrand's Disease.

(y) Allergy to uniform clothing or wool.

(z) Long sleeper syndrome.

(aa) Hyperlipidemia.

(4) ***Circumstances Not Meriting an MEB for Referral to the PEB.*** In addition to the medical conditions listed above, the following circumstances also contraindicate evaluation by an MEB for referring the matter to the PEB (refer to SECNAVINST 1850.4 series, section 3202):

(a) Lack of motivation to perform duty.

(b) Request by member for referral to an MEB or PEB in the absence of appropriate diagnosis(es) meriting an MEB.

(c) Inability of member to meet initial enlistment/appointment standards.

(d) Physical disqualification for special duties.

(e) Inability to meet physical standards for specific assignment or administrative requirement. (This includes participation in physical readiness test (PRT), physical fitness tests (PFT), and physical fitness assessment (PFA) cycle. Referral to the PEB merely due to an inability to participate in PRT, PFT, and PFA is inappropriate; however, if the inability to participate in the PRT, PFT, and PFA is due to an illness or injury that is a potential disability as defined elsewhere in this chapter and in the SECNAVINST 1850.4 series, then referral to the PEB is appropriate. Close coordination with respective service headquarters and respective Service PRT, PFT, and PFA instructions is encouraged in these cases.)

(f) Members being processed for separation or retirement for reasons other than physical disability (unless the member was previously found unfit by the PEB and is in a permanent LIMDU status, or unless the member's physical condition reasonably prompts doubt that he or she is fit to continue to perform their duties pending the separation or retirement).

(5) ***Pregnancy.*** An MEB is not mandatory in cases of servicemembers temporarily unable to perform aspects of their duty due to pregnancy or complications from pregnancy; service directives (i.e., OPNAVINST 6000.1 series and MCO P3000.13 series) provide reporting requirements and amplifying information particularly related to protocols that "some servicewomen may require a significant alteration in work assignment which may adversely impact the command." Referral for administrative separation is not routinely appropriate in cases of pregnant servicewomen; the sole exception to this is recruits found to be pregnant upon reporting to their respective recruit training commands for basic training. In these cases, as conveyed for instance for Navy personnel in MILPERSMAN article 1910-112 "Separation by Reason of Convenience of the Government - Pregnancy:" "Members who are pregnant, and medical authorities certify in writing that the pregnancy existed prior to entry into the service, will be separated following MILPERSMAN article 1910-130, "Separation By Reason of Defective Enlistments and Inductions and Erroneous Inductions - Erroneous Enlistment," and shall be separated without medical benefits." OPNAVINST 6000.1 series provides guidance on the administrative management of pregnant servicewomen.

(6) ***Legal and Administrative Considerations.*** In cases in which the member is facing legal and/or involuntary administrative separation issues that may result in separation, these processes and their outcomes, as mandated by service headquarter directives, supercede MEB action, including referral to the PEB for DES processing. For this reason, it is critical that MTFs contemplating convening an MEB on a patient ascertain whether the patient is pending any legal or administrative proceeding or involuntary administrative separation (as indicated in the patient information sheet, see article 18-9). Any cases in which a legal or involuntary administrative separation concern emerges should immediately be referred to the appropriate service headquarters (PERS-4821 or HQMC MMSR-4) for LIMDU cases, or the PEB in cases submitted to the PEB, for determination on the appropriateness of continuing MEB action. MEB action in these cases should be suspended pending the resolution of the legal and/or administrative separation issues; moreover, cases should not be referred to the PEB for disability evaluation if legal or involuntary administrative separation issues are pending (SECNAVINST 1850.4 series, article 3403, provides amplifying information.). It is incumbent upon MTFs processing MEBs on patients to diligently determine, through patient interviews, non-medical assessment (NMA) review, contact with parent commands, and other appropriate avenues, whether legal or involuntary administrative separation issues are pending in any case.

18-6 Medical Evaluation Board (MEB) Composition

(1) ***CA Responsibility in Appointing Medical Board Members.*** The prime consideration in the composition of an MEB is ensuring that the physicians comprising the Board have sufficient professional training, specialization, and experience, and have been appropriately trained in the operations of DON LIMDU and disability evaluation processes. (At a minimum, this training should consist of a thorough understanding of this chapter, SECNAVINST 1850.4 series, and of all pertinent MTF-specific governing directives.)

(2) ***Number of Physicians Comprising an MEB.*** There are a minimum of two members required on an MEB, a junior member and a senior member; the CA may name a third member to an MEB as deemed appropriate. (A mandatory exception to this is that all MEBs convened in cases adjudicating mental incapacitation require three physician members, one of whom must be a psychiatrist, as defined in article 18-6(8) below.) MEBs will be composed of physicians who are properly credentialed and actively engaged in clinical practice on the staff of a DOD MTF.

(3) ***Senior Member Responsibilities.*** The senior member will ensure that the actions of the MEB conform to established procedures, and the MEBR prepared by the MEB conforms to sound and accepted practices and principles of medicine. The senior member will maintain close liaison with the patient administration and MEB service during the preparation of the MEBR, and will ensure compliance with all timeframes stipulated in the Disability Evaluation Manual (SECNAVINST 1850.4 series) and this chapter. The senior member should ordinarily be the department head of the specialty by which the patient is primarily being evaluated. In cases where this is not possible, (e.g., the clinical department head will be reviewing the MEB with signatory responsibility delegated by the CA as detailed in article 18-3(3)) the department head will designate another appropriate senior physician within the clinical department to serve as the senior member on the MEB.

(4) ***CA Not to Serve as an MEB Member.*** To maintain the requisite impartiality required of the final reviewer of MEBRs prepared in the MTF, the CA (i.e., CO) will not serve as an actual member of MEBs. Likewise, officers to whom the CA has provided signatory responsibility as final command review will not, on any case, serve as both a member of the MEB and the command's final reviewer of the MEBR produced by that MEB.

(5) ***Boards Convened to Evaluate Dental Conditions.*** When the basis for the board is a dental treatment matter, the senior member should be a dentist properly credentialled and actively engaged in clinical practice on the staff of a DOD MTF or dental treatment facility (DTF). Other members must be physicians as detailed in article 18-6(2). An MEB prepared on a Navy or Marine Corps active duty dental patient to determine the patient's fitness for continued Naval service will be processed through a Navy MTF for further routing as indicated to the Navy PEB.

(6) ***Boards Convened on Reservists.*** When an MEB is convened to evaluate an active or inactive Naval or Marine Corps Reserve member, the CA will direct that the MEB membership reflects the Reserve status of the patient being evaluated. The CA will expressly annotate the Reserve representation on the MEB in the MEBR; this annotation will include a distinct citation in the forwarding endorsement to the MEBR if appropriate Reserve representation was not practicable.

(7) ***Clinical Specialty Representation on MEBs.*** Specialist involvement in the preparation of MEBRs is the standard which will be achieved throughout Navy Medicine. Commanders and COs holding CA for MEBs shall ensure that, preferably all MEB members but, at a minimum, the senior member of any MEB shall be trained and either board-certified or board-eligible in the specialty most relevant to diagnosing and treating that condition which is most responsible for the patient being referred to an MEB. In cases where any of the MEB members are not specialists engaged in the active practice of that area of medicine most relevant to the diagnosis primarily responsible for referral to an MEB, the CA will ensure that the MEBR expressly indicates that key clinical information in the MEBR is predicated on specialty consultation by providers other than those comprising the MEB. The CA will also ensure in these cases that the patient is thoroughly instructed on the process

involved in obtaining, and is afforded appropriate opportunity to obtain, all pertinent findings as provided for in article 18-3.

(8) ***MEBs Established to Determine Mental Incapacitation.*** MEBs convened to establish whether a Navy or Marine Corps member is in a state of mental incapacitation (i.e., mental incapability of managing personal and financial affairs) require three physician members. The members must be active members of the Uniformed Services and/or active physicians within the Veteran's Administration and/or civilian physicians credentialled and privileged to practice in a DOD MTF. At least one of the MEB members must be a psychiatrist (refer to 37 USC 602 and the Manual of the Judge Advocate General (JAGMAN)). (The requirement for psychiatrist membership on this type of MEB cannot be satisfied by relying instead on clinical psychologists.) The psychiatrist member(s) of the MEB will be identified as such in the appropriate signature block lines of the MEBR.

18-7 Notifying and Counseling the Patient of the Decision to Convene An MEB

(1) Immediately upon determining that a patient is to be referred to an MEB, the attending physician determining the need for the patient's referral, will personally inform the patient. In cases where a patient is not deemed competent to handle personal and financial matters, or in cases where full disclosure is deemed to have a deleterious effect on the patient, the physician will inform the duly authorized next of kin or guardian of the decision to refer a patient to an MEB (see SECNAVINST 1850.4 series, sections 2035, 2049, 2083, 3414, 4214d, and 12000 for cases being referred to the PEB). MTF Staff JAG Corps officers will be immediately consulted if questions arise over appropriate notification to patients.

(2) During this notification to the patient, the physician will identify whether the intended referral is for LIMDU or for having the DON PEB determine the patient's fitness for continued Naval service. The referring physician will address all clinical and other concerns to the maximum extent practicable.

(3) Finally, the physician will ensure that the patient immediately reports to the patient administration/MEB section for additional counseling and administrative processing. (This step is crucial in that numerous critical elements of information are gathered at this juncture to protect the patient's rights, to ensure appropriate notifications are made to the patient's parent command, and to ensure the MTF complies with timeliness and completion factors for processing the MEBR.)

(4) In those cases in which an MEB will result in a patient's referral to the DON PEB for a determination of fitness for continued Naval service, MTF representatives should expressly refrain from offering their opinions on whether the PEB will render a decision of "fit" or "unfit" for continued Naval service, and should equally refrain from offering opinions on disability percentage ratings which may be offered. These determinations are exclusively within the purview of the PEB, and speculation on the part of MTF staff often only produces negative affects on our patients when the speculations proffered by MTF staff are not in fact the determinations rendered by the PEB.

(5) The physician counseling the patient about his or her referral to any MEB will appropriately annotate this counseling in the patient's medical record as described in MANMED article 18-8.

18-8 Health Record Entries, Record Keeping Requirements, and Transient Monitoring Unit (TMU) Inspections

(1) ***Health Record Entries***

(a) Immediately upon concluding that a patient is to be referred to an MEB, the attending physician determining the need for the patient's referral, will personally annotate this decision in the patient's medical record.

(b) Entries in the health record to appropriately document a patient's being referred to an MEB, must include the date of the evaluation resulting in an MEB referral, the diagnosis, and the recommended disposition and must appear at:

(1) SF 600, Chronological Record of Medical Care.

(2) DD 2766, Adult Preventive and Chronic Care Flowsheet, (which replaced the "Summary of Care" and "Problem Summary List") at page 1, section 4, under "Hospitalizations/Surgeries" or the NAVMED O/P 6150/43 (3-2004), Deployment Health Record.

(c) In addition to these entries, health record entries are also required pursuant to investigations and preliminary inquiries in cases requiring LOD/M determinations; refer to article 18-16 for amplifying information.

(d) Additionally, a complete copy of the MEBR and all supporting documentation must be maintained permanently in the patient's health record. This requirement includes the NAVMED 6100/5, Abbreviated Medical Evaluation Board Report, if this form is used to place an enlisted Sailor or Marine on LIMDU. (Refer to articles 18-10 and 18-17 for information on this process). This requirement also includes the NAVMED 6100/6, Return of a Patient to Duty from Limited Duty. (Refer to article 18-10 for information relative to returning patients from LIMDU.)

(e) In addition to health record entries, information on each patient referred to an MEB must be entered into the MedBOLTT system (or any system that should replace it), as described in detail in article 18-27.

(2) ***Record Keeping Requirements.*** All MTFs will maintain all records on MEB cases for a minimum of 2 years, prior to retiring the records. Retirement requirements appear in MANMED chapter 16.

(3) ***TMU Inspections.*** In recognition of the force readiness issues represented by patients undergoing MEB review, The Chief, Naval Personnel (NAVPERS) and Commander, Enlisted Personnel Management Center (EPMAC) through the OIC TMU, evaluate MTF performance in the execution of MEB processing. The TMU evaluates MTF efficiency in support of the Transients Patients Prisoners Holdees (TPPH) pipeline. The TMU will communicate directly to the MTFs their anticipated inspection schedules, and direct liaison between the MTFs and the TMU pursuant to TMU TPPH inspections is authorized. Excellence in the effective management of the MEB process is recognized by TMUs awarding the "Certified Pipeline Mover's Award" to deserving MTFs. Inspection criteria are available directly from the TMU at: http://www.epmac.nola.navy.mil/tmu.

18-9 Gathering Patient Data and Completing the Patient Information Sheet

(1) Immediately after being notified by their attending physician of being referred to an MEB, patients will be directed by their physician to report to the MTFs patient administration/MEBs office.

(2) The information contained in an MEBR plays a critical role in determining the rights of the member to potential benefits (e.g., compensation, promotion, medical separation or retirement, income tax exemptions, etc.) should the case be referred to the PEB. Accordingly, the CA, MEB members, and the MEB staff at each MTF must ensure that all appropriate information is adequately captured. This information includes data on the clinical presentation of the patient's case, as well as vital administrative facts. An essential first step in the appropriate collecting of the administrative information vital to processing an MEBR is the patient information sheet.

(3) The patient information sheet appears in MedBOLTT, (and systems that may replace it) and may be locally developed at each MTF where a CA is present. A comprehensive patient information sheet will obtain information from the patient on at least the following:

(a) Patient's full first, middle, and last name.

(b) Patient's social security number.

(c) Patient's date of birth.

(d) Patient's parent command and patient's present duty location, including complete mailing

addresses, telephone numbers, plain language address for routing naval message traffic, and name of division officer, leading chief petty officer (LCPO), or direct supervisor.

Note: These will not necessarily be identical in the case of, for example, deployed aviation squadrons. It is vital that complete information be obtained so that all appropriate elements of the chain of command receive the initial and update naval message traffic relative to their servicemembers in the MEB process, and so that the appropriate command can be queried for NMA and LODD/I documentation. This information is also vital in determining appropriate MTF Operational Forces Medical Liaison Services Office and/or medical holding company actions.

(e) Patient's home address and telephone number.

(f) Patient's marital status and status or location of dependent family members (again, this information is vital in determining how MTF patient administration and operational liaison officers can best serve our patients and their family members at the time the patient enters the MEB process).

(g) Patient's branch of service (i.e., USN, USMC, USNR, USMCR, USA, USAR, USAF, USAFR, USCG, PHS, or NOAA).

(h) Patient's status (e.g., active duty, active reservist, inactive reservist, etc.). The designation "-R" must appear when the patient is an inactive reservist (e.g., USNR-R).

(i) Patient's pay grade and rank (and, for USN and USCG enlisted personnel, rate).

(j) Patient's Navy enlisted classification (NEC) (enlisted), or designator and Naval officer billet classification (NOBC) (officer), or military occupational specialty (MOS) (Marine Corps, Army, and Air Force officer and enlisted, as practical).

(k) Patient's end of obligated service (EAOS) or end of service (EOS). This information is critical to appropriately notify service headquarters of conflicts between an impending discharge and a medical condition necessitating referral to a medical board.

(l) Patient's length of service, reported in terms of years and months (i.e., YY (years), MM (months)). This figure must match the length of service data presented in the MEB.

(m) Patient's retirement or separation date for patients who have a mandatory retirement or separation date (e.g., for high year tenure) or who have requested retirement and have received a retirement or Fleet/Marine Corps Reserve date from service headquarters.

(n) Patient's attending physician.

(o) Patient's primary care manager/TRICARE prime enrollment site.

(p) Patient's diagnosis/diagnoses (as indicated in health record, per physician).

(q) Patient's limitations, if any, regarding physical activity and/or needed proximity to an MTF (as indicated in health record, per physician).

(r) Identification of whether patient has ever been referred to an MEB for either temporary LIMDU or adjudication by the PEB, and if so, dates, MTF's convening the board(s), and outcomes. Space for any additional information patient wants to provide may be attached to the sample patient information sheet on the next page.

(s) The following is an example of a comprehensive patient information sheet developed by the National Naval Medical Center.

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK

SAMPLE FORMAT
PATIENT INFORMATION SHEET

Date: _____

Case Manager: _____

MEDICAL EVALUATION BOARDS SERVICE
NAVAL MEDICAL CENTER/HOSPITAL_____
ADDRESS _____
CITY, ST _____
TELEPHONE: _____ DSN: _____
FAX: _____

REVISED: JANUARY 2004

FOR MEDICAL EVALUATION BOARDS SERVICE OFFICE USE ONLY

Select Military Service: ☐ USN ☐ USA ☐ USAF ☐ USMC ☐USCG ☐ MILITARY ACADEMY_____
☐ OTHER: _____
RESERVIST: ☐ YES ☐ NO

Required messages:
☐ INITIATE NOTIFICATION MESSAGE
☐ INITIATE A HOLD SEPARATION MESSAGE
☐ RETIREMENT IN ABEYANCE MESSAGE
☐ LINE OF DUTY INVESTIGATION/DETERMINATION (LODI/LODD) MESSAGE
☐ NON MEDICAL ASSESSMENT MESSAGE

Type of Medical Evaluation Board:
☐ FIRST PERIOD OF LIMITED DUTY (FPLD): ≤6 MONTHS
☐ SECOND PERIOD OF LIMITED DUTY: ≤6 MONTHS
NOTE: FIRST AND SECOND PERIODS OF TLD CANNOT EXCEED 12 TOTAL MONTHS FROM THE DATE OF THE START OF THE FIRST LIMITED DUTY PERIOD
☐ THIRD OR GREATER PERIOD OF LIMITED DUTY (=DEPARTMENTAL REVIEW TO SERVICE HQ)
☐ PHYSICAL EVALUATION BOARD (PEB)

Additional requirements:
☐ NON-MEDICAL ASSESSMENT
☐ SINGLE SIDED COPY OF HEALTH RECORD
☐ PROFESSIONAL AFFAIRS LETTER
☐ PHYSICAL EXAMINATION
☐ NOTICE OF ELIGIBILITY (NOE)
☐ COPY OF MOBILIZATION ORDERS

☐ ALL PREVIOUS LIMDU AND PEB MEDICAL EVALUATION BOARD (S) (Enter date: dd/mmm/yyyy)

_____/_____/_____

ADDENDUM / ADDENDA REQUIRED:

☐ ALLERGY
☐ CARDIOTHORAIC/CARDIOLOGY
☐ CHIROPRACTIC
☐ DERMATOLOGY
☐ DENTAL SURGERY
☐ EENT
☐ ENDOCRINOLOGY
☐ GASTROENTEROLOGY
☐ GENERAL MEDICINE
☐ GENERAL/PLASTIC SURGERY
☐ HEMA/ONCOLOGY
☐ INFECTIOUS DISEASE
☐ INTERNAL MEDICINE
☐ NEPHROLOGY
☐ NEUROLOGY
☐ NEUROSURGERY
☐ OB/GYN
☐ OPTHALMOLOGY
☐ ORTHOPEDICS
☐ PAIN CLINIC
☐ PODIATRY
☐ PSYCHIATRY/PSYCHOLOGY
☐ PULMONARY
☐ RAD/ONCOLOGY
☐ RHEUMATOLOGY
☐ UROLOGY
☐ VASCULAR SURGERY

Instructions: The information requested below is vital in processing your Medical Evaluation Board. Please answer all questions. Please **DO NOT** use abbreviations. All information requested on these pages is for use of the MEB Service Office and the Disability Evaluation System Counselors. If you are uncertain of any question or need assistance in completing the form, please ask for assistance. The Privacy Act of 1974 protects this information.

