SHIPBOARD MEDICAL PROCEDURES MANUAL

COMNAVAIRFORINST 6000.1

DEPARTMENT OF THE NAVY

COMMANDER
NAVAL AIR FORCES

PO BOX 357051
SAN DIEGO, CALIFORNIA 92135-5100

COMNAVAIRFORINST 6000.1
N01M

OCT 21 2005

COMNAVAIRFOR INSTRUCTION 6000.1

Subj: SHIPBOARD MEDICAL PROCEDURES MANUAL

1. Purpose. To promulgate a consolidated functional guide to medical procedures for aircraft carriers of the Naval Air Force. Due to extensive revision, paragraph markings have been omitted. This instruction should be read in its entirety.

2. Cancellation. COMNAVAIRPACINST 6000.2C/COMNAVAIRLANTINST 6000.1E, COMNAVAIRLANT/COMNAVAIRPACINST 6320.5B

3. Scope. The primary mission of the medical department is to maintain the health, safety and well being of the crew by means of a comprehensive program of prevention and treatment of illness and injury. The directives and information contained in this manual address the common medical procedures encountered in Naval Air Forces. Commands shall use this instruction as the basic shipboard medical guide.

4. Summary of Changes.

a. This revision is a complete rewrite and reorganization of the Aircraft Carrier Shipboard Medical Procedures Manual and commands shall review this instruction in its entirety. Significant changes include the following:

(1) Chapter 2 now reflects the consolidation of the AIRLANT and AIRPAC Force Medical offices into the newly organized NAVAIRFOR Force Medical. It also reflects updated individual training requirements that have been incorporated into the Navy Training Management and Planning System.

(2) Chapter 3 now reflects the implementation of the Fleet Response Plan and the subsequent changes to the aircraft

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carrier training and deployment cycles as outlined in the Carrier Assessment Readiness Training Manual, COMNAVAIRFORINST 3500.20 (series).

(3) Chapter 4 reflects the implementation of Clinical Psychology, Physical Therapy, and the Radiation Health Officer within the carrier medical department and defines the roles and responsibilities of these positions.

(4) Chapter 6 changed the reporting requirements for reporting communicable disease occurrences, now requiring the use of the SAMS system for accomplishing these reports.

(5) Chapter 8 establishes the procedures for optional shipboard deployment of blood products. It also provides guidance on the use of the Pre-deployment Medication Analysis and Reporting Tool to provide for chronic medication requirements prior to a deployment.

(6) Chapter 10 now reflects implementation of the Fleet Prime Vendor and the Pharmaceutical Guaranteed Returns programs.

(7) Chapter 13 reflects changes in the requirements for First Aid Boxes, Gun Bags, and Reeves Sleeve Litters. It also includes a new section on use of the Biological Warfare Confirmatory Laboratory.

(8) Chapter 15 enhances guidance on the structure and function of the ship's Health Promotion program.

(9) Chapter 16 includes guidance on the implementation of waterless hand sanitizing stations at key points throughout the ship to reduce the threat of food-borne illnesses.

(10) Chapter 17 clarifies the roles of the Medical Department and the Safety Department in the implementation and monitoring of the Medical Surveillance program.

(11) Chapter 18 is a new chapter on Quality Assurance that combines elements previously contained in Chapter 5 of this instruction and in COMNAVAIRLANT/COMNAVAIRPACINST 6320.5B.

(12) Appendix E provides a new format for the Monthly Report. It is intended to standardize and simplify reporting requirements.

(13) Appendix F provides a new consolidated guide to facilitate shipboard MEDEVAC procedures.

(14) Appendix I provides new sample forms for use in management of elective surgery and various endoscopic procedures.

(15) Appendix K is a new listing of the NAVAIRFOR formulary of available medications.

(16) Appendix M provides a consolidated listing of all carrier Authorized Minimum Medical Allowance Lists.

(17) Appendix Q provides recommended locations for First Aid Boxes and Reeves Sleeve Litters.

(18) Appendix R provides a new comprehensive pre-deployment checklist to assist in the preparation for overseas movement.

(19) Appendix S provides post hepatitis and Human Immuno-deficiency Virus (HIV) exposure prophylaxis protocols.

(20) Appendix T provides new Inpatient Record Review forms to standardize and improve the quality of the inpatient record.

(21) Appendix U provides new Outpatient Record Review forms to standardize and improve the quality of the outpatient record.

b. Changes and additions to this instruction are anticipated. It is to be emphasized that the contents of this instruction are intended to serve as functional guides, not restricting the initiative or discouraging the resourcefulness of individuals. Recommendations for changes increasing the effectiveness of this manual are encouraged and should be forwarded through the administrative chain of command.

c. Basic references are revised or canceled continually. Stock numbers of medical material change frequently. Each Senior Medical Officer is responsible for assuring such changes are posted as they occur.

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5. Action. This instruction is promulgated for action by all NAVAIRFOR ships and is effective upon receipt. The information in this directive need not be reproduced in local instructions.

K. E. FLOYD
Chief of Staff
COMNAVAIRFOR

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RECORD OF CHANGES

Change Number	Date of Change	Date Entered	Entered By

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CHAPTER 1

Introduction

1101. MISSION. The Medical Department is charged with the responsibility for the prevention and control of disease and injury, and the treatment of the sick and injured. To this end, the Senior Medical Officer shall consult with and advise the Commanding Officer in all matters affecting the health of personnel. To accomplish this mission, medical personnel must keep themselves informed of planned operations and anticipate any demands that may be placed upon them. Material and administrative functions are integral to achieving the primary mission. The Medical Department shall cooperate with military and civil authorities in matters pertaining to health and sanitation in the event of local disasters or emergencies.

1102. PURPOSE OF THIS MANUAL. This guide is intended to serve as basic information to standardize operations and provide a ready reference for situations encountered in the day-to-day function of an aircraft carrier's Medical Department.

1103. ACRONYMS. A list of definitions for acronyms contained in this instruction may be found in Appendix A.

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CHAPTER 2

Force Medical

SECTION 1 – ORGANIZATION

2101. ROLE OF FORCE MEDICAL

a. The Naval Air Forces, U.S. Pacific Fleet and Naval Air Forces U.S. Atlantic Fleet are composed of similar type ships with similar type missions. Although there are differences in ship designs, the basic functions of the Medical Departments onboard these vessels remain the same. In compliance with the CNO's realignment initiative, the two Type Commanders (TYCOMs), COMNAVAIRPAC (CNAP) and COMNAVAIRLANT (CNAL), are in the process of combining into one TYCOM: COMNAVAIRFOR (CNAF). The two Force Medical Departments were combined into one CNAF Force Medical Department in December, 2004.

b. The Force Surgeon and Force Medical Officers are staff advisors to the Type Commanders and are available for professional or administrative assistance to subordinate operating units. Force Medicals role is to:

(1) Ensure provision of well-trained, effective medical departments for CV(N)'s through medical, and administrative supervision.

(2) Provide coordination of staffing, training, and equipment for CV(N) medical departments, including technical review of the Authorized Minimal Medical Allowance List (AMMAL).

(3) Review healthcare providers' credentials, grant clinical privileges, and provide guidance and oversight for quality assurance programs.

(4) Revise and implement health care services support instructions and directives.

(5) Conduct Medical Readiness Inspections (MRI), Medical Assist Visits (MAV), and Birth Month Medical Surveillance Inspections (BMMSI).

(6) Consolidate input on current and future issues facing the Fleet.

(7) Provide oversight for aero medical activities of carriers and facilitate coordination with supporting MTFs and clinics in the provision of health care.

2102. FORCE MEDICAL OFFICE STAFF. The Force Medical Office staff includes the following personnel:

TITLES	COMNAVAIR FORCE PACIFIC	COMNAVAIRFORCE ATLANTIC
Force Surgeon	X	
Force Medical Officer, Atlantic		X
Force Medical Officer, Pacific	X	
Force Medical Administrative Officer		X
Force Nurse	X	
Radiation Health Officer	X	X
Force Environmental Health Officer		X
Force Hospital Corpsman	X	X
Professional Affairs Coordinator	X	
Data Analyst	X	

In addition, the TYCOM has other resources, which may be utilized by shipboard Medical Departments. These resources include:

a. COMNAVAIRFORCE ATLANTIC: Aerospace Experimental Psychologist (Code N452), Aerospace Physiologist/AMSO (Code N453), and Industrial Hygiene Officer (Code N454).

b. COMNAVAIRFORCE PACIFIC: Industrial Hygiene Officer (Code N454) and Environmental Health Liaison Officer (NEPMU-5).

2103. FORCE MEDICAL POINTS OF CONTACT. Communication between carrier Medical Departments and the Force Medical Officers is essential. The Force Medical Officers or members of their staff can be contacted via phone, e-mail or fax. Current telephone and e-mail addresses for staff members can be found in the most current issue of "*Bones*".

2104. CHAIN OF COMMAND. Medical Department ADCON/OPCON relationships clearly follow those of the ship. In addition, there is medical advisory support through the TYCOM and COMFLTFORCOM/COMPACFLT. Even when the reporting chain is through another operational commander, it is advisable to inform Force Medical, as this affords them an opportunity to anticipate the need for support/advice.

2105. FORCE MEDICAL PUBLICATIONS. COMNAVAIRFORCE Medical publishes a quarterly newsletter for aero medical professionals entitled "*Bones*" in March, June, September, and December. The newsletter is an official publication and contains articles of interest to the aero medical community written by the COMNAVAIRFORCE Medical staff, articles from selected guest authors, copies of Naval messages of interest, and reference materials and medical phone lists. Copies of this newsletter should be maintained for reference by each shipboard medical department.

SECTION 2 – CREDENTIALS REVIEW AND PRIVILEGING

2201. CREDENTIALS REVIEW AND PRIVILEGING. The Type Commanders serve as privileging authority for the carriers under their cognizance. All health care providers on CNAF ATLANTIC CVs/CVNs that hold credentials are privileged, per COMLANTFLTINST 6320.2 (series) and COMNAVAIRLANTINST 6320.8 (series). Health care providers on CNAF PACIFIC CVs/CVNs that hold credentials are privileged per COMNAVAIRPACINST 6320.4 (series)

2202. EXECUTIVE COMMITTEE OF THE MEDICAL STAFF (ECOMS). The role, responsibilities, and membership of the ECOMS for CNAF ATLANTIC are outlined in COMLANTFLTINST 6320.2 (series), and for CNAF PACIFIC in COMNAVAIRPACINST 6320.4 (series).

2203. CLINICAL PRIVILEGING REQUIREMENTS.

a. All licensed clinical practitioners reporting for permanent duty to COMNAVAIRFOR commands must apply to their respective Type Commanders for clinical privileges. After receipt of the practitioner's application, to the Individual Credentials File (ICF), and supporting documentation, the Professional Affairs Coordinator (PAC) reviews and verifies the applicant's credentials and forwards the package to the privileging authority via the ECOMS for final approval. Notification of privileges granted will be sent to the provider via the unit Commanding Officer. An Inter-facility Credentials Transfer and Privileging Brief (ICTB) documenting the specific privileges granted will be sent to the facility where the provider practices.

b. TAD personnel will be granted permission to exercise their clinical privileges per Article 2205.

c. Operational Medicine training requirements.

(1) All active medical and allied health practitioners are responsible for maintaining current Basic Life Support (BLS) certification according to the standards of the American Heart Association.

(2) Advanced Cardiac Life Support (ACLS) training is required of all Medical Corps officers, Physician Assistants, and Nurse Corps Officers. Current certification is strongly recommended. Those medical officers reporting without ACLS or BLS are required to obtain training at the earliest opportunity.

(3) Advanced Trauma Life Support (ATLS) training is required of all shipboard Medical Corps officers. Current certification is strongly recommended. Medical Corps officers reporting without ATLS training are required to attend a local ATLS program or the Combat Casualty Care Course (C-4) at the earliest opportunity.

2204. INDIVIDUAL CREDENTIALS FILES (ICF). Individual credentials files are maintained at COMFLTFORCOM for east coast based units and at COMNAVAIRFOR for west coast based units. A duplicate file shall not be maintained onboard, however, the ICTB for each provider shall be retained. It is the responsibility of each practitioner to apply for privileges and forward to the PAC any updated, new or changed documents/certifications during their assignment to a COMNAVAIRFORCE unit. The practitioner is responsible for providing accurate and current evidence of professional qualifications. The PAC's mailing address is:

a. East-coast: Commander, Fleet Forces Command(N02MC), 1562 Mitscher Ave STE 250, Norfolk VA. 23551-2487, and can be reached at DSN 836-5538 or commercial (757) 836-5538.

b. West-coast: Commander, Naval Air Force, U.S. Pacific Fleet (N01M6), Box 357051, NAS North Island, San Diego, CA 92135-7051, and can be reached at DSN 735-1148 or commercial (619) 545-1148.

2205. INTER-FACILITY CREDENTIAL TRANSFER AND PRIVILEGING BRIEF (ICTB). Providers from other claimancies must be privileged by their parent command (privileging authority). A message containing the information required in Appendix N of BUMEDINST 6320.66 (series) shall be forwarded from the permanent command to COMFLTFORCOM (N02MC) for east-coast units, and COMNAVAIRFOR for west-coast units, (see Paragraph 2204a and b for the appropriate addresses) for processing and referral to the appropriate Type Commander privileging authority for granting of clinical privileges. The PAC will request a CTB for a reserve practitioner from the Health Care Support Office Jacksonville, FL (HSO JAX). The Type Commander privileging authority is tasked with the responsibility for granting clinical privileges based on information provided in the CTB. When approved, the staff appointment letter and supporting privileging documents will be forwarded granting permission for the practitioner to exercise privileges.

2206. SUBMISSION OF PERFORMANCE APPRAISAL REPORT (PAR). A PAR will be completed and submitted to the responsible ECOMS on each practitioner as required by BUMEDINST 6320.66 (series). A PAR shall

be completed on each practitioner at least every two years, upon detachment of the practitioner, and upon completion of periods of temporary duty to COMNAVAIRFOR commands exceeding four continuous days. Clinical competency for each supplemental privilege granted will be addressed in section XI of the PAR. All PARs will be submitted prior to the departure of the provider being evaluated. All PARs from previous periods of practice must be received prior to granting of initial privileges. To support the timely processing of privilege renewal actions, a current PAR must be received by the PAC 45 days prior to privilege expiration. Failure to submit PARs in a timely manner will result in the provider in question being placed in a period of supervision. (NOTE: PARs on CV/CVN SMOs will be completed by the respective Force Medical Officer. Forward a PAR to the Force Medical Officer with sections I through IV, and VII completed by the SMO, and section VI completed by the Quality Assurance Officer.)