SECTION 1: PATIENT INFORMATION

NAME _____ SSN: _____/_____/_____ RACE: _____
LAST FIRST MI

DESIG/MOS/AFSC/NEC: _____ JOB TITLE: _____ BRANCH OF SERVICE:_____
(e.g., Infantry, Med Tech, Boatswain Mate)

RANK/GRADE: _____ RATE: _____ DATE OF BIRTH: _____ SEX: ☐ FEMALE ☐ MALE
(dd/mmm/yyyy)

LOCAL MAILING ADDRESS:

_____

PERMANENT HOME ADDRESS:

_____

LOCAL TELEPHONE NUMBER:

_____

PERMANENT TELEPHONE NUMBER:

_____

E-MAIL: _____
(List only official military/.mil e-mail address)

SECTION 2: MILITARY SERVICE INFORMATION

LENGTH OF SERVICE: _____YRS. _____MOS. HIGH YEAR TENURE DATE: _____ (dd/mmm/yyyy)

EAOS/EAS: _____ END OF ACTIVE OBLIGATED SERVICE (dd/mmm/yyyy) PEBD: _____ PAY ENTRY BASE DATE (dd/mmm/yyyy)

DO YOU HAVE A VOLUNTARY RETIREMENT DATE? ☐ YES ☐ NO PROVIDE DATE: _____(dd/mmm/yyyy)

DO YOU HAVE A MANDATORY RETIREMENT DATE? ☐ YES ☐ NO PROVIDE DATE: _____(dd/mmm/yyyy)

ARE YOU AN ACTIVE RESERVIST? ☐ YES ☐ NO ARE YOU A DRILLING RESERVIST? ☐ YES ☐ NO

ARE YOU IN THE USNR/FTS(formerly TAR?) ☐ YES ☐ NO ARE YOU ON ADSW? ☐ YES ☐ NO

ARE YOU AN OFFICER CANDIDATE? ☐ YES ☐ NO

For Reserve Component Members: HAS A NOTICE OF ELIGIBILITY (NOE) BEEN ISSUED/REQUESTED? ☐YES ☐ NO NOE DATE:_____ (dd/mmm/yyyy)

SECTION 3: COMMAND INFORMATION

YOUR PERMANENT COMMAND/SHIP/DUTY STATION (INCLUDE CITY/STATE/NAME OF BASE WHERE COMMAND IS LOCATED) and any command to which you are currently TAD/TEMDU/ADDU: _____

DEPARTMENT NAME OR CODE IN WHICH YOU WORK: _____

IMMEDIATE SUPERVISOR'S NAME/TELEPHONE NUMBER: _____

DUTY TELEPHONE NUMBER: (_____)_____ DSN PREFIX: _____ UIC/RUC_____

COMMAND'S PLAIN LANGUAGE ADDRESS (PLAD): _____

ARE YOU IN RECEIPT OF ORDERS? : ☐YES ☐NO IF YES, TO WHAT COMMAND? _____

PERSUPPDET'S ADDRESS/ADMIN SHOP: _____ PSD UIC or S1 Shop:_____

SECTION 4: PATIENT RECORDS INFORMATION

WHERE IS YOUR SERVICE RECORD/BOOK MAINTAINED? _____

WHERE IS YOUR HEALTH RECORD MAINTAINED? _____

WHERE IS YOUR DENTAL RECORD MAINTAINED? _____

SECTION 5: MEDICAL CONDITION INFORMATION

WHAT IS YOUR DIAGNOSIS? _____

WHAT IS THE CAUSE OF YOUR MEDICAL PROBLEM? (PLEASE SELECT ONE OF THE ITEMS LISTED BELOW):

☐ BATTLE CASUALTY ☐ ACCIDENT ☐ MOTOR VEHICLE ACCIDENT
☐ SPORT/PT INJURY ☐ DISEASE ☐ ASSAULT BY ANOTHER
☐ FALL ☐ OTHER: (Please explain below)

_____

_____

IF THE PROBLEM WAS DUE TO TRAUMA, INJURY OR AN ACCIDENT, PLEASE PROVIDE A BRIEF STATEMENT WITH DATE AND CIRCUMSTANCES BELOW:

_____

_____

WHAT COMMAND WERE YOU ATTACHED TO AT THE TIME OF YOUR ACCIDENT/INJURY? _____

WAS A LINE OF DUTY INVESTIGATION (LODI) CONDUCTED? ☐ YES ☐ NO

IF YES, WHAT COMMAND CONDUCTED THE LODI? _____

_____

_____

SECTION 6: MEDICAL BOARD INFORMATION AND HISTORY

WHAT TYPE OF MEDICAL EVALUATION BOARD IS YOUR HEALTH CARE PROVIDER RECOMMENDING? (Please select one item below)

☐ FIRST PERIOD OF LIMITED DUTY
☐ SECOND PERIOD OF LIMDU
☐ THIRD OR SUBSEQUENT PERIOD OF LIMDU (=DEPARTMENTAL REVIEW)
☐ PHYSICAL EVALUATION BOARD (PEB)
☐ RETURN TO MEDICALLY UNRESTRICTED DUTY
☐ OTHER:

HAVE YOU EVER HAD A MEDICAL EVALUATION BOARD (PEB/LIMDU) BEFORE? ☐ YES ☐ NO IF YES, PLEASE LIST THE DATE (S) AND LOCATION (MTF THAT CONVENED THE MEB) BELOW:

(1) _____
(2) _____
(3) _____

IS THIS MEDICAL TREATMENT FACILITY (MTF) YOUR PRIMARY CARE MANAGER (PCM) MTF? ☐ YES ☐ NO
IF NOT, WHICH MTF IS YOUR PCM PROVIDER? _____

WHO IS YOUR PRIMARY CARE PROVIDER (PCP)? _____

WHO IS YOUR ATTENDING HEALTH CARE PROVIDER/SPECIALIST AT THIS MTF? _____

WHICH SPECIALTY CLINIC IS FOLLOWING YOUR CASE? _____

WHAT OTHER CLINICS/PHYSICIANS ARE TREATING YOU AND FOR WHAT CONDITION?

CLINIC: _____PHYSICIAN: _____ CONDITION: _____

CLINIC: _____PHYSICIAN: _____ CONDITION: _____

CLINIC: _____PHYSICIAN: _____ CONDIITON: _____

DO YOU HAVE ANY PENDING SURGERY? DATE: _____ PROCEDURE: _____ MTF_____

☐ YES ☐ NO DATE: _____ PROCEDURE: _____ MTF_____

SECTION 7: DISCPLINARY ACTION INFORMATION

ARE YOU CURRENTLY PENDING ANY DISCIPLINARY ACTION? ☐ YES ☐ NO

SECTION 8: GENERAL INFORMATION

DISABILITY TRANSITION ASSISTANCE PROGRAM: I have been informed that if I am being referred to the Physical Evaluation Board I must call and reserve a seat in the Disability Transition Assistance Program (DTAP) Class. @ xxx-xxx-xxxx. I understand that I must be scheduled to attend the next class and it is to my advantage to attend this class. I also understand that failure to attend may result in administrative action being taken. Member's Initials: _____

PHYSICAL EXAMINATION: If I am being referred to the Physical Evaluation Board I must schedule a Physical Examination within 72 hours of completing this form. Member's Initials: _____

MEDICAL RECORD: If I am undergoing a Physical Evaluation Board, I understand that I am to work with the Medical Evaluation Boards Service Office to ensure they receive a complete copy of my health record within 5 working days of completion of this form. Medical record is due by _____ (dd/mmm/yyyy). Member's Initials: _____

NON-MEDICAL ASSESSMENT AND NARRATIVE SUMMARY: I am aware that my commanding officer or his/her designated representative has the responsibility to complete and submit a Non-Medical Assessment (NMA) and Narrative Summary within the time frame as specified by the Secretary of the Navy directive 1850.4 series. (NOTE: For PEB and Marine Departmental Review cases only.) Member's Initials: _____

MEDICAL HOLDING COMPANY: I understand that if I am currently stationed in some OCONUS location overseas or attached to a deployable unit that I may be required to check-in to the Medical Holding Company, Bldg. xxx. In some rare instances, if I am required to receive frequent care at NAVHOSP_____ on an ongoing/ weekly basis and I am at a shore facility located greater than 50 miles from NAVHOSP I may be required to check-into the Medical Holding Company IAW BUPERSINST1360.72 series Member's Initials: _____

REBUTTAL: I understand that I am required to review and sign my Medical Evaluation Board Report when it has been prepared. If I desire I may submit a rebuttal to the MEBR; however, I understand that I have 5 working days to submit the rebuttal or my acceptance of the findings of the Medical Evaluation Board Report will be presumed and the MEBR and all accompanying documentation will be forwarded to higher authority without my rebuttal. Member's Initials: _____

CONVALESCENT/REGULAR LEAVE: I understand that if I am going on convalescent/ regular leave that I must provide the Medical Evaluation Boards Services Office with a leave address and telephone number where I may be reached during the leave period. Member's Initials: _____

SURGICAL PROCEDURES: I understand that I am to notify the MEBs Services Office prior to undergoing any planned (i.e., not emergency) surgical procedures as such procedure(s) may have a critical impact on my MEB process. Member's Initials: _____

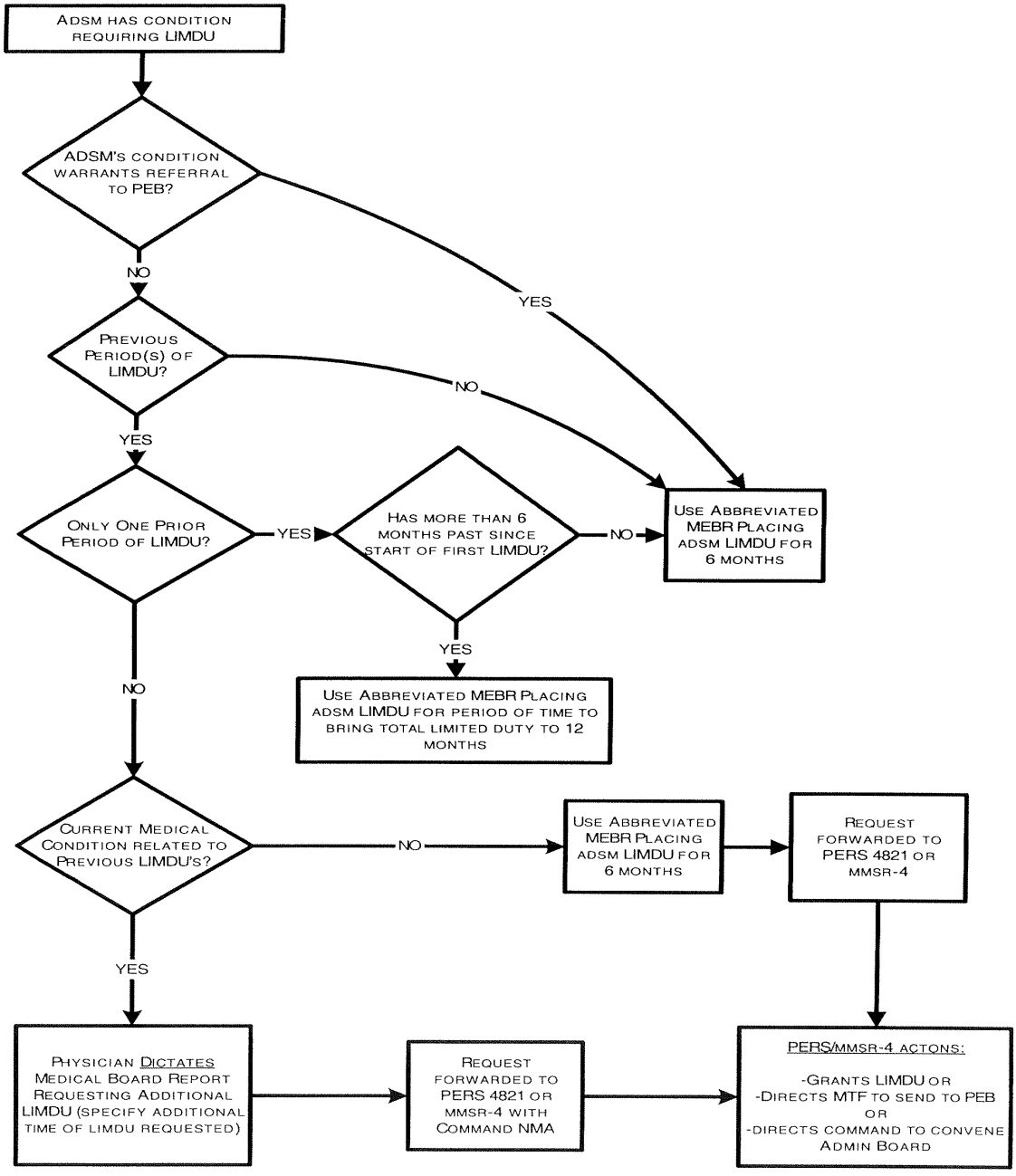
I hereby certify that the above information is accurate, correct, and complete to the best of my knowledge.

PATIENT'S SIGNATURE: _____ DATE: _____

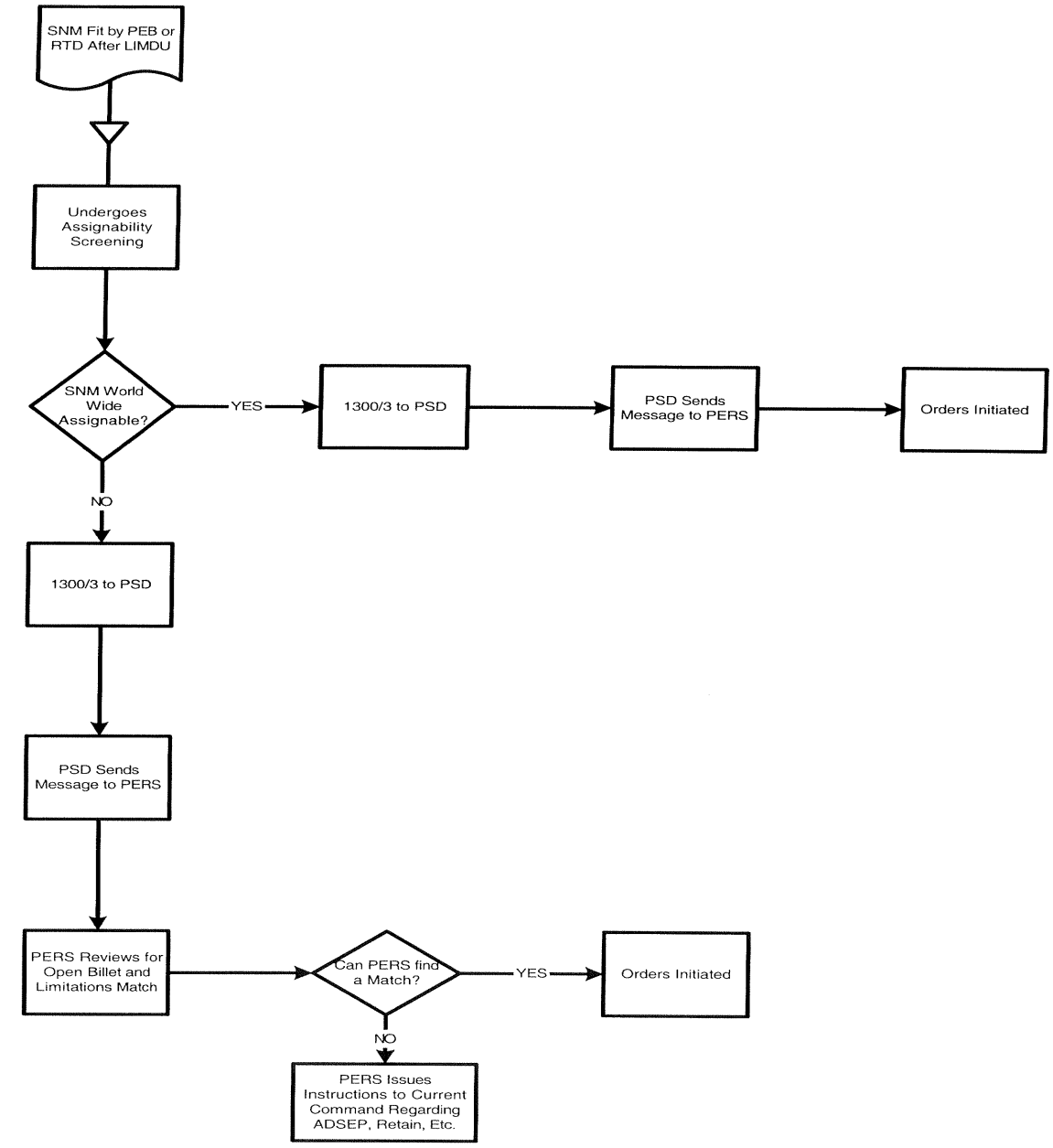
MEDICAL EVALUATION BOARDS SERVICE ACCEPTING OFFICIAL'S SIGNATURE:_____ DATE: _____

PRINTED LAST NAME OF ACCEPTING OFFICIAL:_____

OVERVIEW OF LIMITED DUTY



OVERVIEW OF LIMITED DUTY
(CONTINUED)



18-10 Limited Duty

(1) ***Limited Duty (LIMDU).*** As defined in article 18-2, LIMDU is a documented period of medically restricted duty, in consideration of a patient's illness, injury, or disease process. LIMDU may only be provided a patient as the result of the actions of an MEB properly convened at an MTF. LIMDU is a period when the member reports to their workspace, but during the period the member is excused from the performance of certain aspects of military duties, as defined in their individual LIMDU write-up. During LIMDU, the patient undergoes continuing care, recovery, and rehabilitation aimed at returning the member to a medically unrestricted duty status. For this chapter, and in the actions of all MEBs throughout Navy Medicine, "limited duty" will refer to temporary limited duty. Temporary limited duty is also known as LIMDU and/or TLD; these terms are used interchangeably throughout this chapter.

(a) ***Placement on LIMDU*** is most appropriate only for those patients for whom a return to medically unrestricted status is anticipated. (The exception to this policy is those cases in which a significant illness or injury necessitates ongoing patient care to maximize the therapeutic benefit derived by the patient prior to the patient's referral to the PEB pursuant to the SECNAVINST 1850.4 series.) Additionally, a patient whose case is referred to the PEB for DES adjudication, if the patient is not already in a LIMDU status, will be concurrently placed on LIMDU pending the PEB outcome. The Abbreviated Limited Duty MEBR detailed in article 18-17 may be used for this purpose.

(b) ***LIMDU is a Personnel and a Medical Function.*** The respective service headquarters (i.e., NAVPERSCOM and HQMC) sets LIMDU policy and provides program oversight for members on LIMDU status. For Navy personnel, the controlling agency for LIMDU is PERS-4821; for Marine Corps personnel, it is MMSR-4. These service headquarters publish directives for the operation of LIMDU programs in: for Navy, the MILPERSMAN, and for Marine Corps, the Marine Corps Separation and Retirement Manual (MARCORSEPMAN).

(2) ***Temporary vs. Permanent LIMDU.*** This chapter of MANMED deals exclusively with temporary LIMDU. Programs for permanent LIMDU are exclusively under the purview of HQMC and NAVPERSCOM, and members are only eligible to request consideration for permanent LIMDU for medical conditions after a finding of "unfit for continued Naval service" has been rendered by the PEB per SECNAVINST 1850.4 series. For this chapter, and in the actions of all MEBs throughout Navy Medicine, "limited duty" will refer to TLD. TLD is also known as LIMDU; these terms are used interchangeably throughout this chapter.

(3) ***Light Duty vs. Limited Duty.*** Article 18-2 thoroughly delineates the various categories of removal from duty for medical reasons of a Navy or Marine Corps ADSM and should be reviewed for a more comprehensive discussion of light duty policy. LIMDU is similar in many respects to light duty; major differences between the two are that LIMDU periods:

(a) Last longer than light duty periods.

(b) Require notification to not only the parent command, but to the supporting personnel support detachment (PSD) or administrative office and to the respective service headquarters of the member's status.

(c) May necessitate the transfer of the member from the parent command if it is a deployable unit.

(d) Do not necessarily require the consent of the member's parent command, or of the respective service headquarters. Certain MTF commanders possess, by virtue of their position, "convening authority (CA)" allowing them to empanel MEBs. Should such an empanelled MEB recommend LIMDU for a patient it evaluates, the MTF commander or CA can concur with the MEBR and, provided the LIMDU period is scheduled for no more than 6 months and will be the first LIMDU in an enlisted Sailor or Marine's career, place the patient on LIMDU without further referral to the parent command or to service headquarters for concurrence. Second TLD periods for enlisted Sailors and Marines also may be ordered by the MTF CA without referral to service headquarters so long as the total time of the first and second periods does not exceed 12 total cumulative months from the date of the first TLD period. All

TLD for officers must be requested and approved by the respective service headquarters. All third or greater, or other TLD period requests resulting from additional medical conditions arising in the member's career, must be submitted for approval to PERS-4821 or HQMC MMSR-4. The CA must ensure in all LIMDU cases that there are appropriate business practices to alleviate undue burden on both the patient and the patient's parent command. As detailed in article 18-2(4), light duty may be most clinically appropriate prior to referral to an MEB for LIMDU placement. Light duty presumes frequent provider and patient interaction to determine whether return to medically unrestricted duty status or more intensive therapeutic intervention is appropriate in any given case. Therefore, if used, light duty will be ordered in periods not to exceed 30 days to ensure appropriate patient oversight. Consecutive light duty for any "new condition" up to 90 days may be ordered by the provider (in maximum 30-day periods) but ***in no case*** will light duty exceed 90 consecutive days, inclusive of any convalescent leave periods. At the end of the light duty period, the member will either be immediately returned to medically unrestricted duty or will be referred to an MEB placing the member on TLD and/or referring the member to the PEB for DES processing.

(4) ***Convening an MEB for Placement on LIMDU.*** An MEB must be convened to place or recommend to the service headquarters placement of a member on LIMDU. (Article 18-3 guidance on convening MEBs must be complied with; as defined there, only MTFs with CA, (i.e., the naval medical centers, naval hospitals, naval medical clinics, and naval ambulatory care centers) may execute MEBs.) Branch medical clinics, by definition, do not have a CA; neither do surgeons of operational units or medical officers of ships. Accordingly, these organizations and their providers cannot unilaterally dictate LIMDU MEBRs or unilaterally place a service member on LIMDU. Only MTFs with CA can effect a LIMDU placement. (See article 18-3(4) for discussion of the initiation of MEBRs for placement on LIMDU by branch clinics.)

(5) ***Length of LIMDU Periods***. Length is established by the respective service headquarters at a maximum of 6 months for any LIMDU period.

(6) ***Number of LIMDU Periods Per a Career*** that can be granted to an ADSM by an MTF CA, without referral to service headquarters, is set at a maximum of two periods not to exceed 12 months cumulatively. Any additional TLD period requests must be forwarded by the MTF to service headquarters (for Navy personnel, PERS-4821 or for Marine Corps, MMSR-4) for approval. The underlying logic of establishing a career maximum for LIMDU periods is to ensure that, rather than undergoing multiple consecutive periods of LIMDU for the same or closely interrelated diagnoses, patients are either returned to medically unrestricted duty or referred for DES adjudication as clinical circumstances dictate. MTFs are to ascertain information on the number of previous LIMDU periods through interviews of patients (see article 18-9), medical records reviews, and queries to the MedBOLTT, or systems that may replace it (see article 18-27).

(7) ***Abbreviated MEBRs for LIMDU Periods.*** To facilitate appropriate clinical and administrative case management while curtailing overly burdensome paperwork requirements, MTFs can rely on the NAVMED 6100/5, "Abbreviated Limited Duty Medical Board Report" for the following LIMDU actions:

(a) First periods of LIMDU in the career of enlisted Sailors or Marines that are < 6 months (no referral to service headquarters necessary).

(b) Second LIMDU periods for enlisted Sailors and Marines that are < 6 months (no referral to service headquarters necessary). Note that the first and second TLD periods cannot exceed 12 months cumulatively from the date of the first TLD period.

(c) First and second LIMDU periods for Navy and Marine Corps officers (for referral to service headquarters for "departmental review").

(d) Third or subsequent LIMDU periods on Navy and Marine Corps ADSM involving a distinctly different condition than that responsible for the first and/or second TLD periods (for referral to service headquarters for "departmental review").

(e) Placement on LIMDU, if the patient is not already in a LIMDU status, at the same time the patient's case is referred to the PEB for adjudication.

Any other LIMDU requires a dictated MEBR to be sent to respective service headquarters. Use of any editions before NAVMED 6100/5 (Rev. 8-2004) are immediately prohibited. MTFs using the "Abbreviated MEBR" for LIMDU are reminded that the MTF's LIMDU recommendation is not deemed final until the CA of the MTF has signed the MEBR. MTFs must be mindful that, given the nature of LIMDU as both a medical and personnel function, specificity of information necessary for the appropriate clinical and administrative case management of patients entered into LIMDU status is vital. Patients placed on LIMDU via the abbreviated MEBR must be recorded into MedBOLTT (or systems that replace it; see article 18-27). Use the approved NAVMED 6100/5 (Rev. 8-2004) in article 18-17.

(8) ***Dictated MEBRs*** are required for LIMDU situations not discussed in the preceding paragraph which require referral to service headquarters for "departmental review." A sample of the dictation report format appears in article 18-14. It is the prerogative of service headquarters in these and all cases referred for departmental review to deny "LIMDU" status and order instead referral of the case to the PEB for adjudication. Cases in which service headquarters deny an MTF's LIMDU recommendation and order instead the patient's referral to the PEB will be returned for appropriate action to the MTF originating the LIMDU request to convert the MEBR into a PEB case. The CA and the patient administration or MEBs officer will ensure all appropriate patient counseling (as defined in article 18-7 and other applicable directives) occurs, and will ensure that appropriate reporting via naval message traffic to the patient's parent command, servicing personnel headquarters, and service headquarters is completed.

(9) ***Contents of the MEBR Package Submitted to Service Headquarters.*** Cases defined in article 18-10(8) as those being referred to service headquarters will take the following format:

(a) For USMC Members: (case referred to MMSR-4).

(1) Dictated or Abbreviated MEBR (as appropriate).

(2) MEBR Cover Sheet, NAVMED 6100/1 (Rev. 8-2004).

(3) NMA following the format contained in SECNAVINST 1850.4 series.

(b) For Navy Members: (case referred to PERS-4821).

(1) Dictated or Abbreviated MEBR (as appropriate).

(2) MEBR Cover Sheet, NAVMED 6100/1 (Rev. 8-2004).

(3) NMA following the format contained in SECNAVINST 1850.4 series.

Note: This requirement differs from previous guidelines in that complete medical record copies and all other supporting documentation (i.e., the contents of a case referred to the PEB) are no longer required by service headquarters to evaluate LIMDU case decisions.

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(10) ***Patients in LIMDU Status Following Failure of Suitability Screening.*** BUMEDINST 1300.2 series details the process for the suitability screening processes. For patients that have been placed on a LIMDU period subsequent to failing a suitability screening, the follow-up requirements are more frequent than those for patients otherwise entered into LIMDU. In general, patients on LIMDU pursuant to BUMEDINST 1300.2 series provisions will be evaluated at recurring intervals not to exceed 2 months until a final resolution of the case is determined. Consult BUMEDINST 1300.2 series for additional information.

(11) ***Returning a Patient To Duty From LIMDU Status***

(a) The attending physician may clear a patient from LIMDU at any clinically appropriate point during the course of LIMDU (i.e., the return to duty does not have to be deferred until the originally scheduled end of the LIMDU period). A return to duty from LIMDU status does not necessitate the convening of an MEB, but does require the approval of the CA (or his or her designee for signatory responsibility, as defined in article 18-3) prior to becoming effective.

(b) The attending physician shall record the information relevant to the return to medically unrestricted duty in the patient's medical record using the NAVMED 6100/6 (8-2004), Return of a Patient to Medically Unrestricted Duty from Limited Duty. A note merely stating "returned to duty," "fit for

duty," or using similar language is clinically insufficient and not appropriate. The NAVMED 6100/6 (Rev. 8-2004) appears at the end of article 18-10. The NAVMED 6100/6 (8-2004) note must depict the findings, prognosis, and any residual effects that may be apparent; additionally, clinically appropriate information must be annotated on the patient's DD 2766 (Adult Preventive and Chronic Care Flow Sheet) at page 1, section 4, under "Hospitalizations/Surgeries."

(c) The physician will counsel the patient of the return to duty status. The physician will ensure that the patient–with the completed NAVMED 6100/6 (Rev. 8-2004) and the medical record–presents immediately following the determination that a return to medically unrestricted duty is clinically appropriate to the MTF patient administration/MEBs office for appropriate counseling, and to ensure appropriate notification processes are completed. The patient administration/MEBs office will ensure that the NAVMED 6100/6 (Rev. 8-2004) is expeditiously delivered to the CA for signature. All MTF personnel involved with returning patients to medically unrestricted duty from LIMDU must ensure that all stakeholders are aware that the return to medically unrestricted duty is not effective until signature by the CA, and that this action will be reported to the member, the member's parent command, and the service headquarters via message traffic.

(d) The MTF clearing a patient from LIMDU status will ensure via naval message traffic that the patient's parent command, any command to which the patient may be TAD for treatment, the supporting PSD or administrative office, the TMU, and the respective service headquarters are notified of the return to medically unrestricted duty status within 3 working days of the determination. For Marines, the return to duty message will include as an addressee MMSR-4; for Navy members, the message will include as addressees COMNAVPERSCOM-4 and COMNAVPERSCOM-4821.

(e) A return to duty from LIMDU is not an adverse action, and accordingly does not automatically confer rights of appeal to the patient. There may be cases, however, where patients wish to contest a return to duty from LIMDU. In such cases, resolution should first be attempted between the attending physician, the attending's department head or director, and the patient, in accordance with avenues prescribed for resolving any difference of opinion about a course of medical care. Should this review uphold the return to medically unrestricted duty status, the servicemember will be "made available" to the service headquarters, and message notification as described in the preceding paragraph will be initiated. The member will be advised of this action, as well as of the opportunity to submit to the CO of the MTF, via the member's CO, written appeal to the "return to duty" determination. The appeal package should include objective statements from the member regarding the basis of the appeal, as well as copies of all pertinent medical documentation. The package should also include the NMA prepared by the member's CO pursuant to the LIMDU board. (If an NMA was not previously prepared, information from the member's CO following the format of an NMA (as defined in SECNAVINST 1850.4 series) must be included in the appeals package.) Should the appeal process yield a determination that the return to duty from LIMDU is clinically appropriate, the MTF will report this information to the patient and the patient's parent command, as well as to the appropriate Service headquarters, for their resolution of the matter as a personnel vice a medical issue.

(12) ***The MTF LIMDU Coordinator.*** To comport to the requirements of MILPERSMAN articles 1306-1200 and 1301-225 (for Navy enlisted and officer personnel, respectively) and to ensure appropriate service from the MTFs to the parent commands of members placed on LIMDU, each MTF with CA will appoint, in writing, a LIMDU coordinator, preferably at least holding the rank of chief petty officer or equivalent. While the management of members in LIMDU remains the responsibility of those members' respective COs, and not the MTFs, the MTFs can and must contribute significantly to the successful administration of this population through appropriate liaison by MTF personnel with those commands who have LIMDU members. Monthly LIMDU coordinators meetings, timely evaluation appointment scheduling, and appropriate contact with regional commands are among the responsibilities envisioned for the LIMDU coordinators. The effectiveness of the LIMDU coordinators is one of the key areas evaluated by the TMU relative to their site visits and consideration of awarding of the "Certified Pipeline Movers Award" in the Transient, Patient, Prisoner, Holdee (TPPH) and student pipelines. Each MTF with CA will ensure the placement and effectiveness of a representative into this key role as a vital liaison with the Fleet regarding patients in a medically restricted status.

RETURN OF A PATIENT TO MEDICALLY UNRESTRICTED DUTY FROM LIMITED DUTY

SECTION 1: CLINICAL INFORMATION - TO BE COMPLETED BY MEDICAL OFFICER

Date: _____ Patient Name: _____ Patient SSN: _____

(Last, First, MI)

Diagnosis: (1) _____ ICD-9 CM Code _____

(2) _____ ICD-9 CM Code _____

Notes on return to duty, including findings, prognosis, and any residual effects:

_____

_____

_____

_____

_____

_____

Effective date (Proposed) of return to Unrestricted Duty: _____

_____
Printed physician name/signature/date

Returned to duty (select one):

☐ Disapproved

☐ Approved Effective date: _____

_____
Printed physician name/signature/date

SECTION 2: PATIENT INFORMATION - TO BE COMPLETED BY PATIENT

I have received full information on my "return to duty." I understand that my return to duty becomes effective once approved by the MTF convening authority. The MTF will report my return to medically unrestricted duty to my parent command and I will personally notify my immediate chain of command.

_____
Patient signature/date

SECTION 3: PATIENT ADMINISTRATION/MEDICAL EVALUATION BOARDS OFFICIAL

The following actions have been completed (the completing official will initial and date next to each entry):

_____ Entry into MedBOLTT

_____ Briefing to patient on limited duty/MEBs

_____ Notification to MTF LIMDU coordinator

_____ Notification to parent command

_____ Notifications to PSD/personnel office

_____
Printed patient administration/medical evaluation boards official name, signature, and date

ROUTING: Original to patient health record;copies to patient, parent command, PSD, MEBR case file, PERS-4821 or MMSR-4.

NAVMED 6100/6 (8-2004)

18-11 Determining Disability Evaluation Cases To Be Referred to the DON PEB

(1) ***General.*** The Navy DES derives from Title 10 USC 61 and is the mechanism by which retirement or separation for disability is effected for Navy and Marine Corps members. The DES provides for the removal from active duty of those members who can no longer perform the duties of their office, grade, rank, or rating owing to disability, and ensures that fair compensation is awarded to members whose military careers are cut short due to a service-incurred or service-aggravated disability.

(2) ***Implementing Directive for DES.*** The directive used for DES in the Navy and Marine Corps is the current edition of the SECNAVINST 1850.4 , the Disability Evaluation Manual. Throughout this chapter, SECNAVINST 1850.4 series and Disability Evaluation Manual are used interchangeably and are synonymous.

(3) ***Cases where a Navy or Marine Corps member's fitness for continued Naval service,*** owing to a condition that may constitute a disability, is called into question will be referred to the DON PEB for adjudication in accordance with the DON Disability Evaluation Manual. The PEB is in the organizational chain of command of the DIRSECNAVCORB, not of the Chief, BUMED. Some members may petition to waive their entitlement to PEB processing; these patients will predominantly be at the end of their obligated service and must be unwilling to be extended on active duty while their PEB case is being adjudicated. Waivers to PEB processing are submitted to the President, PEB for final approval. These voluntary waiver cases are to be contrasted with those Reserve Component (RC) patients who request to be released from active duty while their cases are being adjudicated (see article 18-23), and from those patients who have sufficient years to qualify for longevity retirement and wish to pursue this avenue rather than disability retirement or separation following a PEB determina-tion of unfitness for continued naval service (refer to SECNAVINST 1850.4, sections 3209, 3709, and enclosure (13)).

(4) ***Determining Fit or Unfit for Continued Naval Service.*** The determination that a member is fit (or unfit) for continued naval service (and if unfit, at what percentage of disability rating and which disability benefits apply) is solely and exclusively the responsibility of the PEB. Accordingly, MTFs do not determine fitness for continued service (this is not the same as determining "fit for duty" terminating a period of LIMDU, which MTFs do accomplish, as further explained in articles 18-1(2) and 18-10(11)). MTFs refer disability evaluation cases to the PEB for determination of fitness and of eligibility for disability benefits (refer to SECNAVINST 1850.4 series). As such, MTFs must be diligent in this regard to ensure that their staffs:

(a) Refrain from conveying to patients opinions on the patients' fitness to continue naval service and/or opinions on disability percentage rating and potential disability benefits until findings are received from the DON PEB.

(b) Refrain in their MEBRs from direct statements regarding whether patients are fit or unfit for continued naval service and/or opinions on disability percentage rating and potential disability benefits until findings are received from the PEB.

(5) ***Line of Duty Determinations/Line of Duty Investigations (LODD/LODI).*** MTFs shall not unilaterally decline to process and forward to the PEB MEBRs in which parent command LODD/LODI indicate a member's condition was incurred outside the line of duty and due to the member's misconduct, as final decision-making authority of this decision also rests definitively with the PEB. Article 18-16 provides more detail on LODD cases.

(6) ***Cases Involving Conditions Which May Have Existed Prior to Service (EPTS) merit special consideration.*** DOD Instruction 1332.38 (E3.P4. 5.2) and articles 3804m-3804p of the DON Disability Evaluation Manual delineate the following characteristics of EPTS considerations, but it is critical to note that exclusive and final authority for rendering EPTS determinations rests with the DON PEB, and MEBRs should accordingly refrain from presumptively labeling any condition "EPTS":

(a) Except for medical defects and physical disabilities noted and recorded at the time of entrance, any injury or disease discovered after a

servicemember enters active duty, with the exception of congenital and hereditary conditions, is presumed to have been incurred in the line of duty.

(b) Hereditary and genetic conditions shall be presumed to have been incurred prior to entry into active duty. They will be presumed service aggravated unless evidence clearly establishes that the condition is solely the time result of the condition's natural progression.

(c) Generally recognized risks associated with treating preexisting conditions shall not be considered service aggravation.

(d) Signs or symptoms of chronic disease identified so soon after the day of entry on military service (usually within 180 days) that the disease could not have originated in that short a period will be accepted as proof that the disease manifested prior to entrance into active military service (See DOD Instruction 1332.38 (E3.P4.5.4)).

(e) Signs or symptoms of communicable disease within less than the medically recognized minimum incubation period after entry on active service will be accepted as evidence that the disease existed prior to military service (See DOD Instruction 1332.38 (E3.P4.5.4)).

(f) Per service headquarters directives (e.g., MILPERSMAN 1910-130) the PEB is the final arbiter of EPTS disputes; any case which cannot be conclusively determined at the MTF level as to whether the condition actually EPTS or whether the condition was aggravated at any time after the member was enlisted or inducted will result in the convening of an MEB for referring the case to the PEB for final determination.

(g) Per the SECNAVINST 1850.4 series, enclosure (10), "servicemembers found unfit for continued naval service whose medical conditions have not been permanently aggravated by military service, i.e., "Unfit-EPTS" are not eligible for disability severance pay or disability retirement if they have less than 8 years cumulative active service." Further details on this "8-year rule" are found at enclosure (10) of the DON Disability Evaluation Manual.

(7) ***Determining Which Cases Merit Referral to the PEB for Disability Evaluation.*** MANMED article 18-4 provides guidance on determining those patients for whom referral to the PEB may be appropriate. Moreover, dilemmas at the MTF level over whether a disabling condition exists that renders a member unfit for continued naval service will be resolved by referral of the case to the PEB.

(8) ***Identifying Cases for Which PEB Referral May Not Be Appropriate.*** There are cases in which PEB referral is not appropriate; the following decision criteria will be helpful in allowing the MTF CA to determine whether an MEB for PEB referral will be convened. Additional guidance is available at article 3202 of the SECNAVINST 1850.4 series:

(a) ***The mere presence of a diagnosis does not constitute a disability.*** As stipulated in the Navy Disability Evaluation Manual (article 2068), "a medical impairment or physical defect standing alone does not constitute a physical disability. To constitute a physical disability, the medical impairment or physical defect must be of such a nature and degree of severity as to interfere with the member's ability to adequately perform his or her duties." Article 2068 of the Navy Disability Evaluation Manual continues, "that the term "physical disability" includes mental disease, but not such inherent defects as behavioral disorders, adjustment disorders, personality disorders, and primary mental deficiencies."

(b) ***Certain conditions and defects of a developmental nature are not ratable in the absence of an underlying ratable causative disorder and accordingly referral to the PEB is not appropriate.*** (Examples of these conditions appear in MANMED article 18-5 above, and in the SECNAVINST 1850.4 series, sections 2016, 3202, and attachment (b) to enclosure (8).) The PEB will reject all cases in which the sole diagnoses involve conditions not constituting a physical disability, as defined in article 2016 of the Navy Disability Evaluation Manual.

(c) Lack of motivation for performance of duty does not justify referral to the PEB.

(d) Request for referral to the PEB by the servicemember is not an independently sufficient reason for referral of a case to the PEB.

(e) Physical disqualification from special duties, such as flying, serving on submarines, or in a medical specialty, does not necessarily imply unfitness for continued naval service. Referral to the PEB is appropriate only in cases where the member's ability to reasonably perform active military service is in doubt.

(f) ***Inability to Meet Initial Enlistment/ Appointment Standards.*** Once enlisted or commissioned, the fact that a member may fall below initial entry or appointment standards, specified in MANMED chapter 15, does not require that an MEBR be referred for disability evaluation. Additional information on issues involving "Fitness to Separate" is found in article 18-25.

(g) ***Physical Fitness and Overseas/Operational Suitability Situations Are Not in-and-of Themselves Sufficient Reasons to Forward a Case to the PEB.*** The inability to meet screening criteria for a specific assignment or administrative requirement (i.e., deployment, overseas or sea duty assignment, or participation in PRT/PFT/PFA cycle) does not alone justify referral to the PEB. Referral to the PEB is appropriate only in cases where the condition appears to be permanent in nature or of such a degree as to render the member unable to return to naval service within a reasonable period. MANMED, chapter 15 and BUMEDINST 1300.2 series provide amplifying information on fitness criteria.

(h) ***Members Being Processed for Separation or Retirement for Reasons other than Physical Disability.*** Do not refer a member for disability evaluation who is being processed for separation or retirement for reasons other than physical disability, unless the member previously was found unfit but retained on active duty in a permanent limited duty (PLD) status, or the member's physical condition reasonably prompts doubt that he or she is fit to continue to perform the duties of office, grade, rank or rating/MOS.

(i) ***Cases in Which Members Have Upcoming Surgical Procedures for Diagnosis(es) Relevant to the MEBR Being Considered by the PEB.*** These cases are discussed in more detail at MANMED article 18-25. As a general protocol, patients on whom an MEBR has been prepared and submitted to the PEB should not undergo surgery for any diagnosis unless that surgery is of an emergent nature. The PEB will be consulted immediately upon the MTF becoming aware of surgery planned for a patient for whom an MEBR has been submitted to the PEB.

(j) ***Cases of Members Previously Evaluated by the PEB as Fit for Continued Naval Service Warrant Close Scrutiny by the MTF CA Prior to Any Proposed Resubmittal to the PEB.*** The President, PEB may reject any case (medical information submitted as a new MEBR, or addendum to a previous board) in which the date of the newly dictated medical information is within 6 months of the date of the PEB's notification of decision if, upon review by a medical officer assigned to the informal PEB, the medical officer advises:

(1) The condition reported does not alter the subject member's previous findings.

(2) The condition reported is not a significant deterioration of the previously reported condition.

(3) The servicemember's treatment has not significantly changed.

(4) The servicemember has required no significant outpatient treatment other than that required for maintenance.

(9) The SECNAVINST 1850.4 current edition (as modified by PEB policy letters) is the definitive governing directive on cases being referred to the PEB. As such, in any situation where MANMED Chapter 18 and SECNAVINST 1850.4, DON Disability Evaluation Manual series appear in conflict concerning cases for the PEB, SECNAVINST 1850.4 will supersede MANMED chapter 18. CAs will ensure their personnel involved in any aspect of the disability evaluation process are thoroughly versed in the provisions of the DON Disability Evaluation Manual.

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Section III
PROCESSING MEDICAL EVALUATION BOARD REPORTS (MEBRs)

18-12 Format of the MEBR for Referral to the DON PEB

(1) Once a determination is made that an MEB will be convened referring a patient's case to the PEB for disability evaluation, the MEBR becomes of critical importance in ensuring appropriate clinical and administrative management of the patient.

(2) When developing an appropriate MEBR, the following criteria defined in the DON Disability Evaluation Manual (SECNAVINST 1850.4 series) must be satisfied. CAs shall ensure that this information is conveyed to their physicians comprising MEBs. Among the CA responsibilities surrounding medical boards is that all members of any MEB, as well as all MEB's staff involved with processing and administrative overview of MEBRs, must be thoroughly familiar with this MANMED article and chapter 8 of the DON Disability Evaluation Manual. The following depict criteria provided by the PEB

for establishing a viable MEBR. A sample of an appropriate MEBR for submission to the PEB, developed in conjunction with the PEB, appears at the end of this article.

(3) ***MEBR Documentation***

(a) ***Required Information***

(1) Member's name, rank or rate, grade, and social security number.

(2) The specialty of the physicians comprising the MEB/signing off on the MEBR.

(3) The clinical department and/or service authoring or sponsoring the document.

(4) The MTF and its location.

(5) Date the MEB was conducted and date the MEBR was dictated.

(6) A legible, single-sided copy of the member's health record should accompany the MEBR. Any supplemental records should be submitted.

(7) Copies of all narrative summaries of hospitalizations and all procedure reports are to be submitted with the MEBR.

(8) Signatures of the MEB members on the NAVMED 6100/1 (Rev. 8-2004), cover sheet. Electronic signatures will not be accepted by the PEB as of this writing.

(b) ***On Each Page***

(1) Member's last name, social security number, and date typed or transcribed in bottom margin.

(2) Page number will be annotated at the bottom center of the page.

(3) Document is marked "For Official Use Only – Privacy Act Protected."

(c) ***Reason For Convening the MEB*** (e.g., physician-directed, command-directed)

(1) The mere presence of a diagnosis is not synonymous with disability. It must be established that the medical disease or condition underlying the diagnosis actually interferes significantly with the member's ability to carry out the duties of his or her rank or rate.

(2) When assessing the severity of symptoms, physicians must evaluate the subjective symptoms in light of objective findings and report discrepancies in addition to positive findings.