SECTION 3 – INSPECTIONS, CERTIFICATIONS, & ASSIST VISITS

2301. CREW CERTIFICATION. Crew certification is the process by which the Type Commander ensures a ship is ready to proceed safely to sea with a qualified crew. Force Medical will participate in the crew certification by evaluating equipment and readiness issues. Crew Certification (Phases 1A, 1 and 2) shall be conducted onboard all NAVAIRFOR ships that have undergone extended shipyard overhauls or as directed. Paragraph 3206 of this instruction provides additional information regarding Crew Certification.

a. CNAF ATLANTIC Ships: COMNAVAIRLANTINST 9080.2 (series), COMNAVAIRLANTINST 9090.2 (series) and COMNAVAIRFORINST 3500.20 (series).

b. CNAF PACIFIC Ships: COMNAVAIRPACINST 4730.12 (series) and COMNAVAIRFORINST 3500.20 (series)

2302. MEDICAL READINESS INSPECTION (MRI).

a. The MRI is a comprehensive administrative and material inspection conducted by Force Medical. It is a formal inspection designed to determine whether the Medical Department is effectively carrying out its assigned functions and tasks, has adequate resources (personnel, facilities, equipment and supplies), and is responsively complying with directives from higher authority. The MRI occurs once per Fleet Response Training Plan (FRTP) and will be conducted approximately three months prior to deployment. With the continued implementation of the new Fleet Response Plan (FRP), the periodicity of MRIs will be adjusted accordingly. Per COMNAVAIRFORINST 3500.20 (series), the MRI is part of the Blue M and Battle “E” awards.

b. The Force Medical Officer will conduct a Medical Readiness Inspection (MRI) of each CNAF carrier, preferably while the ship is at sea. Areas inspected will include, but are not limited to: Patient Care Quality Assurance, Medical Department Administration, Battle Readiness and Medical Supply, Medical Equipment, Substance Abuse Rehabilitation Program (SARP), Health Promotion, Preventive Medicine Programs, and Waste Disposal. It is highly desirable that Medical, Engineering and Supply personnel participate in the evaluation of those areas and programs under their responsibility.

c. CINCLANTFLTINST/CINCPACFLTINST 6000.1 (series) provides a standardized assessment guide and reporting format for use by inspection teams authorized to conduct the MRI. The checklist is comprised of five sections, including:

Section A – Administration and Training

Section B – Supplies and Equipment

Section C – Emergency Medical Preparedness

Section D – Ancillary Services

Section E – Force Health Protection

d. Each section, as well as the overall inspection, will be assigned a C-Status based upon the following criteria.

(1) Section grading is generally based upon the percentage of satisfactory subsections.

(2) Overall MRI C-Status is determined by averaging the percentage scores of Sections A through E. C-Status assignment is as follows:

C-1	Fully Ready	>=90%
C-2	Substantially Ready	>=80%
C-3	Marginally Ready	>=65%
C-4	Not Ready	<65%

e. The senior evaluator will verbally debrief both the Senior Medical Officer and the Commanding Officer at the conclusion of the inspection. A final written report, containing the MRI checklist and written comments from the inspection team, will be forwarded to the ship’s Commanding Officer from the Type Commander. Specific items identified as requiring correction in the report will be followed up by the inspection team prior to deployment.

2303. MEDICAL ASSIST VISIT (MAV)

a. This visit is conducted similar to an MRI with the focus on identifying areas for improvement in preparation for an MRI. A written debrief will be provided to the Senior Medical Officer. The Commanding Officer or Executive Officer may also be provided a verbal or written debrief if desired. Medical assist visits are provided only upon request. If requested, the assist visit should be scheduled at least three months prior to a MRI. Arrangements may be made, with the approval of the ship's Commanding Officer, by letter or message to the Force Medical Officer.

b. If requested, the MAV may be used as a substitute for the MRI. If all five sections are fully ready (C-1), a subsequent MRI will not be necessary. If several sections are fully ready, only those sections, which are not fully ready, will be inspected during the subsequent MRI.

2304. BIRTH MONTH MEDICAL SURVEILLANCE INSPECTION (BMMSI). The purpose of this inspection is to determine the ship's level of personnel medical readiness and to evaluate the effectiveness of the Birth Month Recall Program. Force Medical will conduct this inspection on an annual basis aboard each carrier. This inspection will be conducted concurrent with a regularly scheduled MRI. If no MRI is scheduled for the calendar year, a separate BMMSI will be conducted. The inspection will consist of a review of a minimum of 120 randomly selected records. Areas to be reviewed include routine immunizations, PPD, HIV, DNA, audiograms, physicals, women's health exams, and annual verification.

2305. COMPETITIVE EXERCISES

a. Competitive Exercises (COMPEXs) reflect daily management of departmental and ship-wide battle readiness requirements and adherence to the Fleet Commander's Tactical Training Strategy. For competitive purposes, COMPEX's are only valid for the calendar year in which completed and contribute to the "M" rating. See COMNAVAIRFORINST 3500.20 (Carrier Readiness and Training Manual)for periodicity and an explanation of M-ratings.

b. A listing of all required medical competitive exercises is provided in the table at the end of this section. Ships should coordinate with TYCOM/Afloat Training Group (ATG) Teams to take advantage of subject matter experts to grade competitive exercises during training/assessment visits. Additional instructions of a general nature follow:

(1) Competitive exercises shall be graded by the ISIC and/or observers specifically designated in writing by the ISIC. Observers shall be carefully chosen based on seniority, technical background and experience and shall not be assigned to the ship or its associated air wing.

(2) Once an exercise is scheduled to meet the competitive requirements and conduct of the exercise is started, it shall be reported regardless of the mark assigned. Competitive exercises are now evaluated based on Measures of Performance (MOPs). Enabling objectives for each COMPEX are designated as either critical or non-critical. In order to receive a satisfactory score, the watchstander must complete 100 percent of those objectives designated critical and 70 percent of those objectives designated non-critical. COMPEXs scored as unsatisfactory may be rescheduled and conducted to obtain a satisfactory grade if desired.

(3) Ships in an operational status for a total of six months or more shall complete all required exercises. Uncompleted exercises, unless waived by the Type Commander, will be scored "zero." A request for waiver will be submitted only in the fourth quarter, via the carrier's Group Commander, and will explain in complete detail why it was impractical to complete the required exercises. The Group Commander's endorsement will indicate what efforts were made to assist the ship in obtaining opportunity, observers, and/or services for the exercise/trial to be waived, together with the recommendations of the Group Commander. If the Type Commander grants the requested waiver, that exercise will be computed as an average of the grade submitted by other competitors. If the exercise/trial is not waived, it will be considered incomplete and will be scored zero and so counted in the computation for relative standing. Except in unusual circumstances, waiver requests received by the Type Commander later than 15 days after completion of the competitive cycle will be automatically disapproved.

(4) Competitive exercises shall be conducted per designated Measures of Performance using criteria for scoring and reporting per the applicable objective or Type Commander grade sheet. Aircraft carrier-specific MOPs are to be used for FSO-M-9-CV (Mass Casualty) and FSO-M-12-CV (Medical Response Team). Measures of Performance for these two exercises will be incorporated into COMNAVAIRFORINST 3500.20. In order that maximum realism can be achieved, Commanding Officers may combine exercises or vary conditions for COMPEXs if approved in advance by the ISIC. Due to individual ship differences, departure from exercise procedures in MOPs is authorized when necessary so long as the intent of the exercise is maintained.

FLEET SUPPORT OPERATIONS MEASURES OF PERFORMANCE (MOPS)	
Number	**Title**
FSOM03.01	First Aid-Compound Fracture
FSOM03.02	First Aid-Sucking Chest Wound
FSOM03.03	First Aid – Abdominal Wound
FSOM03.04	First Aid - Amputation
FSOM03.05	First Aid - Facial Wound/Fracture of Jaw
FSOM03.06	First Aid – Electrical Shock
FSOM03.07	First Aid - Burn

FLEET SUPPORT OPERATIONS MEASURES OF PERFORMANCE (MOPS)	
Number	**Title**
FSOM03.08	First Aid - Smoke Inhalation
FSOM03.09	Personnel Casualty Transport
FSOM04	Battle Dressing Station
FSO-M-9-CV	Mass Casualty
FSO-M-12-CV	Medical Response Team

(5) **Grading criteria for Final Evaluation Period (FEP).** The FEP grade will be based on the average of the below four MOPs, each of which must be satisfactorily demonstrated by three departments selected at the discretion of the Senior Medical Representative from the Afloat Training Group (ATG). Proficiency in the four identified MOPs will constitute 40 percent of the FEP grade. In preparation for this testing phase, departments should focus on building proficiency in the following areas; Basic Life Support, control of hemorrhage, management of shock, and casualty transport.

Medical department proficiency in demonstrating FSO-M-12-CV (Medical Response Team) and FSO-M-9-CV (Mass Casualty Exercise) will additionally be assessed and will comprise 60 percent of the FEP Grade. Overall, the FEP grade will comprise 20 percent of the Blue M award computation. The following is a breakdown of how the FEP grade will be calculated:

FSOM03.01 (Compound Fracture) – 0.1 X grade
FSOM03.06 (Electrical Shock) – 0.1 X grade
FSOM03.07 (Burns) – 0.1 X grade
FSOM03.09 (Personnel transport) – 0.1 X grade

FSO-M-12-CV- (MRT) – 0.3 X grade
FSO-M-9-CV - (Mass Casualty) - 0.3 X grade

2306. OTHER MAJOR CV/CVN INSPECTIONS AND ASSESMENTS. The following list of other inspections/assessments are conducted during the IDTC for all CVs/CVNs:

INSPECTION/ASSESSMENT	INSPECTORS/DIRECTIVES
Command Assessment of Readiness & Training (CART) CART I- Conducted prior to ship's return from deployment. Internal event to assess the inter-deployment period. A proposed schedule of major events and comprehensive training plan are developed. CART II- Appraisal of readiness for training by the CO, ISIC, and ATG after the ship's IDTC maintenance period.	Afloat Training Group (ATG) COMAFLOATRAGRUPAC/LANT COMNAVAIRFORINST 3500.20 (series)
Tailored Ship Training Availability (TSTA) TSTA I through III- Intensive training periods following CART. The Final Evaluation	ATG/TYCOM COMNAVAIRPAC/LANTINST

INSPECTION/ASSESSMENT	INSPECTORS/DIRECTIVES
Period (FEP) is held during the last 3 days of TSTA III.	3500.2 (series)
Pre-Critical Reactor Safeguards Examination Conducted on CVNs only prior to initial criticality of newly installed reactor core.	Director, Naval Nuclear Propulsion/COMLANTFLT
Post-Overhaul Reactor Safeguards Examination (PORSE) Conducted on CVNs only prior to initial reactor operation during shipyard availability	Naval Nuclear Propulsion Examining Board CINCLANTFLTINST 3540.1 (series)
Operational Reactor Safeguards Examination (ORSE) Conducted on CVNs only within one year of last Pre-Critical or Post-Overhaul Reactor Safeguards Examination and within 3 months of the Anniversary of the last ORSE	COMNAVAIRLANTINST 3540.20 (series) COMNAVAIRPACINST 3540.4 (series)
Inspection and Survey (INSURV) Conducted every 5 years. Determine and report ship's fitness for further service and identify material conditions which limit capability to carry out assigned missions.	Board of Inspection and Survey OPNAVINST 4730.5 (series)
Crew Certification Conducted following shipyard periods greater than 6 months	TYCOM/ISIC COMNAVAIRLANTINST 9080.2 (series) COMNAVAIRLANTINST 9090.2 (series) COMNAVAIRPACINST 4730.12 (series) COMNAVAIRFORINST 3500.20 (series)
Radiological Affairs Support Program (RASP) Inspection Conducted every 3 years. Inspection of AIMD RAD Health Program	NAVSEA NAVMED P-5055 NAVSEA S04020-AA-RAD-010
External/Internal Radiation Health Program Audit Annual radiation health program external audit with the Executive Officer as member of audit team. Semiannual radiation health program internal audit conducted by the Executive Officer.	TYCOM/Executive Officer NAVMED P-5055 COMNAVAIRFORINST 6470.4 (series)
Flight Deck Certification Flight Deck Physical Examinations and HM PQS as Flight Deck Observer	TYCOM COMNAVAIRFORINST 3500.71 (series) NAVMED P-117, 15-65
Nuclear Power Mobile Training Team (NPMTT) Training/assessment audits of radiation. Health Program on CVN only.	Air/Sub TYCOMs NAVMED P-5055 COMNNAVAIRFORINST

INSPECTION/ASSESSMENT	INSPECTORS/DIRECTIVES
Conducted prior to ORSE/PORSE.	6470.4 (series)

SECTION 4 – BATTLE EFFICIENCY DEPARTMENTAL AWARD

2401. MEDICAL DEPARTMENTAL AWARD (BLUE M). The Blue M is awarded for outstanding medical readiness. This is an annual award based upon the calendar year. Multiple recipients are possible. To be eligible, a MRI must have been conducted within the competitive cycle calendar year or previous calendar year. If a MRI has not been conducted within the last two years, the CO may request one MRI for the current competitive cycle. The Blue M is one of the departmental awards that count toward the overall aircraft carrier Battle Efficiency Award. Criteria for determining award of the Blue M is detailed in COMNAVAIRFORINST 3500.20 (series).

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CHAPTER 3

Aircraft Carrier Employment/Training Cycle

SECTION 1 – GENERAL

3101. EMPLOYMENT CYCLE. The Navy is employing the Fleet Response Training Plan (FRTP) in response to the CNO's tasking to "streamline the old IDTC" and produce a significant (6 + 2) institutionalized surge capability. With refined maintenance, modernization, manning, and training processes, as well as fully-funded readiness accounts, the Fleet can consistently sustain a level of at least six surge-capable carrier strike groups, with two additional strike groups able to deploy within approximately 90 days of an emergency order. FRTP shifts focus away from rotational deployments & presence to being capable of surging substantial forces. This will create a more employment-capable and responsive force that is more readily available to surge, more efficient to sustain, and able to reconstitute rapidly.

3102. FLEET READINESS TRAINING PLAN. The process of progressive training described is called the Fleet Readiness Training Plan (FRTP) and is illustrated in figure 3-1. The Numbered Fleets and Leading TYCOM’s developed the 6 + 2 CSG capability through the creation of the FRTP, a 27-month cycle that replaces the old Inter-Deployment Training Cycle (IDTC). The FRTP consists of four phases: Maintenance, Unit Level training, Integrated training, and Sustainment. Figure 3-2 illustrates a CV(N) Notional Fleet Readiness Training Plan. Each phase is discussed in detail in COMNAVAIRFORINST 3500.20 (series). The Maintenance Phase is followed by a period of unit-level training to achieve a level of readiness for the carrier Strike Group to be considered “Emergency Surge Capable.” The idea is to have the major prerequisites for a surge deployment (manning, maintenance, and training) completed so that additional tailored training can be completed quickly if necessary to surge the CSG due to a crisis or contingency operation. The Integrated Phase of training is tailored to individual ship and air wing strengths and weaknesses and concludes after completion of COMPTUEX (C2X) and air wing training. At this point a CSG is considered Surge Ready, meaning it could deploy on short notice if required. The Sustainment part of the FRTP consists of a variety of training evolutions designed to maintain a CSG’s readiness until it actually deploys, and might include a Joint Tactical Fleet Exercise (JTFEX).

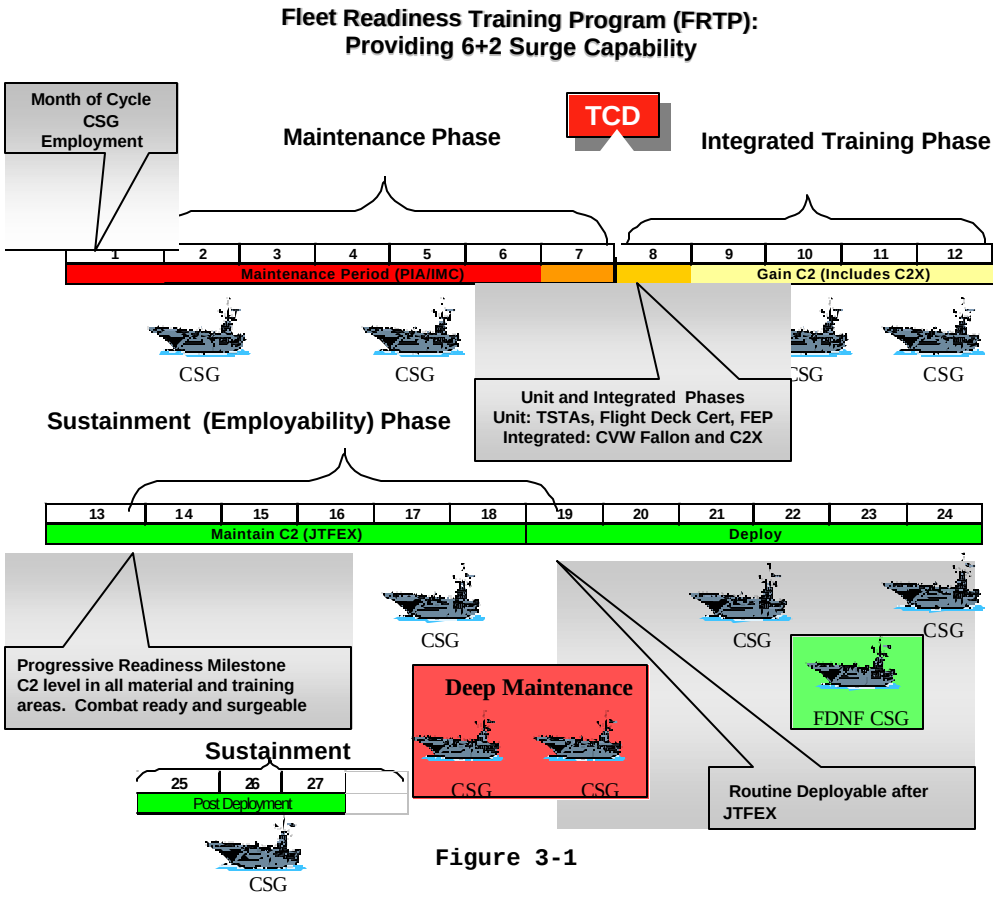

Figure 3-1

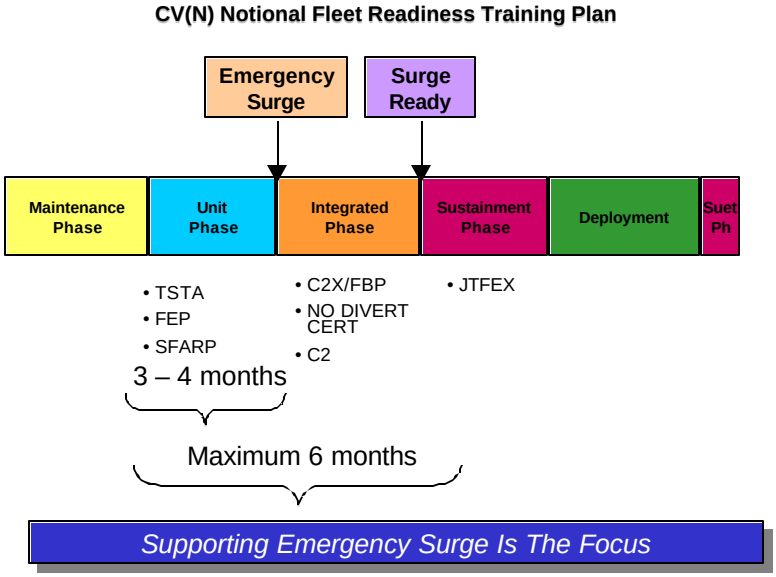

Figure 3-2

SECTION 2 – MAINTENANCE

3201. GENERAL. Shipboard operations during new construction, Refueling Complex Overhaul (RCOH) or Selected Restricted Availabilities (SRA)/Planned Incremental Availability (PIA) differ markedly from those of ships operating in a readiness cycle. Specialized skills and procedures, which have limited use and application during normal operations, are critical to safety and productivity during an extensive repair period. The first phase of training for a maintenance period focuses on repair period-specific subjects such as:

a. Shipyard organization and protocols for interface between shipyard and ship's force personnel;

b. Shipyard maintenance provider work procedures and related documentation, including planning and work authorization documents, and discrepancy reports;

c. Procedures for planning, accomplishing and documenting ship's force work;

d. Skills and knowledge required to support shipyard activities, such as fire watch, habitability projects and quality assurance; and

e. Maintenance period safety precautions and procedures. Training on the subjects listed above should be complete when the maintenance availability starts. Training on maintenance topics must continue early in the maintenance availability, tapering off as sea trials approach, but sufficient to ensure newly reporting personnel can function safely and effectively in the shipyard.

3202. AIRCRAFT CARRIER CONTINUOUS MAINTENANCE PROGRAM (ACCMP). The ACCMP is a systems oriented maintenance strategy in which depot (shipyard), intermediate (IMA), and organizational (shipboard) level maintenance requirements are performed in a planned, integrated, and coordinated manner throughout the life cycle of each carrier. The ACCMP identifies maintenance goals, by system, and implements improvements systematically and continuously throughout the maintenance and operating cycle of the ship. The ACCMP ensures that carriers are ready to meet Carrier Strike Group (CSG) operational requirements. The planning for continuous maintenance requires knowledge of the day-to-day maintenance requirements of each ship, and takes advantage of all ship inport periods. The primary influences on scheduling of ACCMP maintenance opportunities are: Operational Schedule, Operational Tempo (OPTEMPO), Personnel Tempo (PERSTEMPO), Repair and Modernization Requirements, Funding, Industrial Capacity (public and private), and Ship's Force Workload.

3203. DEPOT (SHIPYARD) LEVEL MAINTENANCE AVAILABILITY. Generally, CV/CVN availabilities can be broken down into two major groups by funding: CNO Scheduled Depot-Level Availabilities and Fleet/Type Commander availabilities. Refer to the ACCMP for a description of Fleet and Type Commander Availabilities. CNO Scheduled Depot-Level Availabilities can be further refined into two major philosophies: Engineered Operating Cycle (EOC) and Incremental Maintenance Plan (IMP). The following availabilities are those CNO Scheduled Depot Level Availabilities used in the ACCMP. They are grouped according to the maintenance philosophy utilized.

a. Engineered Operating Cycle

(1) Complex Overhaul (COH). A major availability, normally exceeding six months duration, for the accomplishment of maintenance and modernization. Ship overhauls restore the ship, including all operating subsystems which affect safety or current combat capability, to established performance standards. This overhaul includes the correction of all discrepancies found during pre-overhaul tests and inspections or developed from maintenance history analysis. A COH restores material condition and significantly modernizes warfighting capability to meet projected threats.

(2) CVN Refueling Complex Overhaul (RCOH). Mid-life recapitalization, with the additional objective of refueling CVNs.

(3) Selected Restricted Availability (SRA). A shorter (usually one to three months), labor-intensive industrial period for the accomplishment of maintenance and selected modernization. The SRA is an interim depot availability providing industrial repairs and modernization to sustain material condition and warfighting capabilities for the next scheduled deployment.

(4) Dry-Docking SRA (DSRA). In addition to the work accomplished during an SRA, a DSRA is an availability where the ship is dry-docked for hull and other related maintenance that cannot be performed while the ship is waterborne.

(5) Incremental Selected Restricted Availability (ISRA). A special classification of availability developed to fully exploit the advantages of the forward deployed aircraft carrier in Yokosuka, Japan. This approach permits maximum operational schedule flexibility while maintaining a high state of material readiness. An ISRA is scheduled for each fiscal year and its duration runs the entire 12-month period. Repairs and alterations are accomplished incrementally in approximately two-week inport windows with an extended depot period of about three months as necessary.

(6) Incremental Docking Selected Restricted Availability (IDSRA). Complements the ISRA for the forward deployed aircraft carrier in Yokosuka, Japan by providing the docking period necessary

to accomplish underwater body maintenance and repairs. Scheduled at approximately six-year intervals, the docking duration can extend to six months. After undocking, the availability takes on the same characteristics as an ISRA with short inport depot periods throughout the fiscal year.

b. Incremental Maintenance Plan Availabilities

(1) Planned Incremental Availability (PIA). PIA is similar to an overhaul in that it restores the ship, including all operating subsystems which affect safety or current combat capability, to established performance standards. The PIA is a ship depot availability of approximately six months duration that restores or maintains material condition and incrementally modernizes the warfighting capability to meet current and projected threats.

(2) Docking Planned Incremental Availability (DPIA). In addition to the work accomplished during a PIA, a DPIA provides a window during which required underwater maintenance is accomplished. The DPIA also provides sufficient time to perform more extensive propulsion plant repairs and testing than is possible during the PIA. The combination of PIAs and DPIAs during the ship's life removes the requirement for performing COHs as per the EOC strategy with the exception of the RCOH.

c. Post Shakedown Availability (PSA). A CNO Scheduled Depot Level Availability that is not included in the EOC or IMP. PSA is assigned to commence after delivery and to be completed prior to the expiration of the Shipbuilding and Conversion, Navy (SCN) obligation work limiting date. This date occurs at the end of the eleventh month after the month in which the Fitting Out Period completes. PSA will normally be of three months duration. It is planned that authorized Acceptance and Final Contract Trials deficiencies will be corrected during PSA. PSA is typically scheduled in conjunction with a SRA. Information concerning Trials, Acceptance, Commissioning, Fitting Out, Shakedown, and Post Shakedown Availability of U.S. Naval Ships undergoing construction and conversion is contained in OPNAVINST 4700.8 (series).

d. Notional Schedule/Interval for Maintenance and Modernization Requirements.

(1) SRA/DSRA/PIA/DPIA. After every deployment; generally every 24 months (start of availability to start of availability) due to typical operation cycle.

(2) COH. Applies to conventionally powered aircraft carriers only, generally every 60 months.

(3) RCOH. Applies to CVNs only. Occurs at approximately the midlife point in the life cycle of a nuclear powered aircraft carrier.

3204. GUIDELINES FOR DEPOT LEVEL MAINTENANCE AVAILABILITY

a. Introduction. Availability periods for maintenance and modernization are a routine experience for the ship. A short (three to six months) shipyard period poses a significant distraction to the function of the Medical Department. A long (one to three years) shipyard period may necessitate relocation of the Medical Department off-ship to a Floating Accommodation Facility (FAF) and result in the complete redesign/reconstruction of departmental spaces. The preparation requirements for shipyard periods begin long before the ship conducts a berth shift to the shipyard. Planning 6 to 12 months ahead of time (three or more fiscal years in the case of COH/RCOH due to the requirement for early dedication of significant financial and material resources) is essential for a successful availability period. Advance liaison with the Ship's Maintenance Manager is essential to ensuring the inclusion and prioritization of Medical Department deferred maintenance and alteration actions in the Current Ship's Maintenance Project (CSMP). Refer to OPNAVINST 4790.4 (series) for guidance on the submission of deferred maintenance actions via the Ship's Maintenance Action Form, OPNAV 4790/2K. Medical Department planning personnel must be knowledgeable with the Organizational Maintenance Management System (OMMS). The work package is derived from this system, and all work during the yard period is tracked from it.

b. Unique Challenges of Shipyard Periods. Shipyard periods constitute a significant change in the routine and emphasis of the Medical Department. Demands significantly increase for the Medical Department leadership. The challenge is to plan ahead, manage resources successfully, and ensure maintenance actions remain on schedule. The absence of a well-planned employment schedule can lead to shortsighted goals and ultimately cause severe morale problems. A shipyard period tends to be more difficult on the Medical Department than a major deployment. As for many other departments, these periods can afford individuals the time necessary for more extensive off-ship training.

c. Medical Surveillance Programs

(1) General. During any shipyard period, there will generally be an increase in personnel placed in the hearing conservation, sight protection, and respiratory protection programs. The Industrial Hygiene Officer must identify all yard-period specific occupational health programs. Personnel should receive appropriate physical examinations prior to arriving in the shipyard. Personnel requiring specific physical examinations must be identified based on industrial hygiene data. Most medical surveillance programs will continue during the yard period as identified in the industrial hygiene baseline survey. However, special or additional physical examinations may be required for unique overhaul requirements such as asbestos rip outs

and gasket repairs, lead based paint removal, ventilation duct cleaning, void rehabilitation teams, fire watch teams, and habitability improvement. Good communication between departments is essential, both at the CPO and department head level. Sailors must be identified for hazard exposure by their department organization and referred/recalled by the Medical Department for care. Ensure continuous monitoring of the Birth Month Medical Surveillance Program. An updated SAMS roster and diligent tracking and follow-up of "no-shows" are essential for maintaining a successful program.