(d) ***Eligibility for MEB*** (i.e., duty status).

(e) ***Military Information***

(1) Date of first and most recent entry into service.

(2) Estimated termination of service (i.e., EAOS/EAS).

(3) Administrative actions ongoing, pending, or completed (e.g., LODI, courts-martial, selective early retirement, retirement, or separation dates).

(f) ***Chief Complaint.*** Preferably stated in servicemember's own words as contained in the health record.

(g) ***History of Present Illness.*** Exact details, including pertinent dates regarding illnesses or injuries, how injuries were incurred. Enclose and summarize any pertinent previous MEBRs. References to "interval history" are inappropriate as they assume that the PEB has access to the previous MEBRs which is not always the case. The author of the MEBR must give a complete history chronologically as well as simply event-based.

(h) ***Past Medical History***

(1) Past injuries and illnesses.

(2) Prior disability ratings (e.g., given by either the PEB or Department of Veterans Affairs).

(3) Past hospitalizations and relevant outpatient treatment, including documentation of diagnosis and therapy, pertinent dates, and location should be listed.

(4) Social information pertinent to the member's condition (e.g., activity level and sports activities engaged in would be pertinent to orthopedic evaluation; alcohol and drug usage rates must also be included in all cases) should be provided. (There is an inclusive list of applicable items under the specialty specific section for psychiatric disorders.)

(5) Illnesses, conditions, and prodromal symptoms, existing prior to service (referred to as EPTS or existed prior to enlistment (EPTE) conditions).

(i) ***Laboratory and Other Ancillary Studies.*** All studies that support and qualify the diagnosis(es) should be included as should any studies that conflict with the diagnosis(es).

(j) ***Present Condition/Review of Systems and Current Functional Status***

(1) Current clinical condition(s) should be noted including all current complaints and review of systems; required medications and any non-medication treatment regimens (e.g., physical therapy) in progress.

(2) Functional status

(a) The servicemember's functional status as to the ability to perform his or her required duty should be indicated.

(b) If possible, a summation of the member's ability to perform the civilian equivalent of their assigned duties should be indicated.

(3) A statement should be given regarding the prognosis for functional status after completion of treatment, if chronic treatment is not necessary.

(4) A statement should be given regarding the prognosis for functional status in cases requiring chronic treatment.

(5) The stability of the current clinical condition and functional status should be addressed.

(6) Statement of compliance with treatment recommendations and reasonableness of any refusal of recommended treatment procedures, including surgery. NAVMED 6100/4 (Rev. 8-2004) must be submitted as a portion of the MEBR when refusal of surgery or treatment is considered "unreasonable."

(7) Requirement for monitoring including frequency of indicated treatment and/or therapy visits and associated operational assignment limitations.

(k) ***Conclusions***

(1) An informed opinion should be stated as to the servicemember's ability to meet current retention standards.

(2) If a servicemember does not meet retention standards, the specific reasons why should be stated.

(3) Treatment recommendations including medications, procedures, and behavior and/or lifestyle modifications must be depicted. Include a statement concerning the member's compliance. If non-compliant, indicate whether the patient's non-compliance is reasonable.

(4) ***Under no circumstances is the narrative to indicate that the member is unfit, nor recommend a disability percentage rating.*** It is the PEB's responsibility to determine fitness and disability percentage ratings. The MEBR may state something to the effect, "the member is referred to the PEB because we are of the opinion that the member's condition may interfere with the performance of his or her duties because the member does not meet medical retention standards as described in..."

(l) ***Drug Therapy.*** There may be certain instances where a specific drug therapy may in and of itself preclude the full performance of duties. This must be stated specifically if it is the reason for the board.

(m) ***Limited Duty.*** The authoring physician should not only address previous periods of LIMDU (and what they were for) but also consider whether a member might obtain greater benefit by being referred to a LIMDU board for placement on LIMDU vice direct submission to the informal PEB. Reference to MANMED article 18-10 on LIMDU is recommended in such cases.

(n) ***Surrebuttal.*** When the member submits a rebuttal to a medical board or an addendum, the authoring physician must address the member's specific issues.

(o) ***Referral of Hospitalized Patients.*** Referral of such cases to PEB is appropriate only in the presence of significant extenuating circumstances. The MEBR will cite the reasons for continued retention in the hospital. For members who are hospitalized for an acute psychiatric emergency, the MEBR should include a mental status exam and statement of functional status within 30 days of submission of the MEBR to the PEB.

(p) ***Competency Statements.*** Competency statements are required on all psychiatric diagnoses (except where the psychiatric condition has resolved).

The statement of competency must be made by a psychiatrist, as the specific determination is to be made in accordance with the JAG Manual. Therefore, most cases that contain a psychiatric diagnosis should be referred to or evaluated by a psychiatrist.

(q) ***Trauma.*** (i.e., severe trauma and acute clinical, fulminant presentations.) In clinical situations where the level of impairment is likely to change significantly within or over the following 2 months, submission of the MEBR should be delayed until this period of time has elapsed.

Note: MANMED article 18-19(2) addresses MTF timeliness for processing MEBRs; owing to the dynamic nature of trauma cases, MTFs should refrain from dictating and submitting MEBRs to the PEB if significant change in the patient's condition—which would have a material effect on the MEBR documentation—is anticipated within a 2-month period. Patients in this condition, however should be placed on a period of LIMDU (see article 18-10) pending the resolution of the case to a sufficient point that an appropriate MEBR dictation is possible.

(1) It is important that the MEBR be dictated at the latest possible time prior to submission. This is particularly important when the MEBR is done and then months pass while waiting for completion of the LODI. If the MEBR has previously been dictated, an addendum should be included stating current condition. Statements such as "There has been no change since the previous medical board was dictated" are generally insufficient.

(2) Ensure that all of the member's complaints and conditions are addressed by the appropriate specialty in attached addenda. The authoring service, in conjunction with the MEBs department of the MTF, is responsible for ensuring that all required addenda and non-medical information are included in the original package.

(r) ***Submission of Photographs.*** Current photographs are essential in burn cases, and very useful in cases with significantly disfiguring scars. Photographs submitted should be certified, by the medical photography department, to have been taken within 1 month of the date of dictation of the MEBR.

(s) ***Organ Transplants.*** When the MTF has opted to retain the member to receive his or her transplant, the MTF will place the member on a LIMDU status pending the transplant. MEBR referral to the PEB should be delayed until the procedure has been done and the maximum therapeutic benefit of treatment has been achieved.

(t) ***TDRL Evaluations.*** Physicians performing TDRL evaluations are responsible for knowing the information contained in SECNAVINST 1850.4 series, part 6 of enclosure (3), that addresses TDRL reevaluations.

(u) ***Physical Examination (PE).*** A complete PE must be recorded in the MEBR and must have been conducted within 6 months of the date of the MEBR. For all conditions, hand dominance must be stated. Height and weight must be documented in all MEBRs (in the narrative).

(v) ***Selected Specialty-Related Considerations and Guidelines***

(1) ***Cardiology***

(a) Results of special studies to support and quantify the cardiac impairment should be noted, e.g., treadmill and thallium stress tests, angiography, and other special studies.

(b) The functional therapeutic classification of the cardiac condition must be included. Either the New York or Canadian classification system may be used (see SECNAVINST 1850.4 series, enclosure (9), attachment (b), table 3, for assessment criteria).

(c) ***General Information.*** Evaluation and reporting of cardiovascular function should be in terms of metabolic equivalents (METs) of energy expended to produce a certain level of symptoms.

1. Objective measurements of the level of physical activity, expressed as METs, at which cardiac symptoms develop is the main method of evaluating cardiovascular entities now.

2. Exercise capacity of skeletal muscle depends on the ability of the cardiovascular system to deliver oxygen to the muscle, and measuring exercise capacity can, therefore, also measure cardiovascular function. The most accurate measure of exercise capacity is the maximal oxygen uptake, which is the amount of oxygen, in liters per minute, transported from the lungs and skeletal muscle at peak effort. Because measurement of the maximal oxygen uptake is impractical, multiples of resting oxygen consumption (or METs) are used to calculate the energy cost of physical activity. One MET is the energy cost of standing quietly at rest and represents an oxygen uptake of 3.5 milliliters per kilogram of

body weight per minute. The calculation of work activities in multiples of METs is a useful measurement for assessing disability and standardizing the reporting of exercise workloads when different exercise protocols are used.

3. Alternative methods of evaluating function are provided for situations where treadmill stress testing is medically contraindicated: the examiner's estimation of the level of activity, expressed in METs and supported by examples of specific activities, such as slow stair climbing or shoveling snow that results in dyspnea, fatigue, angina, dizziness, or syncope is acceptable.

(2) ***Gastroenterology.*** Servicemembers with fecal incontinence should have recorded findings of rectal examination, e.g., digital exam, manometric studies as indicated, and radiographic studies. The degree and frequency of the incontinence should be noted as well as the incapacitation caused by the condition.

(3) ***Neurosurgery/Neurology***

(a) For vertebral disc problems, radicular findings on PE should be supported by laboratory studies such as computer-aided tomography (CT) scan, magnetic resonance imaging (MRI), electromyogram (EMG), or nerve conduction velocity (NCV). In cases where surgery has been performed, both pre- and post-operative deep-tendon reflexes should be documented.

(b) ***General***

1. ***Dementia and Head Trauma.*** Neuropsychiatric or neuropsychological assessment should be accomplished in all head injury cases. Results should be included. Neuropsychiatric or neuropsychological measurements should be performed as early as possible. Current tests (performed within 6 weeks of submission of the board) are also required.

2. ***Migraine Headaches.*** The number of incapacitating episodes (those that require the individual to stop the activity in which engaged and seek medical treatment) per week, month, or year should be noted and verified by a physician.

3. ***Seizure Disorder.*** The evaluation will be done by a neurologist. An electroencephalogram (EEG), MRI, or CT will be included in the initial examination. When subsequent seizure episodes occur while on medical therapy, blood levels of prescribed medication(s) will be determined.

4. ***Neuropathies.*** EMG and nerve conduction studies will be performed.

5. ***Multiple Sclerosis.*** Appropriate MRI(s) will be performed.

6. ***Industrial (and Industrially Related) Social Impairment.*** Estimate the degree of impairment that will be incurred by the servicemember.

7. ***Imaging Studies.*** For all neurological and neurosurgical conditions appropriate imaging studies should be obtained in concert with current standards of practice.

(4) ***Ophthalmology***

(a) If retention standards are not met for reasons related to vision, visual fields must be included in the PE and verified by an ophthalmologist. Specialist examination should include uncorrected and corrected central visual acuity. Snellen's test or its equivalent will be used and if indicated measurements of the Goldmann perimeter chart will be included.

(b) Visual field deficits must be documented on a Goldmann field chart using the III-4-e objective. Cases of diplopia must be documented using a Goldmann perimeter chart plotting the fields of diplopia.

(5) ***Orthopaedics***

(a) Range of motion (ROM) measurements must be documented for injuries to the extremities. The results of the measurement should be validated and the method of measurement and validation should be stated.

(b) In cases involving back pain, the use of Waddell's signs should be included in assessing the severity and character of the pain. (Refer to SECNAVINST 1850.4 series; also refer to Waddell G, McCulloch J.A., Kummel E, Venner R.M.. Nonorganic physical signs in low back pain. Spine. 1980; 5:117125. Waddell G. Somerville D., Henderson I., Newton M.. Objective clinical evaluation of physical impairment in chronic low back pain. Spine. 1992; 17:617-628.)

(c) For vertebral disc problems, radicular findings on PE should be supported by laboratory studies such as CT scan, MRI, EMG, or NCV. In cases where surgery has been performed, both pre- and post-operative deep-tendon reflexes should be documented.

(6) ***Otolaryngology.*** Audiograms must include speech discrimination scores. Current and entry level audiograms must also be included.

(7) ***Psychiatry***

(a) Particular attention should be paid to documenting all prior psychiatric care. Supportive data should be obtained for verification of the patient's verbal history.

(b) Psychiatric hospitalization is not *prima facie* evidence of an unfitting psychiatric disorder. It may, however, be evidence that the condition is administratively unsuiting.

(c) Psychometric assessment should be carried out if such assessment will help quantify the severity of certain conditions and allow a reference point for future evaluation.

(d) The Diagnostic and Statistical Manual of Mental Disorders (most recent edition) will be used for diagnostic terminology. The multiaxial system of assessment will be used to include axes I-V. The degree of industrial and industrially related social impairment must be individually determined and documented, for each axis I and axis II diagnosis, and correlated to the servicemember's clinical manifestations. Increased severity of symptoms due to transient stressors associated with the PEB and prospect of separation, retirement, relocation or re-employment will not be considered in determining the degree of impairment. The servicemember's total impairment for civilian industrial adaptability from all sources (axes I, II, III) should be determined and documented. The contribution of each condition to the total adaptability impairment should then be individually noted and correlated with the servicemember's clinical manifestations.

(e) Every effort must be made to distinguish symptoms and impairment resulting from personality disorder, or maladaptive traits, from impairments based on other psychiatric conditions. The MEBR must specifically address the issues of relative contribution of noncompensable conditions (e.g., personality disorders, adjustment disorder, impulse control disorder, substance abuse, etc.).

(f) Documentation shall be submitted addressing the following:

1. ***Living Arrangements*** (e.g., by oneself, with spouse and children, with parents and siblings).

2. ***Marital Status.*** Single, married, separated, divorced, and the type of relationship (harmony or strife).

3. ***Leisure Activity.*** Sports, hobbies, TV, or reading.

4. ***Acquaintances.*** Male, female, both sexes, many, few.

5. ***Substance Use or Abuse.*** Alcohol or drugs.

6. ***Police Encounters/Record.***

(8) ***Pulmonary.*** When the MEB is held for restrictive or obstructive pulmonary disease, rating is usually based upon pulmonary function tests measuring residual function. There must be a minimum of one set of PFTs.

(a) Studies should be performed both before and after medication.

1. Pre-bronchodilator PFTs. When the results are normal, post-bronchodilator studies are not required.

2. In all other cases, post-bronchodilator studies should be done unless contraindicated (because of allergy to medication, etc.) or if a patient was on bronchodilators before the test and had taken his or her medication within a few hours of the study.

a. A physician who determines that a post-bronchodilator study should not be done in a given case should provide an explanation.

b. The members of the informal PEB shall request either the explanation when not provided or a repeat of the studies.

c. The post-bronchodilator results will be used in applying the evaluation criteria in the rating schedule. There is a small group of patients (5 percent or less) in whom there may be a paradoxical reaction to bronchodilators; i.e., the post-bronchodilator results will be poorer than the pre-bronchodilator results. When there is a paradoxical response, the better (pre-bronchodilator) values will be used in the rating.

d. When there is disparity between the results of different tests (FEV-1, FVC, etc.) so that the level of evaluation would differ depending on which test result is used, the test with the better (higher) values (i.e., that would give the lower evaluation) will be used. This is because such tests are effort-dependent, and such a difference is ordinarily due to a difference in effort from test to test. However, if there is a substantial disparity in the results, the MEB physician may be asked for an explanation and/or request that the test be repeated if there is no clear reason.

e. When the FEV-1 is greater than 100 percent, an FEV-1/FVC ratio that is below normal should be considered a physiological variant rather than an abnormal value.

(b) Where warranted, the member should have a methacholine challenge, especially when the original set of PFTs are "normal."

(c) In cases of exercise-induced asthma, pulmonary function tests after exercise should be performed.

(9) ***Urology***

(a) Cases involving neurogenic bladder must include studies that document the condition.

(b) All cases involving incontinence must include studies that document the condition.

(c) Cases involving incontinence and/or neurogenic bladder should have documentation regarding severity as indicated by the number of times self catheterization is required, the number and type of pads required in a day, or the soilage frequency.

(4) ***Format of the Dictated MEBR.*** As detailed in the DON Disability Evaluation Manual, enclosure (8), the following is an example of a well-prepared MEBR. MTFs will ensure compliance with this template in the preparation and forwarding of MEBRs to the PEB.

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SAMPLE MEBR FOR REFERRING A CASE TO THE PEB

FOR OFFICIAL USE ONLY

NAME AND SSN:

RATE: (To include rank and rating, e.g., Yeoman First Class) OR MILITARY OCCUPATIONAL SPECIALTY (MOS) AS INDICATED BY BRANCH OF SERVICE:

UNIT/COMMAND:

DATE: (DD/MM/YYYY)

MILITARY HISTORY:

Petty Officer_____ entered into active duty on _____. She attended Recruit Training Command in Orlando, Florida. She then attended Yeoman A School in Meridian, Mississippi. She has been stationed at various locations and received awards for her exemplary service. She was twice named sailor of the quarter and once sailor of the year for the _____ area. She has received three consecutive good conduct medals and two Navy and Marine Corps achievement medals.

CHIEF COMPLAINT: Back and Foot Pain

HISTORY OF PRESENT ILLNESS:

Petty Officer _____ back pain began in 19_____ after a motor vehicle accident. She developed worsening of her symptoms in _____ after a second motor vehicle accident. The back pain is constantly present with varying intensity. Exacerbating factors include walking or standing for greater than 2 minutes. Some palliation is noted with non-weight bearing rest. The symptoms have progressed insidiously to include plantar foot pain and arthralgias involving the hips, knees, and ankles. The plantar foot pain occurs daily and is exacerbated by any weight bearing activity. She has received a variety of health care evaluations with subsequent therapeutic recommendations. Unsuccessful treatments employed have included NSAIDS, muscle relaxants, tricyclic antidepressants to modify the pain threshold, orthotics, physical therapy, plantar and sacroiliac anesthetic injections, nighttime ankle splints, and local ultrasound treatment. A lumbosacral series revealed sacralization of the 5th lumbar vertebrae. She was evaluated by Physical Medicine and Rehabilitation at which time a bone scan was obtained that showed mild increased tracer uptake in both sacroiliac joints consistent with sacroiliitis. She was then referred to Rheumatology where she was initially evaluated in March 1997. Sacroiliac radiographs were suspicious for sacroiliac disease. An MRI subsequently revealed no evidence of sacroiliitis. Her symptoms have persisted despite maximal therapy and negatively impacted on her ability to perform her naval duties. She is therefore being referred to the Physical Evaluation Board for further review and disposition.

ALLERGIES: None

MEDICATIONS: Indomethacin SR 75mg bid, Norplant

PAST MEDICAL HISTORY: Spina bifida occulta, childhood asthma, duplicated left renal collecting system without reflux or obstruction (urology evaluation completed in 1997), perivaginal cyst, tinea versicolor

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PAST SURGICAL HISTORY: None.

SOCIAL HISTORY: No tobacco or alcohol.

REVIEW OF SYSTEMS:

Musculoskeletal: Arthralgias involving hips, knees, and ankles, occurs with resting or ambulation, occasionally resolves with rest or spontaneously, chronicity 11 years, episodes last days to weeks; back pain of 11 years duration with symp-toms worsening since 1992, pain is worse with activity, palliation with resting and laying supine, prevents restorative sleep; plantar foot pain with radiation into achilles tendon and gastrocnemius, pain is constantly present and worse with weight bearing and ambulation, refractory to shoe inserts and nighttime splints.

Neurologic: midline occipital headaches, occurs in the AM upon awakening, resolves with aspirin, chronicity 11 years; dizziness and fainting spells, episode duration approximately 2 minutes, chronicity 7 years, associated with gastro-intestinal symptoms, no known loss of consciousness.

Gastrointestinal: "knot-like" sensation with pain in the epigastrium, associated nausea and increased bowel motility, associated salivary regurgitation without acid brash, no diarrhea or bloating, onset is spontaneous and without identifiable provocative factors, chronicity 7 years.

PHYSICAL EXAMINATION:

BP 123/77 P 75 T 98.9F Wt 123lbs
HEENT - extraocular movements intact, Fundi normal, no oral ulcers, tympanic membranes clear
NECK - normal range of motion, nontender, no lymphadenopathy, no thyroid enlargement or nodules
LUNGS - clear
HEART - regular rhythm, no murmurs or gallops
ABDOMEN - no hepatosplenomegaly, nontender, bowel sounds present
PELVIC - (Ob-Gyn) normal

MUSCULOSKELETAL:

Feet: plantar pain bilaterally at the calcaneus and metatarsal heads, callus formation overlying #1, 2, 5 bilaterally at the metatarsal heads.
Back: focal area of palpable low pain overlying sacrum and lumbosacral junction, presacral fat pad, Schober's test reveals 2.5 cm lumbar distraction with back flexion, straight leg raise test negative, hyperextension hips without pain provocation, flattening appearance to lumbar spine, FABERE negative, no leg length discrepancy.
Joints: no synovitis

NEUROLOGIC - strength normal, deep tendon reflexes present and equal bilaterally, babinski absent, no sensory deficits elicited, muscle tone normal

DERMATOLOGIC - scar at dorsum of left wrist, acneiform lesions on back.

LABORATORY:

Urinalysis - SG 1.026, trace protein, 1-2 RBC/HPF, 5-9 EPI/HPF
Chemistries - normal
complete blood count - normal
erythrocyte sedimentation rate - 9 - <0.l
HLA - B27 negative

ELECTROCARDIOGRAM: sinus bradycardia.

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RADIOLOGY:

(23 May 97) chest x-ray - normal
(4 April 97) MRI pelvis - normal
(21 Mar 97) ferguson pelvis - normal
(6 Mar 97) bone scan - increased uptake in the spinous processes of L4, 5; mild increased uptake in both sacroiliac joints
(27 Feb 97) lumber spine series - sacralization of L5 vertebrae

FINAL DIAGNOSES:

(1) Plantar Fasciitis
(2) Mechanical low back pain
(3) Duplicated collecting system of left kidney without evidence of reflux or obstruction

PRESENT CONDITION:

Petty Officer _____ is currently unable to successfully perform her military duties as reflected by the member and her direct supervisors. Her condition has placed an undue burden on coworkers in her office attempting to support those duties which Petty Officer _____ is unable to perform. Her current medical problems have also significantly impacted her personal life by limiting her hobbies, interrupting normal sleep patterns, and making activities of daily living difficult.