(2) Hearing Conservation. Usually, the audiometric booth is not certifiable while in the shipyard. Excessive noise on the hangar bay makes it almost impossible to perform audiograms. If possible, arrangements should be made with shipyard personnel to avoid noisy or vibrating machinery from being placed directly over medical spaces. Audio booth support services can be arranged with the local Military Treatment Facility (MTF).

d. Collecting Holding and Transfer (CHT) and Potable Water Supply Problems. CHT and potable water services are occasionally interrupted. A contingency plan must be available to import water from other locations for proper hand washing between patients. If accessible, the potable water tank located in the Main BDS can also be utilized. Potable water supplied onboard should continue to be tested for halogen residual and bacterial contamination by Preventive Medicine Technicians.

e. Preventive Medicine Inspections. The Commanding Officer and department heads should be advised that certain sanitation and habitability inspections might be reduced or not conducted as spaces are being reworked or are inaccessible.

f. Pest Control. Pest infestation may increase during the beginning of the shipyard period. Prior to entering the yards, all personnel should be educated concerning the correlation between food debris and pest infestation. This education can be accomplished through training classes or Plan of the Day (POD) notes.

g. Medical Care in the Yards. Continue to provide the full range of medical care for ship's company, except for inpatient care. Sick call, routine appointments, and physical examinations continue, and may increase, due to the stress of the shipyard environment. Consultations to medical treatment facilities continue to require management and may be more difficult, since shipyards may be far from the supporting MTF. The medical response teams continue to be important for crew and worker safety, but patients will usually be turned over to shore facilities for treatment. Advance liaison with any shipyard medical assets should include discussions about maintaining medical control of medical emergencies on the ship and procedures for turning over the patient to responding medical

personnel. Advance liaison with the local MTF for ancillary services support should also be considered if necessary.

(1) Keep Medical close to the Ship. Keep the commitment to providing the highest quality care as close to the ship as possible. While all care might be able to be referred to the local medical treatment facility, such a practice would waste work hours by ship's force members. The Commanding Officer will be very concerned about the work accomplished by the ship's force, and every additional hour of work counts. Expect a lot of command scrutiny about medical TAD for treatment, personnel losses from medical boards, and status of inpatient care at shore MTFs.

(2) Yard Period Effects on Medical Complaints. Orthopedic, respiratory illness, and communicable diseases tend to increase during the yard period. The management of psychiatric patients with suicidal ideation, stress and occupational problems also tend to increase significantly.

(3) Medical Response Team (MRT) Emergencies and Deep Extrications. Most deep rescue victims provide unique rescue circumstances. Coordination with the Damage Control Assistant (DCA) to obtain more deep rescue drill training prior to entering the shipyard is prudent. These rescues are not conducted by medical alone. A team shall be formed with the necessary expertise, to include riggers, and other required personnel per Paragraph 13207d. Additional coordination will need to be established with the local Emergency Medical System.

h. Reactor Work and Effect on Main Medical. During reactor refueling, the entire Medical Department will be completely removed to allow access to the reactors. Medical care will be provided onboard the Floating Accommodation Facility (FAF). Extra effort may be required to maintain Birth Month Medical Surveillance, occupational health surveillance programs, and medical support programs. The shipyard has teams that respond to nuclear contamination incidents. Ship’s force will need to coordinate efforts with the shipyard’s response teams.

i. Medical Department Maintenance and Modernization

(1) Shipyard Liaison and Tracking of Maintenance Actions. Establish liaison with the Availability Project Team and work centers performing ship's force maintenance actions in medical spaces. Interface on a regular basis with shipyard personnel who are performing maintenance and alterations. Ensure accurate tracking and timely follow-up of all medical department maintenance actions. Even with persistent daily tracking, be prepared for numerous delays. Ensure maintenance actions have been screened for accuracy and reviewed by the Medical Department POC prior to close-out/acceptance. Once accepted, any further action to repair/replace faulty equipment

or perform additional work will, most likely, require additional expenditure of scarce funds. Any action that causes a work stoppage may have similar effects.

(2) Medical Personnel Performing Maintenance/Rehabilitation. If rehabilitation of medical spaces is performed by medical personnel (lagging, painting, tiling, terrazzo), teams must be established to ensure that they are properly trained to perform the task. The teams must be dedicated to rehabilitation duties if the work is to be completed on time. These personnel will usually not be available to assist in daily patient care. If available, utilize ship's teams (e.g. paint team, etc.). This process will free up medical personnel to perform other rehab duties in the medical spaces.

(3) Impact on Patient Care. If the Medical Department remains on the ship during the yard period, changes and moves should be expected to perform any rehabilitation of medical spaces. This requirement may necessitate a change in sickcall hours and create numerous difficulties for ensuring efficient patient flow and effective patient privacy.

(4) Anticipating Potential Problems. Anticipate that work being done in other areas of the ship may impact work done (or not done) in Medical Department spaces (i.e., hot work being done in spaces above, below, or adjoining medical spaces could cause resulting damage to existing decks, paint, equipment, etc.; or work being done by shipyard personnel in medical spaces may delay Medical Department rehabilitation efforts until completed). Equipment not properly prepared/protected for storage or subjected to unexpected environmental conditions may become irreparably damaged and require Force Medical assistance for emergent procurement action. This equipment damage should be preventable if proper Inactive Equipment Maintenance (IEM) procedures are followed, per OPNAVINST 4790.4 (series), and the equipment is properly secured/protected. Unexpected shipyard delays may result in medical moving back onboard the ship immediately preceding the ship's departure from the yards. This delay may allow little time for spaces to be cleaned, set up, and stocked for return to sea. Also, anticipate the potential for the AMMAL to become severely depleted during an availability period, especially if supplies are moved off the ship and expired shelf life items have not been routinely surveyed and reordered. A complete AMMAL will be required when the ship leaves the shipyard and returns to normal operations.

j. Ship Coordinated Offload and Outfitting Plan (SCOOP). Applies only to CVNs immediately preceding RCOH. The purpose of SCOOP is to make preparations for RCOH. Equipment is removed from the ship, sorted and designated for either disposal or retention.

(1) Equipment/Supplies. In preparation for going into the

shipyard for RCOH, the Medical Department will be required to package, inventory, sort and remove all equipment and supplies for storage or disposal. The majority of the Medical Department will be required to conduct this event. Equipment/supplies will be transferred to temporary storage (if pending FAF availability), long term warehouse storage (anything that will be returned to the medical spaces when the department is put back together at the end of RCOH), or Defense Reutilization Management Office (DRMO) for disposal. Ensure proper Inactive Equipment Maintenance (IEM) procedures are followed, per OPNAVINST 4790.4 (series), for equipment that will be inactivated for periods of prolonged idleness (i.e., equipment designated for long-term storage). Ensure proper accounting for all emergency supplies distributed throughout the ship such as First Aid Boxes (FAB), Mass Casualty Boxes, etc.

(2) Medical Care

(a) Sick Call. If the FAF is not immediately available at the time of SCOOP, arrangements will need to be made with the local MTF to provide space for the Medical Department to provide basic sick call for the ship's crew. This problem frequently occurs due to the fact that this event occurs prior to entering the shipyard where the FAF is located. If such arrangements are made, some supplies and equipment may need to be transferred to the MTF to support this interim period. Lab, pharmacy, and x-ray will be maintained to the maximum extent possible.

(b) Emergency Care. At least one MRT will be maintained onboard for the provision of emergency care.

(c) Transportation. Transportation to the sick call site (if relocated to the local MTF) will need to be provided for the ship's crew. Separate transportation (duty van) may also be required for transport of lab samples and x-rays, or to complete other medical related errands.

k. Preparation Timeline Guide. The following guide should be used in anticipation of a yard period:

(1) <u>12 Months Prior</u> to entering the yard:

(a) Establish rapport with the Industrial Hygiene Officer and agree on strict criteria for placing personnel on medical surveillance programs.

(b) Thoroughly review OPNAVINST 5100.19 (series) and OPNAVINST 5100.23 (series) requirements for the hearing conservation program, respiratory protection program, lead medical surveillance, isocyanates, CHT systems and spills, heat stress program, asbestos medical surveillance program, polychlorinated biphenyls, and other programs.

(c) Be involved in overhaul issues.

(2) Nine to 12 Months Prior to entering the yard:

(a) Provide in-depth on-the-job training using occupational health assets.

(b) Provide in-class training using current OPNAV instructions, The Navy Occupational Safety and Health (NAVOSH) program manual, and local command instructions.

(c) Train LCPOs, Division Officers and Department Heads in the requirements for different occupational health programs.

(d) Identify specific personnel who will be assigned to the habitability team.

(3) Six to Nine Months Prior to entering the yard:

(a) A major part of the Medical Department's shipyard period may revolve around coordinating space allocation or moving off the ship. Spaces must be identified well in advance to avoid disruption.

(b) Local MTF and service support must be identified. Medical support may be required from other DoD services or civilian hospitals. These facilities must be prepared to accept a large influx of Navy active duty personnel.

(c) Safety Department will assist other departments by augmenting their personal protective equipment needs. Safety equipment must be ordered by the Safety Department including respirators, respirator cartridges, Tyvex coveralls, goggles, gloves, eye and hearing protection.

(4) Three to Six Months Prior to entering the yard: Construct database for assigned personnel.

(5) Zero to Three Months Prior to entering the yard:

(a) Physical examinations and routine follow-ups are required for crewmembers conducting maintenance and modernization of the ship. Examples of systems that may require monitoring during overhaul are: boilers (conventionally powered carriers only), CHT system, fuel tanks, catapult systems, removal and replacement of lagging, surface restoration, gasket repair/ replacement, brake maintenance, and vent cleaning.

(b) Personal protection equipment training must be conducted in advance for the use of Tyvex coveralls, gloves, eye protection, hearing protection and all respirators.

(c) Training must be provided to Medical Department personnel if they will be required to use fire extinguishers (water, CO_2, PKP), fire hoses and nozzles, pneumatic grinders, sanders and deck crawlers.

(d) Try to arrange "one stop" occupational health physical examinations and ensure that the Medical Officer is allotted adequate time to see personnel using appointments. Although initial physical examinations will not be synchronized with the Birth Month Medical Surveillance Program, follow-up can be incorporated as part of the Birth Month Medical Surveillance Program.

3205. COMMAND ASSESSMENT OF READINESS AND TRAINING (CART). To gain maximum benefit from limited training time and resources, a ship must enter each training cycle with a clear understanding of what specific training is required and a detailed plan for accomplishing it. CART is a two-part event intended to help the ship meet this objective. During CART I, normally conducted during the first half of deployment, the ship looks ahead with its strike group commander and air wing to the FRTP period and lays out a proposed schedule for major events. CART II will be conducted aboard the ship no earlier than 90 days prior to TSTA I. The purpose of CART II is to ensure the ship is ready to conduct training and to prepare a detailed, tailored schedule for the unit level phase of the training cycle. It is imperative that the TYCOM, ATG, Strike Group Commander and Air Wing Commander representatives be integrally involved with the ship during CART II. The CART process is discussed in detail in COMNAVAIRFORINST 3500.20 (series).

3206. CREW CERTIFICATION. Crew certification is the process by which the Carrier Strike Group Commander, supported by Afloat Training Group, ensures a ship is ready to proceed safely to sea with a qualified crew upon completion of new construction or a repair period of greater than nine months duration. This process is accomplished through a series of visits by ISIC and ATG representatives tasked with confirming that the ship has (1) appropriate administrative programs in place, (2) required instructions and bills in force and up-to-date, (3) an effective PMS program and (4) meaningful training and PQS programs in place. Representatives of Force Medical are included as members of the crew certification team. COMNAVAIRFORINST 3500.20 (series) sets forth policies and prescribes procedures for crew certification based on the duration of the overhaul/availability period. The duration of the overhaul/availability period also determines the requirement for the phases of crew certification that must be completed. Team members from Force Medical will report the results of the crew certification in the format provided in Appendix B. The following is a brief description of each phase of the crew certification process and the items to be assessed in the Medical Department:

a. Phase IA. Phase IA is a one-day assist visit that is normally conducted four to six months prior to fast cruise. For the ship, Phase 1A consists primarily of a review of the ship's training plans and schedule, and a review of status of implementation or update of support areas such as PQS, technical documentation and logistic support. PMS implementation shall be checked on a separate schedule by the COMNAVAIRFOR 3-M Team. Force Medical will utilize portions of the MRI checklist to conduct the Medical Department section of the crew certification.

b. Phase I. Phase I is a one-day inspection normally conducted approximately one to two months prior to fast cruise. Force Medical will utilize portions of the MRI checklist to conduct the Medical Department section of the crew certification. Phase 1 consists of:

(1) A review of past training conducted and future training planned.

(2) Examination of watchstanders with emphasis on their knowledge of emergency/casualty bills and general ship operational procedures.

(3) An audit of the ship's SORM, administrative, operational and emergency bills and Watch Quarter and Station Bills.

(4) Rules of the Road written examinations for OODs, JOODs, JOOWs and CDC watch officers.

(5) The Auxiliaries Assist Team shall direct the auxiliary's certification (Engineering and Reactor Departments).

(6) The CSG Commander will conduct this phase of the assessment. He/she may request assistance from ATG, other ships in the group, and other commands in the area to augment the staff in support of this assessment.

(7) TYCOM Aircraft Handling Teams will coordinate with the ship and the Group Commander to evaluate flight deck handling procedures.

c. Phase II. Phase II is an evaluation of the crew's ability to perform routine and emergency procedures during simulated underway operations. This two-day inspection will be conducted by the CSG Commander (with assistance from ATG, other ships in the group, other commands in the area, and TYCOM Fight Deck Handling Team as requested). For conventionally powered ships, it is conducted coincident with the final fast cruise preceding sea trials. For nuclear powered ships, it is conducted during a two-day simulated underway-training period prior to fast cruise. Force Medical will utilize portions of the MRI checklist to conduct the Medical Department section of the crew certification.

3207. FAST CRUISE. The objective of fast cruise is twofold: to train the crew in a simulated underway environment, and to give the Commanding Officer a final opportunity to confirm the crew is ready to take the ship to sea safely. Fast cruise is a period immediately prior to underway trials during which the ship is made available to the ship's force for dockside testing in order to simulate, as far as practical, at-sea operating conditions unhampered by construction, conversion or overhaul work, or the presence of shipyard personnel in the ship. Specific guidance for conducting all fast cruises, including all requesting and reporting procedures, is included in the Joint Fleet Maintenance Manual (JFMM) CFFCINST 4790.3 volume 2 section 3.6.8 and 3.6.8.3 (3.6.8.3 applies to ships in a CNO scheduled availability). Additional requirements for nuclear powered carriers are included in OPNAVINST 9080.3 (series) and the EDM. For conventionally powered aircraft carriers, the required duration of fast cruise depends on the type and length of the overhaul.

3208. SEA TRIALS. Sea trials are conducted upon completion of all availabilities. Primary emphasis during this nominal five-day underway period is on testing equipment and certifying systems and capabilities per the direction provided in the JFMM; however, training in basic underway functional areas is conducted as well.

3209. FLIGHT DECK CERTIFICATION. Flight deck certification is required prior to conducting aircraft carrier (CV/CVN) flight operations following Complex Overhaul (COH), Selective Restricted Availability (SRA), new construction, or other extended non-flying periods. The primary emphasis is on completion of basic training, satisfactory operation of aircraft launch and recovery equipment and verification of the aviation fuel system.

Section 3 - Unit Level Training

3301. GENERAL. The Unit Level Phase focuses on completion of TYCOM unit level training requirements: team training both onboard and ashore, unit level exercises inport and at sea and unit inspections, assessments, certifications, and qualifications. During this phase, maximum use of distributed (web-based) learning options for individual skills development and maintenance should be made. Training during the Unit Level Phase is to ensure units are proficient in all required capabilities, meet TYCOM certification criteria, and are ready for more complex integrated training events. It follows an "assess, train, and certify" process, which has been instituted by TYCOM's.

3302. TAILORED SHIP'S TRAINING AVAILABILITIES (TSTAs). Conducted under ISIC supervision by the ATG. The purpose of TSTAs is to give the crew a solid foundation of unit-level operating efficiency and develop or enhance the ship's ability to self-train following

completion of the basic phase. The purpose of TSTA is not merely to give the crew a solid foundation of unit-level operational proficiency, but also to develop or enhance the ship's ability to self-train following completion of the unit phase.

a. TSTA INPORT. This five day inport period is primarily used to resolve CART II discrepancies. Additionally, ATG will review Condition III scenario packages and conduct 1 or 2 actual scenarios.

b. TSTA UNDERWAY. The TSTA will normally be conducted as a single 25-day underway block, with the air wing embarked throughout. The following breakdown provides notional emphasis points during this underway period:

(1) TSTA Phase I. Emphasis during this nominal eight-day underway period is on navigation, seamanship, engineering, damage control (CBR) and other training. Basic flight deck operations consist of drills and limited air wing carrier qualifications. Combat Systems training is focused on areas where support from the air wing is not required.

(2) TSTA Phase II. Emphasis during this nominal eight-day underway period is on flight deck operations, increased emphasis on Combat Systems, Engineering and Damage Control Condition I and III tactical and casualty control scenario execution, while maximizing use of air wing support.

(3) TSTA Phase III. TSTA Phase III is a nominal seven-day period with three purposes: to train the crew on complex unit phase exercises, to prepare for a Final Evaluation Period (FEP), and continued air wing integration with increased complexity of integration drills.

3303. FINAL EVALUATION PERIOD (FEP). FEP is a nominal two-day graded event and represents the culmination of the unit level phase of training and evaluates the ship's "within the lifelines" ability to conduct combat missions, support functions, and survive complex casualty control situations. It provides the ISIC the opportunity to evaluate ship readiness prior to entering Integrated/Sustainment Phases of training as well as a ship's ability to sustain readiness through self-training. Ships completing FEP will have demonstrated the minimum required skills to proceed to the integrated phase of the FRTP.

SECTION 4 – INTEGRATED PHASE TRAINING

3401. GENERAL. The goal of Integrated Phase Training is to bring together the individual units to allow strike group level integrated training and operations in a challenging operational environment. It provides an opportunity for units and staffs to complete CSG/ESG Commander Staff Planning and Warfare Commanders Courses, conduct

multi-unit inport and at-sea training, and build on individual skill proficiencies attained during Unit Level Phase.

3402. COMPOSITE TRAINING UNIT EXERCISES (COMPTUEX)/INTERMEDIATE TRAINING ASSESSMENT (ITA). COMPUTEX consists of an 18-day schedule of event (SOE) driven exercise, and a three day Final Battle Problem (FBP). It is conducted and directed by the training carrier group commander, and is focused on developing the carrier/air wing team into a cohesive unit and, if additional assets are available, integrating these units into the associated deploying CSG operations that will be further defined during the Sustainment phase of training.

SECTION 5 – SUSTAINMENT PHASE TRAINING

3501. GENERAL. Sustainment Phase exercises units and staffs in multi-mission planning and execution, including the ability to inter-operate effectively in a wartime environment. Once a unit or a group attains the required readiness levels to be available for forward deployed operations, key proficiencies required to carry out anticipated tasks must be maintained through tailored Pre-Deployment Sustainment training approved by the Numbered Fleets. Post-Deployment Sustainment training, also approved by the Numbered Fleets, may be required to ensure adequate coverage of six plus two.

3502. FLEETEX/JTFEX. Advanced Phase training – (FLEETEX)/ (JTFEX) is a Combatant Commander directed exercise designed to build upon previous demonstrated Strike Group (CSG) competencies across all warfare areas. The at-sea portion of advanced phase training consists of a nominal 20 days underway, with a combined CSG/ECG (MEU) operating as part of the JTF. This period represents the final at-sea training event for the Task Group Commander before deployment.

SECTION 6 – PREPARATION for OVERSEAS MOVEMENT (POM)

3601. PREPARATION for OVERSEAS MOVEMENT. Normally the 30-day period prior to deployment in which significant logistics, personnel, and material routines are scheduled to ensure readiness.

SECTION 7 - DEPLOYMENT

3701. GENERAL. During periods of deployment, Combatant Commander scheduled exercises and operations are conducted.

CHAPTER 4

Organization and Personnel

4101. MEDICAL DEPARTMENT ORGANIZATION

a. The ship's Medical Department organization shall be documented in a ship's bill or instruction and shall delineate the organization, chain of command, duties and responsibilities of each functional area or significant position within the Medical Department. This document will include job descriptions for all Medical Department personnel.

b. All medical department personnel shall familiarize themselves with the contents of the medical department's organization instruction.

c. The ship's Medical Department organization instruction should contain a diagram outlining the organizational relationships that exist within the department and the chain of command. Figure 4-1 shows a typical Medical Department organizational chart.

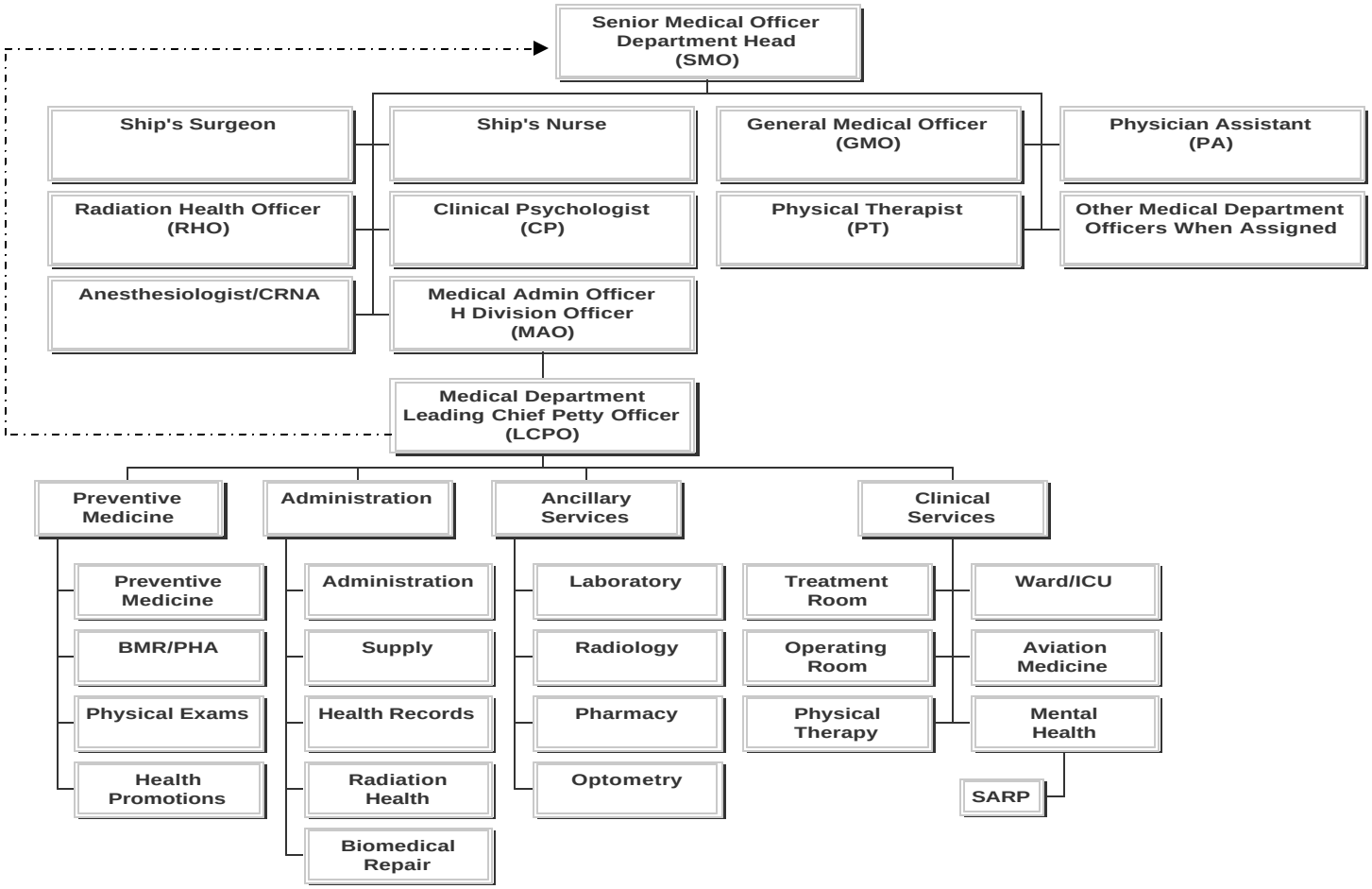

Figure 4-1. Typical Medical Department Organization.

4102. MANNING. Manning for each ship's Medical Department may be found within the Activity Manning Document. This document lists all billets and associated specialty codes for both officer and enlisted personnel. A listing of typical billets authorized for aircraft carrier medical departments may be found in Appendix C. All unplanned losses of Medical Department personnel shall be reported to the TYCOM Force Medical Office (refer to Paragraph 4107 of this instruction for TAD medical support).

4103. DUTIES, COGNIZANCE AND QUALIFICATIONS

a. Senior Medical Officer (SMO). The head of the Medical Department aboard an aircraft carrier is required to be both a Medical Corps Officer and a designated Naval Flight Surgeon. It is preferable that the SMO has completed a residency in aerospace medicine. The SMO is required to hold an active staff appointment with clinical privileges in primary care medicine, operational medicine, and either flight surgery or aerospace medicine. In addition to those general duties prescribed by Navy Regulations for a Head of Department, the SMO shall be responsible for maintaining the health of the crew, conducting inspections incident thereto and advising the Commanding Officer as to the hygiene, habitability, sanitation and safety matters within his purview which affect the command. He shall additionally be responsible for the administrative and material readiness of the Medical Department. The Senior Medical Officer reports to the Commanding Officer in matters related to the health or well being of the crew, keeping the Executive Officer appropriately informed. The SMO reports to the Executive Officer in matters related to the administration of the Medical Department and to the embarked Flag or Chief of Staff in medical matters of Flag cognizance. The SMO directly supervises the Ship's Nurse, General Medical Officer, Medical Administrative Officer, Physician Assistant, Ship's Surgeon, Anesthesiologist/CRNA, Clinical Psychologist, Physical Therapist, Radiation Health Officer, Leading Chief Petty Officer, and Air Wing Flight Surgeons (when embarked). Specifically, the SMO shall:

(1) Supervise and direct their department to provide health and medical services for personnel of the ship, all embarked military personnel, and all other authorized personnel.

(2) Report to the Commanding Officer any condition within the command or community that may endanger the health of either. In this regard, they shall fully cooperate with local health authorities.

(3) Conduct physical examinations and advise the Commanding Officer as to the health of personnel.

(4) Ensure that the crew is adequately trained in the techniques of basic first aid, radiation health, the use of litters and the handling of multiple casualties.

(5) Order, inspect, issue and account for medical stores and equipment located within the Medical Department. See Chapter 10, which outlines the responsibilities of medical stores controlled by the Supply Officer.

(6) Conduct aviation physical and psychological examinations as necessary to determine the fitness of flight personnel and recommend to the Commanding Officer the grounding of flight personnel found not qualified or not aeronautically adapted for duty involving flying.

(7) Ensure compliance with all pertinent quarantine regulations and assist local health authorities as necessary.

(8) Conduct an effective Radiation Health Program.

(9) Report to the embarked Flag for additional duty as Strike Group Medical Officer.

(10) Establish policies and procedures for the administration of the Medical Department per current directives.

(11) Ensure inspections of all areas related to food service and inspections of living and working spaces are conducted as required, and report on sanitation to the Commanding Officer.