PROGNOSIS:

Petty Officer _____ is likely to require ongoing therapy and medical follow-up by clinicians interested in musculoskeletal ailments.

RECOMMENDATIONS:

1. Petty Officer_____ medical condition at this time precludes her from continuation on active duty. She is therefore being referred to the Physical Evaluation Board for further evaluation and disposition.

2. Continued use of proper shoe inserts and nighttime splints on a regular basis.

3. Daily stretching exercises targeting the plantar fascia and low back.

4. Daily strengthening exercises targeting the abdominal muscles and intrinsic muscles of the feet.

5. Regular use of NSAIDS at analgesic doses.

6. Periodic formal physical therapy evaluations to document proper self-directed rehabilitation routines and to monitor progress.

7. Evaluation every 3-4 months by a physician interested in the diagnosis and treatment of musculoskeletal problems.

_____
Signature and typed Name and Status
(to include specialty) of MEB Member

_____
Signature and typed Name and Status
(to include specialty) of MEB Member

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18-13 Format of the MEBR for Referral to the DON PEB under Death Imminent Conditions

(1) Prior to December 2003, the Navy Disability Evaluation Manual allowed that in cases in which "competent medical authority determines that a service member's death is expected within 72 hours and it is determined to be in the best interests of his or her estate, the member may be referred expeditiously into the DES. To protect the interests of the Government and the service member, disposition shall be placement on the TDRL provided all requirements under statute, legal opinions, and regulation are met."

(2) On 23 December 2003, the Principal Deputy to the Undersecretary of Defense for Personnel and Readiness rescinded the authority for the services to perform such "death imminent" PEB cases, predicated on Survivor Benefit Program (SBP) changes incorporated in the National Defense Authorization Act (NDAA) of 2004.

(3) Accordingly, effective 30 December 2003, the DON PEB issued guidance that from that date forward there are no longer "death imminent" PEB procedures for the DON.

18-14 Format of the MEBR Prepared for Placement on Limited Duty or for Referral to Service Headquarters Requesting Limited Duty (Departmental Review)

(1) As discussed in MANMED article 18-10 regarding LIMDU, some LIMDU cases must be referred by MTFs to Navy or Marine Corps headquarters for approval.

(2) As developed in article 18-3(1) through 18-3(4), only CAs can effect an MEB, and an MEB must be convened for LIMDU cases. Commands must ensure that their providers and patients realize that a recommended period of LIMDU must be forwarded to service headquarters for adjudication does not commence until it has been approved by NAVPERSCOM or HQMC, as appropriate. Branch medical clinics and providers attached to ships and operational units do not—by definition—hold CA. Strict compliance with the criteria established in articles 18-3 and 18-10 regarding CA and LIMDU is mandatory for all MTFs and units with assigned medical personnel so that the most efficacious clinical and administrative case management activities are provided to our patients.

(3) Appropriate clinical and administrative case management of patients in a LIMDU status is vital. This includes ensuring that cases requiring service headquarters approval for continuation on LIMDU are forwarded in ample time to enable the service headquarters to render timely decisions on either ordering LIMDU continuation or referral of cases to the DON PEB. MTFs must ensure close liaison with the LIMDU coordinators of the commands they serve to foster this timely referral of cases. MANMED article 18-10(11) addresses the reevaluation of patients in a LIMDU status.

(4) Once a determination is made that an MEB will be convened to recommend a member to service headquarters for LIMDU, the MEBR becomes of critical importance in appropriate clinical and administrative management of the patient.

(5) All MTFs will ensure compliance with the template (on the next page) in the preparation and forwarding of MEBRs to service headquarters for consideration of periods of LIMDU.

(6) Procedures for returning members to "fit for duty" status from a period of LIMDU are contained in article 18-10(11).

SAMPLE MEBR FOR SUBMITTING A CASE TO SERVICE HEADQUARTERS FOR LIMITED DUTY CONSIDERATION

FOR OFFICIAL USE ONLY

NAME AND SSN:

RATE: (To include rank and rating, e.g., Yeoman First Class) OR MILITARY OCCUPATIONAL SPECIALTY (MOS) AS INDICATED BY BRANCH OF SERVICE:

UNIT/COMMAND:

DATE: (DD/MM/YYYY)

MILITARY HISTORY:

Petty Officer _____ entered into active duty on _____. She attended Recruit Training Command in Orlando, Florida. She then attended Yeoman A School in Meridian, Mississippi. She has been stationed at various locations and received awards for her exemplary service. She was twice named sailor of the quarter and once sailor of the year for the_____ area. She has received three consecutive good conduct medals and two Navy and Marine Corps achievement medals.

CHIEF COMPLAINT:

HISTORY OF PRESENT ILLNESS:

PAST SIGNIFICANT MEDICAL HISTORY:

PAST SURGICAL HISTORY:

DATES OF AND DIAGNOSES CAUSING PAST LIMITED DUTY PERIODS:

FINAL DIAGNOSES (LIST ALL PERTINENT DIAGNOSES):
(1)
(2)

PRESENT CONDITION:

Petty Officer _____ is currently unable to successfully perform her military duties as reflected by the member and her direct supervisors. Her condition has placed an undue burden on coworkers in her office attempting to support those duties which Petty Officer _____ is unable to perform. Her current medical problems have also significantly impacted her personal life by limiting her hobbies, interrupting normal sleep patterns, and making activities of daily living difficult.

PROGNOSIS, TO INCLUDE ESTIMATED PERIOD OF LIMITED DUTY:

Petty Officer _____ is likely to require ongoing therapy and medical follow-up by clinicians interested in musculoskeletal ailments.

PERIOD OF LIMITED DUTY RECOMMENDED BY THIS BOARD:

COURSE OF CARE—INCLUDING SURGICAL PROCEDURES AND TIMEFRAMES—ANTICPATED DURING THIS RECOMMENDED PERIOD OF LIMITED DUTY:

DISCUSSION OF LIKELIHOOD THAT PATIENT WILL RETURN TO MEDICALLY UNRESTRICTED DUTY DURING OR AT THE END OF THE RECOMMENDED PERIOD OF LIMITED DUTY:

LIMITATIONS ON SERVICE DURING THE RECOMMENDED PERIOD OF LIMITED DUTY:

ADDITIONAL FINDINGS AND/OR RECOMMENDATIONS:

_____
Signature and typed Name and Status
(to include specialty) of MEB Member

_____
Signature and typed Name and Status
(to include specialty) of MEB Member

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18-15 Non-Medical Assessment (NMA)

(1) Since December 1998, the PEB has required that each MEBR referring an ADSM into the DES in accordance with SECNAVINST 1850.4 series will contain an NMA. This tool, a CO's assessment of a service member's performance of duty relative to MEB considerations, has proven invaluable as an input to the deliberations of the PEB.

(2) HQMC (MMSR-4) and NAVPERSCOM (PERS-4821) have also mandated an NMA will be included with selected MEBR sent by an MTF for "departmental review" to service headquarters relative to LIMDU requests (see articles 18-5 and 18-14).

(3) The NMA is to be completed by the service-member's parent command, and to the maximum extent practicable be signed by the patient's CO. MTFs must request an NMA from a member's parent command immediately at the commencement of any MEB likely to refer a patient to the PEB for disability evaluation or to service headquarters for LIMDU consideration. MTFs should not presume that parent command's have ready access to the NMA format developed in SECNAVINST 1850.4 series, and should in their requests for NMA ensure that parent commands are provided reference locations where they can readily obtain the NMA format. These are to include:

(a) Navy Directives online at http://neds.daps.dla.mil where the entire SECNAVINST 1850.4 series is available.

(b) The Web site of the PEB at http://www.hq.navy.mil/ncpb, where a downloadable version of the NMA is available for parent comment use.

(c) NMA templates embedded in messages from MTFs to parent commands advising of LIMDU recommendations and requirements for parent command NMA submittal. MTF requests for NMA should cite all these reference sources. MTFs should additionally ensure that their respective Web sites offer links to the PEB site, and should make this information available to parent commands as part of the NMA request documentation.

(4) SECNAVINST 1850.4 series mandates that "commanders will ensure that NMAs are submitted to the requesting facility within 15 calendar days from the date of receipt of such request." For patients having transferred PCS from the previous parent command or having been sent TEMDU from the previous parent command to an MTF for treatment, the MTF is still obligated to obtain the NMA from the previous parent command. MTFs experiencing difficulty receiving NMAs from parent commands within the 15 calendar day timeframe are to judiciously direct requests for further assistance as deemed necessary to NAVPERSCOM (PERS-4821) or HQMC (MMSR-4). Obtaining NMAs often presents as one of the most time-consuming endeavors facing the MTFs in preparing complete MEBRs; MTF commanders shall ensure their respective MEBs staffs are diligent in pursuing NMAs to facilitate compliance with the "30-day window" for completing MEBRs as defined in article 18-19. To foster compliance with processing timeframes, parent commands should be encouraged to provide the NMA via naval message traffic or, as an alternative, to fax NMAs on their command letterhead to MTFs.

(5) SECNAVINST 1850.4, enclosure (11), provides additional information on, and the format template for, the NMA, and pertinent sections thereof are reproduced here: (See sample command letter on next page.)

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COMMAND LETTERHEAD

Date:

From: Commanding Officer
To: Medical Treatment Facility

Subj: NON-MEDICAL ASSESSMENT (NMA); CASE OF _____(name, SSN)

1. Questionnaire. The following assessment is submitted to assist the PEB in their determination of Fitness/Unfitness and/or service headquarters in determining appropriate limited duty:

a. Service member's Rating/NEC/MOS/Specialty _____ (Numerical designator and description; e.g., 031 I/Rifleman, A03/Aviation Ordnanceman).

b. Is the member currently working out of his/her specialty because of the medical condition?

c. Last date the member took PRT/PFT.

d. Last date the member passed the PRT/PFT.

e. Member's height and weight (inches/lbs) _____.

f. Is the member within weight and body fat standards?

g. To your knowledge, is the member fully complying with the prescribed appointments and treatment for the therapy?

h. How much time has the member's condition required him/her to be away from duties for treatment/evaluation/recuperation?

i. Estimate the average number of hours per week the member is absent from command duties.

j. How has this impacted member's performance?

k. Is member pending disciplinary action or involuntary administrative separation for misconduct? If so, for what?

l. Does the member have good potential for continued service in his/her present physical and mental condition?

m. Is member motivated for continued active duty?

n. Is this member's performance worthy to remain on active duty in a Permanent Limited Duty status if found Unfit?

2. Commanding officer's comments: This paragraph is crucial to summarize member's situation in the perspective of the commanding officer. In a concise and succinct paragraph, statements are needed to assist in determining the fit/unfit potential of the member. Highlight the Sailor or Marine's ability to execute duties as required of his/her rating and the reality of their contribution. Discuss how their performance has been impacted. Discuss how the patient is attempting to work through his/her medical problem and meet daily goals to support the command's mission. The following guidelines should be followed in completing this paragraph:

a. The NMA narrative summary is to be completed by the commanding officer. It captures his/her observations and those of other senior command personnel as to how the service member's medical impairments have or have not impacted upon the member's ability to function within the command. The NMA should describe how well the member performs military duties; i.e., MOS/rating duties, field duties or exercises, participation in the PRT/PFT, etc. Comment on what the member can or cannot do. Equally important is a description of the member's off-duty social and athletic activities. How have these activities been affected by the member's medical impairments?

b. Commanding officers perform a vital role in assisting the PEB to make the proper Fit or Unfit determination. The commanding officer and senior command personnel are in the unique position to provide valuable information as to how the service member's physical and/or mental condition(s), as reported in the MEBR, affect the member's ability to function on a daily basis. The purpose of the NMA is to provide the PEB with those insights.

c. The medical evaluation board has the responsibility to document the medical status of Sailors and Marines by describing the nature and severity of their medical conditions in the MEBR. The PEB function is to determine the servicemember's fitness to continue naval service. In the case of an unfitting condition, the PEB determines the required disability rating. Performance plays a large part in these decisions.

d. For service members assigned to temporary holding units (TPUs), medical holding companies, or medical centers, commanding officers will complete those questions that pertain to the period of observation. If the TPU/medical center commanding officer has had sufficient observation of the member, then he or she will complete the questionnaire. If not, coordination with the previous command will be required to assist in answering questions covering the member's period of assignment to that command.

3. POC at this command is _____ (name/rank/position) at Commercial _____, DSN _____, or e-mail _____.

_____
Commanding Officer

18-16 Line of Duty/Misconduct (LOD/M) Determination

(1) Under the laws (Title 10 USC, sections 1201-1204, 1206, and 1207) and regulations (SECNAVINST 1850.4 series) governing the Navy DES, members entitled to basic pay who incur or aggravate medical conditions which make them unfit to perform their military duties may be eligible to receive disability retirement or separation benefits. Members' eligibility to these benefits may be overcome however, if the physical disability resulted from the member's own intentional misconduct or willful neglect, was incurred while not in the LOD, or was incurred while the member was in an unauthorized absence status.

(2) The SECNAVINST 1850.4 series details the LOD/M determination process, and critical attention should be paid to that section by MTFs determining whether to request LOD/M determination from parent commands. There is a legal presumption that any disease or injury discovered after a member enters active military service, with the exception of congenital and hereditary conditions, is presumed to have been incurred "in the line of duty" and "not the result of misconduct." While SECNAVINST 1850.4 series delineates several examples not considered in the line of duty, to include conditions incurred:

(a) As a result of the member's own misconduct.

(b) While avoiding duty by deserting the service.

(c) During a period of unauthorized absence.

(d) While confined under sentence of a court-martial which included an unmerited dishonorable discharge.

(e) While confined under sentence of a civil court following conviction for an offense which is defined as a felony by the law of the jurisdiction where convicted.

(f) While on appellate leave.

The legal standard of "clear and convincing evidence," not the less-demanding evidentiary standard of "beyond a reasonable doubt," is required to overcome the presumption of "in the line of duty" and "not the result of misconduct."

(3) Intentional misconduct or willful neglect. Misconduct is wrongful conduct. However, simple or ordinary negligence or carelessness, standing alone, does not constitute misconduct. To support an opinion of misconduct, it must be established by clear and convincing evidence that the injury or disease either was intentionally incurred or the proximate result of such gross negligence as to demonstrate a reckless disregard of the consequences. If a resulting injury or disease is such that it could have been reasonably foreseen from the course of conduct, it is said to be a "proximate result." The fact that the conduct violates a law, regulation, or order, or the fact that the conduct is engaged in while the individual is intoxicated, does not, of itself, constitute a basis for a determination of misconduct. Such circumstances will however be considered along with all other facts and circumstances by the PEB in determining whether the conduct of the individual was grossly negligent, and whether the incurrence of injury or disease was reasonably foreseeable as a probable result of such conduct.

(4) JAGINST 5800.7C (JAGMAN), chapter II, outlines policies and procedures for making LOD/M determinations. If a member incurs a disease or injury that may result in a permanent disability or that results in the member's physical inability to perform duty for a period exceeding 24 hours (as distinguished from a period of hospitalization for evaluation or observation) then determination of whether the disease or injury was incurred in LOD or as a result of misconduct is required. At a minimum, in accordance with JAGMAN 0220d, a command must convene an investigation and make findings concerning misconduct and LOD when:

(a) The injury was incurred under circumstances which suggest a finding of "misconduct" might result (for example, but not limited to, cases involving illegal drug use, intoxication, or bona fide suicide attempts).

(b) The injury was incurred under circumstances that suggest a finding of "not in the line of duty" might result.

(c) There is a reasonable chance of permanent disability and the CO considers the convening of an investigation essential to ensure an adequate record is made concerning the circumstances surrounding the incident.

(d) The injured member is in the Naval or Marine Corps Reserve and the CO considers an investigation essential to an adequate official record made concerning the circumstances surrounding the incident.

(5) JAGMAN section 0221details that each injury or disease requiring an LOD/M determination must be the subject of a preliminary inquiry. If, per JAGMAN 0221c, the preliminary inquiry shows in the opinion of the medical officer and with concurrence of the member's CO, that the injury or disease was incurred "in the line of duty" and "not as a result of the member's own misconduct" and appropriate medical record entries are made, no investigation need be convened.

(6) JAGMAN sections 0230 and 0231 prescribe that commands record LOD/M determinations in the member's health or dental record. When a command investigation or written preliminary inquiry (as discussed in the preceding paragraph) has been prepared per JAGMAN, chapter II, commands will provide a copy of the inquiry or investigation with the General Court-Martial Convening Authority (GCMCA) endorsement, to the MEB convening authority for inclusion in the official records of the case which are forwarded with the MEBR for PEB consideration. The MEB will ensure the attending physician has made appropriate medical record entries concerning the preliminary inquiry, as detailed in the preceding paragraph.

(7) As detailed in SECNAVINST 1850.4, section 3410, normally the PEB will accept the command LOD/M determination as binding. However, there may be cases in which the Informal Board, Formal Board, or Legal Advisor considers an LOD/M determination to be contrary to the evidence of record, contrary to additional evidence obtained during the PEB review and hearing process, or predicated upon an investigation that may be deficient. In these cases, the President, PEB shall forward the LOD/M determination to DIRSECNAVCORB for review and decision prior to the signing either of a preliminary findings letter or a findings letter. For this reason, and as explained in article 18-11(5), MTFs shall not unilaterally decline to process and forward to the PEB MEBRs in which parent command LODD indicate a member's condition was incurred outside the LOD and due to the member's misconduct, as this decision rests definitively with the PEB and the DIRSECNAVCORBs.

(8) Responsibilities of the MTF commander/CA in obtaining LOD/M determinations are conveyed in SECNAVINST 1850.4. Before referring a case for PEB review, the MEB CA shall review case records to ensure they contain required LOD/M determinations from the responsible field commander. The MEB CA shall process a case which fails to contain a required LOD/M determination according to the following principles:

(a) If the date of the injury giving rise to the requirement for an LOD/M determination was more than 2 years prior to the date of the MEB, the MEB CA shall continue to process the member's case, including forwarding the case to the PEB, without further effort to obtain the LOD/M determination or information normally required for making the determination. Consistent with the JAGMAN, the MEB will presume a finding of "in the line of duty and not due to the member's own misconduct" in processing such cases.

(b) If the date of the injury giving rise to the requirement for an LOD/M determination is less than 2 years from the date of the MEB, the MEB CA will contact the responsible field commander and request that steps be taken to properly investigate the facts surrounding the injury and to document and record appropriate findings. The MEB CA only shall forward the MEBR to the PEB for processing if:

(1) MEB CA obtains a copy of the LOD/M investigation and includes it as part of the MEBR.

(2) MEB CA obtains a copy of the health/dental record entry recording the LOD/M determination, and includes it as part of the MEBR package.

(3) MEB CA obtains a statement from the cognizant GCMCA stating that an LOD/M determination was not required (JAGMAN article 0221) or was not able to be obtained (i.e., that diligent efforts to complete the investigation were not productive due to witness unavailability).

(c) MTFs debating whether to request LOD/M from parent commands should err on the side of requesting the LOD/M. Whether decisions on convening MEBs for PEB referral have yet to be made, or PEB referral will occur at some indeterminate point in the future, an LOD/M contemporary to the time of the incurrence of illness or injury will facilitate appropriate medical record entries, and as obtaining LOD/M is often one of the most time-consuming steps in an MTFs preparation of MEBRs, early requests for LOD/M to parent commands will assist MTFs in complying with the "30-day window" for preparing MEBRs developed in article 18-19. Questions on obtaining LOD/M should be referred to the PEB to ensure cases are not unnecessarily delayed.

18-17 The Abbreviated MEBR

(1) As discussed in article 18-10, to facilitate appropriate clinical and administrative case management while curtailing overly burdensome paperwork requirements, MTFs can rely on NAVMED 6100/5 (Rev. 8-2004), Abbreviated Medical Evaluation Board Report for the following LIMDU actions:

(a) 1st periods of LIMDU in the career of enlisted Sailors or Marines that are < 6 months (no referral to service headquarters necessary).

(b) 2nd LIMDU periods for enlisted Sailors and Marines that are < 6 months (no referral to service headquarters necessary). Note that the first and second TLD periods cannot exceed 12 months cumulatively from the date of the first TLD period.

(c) 1st and 2nd LIMDU periods for Navy and Marine Corps officers (for referral to service headquarters for "departmental review").

(d) 3rd or subsequent LIMDU periods on Navy and Marine ADSM involving distinctly different condition than that responsible for the first and/or second TLD periods (for referral to service headquarters for "departmental review").

(e) Placement on LIMDU, if the patient is not already in a LIMDU status, at the same time the patient's case is referred to the PEB for adjudication.

Note: Any other LIMDU requires a dictated MEBR to be sent to respective service headquarters. Use of any edition before NAVMED 6100/5 (Rev. 8-2004) is immediately prohibited. MTFs using the "Abbreviated MEBR" for LIMDU are reminded that the MTFs LIMDU recommendation is not deemed final until the CA of the MTF has signed the MEBR. ***(Not more than 5 working days will elapse between the time the MEB reports out a LIMDU (NAVMED 6100/5 (Rev. 8-2004) and the CA signs the form approving the LIMDU.)*** *MTFs must be mindful that, given the nature of LIMDU as both a medical and personnel function, specificity of information necessary for the appropriate clinical and administrative case management of patients entered into LIMDU status is vital. Patients placed on LIMDU via the abbreviated MEBR must be entered into the MedBOLTT or systems that replace it; see article 18-27.*

(2) The format of the NAVMED 6100/5 (Rev. 8-2004) appears at the end of this article. Previous editions of this form are obsolete and effective immediately are not to be used.

(3) The use of the abbreviated LIMDU MEBR does not change any of the requirements for a LIMDU placement expressed in article 18-10, particularly regarding that the MTFs LIMDU recommendation described in any NAVMED 6100/5 (Rev. 8-2004) writeup is not effective until approved by the MTF CA. (Refer to article 18-3 for CA definitions and responsibilities.)