(12) Ensure inspections of culinary specialists, food handlers and any other personnel employed in food service are conducted as required.

(13) Ensure appropriate medical monitoring of personnel exposed to environmental hazards as identified by the Safety Department.

(14) Prepare and submit appropriate reports to the Commanding Officer, listing the discrepancies noted during habitability and sanitation inspections and recommend corrective actions.

(15) Prepare the initial drafts of fitness reports for all officers assigned to the Medical Department, including concurrent reports for Air Wing Flight Surgeons (when embarked).

(16) Provide required medical items for designated stations for effective personnel decontamination and advise on medical aspects of personnel decontamination training in chemical, biological and radiological (CBR) warfare defense.

(17) Prepare and submit to higher authority any medical intelligence or information of general interest, especially when in foreign waters or ports.

(18) Identify and care for the dead.

(19) Provide training in shipboard pest control procedures for selected Medical and Supply Department personnel and maintain a pest control program.

(20) When appropriate, obtain samples/specimens to detect the possibility of biological attack and advise and assist the Damage Control Assistant (DCA) in decontamination resulting from biological agents.

(21) Perform Competency for Duty Examinations and report the findings to the Commanding Officer.

(22) Ensure that all medical equipment and supplies that comprise the Authorized Minimum Medical Allowance List (both Storeroom Items (SRI) and Operating Space Items (OSI)) are maintained onboard.

(23) Consult with the Dental Officer on patients requiring joint medical and dental care.

(24) Advise the Commanding Officer as to the effectiveness of the command Fitness Enhancement Program (FEP).

(25) Maintain an effective Health Promotion program, emphasizing preventive medicine practices to reduce the risk of illness and disease and improve the overall wellness of the ship’s crew and their families.

(26) Assign the following collateral duties to specific Medical Department Officers:

(a) Overseas Screening Program Coordinator

(b) Exceptional Family Member Program Coordinator

(c) Health Promotion Program Coordinator

(d) Medical Quality Assurance Coordinator

(e) Medical Professional Credentials Coordinator

(f) Patient Contact Representative

b. Ship’s Surgeon. The Ship’s Surgeon shall be a Medical Corps Officer who has completed residency training in general surgery, and holds an active staff appointment with clinical privileges in general surgery, primary care medicine, and operational medicine. The Ship’s Surgeon reports directly to the SMO. They are responsible for the evaluation and management of all patients with surgical pathology. The Ship's Surgeon will also serve as the Ward Medical Officer, ensuring the operating room, emergency treatment room, and ward are

maintained in a high state of readiness to receive patients. At the discretion of the SMO, the Ship's Surgeon may be designated as the acting Department Head in the absence of the SMO. The Ship's Surgeon shall work at a local MTF with surgical services in order to maintain their surgical skills during all inport periods. The Surgeon will report back to the ship one week prior to any underway periods. The surgeon is responsible for obtaining appropriate clinical privileges at the MTF. These duties shall not interfere with the surgeon's primary responsibility to their command. Specifically, the Ship's Surgeon shall:

(1) Assist the SMO in the performance of their duties and make recommendations concerning surgical policies, standards, and practices in the functioning of the Medical Department.

(2) Keep the SMO informed of clinically significant patients under their immediate care and consult with him in regard to their professional treatment.

(3) Obtain explicit approval from the SMO prior to performing any surgical procedure other than minor surgical procedures.

(4) Supervise the functioning of the Operating Room and all phases of care for surgical patients.

(5) Ensure the Operating Room is in a constant state of readiness to receive casualties from any disaster aboard the ship or from other sources.

(6) Provide for the training of the corpsman in operating room and minor surgical procedures.

(7) Perform other functions as directed by the SMO.

c. General Medical Officer (GMO). The GMO shall be a Medical Corps Officer who has completed an internship and holds an active staff appointment with clinical privileges in primary care medicine and operational medicine. The GMO reports directly to the SMO. Specifically, the GMO shall:

(1) Serve as supervisor of sickcall overseeing the professional treatment and care of the sick and injured as directed by the SMO.

(2) Provide recommendations concerning policies, standards and practices of the Medical Department.

(3) Be assigned as the direct supervisor of the Physician Assistant and Hospital Corpsmen engaged in direct patient care.

(4) Keep the SMO informed as to the condition of all patients under their immediate care and consult with the SMO and Ship's Surgeon regarding their professional treatment as needed.

(5) Perform other functions as directed by the SMO.

Note: Effective October 2005, as GMOs rotate off the ship, they will be replaced by Family Practitioners.

d. Medical Administrative Officer (MAO). The MAO shall be a Medical Service Corps Officer (Health Care Administrator). The MAO reports directly to the SMO. The MAO shall assist the SMO in the details of Medical Department administration. The MAO shall be designated the "H" Division Officer. Specifically, the MAO shall:

(1) Evaluate the effectiveness of the Medical Department administrative policies, methods, and procedures, advise the SMO as appropriate.

(2) Prepare and process departmental correspondence, messages and reports; and maintain an effective routing and tickler system to ensure accurate accountability and proper handling of written communications.

(3) Prepare directives under the guidance of the SMO and exercise control over their issuance to ensure effective dissemination throughout the department.

(4) Administer liberty and leave for the Medical Department, subject to the approval of the SMO.

(5) Prepare the Medical Department Watch, Quarter and Station Bill.

(6) Maintain the Medical Department library of official and technical publications, directives, instructions, books and similar materials for ready reference.

(7) Ensure the safeguarding and authorized disposition of all Medical Department classified correspondence and publications assigned to their custody.

(8) Supervise the maintenance of health records.

(9) Supervise the procurement, stowage, preservation and issue of Medical Department supplies and materials.

(10) Serve as the Controlled Medicinals Bulk Custodian for controlled substances on the ship. Assume direct custody of narcotics and other controlled substances and personally supervise the condition, safekeeping and economical expenditure of these items.

(11) Supervise the inspection and replenishment of first aid boxes, mass casualty boxes, battle dressing stations and other emergency medical kits.

(12) Supervise the departmental 3-M Program.

(13) Serve as the Ship's Health Benefits Advisor (HBA) and supervise the TRICARE program.

(14) Assume responsibility for ensuring comprehensive medical records screening in support of the Command Security Program, if directed.

(15) Perform other functions as directed by the SMO.

e. Ship’s Nurse. The Ship’s Nurse shall be a Nurse Corps Officer with subspecialty training and experience in critical care nursing (subspecialty code 1960). They will serve as Nursing supervisor for the Medical Department and as the Medical Training Officer. The Ship’s Nurse reports directly to the SMO. Specifically, the Ship's Nurse shall:

(1) Be in charge of the ward and Intensive Care Unit (ICU). Additionally, he or she will oversee all nursing functions within the department regardless of location, ensuring appropriate nursing care is carried out and properly documented.

(2) Assist health care providers in the professional treatment and care of the sick and injured. Report to the Ward Medical Officer on matters relating to inpatient care.

(3) Be designated as the Medical Training Team leader as set forth in COMNAVAIRFORINST 3500.20 (series).

(4) Maintain ship’s crew BLS education as either BLS Program Administrator or Affiliate Faculty. Maintain BLS Instructor or Instructor-Trainer qualifications.

(5) Be designated as the departmental Quality Assurance Coordinator (QAC) and be responsible for Quality Assurance matters as set forth in chapter 18 of this instruction.

(6) Be designated as the Infection Control Officer and the Bloodborne Pathogen Program coordinator.

(7) Participate in Health Promotions education of ship’s crew.

(8) Coordinate basic first aid/war wound (GITMO wounds) training and stretcher-bearer training of the ship’s crew.

(9) Ensure that supplies are stocked in adequate amounts and that all equipment is in operating order in the ward and intensive care unit.

(10) Provide training to the corpsmen in nursing and critical care procedures.

(11) Perform other functions as directed by the SMO.

f. Physician Assistant (PA). The Physician Assistant shall be a Medical Service Corps Officer (Clinical Care Specialist) who possesses Physician Assistant core privileges. The PA reports directly to the SMO. The PA works under the supervision and direction of the SMO or a credentialed physician clinical supervisor appointed in writing by the Commanding Officer. Guidelines for utilization of Physician Assistants are set forth in detail in COMNAVAIRFORINST 6320.3 (series). Specifically, the PA shall:

(1) Keep their physician supervisor informed as to the condition of all patients under their immediate care and consult with other physicians in regard to their professional treatment as required.

(2) Assist with the performance of daily sick call and provide clinical assistance and training to the Hospital Corpsmen.

(3) Assist in the performance of routine physical examinations.

(4) Perform other functions as directed by the SMO.

g. Clinical Psychologist (CP). The Clinical Psychologist shall be a Medical Service Corps Officer (Clinical Care Specialist) who possesses Clinical Psychology core privileges. The CP reports directly to the SMO. Specifically, the CP shall:

(1) Keep the SMO informed as to the condition of all patients under their immediate care and consult with other physicians in regard to their professional treatment as required.

(2) Maintain clinical responsibility for all services provided by SARP and the psychiatric technician.

(3) Perform other functions as directed by the SMO.

h. Physical Therapist (PT). The Physical Therapist shall be a Medical Service Corps Officer (Clinical Care Specialist) who possesses a current state license in Physical Therapy. They shall possess Physical Therapy core privileges. The PT reports directly to the SMO. Specifically, the PT shall:

(1) Keep the SMO informed as to the condition of all patients under their immediate care and consult with other physicians in regard to their professional treatment as required.

(2) Maintain clinical responsibility for all services provided by the physical therapy technician.

(3) Perform other functions as directed by the SMO.

i. Radiation Health Officer (RHO). The Radiation Health Officer shall be a Medical Service Corps Officer (Health Care Scientist) who has been trained in the Radiation Health Officer Program. The RHO reports directly to the SMO. The RHO also reports directly to the Reactor Officer and the Executive Officer on matters related to nuclear propulsion. Specifically, the RHO shall:

(1) Administer the Radiation Health Program per NAVMED P-5055 (Radiation Health Protection Manual), NAVSEA S9213-33-MMA-000/(V) (Radiological Controls for Ships) and COMNAVAIRFOR 6470.4 (Radiation Health Manual).

(a) Maintain personnel health records per NAVMED P-117 (Manual of the Medical Department), and NAVMED P-5055.

(b) Ensure that all CVN personnel and visitors are medically screened for radiation exposure based on their duties and responsibilities as identified by their Department Head.

(c) Schedule and audit radiation medical examinations for radiation workers not having a valid physical.

(d) Establish a system for ensuring that all assigned radiation workers maintain a current radiation medical examination.

(e) Audit current radiation medical examinations for reporting personnel prior to authorizing that a thermo luminescent dosimeter (TLD) be issued.

(f) Ensure all personnel qualified per Article 208 of NAVSEA S9213-33-MMA-000/(V) and limited radiation workers are briefed on potentially disqualifying medical conditions as stated in that reference.

(2) Establish written check-in and check-out procedures to ensure compliance with radiation health requirements based on all applicable references. Audit all personnel records of occupational radiation exposure workers as part of personnel check-in and check-out. Audit personnel records of occupational radiation exposure workers on a periodic basis as required by NAVMED P-5055.

(3) Complete radiological control training requirements and perform both a TLD read and a surveillance of a TLD read under the

observation of the current RHO prior to relief as RHO. Document the completion of these requirements in the RHO's relieving letter.

(4) Ensure contamination workers receive termination examinations within six months of transferring, if leaving the service or nuclear field duty.

(5) Ensure contamination workers receive internal monitoring within six months of transferring, when applicable.

(6) Review and forward to the CO the command's annual Man-REM evaluation.

(7) Assisted by the Chemistry/Radiological Assistant (CRA), prepare the report of corrective action taken on discrepancies noted from each Radiation Health Audit. The corrective action report shall consist of identifying each discrepancy, root cause, corrective action and measure of effectiveness.

(8) Shall establish, maintain and route a deficiency list through the chain of command that tracks outstanding corrective action items on at least a quarterly basis.

(9) Prepare and submit the monthly dosimetry report to the CO per COMNAVAIRFORINST 6470.4. Ensure all comments are formally resolved following review by the chain of command.

(10) Supervise the preparation and handling of exposure estimates and investigations. Approve final dose estimates and forward to the XO and the CO.

(11) When personnel have transferred, forward radiation exposure information to the Naval Dosimetry Center via a Situational Report and to the individual's new command via an Exposure Transmittal for entry into his medical record within 30 days of transfer.

(12) Prepare termination letters for signature by the CO or his designated representative when requested by an individual.

(13) Forward radiation exposure information for visiting personnel to the Naval Dosimetry Center with a Situational Report, if applicable, and the individual's parent command with an Exposure Transmittal.

(14) Assist the XO in the External and Internal Radiation Health Audits of the Radiation Health Program.

(15) Prepare reports as required by NAVMED P-5055 and NAVSEA S9213-33-MMA-000/(V).

(16) Ensure that training is conducted on decontamination procedures per BUMEDINST 6470.10 (series) and that the material and equipment required for decontamination is onboard.

(17) Administer other dosimetry programs for the command (e.g., X-ray technicians, radiograph technicians).

(18) Analyze radiation exposure information on a monthly, quarterly and annual basis. Report exposure trends up the chain of command via the CO's monthly report. Differentiate between yard, pre-deployment work-up and deployment underway periods. Establish exposure criteria that would require further investigation.

(19) Analyze Dose Investigations (DI) by type and frequency. Report Dose Investigation trends up the chain of command via the CO's monthly report. Identify DI criteria that would require further command action.

(20) Perform other functions as directed by the SMO.

j. Air Wing Flight Surgeons. Carrier Air Wing Flight Surgeons are required to be Medical Corps Officers who have completed an internship and have been designated as a Naval Flight Surgeon. In addition, they shall hold an active staff appointment with clinical privileges in primary care medicine, operational medicine and flight surgery. Carrier Air Wing Flight Surgeons remain under the primary administrative control of the Air Wing Commander while embarked, but shall be under the cognizance of the SMO as fully integrated members of the ship's Medical Department. It is expected that 50 percent of the flight surgeon's time should be utilized in support of the Air Wing. In addition, they shall perform such duties as the SMO may direct, including routine Medical Department watch standing assignments in support of the ship/air wing mission. Specifically, Air Wing Flight Surgeons shall:

(1) Provide medical care and treatment of air wing personnel, and assist in the treatment of ship's company personnel.

(2) Determine by close observation and appropriate clinical investigation the physical and psychological fitness of flight personnel, individually and collectively, and initiate appropriate action as directed by consideration for safety.

(3) Conduct examinations for the selection and re-qualification of flight personnel to ensure their fitness for flight duties.

(4) Recommend to squadron Commanding Officers and the Air Wing Commander measures that will contribute to flight safety.

(5) Recommend to the Air Wing Commander or Squadron Commander suspension from flying or other appropriate action whenever, in their

judgment, pilots or aircrew are not fit to undertake flight duties without risk to the success of the mission or to the flight crew and themselves.

(6) Instruct flight personnel in preventive measures regarding conditions peculiar to geographic locations of operations and the medical aspects of aviation safety.

(7) Frequently consult with the SMO, Air Wing Commander, and Squadron Commanders and keep them informed on all matters relative to the health and welfare of air wing personnel, particularly those in actual control of aircraft.

(8) Request, when appropriate, a Local Board of Flight Surgeons to determine eligibility of flight status of personnel whose physical or psychological well being is in question.

(9) Maintain oversight of assigned squadron corpsmen, and ensure that the medical readiness of squadron personnel is maintained.

k. Medical Department Leading Chief Petty Officer (LCPO). The LCPO is the primary assistant to the SMO in the administration, supervision, and training of enlisted personnel in the Medical Department. The LCPO reports directly to the SMO. The LCPO shall also perform the Division Officer functions in the absence of the H-Division Officer. Specifically, the LCPO shall:

(1) Assist in the assignment of enlisted personnel to various duties for which the department is responsible and to exercise overall supervision of enlisted personnel under the direction of the H-Division Officer.

(2) Be responsible for the professional growth and development of all enlisted personnel assigned to the Medical Department.

(3) Prepare and submit performance evaluations on all enlisted personnel assigned to the Medical Department.

(4) Assist the H-Division Officer in preparing and maintaining the Watch, Quarter and Station Bill.

(5) Prepare the watch and liberty lists for Medical Department enlisted personnel.

(6) Inspect all Medical Department spaces daily, with the exception of Battle Dressing Stations. The LCPO shall personally inspect all Battle Dressing Stations at least weekly. These inspections will address the general material condition, cleanliness and preparedness to conduct clinical procedures in these spaces. Completion of these inspections, and any discrepancies noted, will be documented in the Medical Department Journal.

(7) Directly supervise the performance of the Leading Petty Officer and Work Center Supervisors.

(8) Coordinate air wing corpsmen assignments with the Air Wing Flight Surgeons to ensure squadron requirements are met, with ample opportunities to rotate to different areas of the Medical Department for training.

(9) Ensure cross training of corpsmen to ensure all areas are covered (i.e., lab, X-ray, etc.)

(10) Draft evaluations for squadron corpsmen.

(11) Perform other functions as directed by the SMO.

l. SARP Director. The senior certified Navy Drug and Alcohol Counselor assigned to the command shall be designated as the SARP (Substance Abuse Rehabilitation Program) Director. The SARP Director shall be a graduate of the Navy Drug and Alcohol Counselor School (to include the Director's seminar) and hold the requisite NEC for their billet. The SARP Director reports directly to the Clinical Psychologist. The SARP Director, all activities of SARP, and the Preceptor Program are supervised by the CP.

m. Division Leading Petty Officer (LPO). Normally, the senior First Class Hospital Corpsman shall be designated the Division Leading Petty Officer and shall assist the MAO and LCPO in the administration, training and overall supervision of the personnel of H-Division.

n. Hospital Corpsmen. Hospital Corpsmen shall perform duties as prescribed by the CO, SMO and other competent authority, and shall be assigned to only such duties as allowed by the Geneva Convention and the Standard Organization and Regulations of the U.S. Navy. Hospital Corpsmen shall perform clinical duties per COMNAVAIRFORINST 6320.3 (series). Operating Room Technicians will spend 50% of their time while inport working in the Operating Room of the local MTF. Whenever possible, the OR Tech should work with the ship's surgeon in the operating room and should also work a wide variety of surgical cases in order to maintain and enhance their skills.

o. Hospital Corps Strikers. In order to maintain an adequate number of Hospital Corpsmen, volunteers from the Fleet are necessary. Only those personnel who possess the requirements as specified by current instructions and are highly motivated to become Hospital Corpsmen should be selected and recommended for assignment to Class A Hospital Corps School. Strikers do not have to be assigned to the Medical Department in order to be recommended for Hospital Corps School, although this is highly desirable. When assigned, they should be rotated throughout the department in order to ascertain their capabilities prior to requesting assignment to Hospital Corps School. Hospital Corps Strikers shall observe and/or assist and will ALWAYS be under direct supervision when conducting any patient care procedures.

They shall receive education and training in patient privacy prior to assignment of any duties in the Medical Department. Selection and use of Strikers as standbys during medical examinations will be per COMNAVAIRFORINST 6320.1 (series).

4104. WATCHSTANDING

a. In homeport, a BLS medical response capability is the minimum medical capability that must be maintained onboard the ship at all times. The Duty Medical Officer may be ashore on weekends or after normal working hours, but must be in contact by pager or telephone at all times. Significant cases should be discussed by telephone with the Duty Medical Officer and all patient treatment entries must be cosigned on the next working day. Each carrier Medical Department shall have a written protocol that defines "significant" cases that require contact with the Duty Medical Officer. Emergency cases may warrant immediate referral to the nearest emergency room if the Duty Medical Officer cannot be reached in a timely manner.

b. In ports other than homeport, the carrier Medical Department shall maintain the capability to provide all of its usual medical services. Specifically, the department shall maintain routine outpatient, inpatient and ACLS medical response capabilities onboard. A duty medical officer (physician) must be onboard at all times, unless a waiver of this requirement has been specifically granted by the TYCOM. All Medical Department Officers will only stand duty in the Medical Department, except in emergencies. This policy does not interfere with standing watches to achieve warfare qualifications as long as the officer can be immediately relieved to respond to an emergency, and they are not assigned as the primary Duty Medical Officer.

c. All Hospital Corpsmen should perform medical duties and watches strictly within the confines of providing medical care, except in emergencies.

d. During flight quarters, the Flight Deck Battle Dressing Station (BDS) shall be manned by two flight deck qualified corpsmen at all times.

4105. WATCH, QUARTER AND STATION BILL. A current Watch, Quarter and Station Bill shall be conspicuously posted within the Medical Department. The bill shall identify assignments for conditions of normal operations, General Quarters, Mass Casualty, Medical Response Teams, Abandon Ship, and Man Overboard. All Medical Department personnel and personnel assigned to medical watch stations (such as stretcher bearers, phone talkers, dental personnel) shall be listed on the bill.

4106. MEDICAL PERSONNEL FROM EMBARKED UNITS

a. Flight Surgeons

(1) Embarked Carrier Air Wing. Whenever a Carrier Air Wing is embarked, all air wing Flight Surgeons will accompany the wing aboard and report to the ship's Senior Medical Officer upon arrival for duty. Carrier Air Wing Flight Surgeons remain under the primary administrative control of the Air Wing Commander, but are responsible to the Senior Medical Officer for medical matters. Flight Surgeons will stand duties and watches as assigned by the Senior Medical Officer.

(2) Carrier Qualifications. The ship's complement will be augmented with at least one Flight Surgeon for each carrier qualification period. Under normal conditions, Flight Surgeons from the units participating in carrier qualifications will embark with their respective units. When squadrons cannot provide the required Flight Surgeons, the TYCOM Force Medical Officer will be informed in time to institute appropriate action. COMNAVAIRPACINST 1301.9 (series) and COMNAVAIRLANTINST 1301.6 (series) apply.

b. Hospital Corpsmen. Whenever a Carrier Air Wing is embarked, all air wing squadron corpsmen will accompany their respective squadrons aboard and report to the ship's Medical Department for duty upon arrival. Squadron corpsmen are considered to be TAD to the Medical Department, and shall be fully integrated into routine Medical Department operations, but still have responsibility to their parent squadron for various medical and administrative matters. Squadron corpsmen shall be allowed to attend squadron meetings/functions when their presence is requested by their command, and shall be required to stand shipboard duties and watches as assigned by the Medical Department LCPO. Whenever the squadron corpsmen accompany their squadrons aboard, they shall bring all squadron personnel medical/dental records and an electronic copy of the squadron SAMS database, and shall be responsible for maintaining their respective squadron's medical records. When squadron corpsmen are embarked, the ship's Medical Department shall provide performance evaluation input to the squadron for each air wing corpsman.

4107. TAD/TEMADD MEDICAL SUPPORT. Active duty support is occasionally needed for short-term coverage. Support for a longer term may also be necessary to bridge the gap between an unplanned loss and the arrival of a permanent replacement. Except in emergencies, a two to three month advance notice is desired. TAD support may also be available through the use of reserve assets. Requests for reserve support shall be submitted as far in advance as possible. Requests for TAD/TEMADD medical support shall specify a required onboard arrival time not later than 48 hours prior to the ship getting underway to allow for unexpected travel delays and inclement weather.

a. Anesthesia. Anesthesia support is provided by an Anesthesia Department at a specific BUMED assigned Medical Treatment Facility per

the current BUMED (Code M3M) "Anesthesia Support to Carriers" message. Contact Force Medical for the latest message update. Direct liaison with the assigned MTF is authorized. Requests for support are to be submitted to the responsible MTF with information addressee copies to BUMED (Code M3M and M3F); OPNAV (N931); Commander, Fleet Forces Command (CFFC); and the Type Commander (TYCOM). Support periods should be identified to the assigned MTF at least three months in advance. The responsible MTF will supply and fund TAD anesthesia support to their designated carrier. See Appendix D for sample TAD Support Request messages.

b. Surgeon/other Medical Department Officers. General surgeon support or any other officer support requirement is requested from BUMED (Code M3M and M3F) via the TYCOM, CFFC and OPNAV (N931). Direct liaison with an MTF is not authorized. Requests should be initiated a minimum of two to three months prior to the dates required (except in the case of an emergency or unplanned loss). See Appendix D for sample messages. When available, contact via phone or e-mail shall be made with Force Medical prior to initiating any request. Requests for TAD support to cover planned absences (such as coverage for surgeons taking boards) shall be submitted with as much lead time as possible. Note: Many surgeons may not have had the opportunity to take specialty boards prior to reporting onboard. Surgical specialty boards usually occur in the October time frame. Proactive inquiry should be made before a new surgeon reports aboard to determine if they will need to take boards. If confirmed, a request for TAD support shall be initiated as far in advance as possible to ensure surgical coverage for underway periods during the absence of the ship’s surgeon. Significant advance notice also improves the opportunity to utilize reserve assets to support the identified requirement. Note: If a reservist is identified to fill the requirement, ensure coordination with the ship’s Reserve Liaison Officer (RLO) for logistics requirements and the assignment of a Billet Control Number (BCN). The requesting carrier will be responsible for providing funding data to the supporting command.

c. Enlisted

(1) Permanent Loss

(a) Notification of enlisted requirements as a result of unplanned loss is accomplished through the submission of the Enlisted Manning Inquiry Report (EMIR). EMIR guidance is delineated in the Enlisted Transfer Manual, Chapter 26. The EMIR notifies the Enlisted Personnel Manning and Assistance Center (EPMAC) of a unit’s concern regarding significant enlisted personnel shortages. To qualify for submission as an EMIR, the personnel shortage should meet one of the following criteria:

(1) Current onboard manning or projected onboard manning in the applicable rating or closed loop/transitory Navy

Enlisted Classification (NEC) is below Navy Manning Plan (NMP) or Billets Authorized (BA), whichever is less.

(2) Personnel in the following categories: Careerist not re-enlisting, personnel being administratively separated, death, humanitarian reassignment, non-volunteers removed from duty involved with flying, diving, EOD, pregnancy, HIV, and immediate availabilities.

(3) In the opinion of the Commanding Officer, the personnel shortage has a significant effect on unit readiness.

(b) The EMIR is not to be used to report general manning problems, or for reporting unplanned loss of personnel who do not have significant effect on unit readiness. Do not submit an EMIR until the member is a permanent loss from the activity.

(c) Ensure submission of an Enlisted Manning Inquiry Report (EMIR) is coordinated with the ship's Personnel Office. EMIR messages are submitted to EPMAC Code 90 with information addressee copy to the TYCOM (Personnel and Force Medical) and CFFC.

(2) Temporary Loss. Notification of enlisted requirements as a result of a temporary unplanned loss will be made via message to the TYCOM (Personnel and Force Medical). When available, contact via phone or e-mail shall be made with Force Medical prior to initiating any request. Other TYCOM assets will be utilized whenever possible, before requests are forwarded to the CFFC or EPMAC for action.

d. Reserves. Medical reservists are available to provide fleet support. Any requirement for reserve support must be coordinated with the ship's Reserve Liaison Officer (RLO) prior to submitting a request to BUMED. The RLO needs to be aware of all reserve embarks and has the responsibility for coordinating logistics and the assignment of a Billet Control Number (BCN) for each requirement. Requests for reserve support will be submitted per the current BUMED (Code M10) "FY-XX Annual Training (AT) for Medical Reservists" message. BUMED (Code-M3F) serves as the BUMED central point of contact for Fleet support. Requests for reserve support will be submitted to BUMED (Code M3F and M10) with information addressee copy to the TYCOM (Force Medical and Reserve Liaison).

4108. OFF-DUTY REMUNERATIVE CIVILIAN EMPLOYMENT. NAVMED P-117, Manual of the Medical Department, Article 1-22 provides policy for off-duty remunerative professional civilian employment, including self-employment, of active duty Medical Department Officers. No Medical Department Officers on active duty may engage in any off-duty employment without first obtaining the permission of the Commanding Officer. The local command has the primary responsibility for control of off-duty employment by Medical Department officers. Guidelines in MANMED Article 1-22 serve as the basis for carrying out this

responsibility. MILPERSMAN 5370-010 establishes policy for all members of the Naval service with regard to off-duty/outside employment. All privileged providers engaged in off-duty employment must notify the privileging authority of their civilian employment.