(4) Procedures for returning members to "fit for duty" status, including mandatory medical record entries and completion of the NAVMED 6100/6 (Rev. 8-2004), from a period of LIMDU are contained in article 18-10(11).

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ABBREVIATED MEDICAL EVALUATION BOARD REPORT

SECTION 1: CLINICAL INFORMATION (TO BE COMPLETED BY MEDICAL OFFICERS)

Date: _____ Patient Name: _____ Patient SSN: _____

Proposed start date for limited duty: _____ Proposed end date (≤ 6 months): _____

This period of limited duty is for: (Select one)

☐ 1st LIMDU (≤ 6 months) Enlisted ADSM (no referral to service headquarters necessary).

☐ 2nd LIMDU (≤ 6 months) Enlisted ADSM (no referral to service headquarters necessary). Note that the first and second TLD periods cannot exceed 12 months cumulatively from the date of the first TLD period.

☐ 1st LIMDU (≤ 6 months) Officer ADSM (referral to service headquarters necessary).

☐ 2nd LIMDU (≤ 6 months) Officer ADSM (referral to service headquarters necessary).

☐ 3rd or subsequent LIMDU periods on Navy and Marine ADSM involving a distinctly different condition than that responsible for the first and second TLD periods (for referral to service headquarters for "departmental review").

☐ Placement on LIMDU - if the patient is not already in a LIMDU status - at the same time the patient's case is referred to the physical evaluation board for adjudication.

Diagnosis: (1) _____ ICD-9 CM Code _____

(2) _____ ICD-9 CM Code _____

(3) _____ ICD-9 CM Code _____

Circumstances of injury/illness:

_____

_____

_____

Treatment plan:

_____

_____

Limitations from full duty (including whether transfer/TEMDU for treatment is indicated, and any PRT limitations):

_____

_____

_____

_____ _____ _____

Printed MEB Member Name and Signature/Date | Printed MEB Member Name and Signature/Date | Printed CA Name and Signature/Date

SECTION 2: PATIENT INFORMATION, TO BE COMPLETED BY PATIENT

I have received full information on the proposed Limited Duty period from my provider. I understand that this period of limited duty is not effective until approved by the MTF Convening Authority, and that the MTF will report this LIMDU action to my parent command. I understand I may be returned to duty prior to the date appearing above as my clinical condition warrants and upon action by my attending provider.

_____

Patient Signature/Date

SECTION 3: TO BE COMPLETED BY PATIENT ADMINISTRATION OFFICER/MEDICAL BOARDS OFFICER

The following actions have been completed:

☐ Completion of Patient Information Sheet

☐ Notification to PSD/Personnel Office

☐ LODD Requested from Parent Command (if LODD required)

☐ Entry into MedBOLTT

☐ Briefing to Patient on Limited Duty/MEBs

☐ Notification to MTF LIMDU Coordinator

☐ Notification to Parent Command

_____

Patient Administration Officer/Medical Boards Official Printed Name, Signature, and Date

ROUTING: Original to Patient Health Record; copies to Patient, Parent Command, PSD, MEBR Case File, and PERS-4821 or MMSR-4

NAVMED 6100/5 (Rev. 08-2004)
PREVIOUS EDITIONS OBSOLETE

18-18 Format of the MEBR for TDRL Reevaluation

(1) In addition to their responsibilities to ADSM, the PEB and Navy and Marine service headquarters maintain responsibility for those former members rated by the PEB as disabled at greater than a 30 percent level of disability and subsequently placed on the TDRL. While the placement and accounting for members on the TDRL are not MTF responsibilities, the proper clinical reevaluation of TDRL members, and presentation of this information to the PEB, is an MTF responsibility, as delineated in the BUMEDINST 6320.79 series. All TDRL evaluation episodes will be entered into the MedBOLTT or any system that replaces it.

(2) Members on the TDRL receive, from their respective service headquarters, orders to report to an MTF for TDRL reevaluation. These reevaluations occur at intervals not to exceed 18 months while a retiree is on the TDRL. (The maximum period, by statute, that a retiree is allowed to remain on the TDRL prior to case finalization is 5 years.) A copy of the orders sent to the member requiring TDRL evaluation is also sent to the MTF responsible for conducting the reevaluation. The MTF is to schedule the appointment as rapidly as possible to satisfy the timeframe stipulated in the orders for the reevaluation to occur, and is to convey this information to the retiree promptly. In scheduling reevaluation appointments and conducting reevaluations, MTFs must be mindful of expediency; it is entirely possible that MTF actions that do not satisfy stipulated timeframes, particularly regarding the 5-year limit on TDRL placement, can result in the suspension of the retirees' disability benefits. Moreover, this 5-year maximum is mandated by statute (Title 10 USC) and cannot be extended unilaterally by service headquarters. Any problems encountered must be rapidly and effectively conveyed to both the appropriate service headquarters and the patient for resolution.

(3) DON Disability Evaluation Manual, part 6 of enclosure (3), is dedicated to processing TDRL cases; MTF providers and medical boards staff involved with TDRL reevaluations must be thoroughly familiar with its contents.

(4) As developed in the DON Disability Evaluation Manual, sections 3614–3617, the report submitted by an MTF pursuant to TDRL reevaluation:

(a) May be prepared in the format of either an MEBR (following MANMED article 18-12), a letter, or a narrative summary.

(b) Shall address or contain:

(1) The member's current address and telephone number.

(2) An interval history since the last examination, with particular reference to the member's employment and time lost there due to the disability for which retired.

(3) A comprehensive PE, reporting all physical impairments, including any impairment from which the member has recovered, and new ones acquired while on the TDRL. Advice of consultants should be obtained if the examining physician is in doubt as to an actual physical condition or diagnosis.

(4) All clinical evaluations and laboratory studies necessary to document the member's physical condition.

(5) Information regarding the member's current condition and prognosis, including current stability of the condition and the likelihood of significant change within the remaining statutory time the member might remain on the TDRL, and a comparative estimate of the changes relative to the member's present condition.

(6) Statement as to the current degree of impairment of industrial and social adaptability for all cases involving psychiatric disabilities.

(7) Statement as to whether disclosure to the member of information relative to his or her physical or mental condition, or a personal appearance before the PEB would be detrimental to the member's physical or mental health.

(8) For members who served in the Southwest Asia Theater of Operations (SWATO) Comprehensive Clinical Evaluation Program (CCEP) evaluation (or waiver) if the medical diagnosis(es) included in the MEBR are assessed to be related to illnesses that are directly or causally related to service in this theater. If this was not done before the original MEBR, it must be included with the periodic examination.

(9) An estimate of changes since the previous examination.

(10) All medical impairments diagnosed since the member was placed on the TDRL, to include: whether the new diagnosis was caused either by the condition for which the member was placed on the TDRL or the treatment received for such a condition; whether, if not caused by the TDRL condition, the member's medical records document incurrence or aggravation of the condition while the member was in a military status; whether the condition is unstable, and a suggested period within 18 months when the next examination should occur.

(11) A detailed occupational history, indication of pertinent social and recreational activities, and activities of daily living.

(12) A competency board, if the member has a functional or organic disorder which makes questionable the member's ability to handle personal affairs and to understand and cooperate in MEB and PEB proceedings. Additionally, all TDRL cases with a previously rated psychiatric diagnosis must have a statement of competency (as shown in article 18-6).

18-19 Definition of, and Processes for Complying With, Mandated Timeframes for Completion and Submission of MEBRs

(1) MTFs have a significant responsibility to expedite all actions involving patients on LIMDU and patients being referred to the PEB for disability evaluation.

(2) For MEBRs being submitted for fitness for continued service determination to the PEB, MTFs must have the board report completed, sent to, ***and accepted by*** the PEB within 30 days of the date of dictation of the MEBR by the attending physician. This requirement replaces the previous standard (appearing in previous editions of both this chapter of MANMED and the SECNAVINST 1850.4 series) of "day of the decision of the attending physician that a referral to the CPEB is clinically indicated" as it more concisely and contemporarily links a physician's determination that a patient requires referral to an MEB and the actions of that MEB. This "30 days from the date of dictation" rule will sponsor a more accurate measuring of compliance by MTFs in timely preparation of MEBRs, and shall be the standard upon which MTF compliance is audited by the Enlisted Personnel Management Center (EPMAC) TMU. Immediately upon being advised that an MEB for referring a case to the PEB will be convened, MTF medical boards staff should concurrently, not consecutively, launch action on, and track completion of, the requirements which comprise the appropriate MEBR package submitted to the PEB.

(a) Immediate requests of parent commands for NMAs, and for LOD/M determinations where appropriate, are vital as these items often present significant obstacles to timely MEBR package completion. SECNAVINST 1850.4 series requires that COs will complete and forward NMAs within 15 days of receiving requests from MTFs. (See MANMED articles 18-15 and 18-16 for additional information on, respectively, NMAs and LOD determinations.)

(b) PEs should be scheduled immediately, and medical boards staffs must take proactive action in this regard, rather than merely instructing patients to schedule their own examinations. While not prescribed by this chapter of MANMED, it is recommended that MTF commanders establish mechanisms where MEB staffs are granted scheduling authority for obtaining rapid PEs for patients being evaluated by MEBs for referral to the PEB. MTFs should also determine their respective best business practices regarding which providers will conduct the PEs (i.e., the provider ordering a patient to an MEB, or a "physical examinations" section, or other appropriate provider). Patient administration and MEBs staffs must, as well, receive PE reports expeditiously from the providers performing the examinations. Regardless of how PEs are scheduled for MEB patients, MTF commanders must ensure that there is in place within their respective commands a method by which PEs performed on all members undergoing an MEB will be received by the MTF patient administration and MEBs staff from the department or branch clinic performing the examination on the day the examination is completed.

(c) Scheduling for indicated diagnostic procedures, particularly those with long lead-times must occur immediately.

(d) Consultations with indicated specialists to provide addenda to the MEBR must also occur immediately and MTF commanders will ensure that patients undergoing MEBs are ensured appropriate priority in seeing required consultant specialists.

(e) MTFs must include in their "30-day window" appropriate time periods for MEBR dictation, review, and signature by the MEBR members, and final review and signature by the CA. For MEBRs being dictated by other commands and providers, MTF commanders will ensure appropriate liaison with those institutions to ensure compliance with the "30-day window." The MEBR package being prepared for forwarding to the PEB will not be presented to the patient until it has been reviewed and signed by the MEB members and by the CA. The MEBR package presented to the patient for signature must be complete, and will contain all information, including NMA, LOD/M, addenda, and other documentation the MTF intends to submit to the PEB (for disability cases) or to service headquarters (for LIMDU cases) as part of the MEBR.

(f) MTFs must account in their "30-day window" the opportunity for patients to rebut their MEBR. From the day they receive their written MEBRs, patients (or for patients declared mentally incompetent or for whom the CA feels presentation of the MEBR information would be deleterious, their next of kin or duly appointed legal agent) have 5 working days to accept the MEBR by signing the NAVMED 6100/2 (Rev. 8-2004), Medical Board Statement of Patient, or to provide the CA with a written rebuttal. In cases in which the patient at the end of this 5-day period has provided neither a signature nor a rebuttal, the patient's acceptance of the MEBR will be presumed, and the MEBR will be forwarded. (Requests for extensions to this 5-day period will be adjudicated on a case-by-case basis by the CA.) If a patient elects to rebut, the patient will prepare a written statement and include any additional relevant information. The MEB members will review the rebuttal and make any appropriate change to the MEBR and forward the MEBR to the CA for review. The MEBR will then be represented to the patient. If changes have been made to the MEBR that result in the member wishing to withdraw his or her rebuttal, the MEBR will be forwarded without surrebuttal. If the patient elects to have the MEBR package contain his or her rebuttal as it is forwarded, the MEBR must contain a written surrebuttal. In all cases where an MEBR is forwarded from the MTF with a member's rebuttal, a surrebuttal must be included. The surrebuttal must specifically address any new information or issues raised by the patient in the rebuttal. A statement such as "I have reviewed the member's rebuttal and the opinions and recommendations made by the MEB still stand" is not sufficient when previously unaddressed information is presented by the patient in the rebuttal. Rebuttals and surrebuttals will become part of the MEBR package. Patients are not provided an additional rebuttal option or additional rebuttal time when presented with the surrebuttal.

(g) MTFs must account in their "30-day window" for periods of travel outside the area of the MTF, such as convalescent leave recommended for their patients, regular annual leave their patients may request, or requests to return temporarily to the parent command for members who were MEDEVAC'd or transferred for care unexpectedly and need to return to take care of their personal affairs. MTFs should carefully monitor the location of patients they have referred to MEBs to ensure that MEBR processing is not delayed due to an inability to contact the patient. Where practicable, regular annual leave out of the area of the MTF should be deferred until the MEBR has been submitted to the PEB. If travel out of the area of the MTF is entertained, there should be a provision for two-way transmission of information relative to the MEBR so as not to unduly delay MEBR processing, and mechanisms for providing appropriate counseling to the patient must also be defined. For patients for whom convalescent leave is recommended, the MTF should evaluate whether the decision to refer the patient to an MEB is most appropriate after the clinical evaluation to be made by the MTF at the conclusion of the patient's convalescent leave.

(h) All actions relative to an MEB case must be entered into MedBOLTT (or systems that replace it).

(3) For dictated MEBRs being submitted to service headquarters for "departmental review" requesting LIMDU, MTFs must submit the request such that the service headquarters receives the request as soon as possible after the decision to refer the case to service headquarters, but in any event within 20 days,

which allows for the MTF to obtain, as required by service headquarters (i.e., MMSR-4 for USMC and PERS-4821 for Navy) the NMA from the parent command, as well as providing time for the MTF to complete the MEBR. The MEBR package will not be presented to the patient until it has been reviewed and signed by the MEB members and by the CA. The MEBR package presented to the patient for signature must be complete, and will contain all information, including NMA, and other documentation the MTF intends to submit to service headquarters. From the day they receive their written MEBRs, patients (or--for patients declared mentally incompetent or for whom the CA feels presentation of the MEBR information would be deleterious--their next of kin or duly appointed legal agent) have 5 working days to accept the MEBR by signing a NAVMED 6100/2 (Rev 8-2004), Medical Board Statement of Patient, or to provide the CA with a written rebuttal. In cases in which the patient at the end of this 5-day period has provided neither a signature nor a rebuttal, the patient's acceptance of the MEBR will be presumed, and the MEBR will be forwarded to the respective service headquarters. MTF providers and MEB staffs must remain aware that in these cases the LIMDU period is not officially commenced or continued until ratified by service headquarters; appropriate liaison must occur with parent commands to ensure that members' medical conditions that necessitated MEB evaluation are not exacerbated pending authorization from service headquarters for LIMDU and that patients already on LIMDU are referred to service headquarters in ample time to provide for uninterrupted LIMDU or rapid referral to the PEB.

(4) For Abbreviated MEBRs being prepared to place an enlisted Sailor or Marine on LIMDU, not more than 5 working days will elapse between the time the MEB reports out a NAVMED 6100/5 (Rev. 8-2004) and the CA signs the form approving the LIMDU. The MTF will notify the member's parent command by Naval message traffic within 5 working days of the MEBR being initiated. (Refer to article 18-17 for information relative to the abbreviated LIMDU MEBR.)

(5) For reevaluation cases for TDRL patients, MTFs will ensure that all reevaluation cases have been accepted by the PEB as soon as possible following the patient's evaluation but in all events within 30 days of the patient's appointment at the MTF. Article 18-18 discusses in detail MTF responsibilities in TDRL reevaluation cases.

(6) All actions relative to an MEB case must be entered into MedBOLTT (or systems that replace it).

18-20 Transmission Methods, HIPAA, and Privacy Maintenance

(1) MTFs must ensure that all information relative to MEBRs is handled and conveyed to ensure the utmost in securing patient privacy and respecting the sensitive nature of the information conveyed by MEBRs. All MEBR information is covered by the Privacy Act. Additionally, as the provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 enact, all MEBR transmissions must comport to the requirements of this Federal legislation which influences the transmission of any data that allow for the identification of any individual patient. Detailed information on ensuring the privacy and confidentiality of all aspects of health care information appears in MANMED chapter 16 and supporting documentation. MTF commanders must ensure that their staff members involved in the production and routing of MEBRs are thoroughly trained in, and remain compliant with, all aspects of ensuring and protecting the privacy and confidentiality of information contained in MEBRs.

(2) Where written documentation is essential, and it is possible to convey this information concisely, naval message traffic is the preferred method of transmitting sensitive information between MTFs, parent commands, service headquarters, and the PEB. Strong consideration should be given by MTFs to sending this message traffic as "Personal For" traffic to the patient's parent commands, to further protect the privacy of sensitive medical information. This reliance on naval message traffic is obviously, however, inappropriate for the transmission of the large volume of documents that appropriately comprises each MEBR being submitted to the PEB, as well as many of those MEBRs submitted to service

headquarters petitioning for periods of temporary LIMDU. Emerging sophisticated technologies are allowing increased reliance on transmitting information electronically. MTFs and parent commands relying on electronic transmission via e-mails, intranets, etc., are responsible for maintaining the privacy of the information so conveyed.

(3) In cases where naval message traffic is impractical, the transmission of information between MTFs, service headquarters, and the PEB by use of telephonic facsimile (fax) equipment may be practical. In all cases where fax transmission is used, MTFs will ensure they are in full compliance with all contemporary applicable DON fax transmission policy. MTFs will also ensure that an appropriate warning statement, citing the Privacy Act and instructing fax recipients receiving any fax in error of specific, appropriate corrective actions required of them, appears prominently on at least the cover sheet of any fax transmittal package.

(4) Where naval message traffic and fax transmission are clearly inappropriate based on the volume of information to be transmitted and/or logistics, MTFs will rely on either the United States Postal Service or commercial carriers to convey information to service headquarters and the PEB. MTF commanders will ensure their staffs are directed to the maximum extent practicable to rely on "overnight" service for package delivery to the PEB, to optimize the time allowed MTFs under the "30-day window" (see article 18-16 to prepare appropriate MEBRs). MTFs should also rely on the "return receipt" or internet-based and other tracking modes made available by these delivery firms, to afford both enhanced tracking of packages in transit and enhanced audit trails to document compliance with the "30-day window." MTF medical board staffs should carefully monitor their respective routing of packages to the PEB such that resources are not wasted in sending packages "one at a time" but neither is rapid delivery thwarted by well-intentioned but inefficient stockpiling of MEBRs to "ship in bulk" to the PEB or to service headquarters.

(5) Electronic mail (e-mail) is not expressly prohibited as a method of transmission of patient information among "internal users" with a need to know. An opinion by BUMED JAG on the matter finds that "we may, when the mission requires, place personal information in an e-mail" but cautions that "we should only transmit such information by e-mail when absolutely required to frame an issue, and alternative methods of transmission would be inadequate." E-mail transmission of private information "should be the exception, not the rule." Accordingly, use of e-mail for conveying MEBR information, whether in the main body of e-mail messages or as attachments thereto, must be strictly evaluated to ensure compliance with Privacy Act, HIPAA, and information security requirements.

(6) An important correlated aspect of the information defined previously in this article is those cases in which an MTF needs to obtain information on ADSMs from a civilian institution. Under the HIPAA enacting legislation, 45 CFR 164.512(k)(1)(i): it is explicit that under the "Uses and disclosures for specialized government functions" provision "a covered entity may use and disclose the protected health information of individuals who are Armed Forces personnel for activities deemed necessary by appropriate military command authorities to assure the proper execution of the military mission, if the appropriate military authority has published by notice in the FEDERAL REGISTER the following information: (A) Appropriate military command authorities; and (B) The purposes for which the protected health information may be used or disclosed." Moreover, pursuant to the Federal Register publication of April 9, 2003, volume 68, number 68, page 17357, "Supplementary Information: In accordance with 45 CFR 164.512 (K)(1)(i), the Department of Defense has established in DoD 6025.18–R, paragraph C7.11.1, the following provisions: 1. General Rule. A covered entity (including a covered entity not part of or affiliated with the Department of Defense) may use and disclose the protected health information of individuals who are Armed Forces personnel for activities deemed necessary by appropriate military command authorities to assure the proper execution of the military mission."…it is obvious that MTF personnel are entitled by law to obtain from civilian facilities that information necessary to adjudicate appropriately continued fitness for duty issues.

Section IV
SPECIAL CONSIDERATIONS

18-21 Recruits: Removal from "Full Duty" Status; MEBs on Recruits and Members Within First 180 Days of Service

(1) The appropriate initial training of recruits as they enter the Navy and Marine Corps is inextricably linked to the protection and maintenance of their health. MTF commanders supporting Naval Training Center, Great Lakes and Marine Corps Recruit Depots, San Diego and Parris Island, as well as the various Navy and Marine Corps officer candidate schools, will construct and maintain appropriate liaison with the training commands to facilitate the vital sequencing of required training regimens while concomitantly ensuring the health of the recruits undergoing that training. Agreement on the proper referral of recruits to Navy Medicine facilities for accession screening, preventive, and restorative care is essential. MTF commanders must ensure collaboration with the training commands regarding interruptions in training due to medical conditions, including "medical holds," convalescent leave, repeating basic training cycles, and medical separations as warranted.

(2) Minor physical conditions or defects need not be reason for separation when they are considered not to interfere with training and they are not expected to interfere with the recruit's ability to perform medically unrestricted duties. Physical conditions or defects discovered during training should be evaluated regarding the recruit's ability to adjust to military service and to perform and function effectively when transferred at the conclusion of training. Recruits found to have physical conditions or defects which, had they been known at the time of entry would have been considered disqualifying for enlistment, are subject to referral for administrative separation by reason of defective enlistment.

(3) Recruits found to have physical conditions or defects which, had they been known at the time of entry would have been considered disqualifying for enlistment, are subject to referral for administrative separation by reason of defective enlistment. Commands with recruits on whom such diagnoses are made can elect to pursue retaining these recruits rather than separating them. In such cases, the command should forward all pertinent medical information to the Physical Qualifications and Review Division (BUMED-M3F1) for a retention recommendation. BUMED will provide this recommendation to the members' command, which has final authority on the decision to administratively separate or retain these recruits.

(4) MTF commanders supporting the Marine Corps recruit depots and the Naval Training Center, Great Lakes will establish recruit evaluation units (REUs) as a branch of their mental health services. The REU is a professional, advisory, and consultant unit to which recruits with possible mental health conditions will be referred for appropriate mental health consultation. The MTF commander must effect appropriate provider and support staff and appropriate physical plant spaces to allow for the clinical and administrative management of patients evaluated by the REU, and must ensure that appropriate inpatient facilities are available for patients requiring admission for observation and/or treatment. When practicable, REU psychiatrists, clinical psychologists, or other appropriate staff should briefly examine each recruit as part of the arrival medical in-processing, making indicated referral appointments at that time. Moreover, the MTF commanders must effect the development of cogent criteria agreed upon by the MTF and the recruit training command, and ensure the enforcement of those criteria, for referral of recruits as indicated to the REU (or, as warranted, to the MTFs mental health and/or emergency departments) and for REU provider examinations of recruits as necessary.

(5) MTF commanders responsible for evaluating recruits for medical separation are, in addition to serving as the Navy and Marine Corp's advocate, the patient's primary advocate in ensuring that the legally appropriate manner of discharge is effected. Accordingly, MTF commanders shall implement processes, and ensure staff members are trained appropriately in these processes, by which decisions are made as to whether medical separation under entry level medical separation (ELMS) conditions or convening of an MEB for possible referral to the PEB for disability evaluation is appropriate.

(6) ***Administrative Separations (ADSEP).*** Article 18-5, multiple articles in the DON Disability Evaluation Manual, and service directives (e.g., MILPERSMAN 1910 series and the MARCORSEPMAN) discuss in detail the administrative separations process. Five key criteria emerge that must be evaluated relative to determining whether medically-based administrative separation or referral to the PEB is appropriate for recruits:

(a) Whether the medical impairment is identified prior to or within 180 days of entry onto active duty.

(b) Whether the condition was the subject of a medical waiver for the member to enter the military.

(c) Whether the condition EPTS as established in DOD Instruction 1332.38 (E3.P4.5.2) and articles 3804m-3804p of the DON Disability Evaluation Manual:

(1) Except for medical defects and physical disabilities noted and recorded at the time of entrance, any injury or disease discovered after a service member enters active duty, with the exception of congenital and hereditary conditions, is presumed to have been incurred in the line of duty.

(2) Hereditary and genetic conditions shall be presumed to have been incurred prior to entry into active duty. They will be presumed service aggravated unless evidence clearly establishes that the condition is solely the time result of the condition's natural progression.

(3) Generally recognized risks associated with treating pre-existing conditions shall not be considered service aggravation.

(4) Signs or symptoms of chronic disease identified so soon after the day of entry on military service (usually within 180 days) that the disease could not have originated in that short a period will be accepted as proof that the disease manifested prior to entrance into active Military service (DOD Instruction 1332.38 (E3.P4.5.4)).

(5) Signs or symptoms of communicable disease within less than the medically recognized minimum incubation period after entry on active service will be accepted as evidence that the disease EPTS (DOD Instruction 1332.38 (E3.P4.5.4)).

(6) Per service headquarters directives (e.g., MILPERSMAN article 1910-130), any case which cannot be conclusively determined at the MTF level as to whether the condition actually EPTS or whether the condition was aggravated at any time after the member was enlisted or inducted will result in the convening of an MEB for referring the case to the PEB for final determination.

(7) Per SECNAVINST 1850.4E, articles 1001d, 2027, and enclosure (10), "service members found unfit for continued naval service with conditions that have not been incurred or been permanently aggravated by military service," i.e., Unfit-EPTS, "are not eligible for disability severance pay or disability retirement if they have less than 8 years cumulative active service." Further details on this "8-year rule" are found at enclosure (10) of the DON Disability Evaluation Manual.

(d) Whether the condition was service aggravated.

(1) DON Disability Evaluation Manual, article 3804m, conveys that "A medical condition manifesting itself or existing prior to entry into military service will be considered "permanently service aggravated" when military service lastingly worsens that medical condition beyond its natural progression. Use generally accepted medical principles to determine "natural progression." "

(2) Generally recognized risks associated with treating pre-existing conditions shall not be considered service aggravated.

(e) Whether the condition is one that merits referral to the PEB. As conveyed in article 18-5, the mere presence of a diagnosis does not automatically confer either "disability" or the requirement for PEB evaluation of a case. Examples of these conditions appear at article 18-5.

(7) ***Referral of Recruit Cases to the PEB***

(a) ***Members with medical waivers.*** For recruits with medical entry waivers granted by appropriate authority upon recommendation by BUMED-M3F1, per article 3308a of the DON Disability Evaluation Manual: "Provided no aggravation has occurred, servicemembers who enter the military with a medical waiver may be separated without physical disability evaluation when the responsible medical authority designated by service regulations determines within 180 days of the member's entry into active service that the waivered condition represents a risk to the member or prejudices the best interests of the Government. Once 180 days have elapsed, or the condition is one that causes referral into the DES, refer the member for physical disability evaluation, if otherwise qualified."

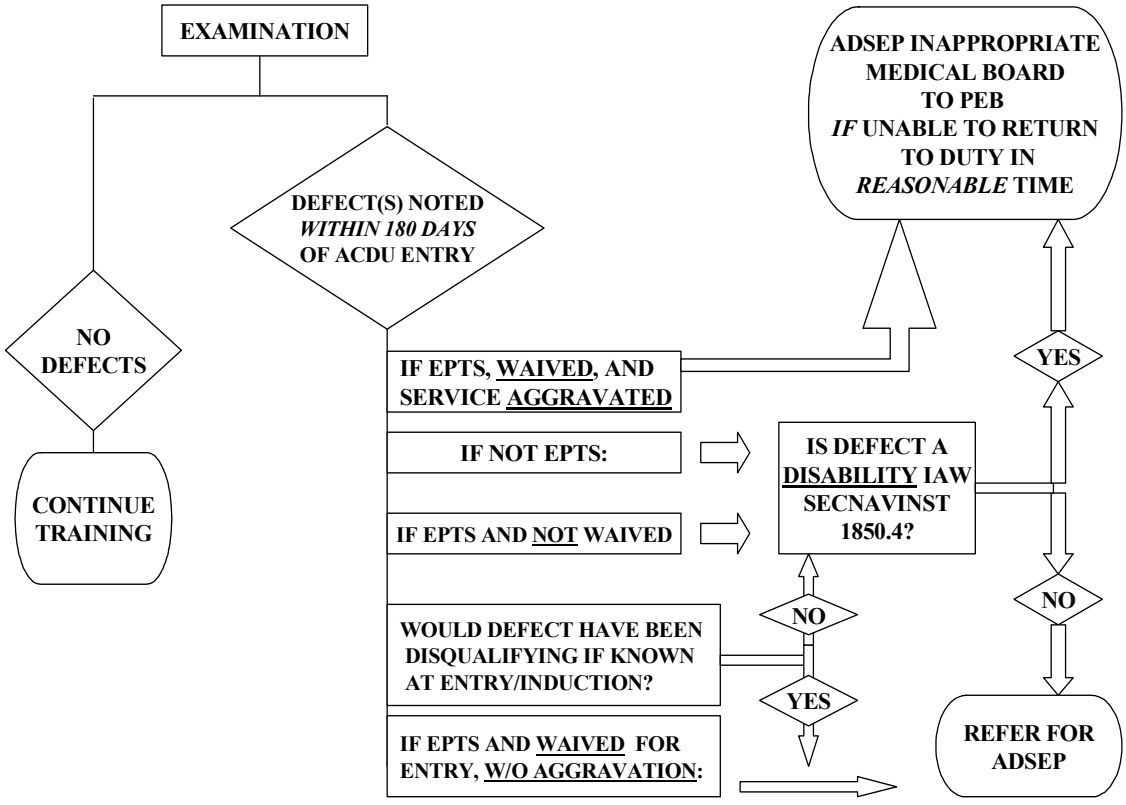
(b) ***Members Without Medical Waivers.*** Per article 3308b of the DON Disability Evaluation Manual: "Members undergoing initial active duty for training who incur an injury or condition which was not waived for the purpose of entry into military service, who will not be returned to training in a reasonable period of time, will be referred to the PEB for disability evaluation."

(8) ***Removal of Recruits from Full Duty Status Upon Diagnosis of a Medical Condition/LIMDU for Recruits.*** Program authorization for all LIMDU, as detailed in article 18-10, rests with service headquarters. While service headquarters directives do not expressly prohibit LIMDU periods for recruits, it is vital that MTFs supporting the recruit training centers realize that the unique, precisely scheduled prerequisites for successful recruit training do not comport to extended periods of LIMDU. Rather than LIMDU, recruits with medical conditions precluding their full participation in recruit training activities are placed in "recruit convalescence units" or in a "medical/administrative hold" status until they are either medically cleared to continue their training, or are referred for medical administrative separation

or to an MEB at the MTF. MTF commanders supporting the recruit training commands must ensure that the MTF and the training command have agreed upon clinical referral criteria that allow for appropriate clinical and administrative management of those patients whose condition renders them less-than-fully physically or mentally capable of participating fully in recruit training activities.

(9) ***Summary Overview.*** The following presents a flow-diagram of the process in determining whether applicable cases are handled through the administrative separation process or necessitate the MTF convening an MEB for potential referral to the PEB for disability evaluation.

Summary: ADSEP Eligibility *vs* PEB Referral



18-22 Students and Midshipmen

(1) ***Midshipmen.*** A prerequisite for eligibility for referral to the Physical Evaluation Board for disability evaluation is that the disease or injury resulting in referral to the PEB must be "incurred while entitled to receive basic pay." This factor had historically precluded midshipmen and cadets at the service academies from PEB referral, as delineated in SECNAVINST 1850.4 series, "Injury or disease which was incurred by a member while not entitled to basic pay specifically is excluded from disability benefits, unless service aggravated (10 USC 1217)." Effective with the enactment in the first quarter of FY 05 of the Ronald W. Reagan National Defense Authorization Act for Fiscal Year 2005 (NDAA 05), 10 USC 1217 was amended such that "Monthly cadet pay and monthly midshipman pay under section 203(c) of title 37 shall be considered to be basic pay for purposes of this chapter and the computation of retired pay and severance and separation pay to which entitlement is established under this chapter." This 10 USC 1217 revision then confers PEB eligibility for those "cadets at the United States Military Academy, the United States Air Force Academy, and the United States Coast Guard Academy, and midshipmen of the United States Naval Academy, but only with respect to physical disabilities incurred after the date of the enactment of the Ronald W. Reagan National Defense Authorization Act for Fiscal Year 2005." Additional implementing guidance on processing PEBs for service academy cadets and midshipmen is available from the DON PEB. Members of ROTC, by definition, are not entitled to basic pay, and are therefore ineligible for disability benefits adjudicated by the PEB. Questions on the disposition of these members in connection with determinations of "physically qualified/not physically qualified" (PQ/NPQ) should be referred to the Patient Administration/Medical Evaluation Boards officer at the MTF, with additional referral to BUMED (Physical Qualifications and Review Division), who renders the PQ/NPQ decision in these cases.

(2) ***Students in Recruiting Command Programs Entitled to Basic Pay.*** There are officer recruitment programs operated by Commander, Navy Recruiting Command (CNRC) and Marine Corps Recruiting Command (MCRC) in which students enrolled in academic programs leading to a commission are, during their college coursework, entitled to receipt of basic pay. Accordingly, these individuals are entitled to DES determinations, just as any other ADSM, in accordance with SECNAVINST 1850.4 guidance. Students in these categories (e.g., the Nuclear Power Commissioning (NUPOC) Program and certain enlisted commissioning programs (ECP)) will be evaluated by BUMED Physical Qualifications and Review Division (BUMED-M3F1) for "PQ/NPQ" determination for retention in the program or for commissioning determination. BUMED-M3F1 will advise whether or not these cases meet the criteria for referral into the DES. For cases meriting referral to the PEB, CNRC, and MCRC staff will contact the Military Medical Support Office (MMSO) in Great Lakes, IL as necessary for assistance in identifying which Navy MTF will be tasked with convening an MEB in these cases. MTF staff are to provide every assistance necessary to CNRC, MCRC, and MMSO in this regard, recognizing the special constraints (e.g., academic responsibilities and sometimes significant geographic separation from an MTF) inherent in the academic settings in which these patients are located. The MTF identified to convene the MEB will follow the case through to completion, ensuring liaison with MMSO, CNRC, or MCRC as appropriate to facilitate the PEB receiving the case for adjudication.

18-23 Reservists: Physical Disqualification and Referral to the PEB

(1) ***Reserve Component (RC) Members are Required to Meet Physical Qualifications as set forth in MANMED.*** Every reservist is responsible for notifying his or her CO immediately of any physical problem that may delay or preclude his or her mobilization. Additionally, if a unit or activity CO receives information from the annual screening or, for other reason, believes a reservist is NPQ for active duty or retention, he or she shall ensure the member is examined by a medical officer as soon as possible. If the medical officer discovers a potentially disqualifying

defect as noted in this chapter, the reserve activity CO will forward the result of the examination to BUMED-M3F1, Physical Qualifications and Review Division, via the echelon 4 command for determination for fitness for continued service. BUMED will review available information, advise service headquarters of the member's medical condition, and recommend disposition (i.e., whether the member should be retained in the RC or separated as being NPQ for retention). Service headquarters will notify the member of this finding and, for NPQ findings, will offer three options, including: retirement, if eligible; administrative separation; or request for adjudication of the case by the PEB. If the PEB determines the member is PQ, he or she may be reassigned in a drilling status.

(2) ***Referral of RC Member Cases to the PEB.*** If an RC member elects a PEB following review by BUMED, the members MEBR will be compiled following the procedures for active component members conveyed throughout this chapter, and forwarded to the PEB. As with all Navy and Marine Corps members, a case referred to the DON PEB must be referred from one of the MTFs whose commander holds CA for MEBs (as delineated in article 18-3). If the physical distance from a Reserve unit to one of these MTFs precludes the patient actually being evaluated at the Navy MTF, all consultant services should be obtained from another appropriate DOD, DVA, or TRICARE facility and reports thereof forwarded to a Navy MTF whose commander holds CA. Per SECNAVINST 1770.3 series, the service headquarters will review the member's eligibility for disability benefits and, when appropriate, issue a notice of eligibility (NOE) or line of duty (LOD) certification. In some cases, it will be clinically mandatory that the member present in person at a Navy MTF to allow for appropriate preparation of the MEBR; the member's CO in these cases should be prepared to ensure appropriate funding and logistic support, and should ensure that unit representatives are in contact with the MTF's patient administration and/or Operational Forces liaison offices to facilitate appropriate clinical and administrative case management. Additionally, some cases may require that the Reservist provide medical documentation of care received from providers not involved with the MHS. Directives (refer to SECNAVINST 1770.3 series) and legal interpretation exist for DON to obtain this clinical information; additional guidance in these cases should be obtained from BUMED JAG and/or the JAG officers serving respective RC units.

(3) As with all MEB actions, there are clinical as well as personnel components inherent in processing RC members' MEBRs. For questions not addressed herein, RC members and their parent commands should refer to the SECNAVINST 1770.3 series and COMNAVRESFORINST 1001.5 series for additional guidance, and should contact their respective service headquarters for more definitive information. Particularly in cases involving an RC member's desire to remain on active duty pending PEB adjudication (as provided under National Defense Authorization Act 2000) or, conversely, to release from an active duty for special work period pending PEB findings without compromising potential benefits (see DOD Instruction 1332.38, section E3.P2.7.2.1) additional guidance should be sought by the member and his or her parent command from elements of their RC chain of command.

(4) ***Temporary Disqualifications.*** Inactive Reservists are not routinely eligible for LIMDU (as developed in previous sections of this chapter). A medical officer may classify a member as temporarily NPQ (TNPQ) when the member has a physical disqualification of a minor or temporary nature that would not preclude the member from attending drill. The prognosis for recovery must be greater than 1 month, but less than 6 months for TNPQ status to be possible. Members may remain TNPQ for a maximum of 6 months. If it appears the disqualifying factor is of a more permanent nature, the procedures for determining PQ/NPQ status as defined above will be initiated by the medical officer and the Reserve activity.

18-24 Flag, General, and Medical Corps Officers: PEB Requirements

(1) Cases involving Marine Corps Generals, Navy Admirals, and Navy Medical Corps (210X) officers (irrespective of rank) that are being referred to the

PEB have additional requirements levied on them as compared to other PEB cases, as it is mandatory they be treated as "special interest" cases following SECNAVINST 1850.4 series.

(2) For Flag and General officer cases, the originating MTFs are advised to refer to the appropriate articles of the DON Disability Evaluation Manual for specific information relative to case processing.

(3) For Medical Corps (210X) cases, MTFs must convene a Peer Review Board and must comport to all particulars of the credentialing and privileging directives; MTF staff preparing Medical Corps officer cases are directed to refer to the appropriate articles of the DON Disability Evaluation Manual for specific information relative to case processing.

18-25 Care at the End of Active Duty, Medical Care Subsequent to Submission of a Case to the PEB, and Fitness to Separate

(1) **Care at the end of active duty** Marine and Navy members in the waning aspects of their service facing non-punitive separation, whether due to voluntary longevity retirement, or voluntary separation at end of active obligated service (e.g., EAS or EAOS), or involuntary separation (e.g., high year tenure or an ongoing case being adjudicated via the DES), often encounter situations requiring a difficult resolution of whether a health problem should force their being retained on active duty beyond the previously established date of separation. These cases are increasingly difficult given that separation from active duty decisions are personnel actions that must be effected in compliance with the Federal laws regulating eligibility for care within the DOD MHS. Accordingly, when a separation or retirement date has been established, every effort must be made to effect the servicemember's discharge on that date. Only the respective service headquarters can alter a servicemember's date of discharge. MTFs caring for patients who have an impending separation date who present with or incur conditions for which care is neither deferrable nor elective, and for which the course of care cannot be completed prior to the scheduled separation date, must ensure that respective service headquarters are made aware of such situations immediately. For patients whose care is deferrable and/or elective, it is not appropriate for MTFs caring for patients with an impending separation date who present with conditions for which care is deferrable and elective to attempt to forestall the established separation or retirement date. MTF staffs shall be attentive in these situations to not launching an elective course of care which cannot be expected to be completed prior to the scheduled separation date.

(a) In cases where patients present or are diagnosed with a condition for which competent MTF authorities determine the care is not elective, the MTF should immediately notify the parent command and the respective service headquarters of the member's condition and anticipated course of care. Actions for retaining the member on active duty until a definitive resolution (i.e., either curative care or referral to the DES) is effected are appropriate. (Provided this is the patient's intent: Provisions in MILPERSMAN articles 1160-040 and 1160-050), the Marine Corps Separation and Retirement Manual (MARCORSEPMAN), and the SECNAVINST 1850.4 series allow servicemembers to waive care and/or referral to the PEB so they may release from active duty at the scheduled release date, so consultation with the patient is paramount.

Cases of this nature involving members for whom a retirement date has been set, will be evaluated under a standard of presumed fit (P-FIT). Such cases must be received by the PEB 60 days prior to the originally scheduled date of retirement or EAOS to allow for adequate processing time. President, PEB will verify dates with the appropriate service headquarters. MEBs received within the 60-day window will be screened by a medical officer of the informal PEB to ensure serious conditions potentially overcoming P-FIT are not overlooked. Cases not accepted after medical review will be rejected and returned to the MTF. Service headquarters will be notified of case rejection to allow continued processing of the member for retirement. Acceptance of cases within this window does not necessarily mean that members will overcome the "presumption of fitness" criteria.

(b) Cases in which the course of care is determined to be "elective" may lead to debate over whether to render that care, particularly if it cannot be accomplished within the member's remaining period of service. DOD 6015.1-M, the Glossary for Healthcare Terminology, defines the following:

(1) ***Deferred Non-Emergency Care.*** "Medical or dental care (such as eye refraction, immunizations, dental prophylaxis, and so on) that can be delayed without risk to the patient."

(2) ***Elective Care.*** "Medical, surgical, or dental care that, in the opinion of professional authority, could be performed at another time or place without jeopardizing the patient's life, limb, health, or well-being." Obviously however, the decision of what constitutes "elective" care is a clinical call that must be determined on a case-by-case basis. Disputes that may emerge among clinicians as to whether a projected course of care is "elective" must also be decided from a clinical perspective with involvement of the appropriate chain of command of the MTF. Predicated on respective command's policies, the senior medical officer, the chief of the clinical staff and/or the CA for medical boards (i.e., the CO) should be consulted as the final arbiter of whether a case involves "elective care."

(c) In cases involving would-be retirees and "elective" care, the requirement to maintain the member on active duty is not compelling in many cases, as retirees still have Federally-mandated access to care within the direct care infrastructure of the MHS. Only in those cases where the would-be retiree can assert an impact on any potential disability determination status should consideration of retention on active duty be entertained.

(d) For personnel being discharged shy of the number of years required to establish an ongoing entitlement to care in the MHS, the decisions on whether to commence "elective" courses of care near the time of an already-determined separation date become more acute, as there is no entitlement to care following the date of discharge (outside the provisions of any Transition Assistance Management Program (TAMP) that may be in effect at the time). For those cases in which it cannot be asserted that a patient's condition represents a potential disability that mandates referral to the DON PEB, the provider must conscientiously determine whether all care can appropriately be rendered prior to the member's projected date of discharge. As it is unlikely that service headquarters would extend a servicemember's period of active duty to receive "elective" care, providers must be exactingly cautious not to commence a course of care that will not be concluded prior to the expiration of the patient's eligibility for care. In these cases, clinically appropriate deferral of care to appropriate civilian providers (or the DVA as applicable) as indicated by the patient should be pursued. As always, extenuating circumstances, unusual cases or any requests for clarifying information should be forwarded to the patient administration officer.

(2) Those cases in which a patient is considered for or undergoes substantive surgical intervention or medical care after his or her case has already been submitted to the PEB merit special attention. It is imperative that the health record of any patient being referred to an MEB contain prominent notation of this so that any provider who engages in a course of care with the patient subsequent to the patient being referred to an MEB is readily aware of this fact. The PEB and the patient's respective service headquarters must be notified immediately of any surgical or significant medical intervention that occurs subsequent to the patient's case being submitted to the PEB, as this may bear a significant impact in the deliberations of the PEB. Elective and deferrable surgeries should not be undertaken following the submission of the MEBR to the PEB, and in consonance with appropriate clinical management, any non-elective surgeries should be completed prior to the submission of the MEBR to the PEB to facilitate comprehensive case adjudication by the PEB members. The role of the provider in communicating with the MTF patient administration or MEBs service cannot be over-emphasized in these cases. The provider and the patient administration officer must ensure that the patient, his or her parent command, the PEB, and the respective service headquarters remain constantly apprised of the patient's status, particularly regarding any attempt to retain the patient on active duty beyond the previously enacted separation or retirement date.

(3) ***Fitness to Separate.*** A substantive number of cases involving potential retention beyond an already established separation or retirement date emerge from findings noted during the member's separation PE (as otherwise, the LIMDU and PEB processes should have led to documentation of significant illness or injury throughout the member's period of service). MTFs must ensure the timeliness and accuracy of separation physicals, including ensuring that all required and indicated follow-on studies and consultations are completed prior to the physical being signed off and the member being separated. These separation physicals are predicated on criteria for retention,

not accession. As such, they are documenting that servicemembers are fit for "continuing" service (e.g., Reserve affiliations following release from active duty, etc.). They are not intended to document that the patient is a "perfect specimen;" neither are they intended as a road map to be followed in returning the patient to the "perfect specimen" condition conveyed by accession standards. The origin of and logic behind the "separation physical" as conveyed in MANMED article 15-29, indicate that the separation physical serves chiefly in:

(a) Documenting the member's suitability for continuing service, (i.e., Reserve affiliation or potential return to active duty) as the measurement of fitness to separate.

(b) Establishing the presence (and, equally important, the absence) of any service-connected disability condition that must be referred to the Navy's PEB following the SECNAVINST 1850.4 series. Routine service, and the years inherent therein, induce wear and tear, and it is likely that after significant service many patients will present with diagnoses that may well have been "disqualifying" on an entrance physical had the diagnoses manifested then. From that perspective it is critical to remember that the mere presence of a "check in the block" on the separation physical paperwork neither prima facie indicates a condition barring on-time release from active duty, nor translates into automatic referral to the PEB. "Fit to separate" status at the time of retirement or separation does not indicate that a departing servicemember is devoid of medical conditions or diagnoses, but rather indicates:

(1) The absence of a service-connected disability condition meriting referral to the PEB (except for, obviously, those cases where the PEB has found a member unfit).

(2) The satisfaction of retention standards allowing a servicemember to satisfy Reserve affiliation obligations and/or be considered for re-entering active service.

(4) ***Cases Involving Punitive Discharge.*** Personnel regulations do not afford members undergoing punitive discharge the same alternatives available to those separating under non-punitive conditions in dealing with medical situations emerging at the time of the separation physical. Retention on active duty to deal with situations emerging on separation physicals in these cases is not permitted. MTFs caring for patients in these situations must be mindful of the overriding legal ramifications; referral to MILPERSMAN article 1900-808 for Navy personnel is required, and conference with appropriate legal and PSD officials is encouraged; referral to MARCORSEPMAN for Marine Corps personnel.

18-26 Checklist Elements for MEBR Being Submitted to the PEB

(1) Article 18-12 provides a comprehensive example of the complete MEBR format to be used in cases being submitted to the PEB for adjudication of fitness for continued naval service. Excerpted here are items, and the order in which they should appear to enhance processing, of those cases referred by MTFs to the PEB:

(a) NAVMED 6100/1 Information (cover) sheet (as defined in MANMED article 18-9, depicting member's identifying information name, rank, grade, and social security number; specialty of the signatory physicians; clinical department and/or service authoring or sponsoring the document; MTF and its location; dates MEBR was conducted and dictated; and signatures of the members of the MEB).

(b) The dictated MEBR, bearing identifying information and signatures as appropriate of the MEB members and the patient. Under no circumstances will the narrative prepared by the MTF state that the member is unfit, or provide recommendation for a disability percentage rating. (See MANMED article 18-12(3)k for information on specific permissible wording in this regard.)

(c) NAVMED 6100/2, Medical Board Statement of Patient.

(d) Specialty related considerations and addenda.

(e) Rebuttal to the MEBR (if prepared by the patient) and surrebuttal. When the member submits a rebuttal to a medical board or an addendum, the

physician authoring the MEBR must address the member's specific issues. (MANMED article 18-19 details handling of rebuttals and surrebuttals.)

(f) A complete PE conducted within 6 months of the date of the MEBR. In all cases, hand dominance must be stated. Height and weight must be documented in all MEBRs.

(g) The NMA from the member's CO (see MANMED article 18-15 for discussion of NMAs).

(h) A copy of the member's health record, single sided. Any supplemental records should be submitted. If the member's medical record is for any reason not included with the MEBR, this fact should be pointed out concisely to the PEB at the time the MEBR package is forwarded to PEB. Cases in which the patients health record is unavailable should be discussed with the PEB prior to forwarding the case.

(i) Copies of all narrative summaries of hospitalizations and all procedure reports.

(j) ***Laboratory and Ancillary Studies.*** All studies that support and quantify the diagnosis(es) should be included as should any studies that conflict with the diagnosis(es). All results maintained in CHCS will be printed and included in the health record to ensure the PEB receives complete information.

(k) ***Photographs.*** Current photographs are essential in burn cases and very useful in cases with significantly disfiguring scars. Photographs submitted should be certified by the medical photography department to have been taken within 1 month of the date of dictation of the MEBR.

(l) ***Competency Statements.*** Competency statements are required on all psychiatric diagnoses (except where the psychiatric condition has resolved). Where a member's competency is in question, an incapacitation board must be held and the report of the incapacitation board must be submitted to the PEB. The statement of competency must be made by a psychiatrist following the criteria established by the JAG Manual.

(m) LODD, where required (See MANMED article 18-16).

(n) Notice of eligibility (NOE) or line of duty (LOD) certification as required in processing cases for RC Personnel (see MANMED article 18-23).

(2) MTFs are encouraged to develop locally-optimized checklists predicated on the above items, to ensure comprehensive and timely compliance with MEBR requirements. In addition to the above elements, these checklists may also include items that do not appear in an MEBR prepared for the PEB, such as: attendance of the patient at Disabled Transition Assistance Programs (DTAPs); acquisition of TEMDU orders (as indicated) from the patient's parent command; provision for family members relocation and/or other needs if the member undergoing an MEB has been transferred from his or her previous command; collaboration between the MTF and the servicing PSD for any patient-specific personnel actions; assignment of caseworker (if the patient administration/MEBs office is using a case management system); evidence of any required interaction between the patient administration or MEBs office and the MTF operational forces medical liaison service; evidence of communications between the MTF and the patient's parent command; confirmation of appropriate briefings to the patient on MEB processes; and other items that the MTF deems appropriate.

18-27 The Medical Board OnLine Triservice Tracking (MedBOLTT) System

(1) The MedBOLTT is a Web-based system accessible to those MTFs with CA to perform MEBs. MedBOLTT is operated by contract under the aegis of NMIMC. Questions on MedBOLTT policy will be directed to the BUMED Patient Administration and TRICARE Operations Branch; questions on technical aspects of MedBOLTT operation will be referred to the MedBOLTT project officer at NMIMC and/or the help desk provided by the MedBOLTT contractor, as determined by NMIMC. It is imperative that MTF commanders possessing CA for MEBs (MANMED article 18-3) ensure they have

adequate numbers of staff appropriately trained in MedBOLTT applica-tions to guarantee all activity involving MEBs is entered promptly and correctly into MedBOLTT. As developed in MANMED article 18-1, the proper exe-cution of MEB and MEBR actions is a significant readiness issue and a force multiplier; MedBOLTT is the method by which Navy Medicine reports its efficacy in executing this vital mission.

(2) MedBOLTT captures and shares data globally, allowing all MTFs with CA to research, for any patient referred to an MEB, both the contemporary board activity as well as historical referrals to any MEB. These historical checks are vital to assisting service headquarters and parent commands with ensuring appropriate personnel community management across the Navy and Marine Corps, and proper routing of MEBRs, given that:

(a) Service headquarters must approve certain LIMDU periods.

(b) Total LIMDU must be tracked to ensure appropriately timed referral to the PEB should the patient's condition(s) not completely resolve while on LIMDU.

(c) Stipulated time intervals must be satisfied before a case previously adjudicated by the PEB can be referred anew by an MTF to the PEB for additional action.

(3) It is imperative that all aspects of MEB and MEBR activity be entered into MedBOLTT. These MedBOLTT entries must include final findings for cases adjudicated by the PEB (whether entered by PEBLOs or by Patient Administration/MEBs staff) as well as cases where members are returned to duty following LIMDU.

(4) MTFs shall take all appropriate steps to protect the privacy of patients by securing the integrity of the sensitive information contained in MedBOLTT.

18-28 Rejection, Suspension, or Termination of Cases at PEB

(1) The PEB can reject cases submitted to it by the MTFs, or elect to suspend or terminate cases, for a variety of reasons at anytime prior to releasing "en bloc" findings. In the overwhelming majority of such cases, the PEB requires additional clinical information from the MTF submitting the MEBR. In the case of PEB suspension or termination of cases, the PEB will communicate directly and immediately upon rendering a cancellation or suspension determination with the MTF MEB staff to delineate cause for suspension or cancellation and remedial actions to be undertaken by the MTF. Cases terminated by the PEB that are resubmitted by an MTF must contain a completely new MEBR and NMA, and must contain no other information older than 6 months old by the time the case is received at the PEB (i.e., patient administration or medical boards staffs must ensure that only contemporary information is submitted in any case forwarded for adjudication to the PEB).

(2) ***An MTF that has submitted an MEBR to the PEB cannot unilaterally cancel that MEBR.*** If a patient who has been submitted to the PEB has experienced, in the opinion of the CA who referred the patient to the PEB, a significant enough change in condition that the PEB referral may no longer be optimal, the MTF shall communicate this information to the OIC of the recorders at the PEB via reliable, confirmable communication methods, (including naval message traffic or fax) as a request to cancel the MEBR. The PEB will confirm receipt of this MTF request immediately, and will convey information indicating when a decision on the cancellation request will be rendered. Both the MTF and the PEB shall ensure that the patient and the patient's parent command are apprised in real time of developments with the PEB referral and it's possible cancellation in such cases.

18-29 Training for MTF Staff, Patient Counseling, and the Role of the PEBLOs

(1) The arena of "MEBs" is unfamiliar to many, and Navy Medicine must eliminate this unfamiliarity by practicing empathy and by ensuring appropriate training exists for providers, MEB staffs, and patients (and their commands) involved with the MEB system. MTFs, in concert with parent commands and service headquarters must assiduously track and manage those patients in the MEB system both to reduce each respective patient's period of medically unrestricted duty, and to optimize the fighting forces of the Navy and Marine Corps. To that end, we must ensure appropriate communications with our patients and their commands to eliminate confusion and facilitate rapid returns to healthy service or, where indicated, expeditious referral to the DON Disability Evaluation Manual.

(2) The Physical Evaluation Board Liaison Officers (PEBLOs) provide a critical, congressionally mandated function of vital importance in the operation of the MTF MEB role. The PEBLOs are guided by SECNAVINST 1850.4 series in their role of counseling Navy and Marine Corps members who have been entered into the DON Disability Evaluation Manual. The DIRSECNAVCORB assigns PEBLOs to eight MTFs whose volume of DES cases warrants a full-time counselor to serve patients at and near those MTFs. (Those MTFs are Bethesda, San Diego, Portsmouth, Jacksonville, Camp Lejeune, Great Lakes, Camp Pendleton, and Pearl Harbor.) At those Navy MTFs where permanently DIRSECNAVCORB-assigned PEBLO counselors are not available, the MTF commander shall designate a staff member to provide disability counseling to patients entered into the DES. PEBLOs and those MTF members assigned collateral duties for counseling DES patients should, wherever practical, be senior enlisted members or equivalent civilian employees. Initial, quarterly, and annual training is provided to all PEBLOs, including the collateral duty PEBLOs or counselors, in a comprehensive training program proffered by the PEB staff; additional information is offered via the PEBs Web site (see article 18-30). MTF commanders are encouraged to define and actuate, via interaction with the PEBs OIC of PEBLOs, that pattern of PEBLO involvement that optimizes their respective MTF's performance. MTF COs are required to maximize the funding for training opportunities for their PEBLOs, and at a minimum will ensure they fund their PEBLOs attendance at the annual PEB Conference, historically held in the spring of each calendar year. (Funding for this conference for DIRSECNAVCORB-appointed PEBLOs will be provided by DIRSECNAVCORB.)

(3) Article 18-3 delineates MTF commander training responsibilities relative to MEBs operation. Other areas of this chapter of MANMED talk to the importance of having MTF-specific written guidance on the proper execution of MEBs. The following are offered as broad-based areas of consideration in developing cogent, effective MEB, and patient administration or MEBs staff training offerings.

(4) For MEBs Staff and PEBLOs the following are integral training points:

(a) Who counsels patients? On what? What is interplay between providers and MEBs staff regarding patient counseling? Who counsels regarding benefits, particularly when the next of kin (NOK) is geographically removed from the MTF? Does the MTF have appropriate practices in place, including for those patients who are hospitalized in non-DOD facilities?

(b) Are procedures for working with clinical staff, including setting consult and PE appointments, clearly delineated?

(c) Does the staff understand the role of EPMACs TMU?

(d) Does the staff understand what comprises a complete MEBR package, whether the final disposition is the PEB or service headquarters (for LIMDU determination)?

(e) Does the staff understand the relationship of their operations to the medical holding company and to the Operational Forces liaison office?

(f) Does the staff know who the MTFs LIMDU coordinator is?

(g) Does the staff realize the importance of, and the mechanisms for, communicating with parent commands and the line activities whose Sailors and Marines are in the MEB process?

(h) Does the staff have ready access to all pertinent directives?

(i) Does the staff understand the MTF's MEBR dictation system?

(j) Does the appropriate staff have access to MedBOLTT and any system that succeeds it?

(5) For providers the following are integral training points:

(a) Are all appropriate providers trained and certified in writing by the CA to sit on MEBs?

(b) Do providers have ready access to all SECNAV, BUMED, and MTF-specific directives on MEBs and MEBRs?

(c) Do providers understand their difficult role as advocates for both their patients and the DON in MEB cases, and have avenues of redress for conflict been appropriately explained?

(d) Do providers understand the PE standards conveyed in MANMED chapter 15, and understand that a complete PE is required pursuant to every MEB? Is there agreement across the MTF on who performs PEs for cases being referred to the PEB, and are appointments readily available and results immediately provided to the MEB office?

(e) Are providers given appropriate guidance in the execution of TDRL reevaluation appointments?

(f) Is there a comprehensive training program in place for providers? Is this mandated at the command level, or delegated to clinical department heads, and if so how is this delegation conveyed?

(g) Are providers required to attend the site visit briefs conducted by the PEB staff?

(h) At institutions with teaching/residency programs, are MEB and/or PEB staff provided lecture time with newly-arriving providers?

(i) Do providers understand the relationship of their practice to the medical holding company, operational forces office, and operational units (e.g., why returning a member in a full leg cast to a ship is contraindicated).

(6) For patients, the following are integral training and counseling points:

(a) Do patients receive comprehensive counseling on the significance of the actions proposed and the related rights, entitlements, and benefits accruing to them under the DES (see DOD Directive 1332.18).

(b) Can patients readily access all pertinent directives? Has the MTF prepared a concise handout and/or Web site information for patients involved in the MEB arena?

(c) Are Transition Assistance Program and Disabled Transition Assistance Program (TAP/DTAP) courses available and appropriate (i.e., timely and informative) for cases being referred to the PEB? Are DVA and other representatives made available to patients in the MEB system?

(d) Are appropriate external agency liaisons available for patients undergoing MEBs?

(e) Have MTF staff explained to the patient who will provide counseling on the MEB process?

(f) Upon receipt of findings do PEBLOs counsel patients receiving findings of unfit for continued naval service on options for "home awaiting orders" status (MILPERSMAN article 1910-900 and MARCORSEPMAN pertains) as well as options for pursuing PLD status? PLD regulations changed with the publication of the SECNAVINST 1850.4E such that the President, PEB, is no longer considering "conditional" acceptances of PEB findings involving granting any PLD. All PLD actions accordingly are regulated by service headquarters, and patients receiving PEB findings of unfit for continued naval service who wish to pursue PLD must submit this request pursuant to receiving their PEB findings. Additional information on this topic is available from the PEBLOs and in SECNAVINST 1850.4 series.

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Reference Listing

Directive Number	Directive Title	Available Electronically at
DOD Directive 1332.18	Separation or Retirement for Physical Disability	http://www.dtic.mil/whs/directives
DOD Directive 6130.3	Physical Standards for Appointment, Enlistment or Induction	http://www.dtic.mil/whs/directives
DOD Instruction 1332.38	Physical Disability Evaluation	http://www.dtic.mil/whs/directives
DOD Instruction 1332.39	Application of the Veterans Administration Schedule for Rating Disabilities (VASRD)	http://www.dtic.mil/whs/directives
DOD Instruction 6025.15	Implementation of Department of Defense Participation in the National Practitioner Data Bank	http://www.dtic.mil/whs/directives
DOD Instruction 6130.4	Criteria and Procedure Requirements for Physical Standards for Appointment, Enlistment or Induction in the Armed Forces	http://www.dtic.mil/whs/directives
SECNAVINST 1850.4 series	Department of the Navy Disability Evaluation Manual	http://neds.daps.dla.mil/
SECNAVINST 1770.3 series	Management and Disposition of Incapacitation and Incapacitation Benefits for Members of Navy and Marine Corps Reserve Components	http://www.bupers.navy.mil/
No Directive Number	PEB Guidebook for Physicians(Authored by Captain Wurzbacher)	http://neds.daps.dla.mil/
No Directive Number	PEBLO Guidebook	Not online, available through PEB
SECNAVINST 6320.24 series	Mental Health Evaluations of Members of the Armed Forces	http://neds.daps.dla.mil/
OPNAVINST 6000.1 series	Management of Pregnant Servicewomen	http://www.bupers.navy.mil/
BUMEDINST 1300.2 series	Medical, Dental, and Educational Suitability Screening and Exceptional Family Member Program Enrollment	http://navymedicine.med.navy.mil/
BUMEDINST 6300.8 series	Donations, Transplants, and Disposition of Organs and Tissue	http://navymedicine.med.navy.mil/
BUMEDINST 6320.79 series	Medical Examinations for Members on the Temporary Disability Retired List	http://navymedicine.med.navy.mil/
NAVMEDCOMINST 6320.72 series	Non-Naval Health Care	http://navymedicine.med.navy.mil/
BUMEDINST 6440.8 series	Operational Forces Medical Liaison Services	http://navymedicine.med.navy.mil/
BUMEDNOTE 6300 of 26 Jul 2001	Implementation of the DD Form 2807-1, DD Form 2807-2, and DD Form 2808	http://navymedicine.med.navy.mil/
MCO P1900.16 series	Marine Corps Separation and Retirement Manual	http://www.defenselink.mil
MILPERSMAN 1300 series	Limited Duty	http://www.bupers.navy.mil/
MILPERSMAN 1900 series	Administrative Separations	http://www.bupers.navy.mil/
BUPERSINST 1001.39 series	Administrative Procedures for Reservists on Inactive Duty	http://www.bupers.navy.mil/
BUPERS/BUMEDINST 1306.72 series	Policy and Procedures concerning Medical Holding Companies	http://www.bupers.navy.mil/
EPMACINST 5000.3 series COMNAVRESFORINST 1001.5 series	Transient Personnel Administration Manual (TPAMAN)	Not available on line.
JAGINST 5800.7 series	JAG Manual	http://neds.daps.dla.mil/jag/5800_7c.pdf
Air Force Instruction 44-157	Medical Evaluation Boards and Continued Military Service	http://afpubs.hq.af.mil
Air Force Instruction 48-123	Medical Examinations and Standards	http://afpubs.hq.af.mil
Air Force Instruction 41-210	Patient Administration Functions	http://afpubs.hq.af.mil
Army Regulation 635-40	Physical Evaluation for Retention, Retirement, or Separation	http://www.usapa.army.mil
Army Regulation 40-501	Standards of Medical Fitness	http://www.usapa.army.mil
Army Regulation 40-400	Patient Administration	http://www.usapa.army.mil
Coast Guard DOMDTINST M6000.1B CH-18	Medical Manual	http://www.uscg.mil/ccs/cit/cim/directives/CN/CN_6000_2004_6_15.pdf
	VARIOUS WEB SITES	
BUMED Web Sites	Navy Medicine Online BUMED Patient Administration	https://navymedicine.med.navy.mil/ https://navymedicine.med.navy.mil/ (Under “Hosted Sites”)
DON PEB Web Site		http://www.hq.navy.mil/ncpb/
MedBOLTT Web Site		http://medboltt.med.navy.mil
Navy & Marine Corps Appellate Leave Activity Web Site		http://hqinet001.hqmc.usmc.mil/namala/
Transient Monitoring Unit (TMU) Web Site	Transient Personnel Administration Manual (TPAMAN)	http://www.epmac.nola.navy.mil/tmu/