CHAPTER 5

Administration

SECTION 1 – RECORDS, REPORTS, AND REFERENCES

5101. MANUALS, DOCUMENTS AND INSTRUCTIONS

a. Organizational Document. The organization of each Medical Department shall be documented in a ships bill or instruction, see Paragraph 4101. The document shall define the chain of command and delineate duties and responsibilities of each functional area or significant position within the Medical Department.

b. Standard Operating Procedure Manuals. Work centers within the Medical Department shall establish a standard operating procedures (SOP) manual providing detailed step-by-step information on the daily routine and how to conduct each procedure and/or function. These procedure manuals shall be reviewed annually by the Senior Medical Officer and the Medical Administrative Officer and updated as necessary. Procedure manuals are a valuable tool to initially provide Hospital Corps personnel with pertinent information to successfully complete Medical Department training requirements and for periodic review thereafter for refresher training. The SMO shall approve each SOP manual by signature on the cover page; the SMO and each member assigned to that work center shall review the SOP annually and document that review by their signature and date on the signature page in the SOP. Ensure that SOPs are used as references and not as a substitute for training. SOP manuals are required, at a minimum, for the following work centers:

Administration	Radiation Health (CVNs only)
Clinical Psychology	Radiology
Laboratory	Substance Abuse Rehabilitation Program
Operating Room (including Anesthesia)	Training
Pharmacy	Treatment Room
Physical Examinations	Ward/ICU
Physical Therapy	

5102. RECORDS AND LOGS. The following records and logs shall be maintained within the Medical Department. They shall be in an electronic, book or log form and in sufficient detail to serve as a complete and permanent historical record for actions, incidents, and other recorded data. Electronic logs are permitted only if daily, weekly, and monthly backup copies are maintained so as to minimize the chance of data loss.

a. Medical Department Daily Journal. Each ship shall maintain a Medical Department Daily Journal. The journal will contain a complete history of the Medical Department. It shall contain personnel admitted to or discharged from the ward; reports of personnel casualties, injuries and death; inspection of fresh provisions; ship drills; brig visits; sanitation inspections; and all other occasions of significance. The journal shall be reviewed daily by the Medical Administrative Officer and signed by the Senior Medical Officer. If the journal is maintained electronically, a hard copy will be printed daily and signed by the Senior Medical Officer. The journal is a permanent record and shall be retired per SECNAVINST 5212.5 (series).

b. Statistical Data Log (Sick Call Log). A daily statistical data or sick call log shall be maintained. The log shall contain the date and time reported, the individual's name, rate, division (or ship if different from treating facility), complaint, diagnosis, treatment, disposition, and time departed sick call. The purpose of the statistical data log is to provide an audit trail for medical care provided to each patient. The SAMS medical encounter module is the preferred method to record sick call log data. Each patient's diagnosis will be coded with the most specific available diagnostic ICD-9 code. This log must not be available for other patients to see to protect patient confidentiality.

c. Consult Log. A consult log must be kept to track the specialty consult process. Follow-up is needed to ensure patients receive appointments and that a Medical Officer review of the completed SF 513 or DD Form 2161 is documented. The following tracking elements will be incorporated in the log: patient name, last four, division, consulted specialty and working diagnosis, date submitted, consult date, consult returned and reviewed by Medical Officer.

d. Pathological Specimen Log. A pathological specimen log is to be maintained with documentation that all patients have been notified of their pathology results, and that a Medical Officer has reviewed the results and the results are filed in the patient's medical record. This log is to be maintained for two years and retired per SECNAVINST 5212.5 (series).

e. Training Log. A training log is to be maintained to document all lectures and training periods conducted per the training program for ship's company and Medical Department personnel. All drills are to be documented in this log. A muster sheet is to be maintained on file for each lecture given. The log shall be reviewed and signed monthly by the SMO.

f. Bulk Controlled Medicinals Record. The Bulk Controlled Medicinals Record shall be retained and maintained by the Bulk Custodian, with a copy kept in the Medical Department.

g. Working Stock Controlled Medicinals Record. The Working Stock Controlled Medicinals Record shall be retained and maintained by the Working Stock Custodian, with a copy kept in the Medical Department.

h. Potable Water Log. Daily chlorine/bromine water testing as well as weekly bacteriological water testing is required to be recorded in a log. The Potable Water log in SAMS will be used to meet this requirement.

i. Pest Control Log. A pest control log shall be maintained, containing the date, time, and location of areas surveyed and/or sprayed aboard the vessel. The SAMS Pest Control log will be used to meet this requirement.

j. Ancillary Service Logs. Records of all laboratory tests and x-ray studies performed shall be maintained per Paragraphs 8204 and 8302 of this instruction.

k. Sterilization Log. A sterilization log shall be maintained per Article 8502 of this instruction.

l. Medical Waste Disposal Log. A medical waste log shall be maintained, and will include the following elements: date, type of waste, amount (volume or weight), storage location, method of disposal, tracking number, and receiving activity with signature of recipient. Refer to the Afloat Medical Waste Management Guide (OPNAV P-45-113-3-99) for the current requirements.

m. Sexually Transmitted Disease (STD) Log. A current STD log will be kept using the SAMS format or equivalent.

5103. HEALTH RECORDS

a. Privileged Communication. The health record is a legal document containing an individual’s past and present medical history. The health record is the property of the U.S. government, and not the individual. The manner of custody will be such as to protect its personal nature. Administration and management of health records will be per MANMED, Chapter 16. The Privacy Act of 1974, the Health Insurance Portability and Accountability Act (HIPAA) and SECNAVINST 5211.5 (series) govern release of information from health records. MANMED, Chapter 23, Section III, sets forth guidelines to be followed.

b. Verification. Health records shall be maintained as directed in The Manual of the Medical Department (NAVMED P-117) chapter 16 and other relevant directives. They shall be verified annually, during a physical and upon receipt or transfer. Ensure that the record is in the proper order, forms on the left side are not upside-down, and that the jacket is in good condition. An entry recording the verification will be made in section 7 of the PHA (DD Form 2766), beginning with line twenty. Deficient items identified during the verification will

be circled to indicate the need for completion. Upon verification, the appropriate block will be marked on the health record jacket. An audit of health records will be conducted at least semiannually to ensure that records are onboard for each crewmember.

c. Sick Call Entries. A SF-600 entry will be prepared for each patient reporting to sick call. The importance of proper record keeping cannot be overemphasized. A properly maintained health record is of great value to the government or to a member in establishing entitlement to pension benefits for a service-connected disability. Entries in the health record shall contain the date, name of ship, vital signs, complaint, and treatment rendered in the following S.O.A.P. format:

S – SUBJECTIVE COMPLAINT (Patient's complaints and history).

O – OBJECTIVE SIGNS (Exam findings).

A - ASSESSMENT (Diagnosis).

P - PLAN (Treatment, Disposition, Follow-up and Patient Education).

The PLAN section of a note will include the specific follow-up time. All signatures in the health record will be in black ink. The name, rank or rating, profession or corps (e.g., MC), and service of the Medical Department representative making entries in the health record will be typed, neatly printed, or stamped under the signature. Stamped facsimile signatures will not be used on any medical form in the health record. In signing, the individual assumes responsibility for correctness of the entry.

d. Charge-out Control of Military Health Records. Health records will be controlled per MANMED, Article 16-10. The SAMS master tickler transfer record or equivalent may be used in lieu of retaining the NAVMED 6150/7 (pink card).

e. Abandon Ship. If at all possible, attempt to salvage the health records during an abandon ship evolution. Saving the records shall not take priority over the medical treatment and evacuation of casualties.

5104. FILING AND RECORDS RETIREMENT. Correspondence and files should be complete, orderly, per SECNAVINST 5210.8 (series). Records, logs, and correspondence should be disposed of per SECNAVINST 5212.5 (series).

5105. REPORTS

a. Daily Reports.

(1) Morning Report of Sick and Injured. This report shall be submitted by the Senior Medical Officer on a daily basis, via the chain of command, to the Commanding Officer. This report shall contain, at a minimum, the following items:

(a) Individuals recommended to be placed Sick In Quarters (SIQ).

(b) Individuals admitted to the ship's ward.

(c) Individuals receiving in-patient medical care off-ship.

(d) Individuals injured within the preceding 24 hours.

(e) Patients MEDEVACed to other facilities.

(f) Patients received from other facilities.

(2) Eight O'clock Report. This report shall be submitted by the Senior Medical Officer, in the format specified by the command, to the Commanding Officer via the Executive Officer.

b. Weekly Reports. When the ship is deployed, a status report is required to be sent to COMNAVAIRFOR Force Medical on a weekly basis. This report should be e-mailed to the Force Medical Officer on the appropriate coast and shall contain, at a minimum, the following items:

(1) Period covered

(2) Inpatient admissions

(3) Surgical procedures

(4) Documented new pregnancies

(5) Medevacs

(6) Any other significant events

Any incident that could result in higher authority interest should be reported immediately to the Force Medical Officer on the appropriate coast via e-mail, naval message, or telephone. These events shall also be included in the next weekly status report.

c. Monthly Reports

(1) TYCOM Monthly Medical Report. A report shall be forwarded each month to Force Medical. The TYCOM monthly report shall be submitted no later than the 15th of the following month. The format for the monthly report is located in Appendix E. An electronic copy

of the Medical Report Data (enclosure (2) of the monthly report) shall be submitted via email to Force Medical no later than the 15th of the following month. The electronic spreadsheet format for reporting this data is available from the TYCOM upon request.

(2) CO's Monthly Report of Radiation Exposure. This report shall be submitted monthly via the SMO, Reactor Officer, and Executive Officer to the CO per COMNAVAIRPAC/COMNAVAIRLANTINST 6470.4 (Series) (Radiation Health Manual).

d. Quarterly Reports: Controlled Substances Inventory Report. The Controlled Substances Inventory Report must be prepared and submitted by the senior member of the Controlled Substances Inventory Board after each inventory. This report must list each item in stock, together with its strength and unit of issue. The report must show the amount remaining from the last report; quantity received, quantity expended, and balance on-hand. The Controlled Substances Inventory Board must conduct an inventory at least quarterly, per MANMED article 21-24. The inventory will be unannounced and a Controlled Substances Inventory Report must be submitted for approval to the Commanding Officer stating the inventory was conducted per Chapter 21 of the Manual of the Medical Department and existing local instructions.

e. Annual Reports

(1) Annual Report of Personnel Exposure to Ionizing Radiation. Any installation, activity, ship or unit at which personnel are monitored for exposure to sources of ionizing radiation is required to submit an Annual Report of Personnel Exposure to Ionizing Radiation. The reference instruction for preparing the Annual Report is the NAVMED P-5055 Radiation Health Protection Manual. Once prepared and verified for accuracy, the report must be forwarded to the Naval Dosimetry Center. The deadline for report submission is 1 April or 30 days after receipt of final exposure information, whichever is later. Every year, each individual in the Radiation Health Program must be informed of their annual exposure.

(2) Annual Tuberculosis Summary Report. A summary record is to be prepared annually covering the period 1 January through 31 December, inclusive. Summary records must contain the items listed in enclosure (5) of BUMEDINST 6224.8 (series) and be retained on file for at least 3 years. A copy must be sent to the cognizant NAVENPVNTMEDU and TYCOM Force Medical Office by 28 February after each year.

f. Situational Reports

(1) Situational Report of Personnel Exposure to Ionizing Radiation. If a monitored individual is transferred, retires, or is released from active duty prior to 31 December, a Situational Report of Personnel Exposure to Ionizing Radiation shall be submitted on NAVMED Form 6470/1 in magnetic media format by the individual's

activity to the Naval Dosimetry Center within 30 days of receipt of the individual's final exposure information.

(2) Situational Report of Personnel Exceeding Radiation Exposure Limits. This report shall be submitted to Chief, BUMED, Attention: Undersea Medicine and Radiation Health Division (M3F7), as follows:

(a) If any individual receives a Total Effective Dose Equivalent in excess of the limits specified in Chapter 4 of the NAVMED P-5055 within 30 days from the determination of such exposure.

(b) A Situational Report shall also be submitted if any individual receives a Total Effective Dose Equivalent of more than 5 REM (0.05 Sv), eye dose equivalent exceeding 15 rem (0.15Sv), or a shallow dose equivalent of 50 rem (0.5 Sv) in a single incident. BUMED (M3F7) will be notified immediately by telephone and/or "IMMEDIATE" message.

(3) Medical Event Report (MED 6220-3). Medical Event Reports will be created and submitted via SAMS or equivalent per BUMEDINST 6220.12 (series). Reportable medical events and specific time frames for reporting are listed in enclosure (2) of the above instruction.

(4) Summary Record of Tuberculosis Contact Investigation. The command initiating the contact investigation must prepare and maintain summaries of the investigation. Summary records are required for the initial investigation and the 3-month follow-up investigation. The records must be retained on file for at least 3 years. The records must include the information shown on enclosure (5) of BUMEDINST 6224.8 (series).

(5) Reporting and Processing Defective or Unsatisfactory Medical Material. For reporting defective or unsatisfactory medical material, refer to BUMEDINST 6710.63 (series).

(6) OPREP-5 Input is provided every 24 hours while underway and is written in a format delineated by the Commanding Officer.

5106. CRUISE REPORT

a. Upon the completion of an extended deployment, a cruise report shall be submitted to Force Medical reflecting any unusual circumstances occurring during the cruise along with the solutions found to be acceptable. This report shall also include any reference material that would be of interest to other NAVAIRFOR units. This report shall be submitted no later than 30 days after the conclusion of any deployment greater than 90 days.

b. The cruise report is an important document to record unusual, unplanned and non-routine events that occurred before and during a

cruise. It should be more than a summary of numbers from routine monthly Preventive Medicine/ Occupational Health reports. This information is valuable to assess operational readiness and support and to personnel who have not deployed to a particular area of operation.

c. Verbosity, kudos, etc., are neither desired nor required. Succinct, worthwhile lessons learned is the intent; i.e., port calls, medical facilities available, significant incidence of disease, MEDEVAC summary, lessons learned, equipment maintenance, supply lag time, etc. Although no standard format is provided, the format used should be submitted in brief presentation format accompanied by narrative supporting documentation. A cover letter summarizing the contents should be included.

d. The preventive medicine section of the cruise report shall address significant issues concerning:

(1) Food Sanitation

(2) Potable Water

(3) CHT System

(4) Medical Event Reporting

(5) Communicable Diseases (including STD)

(6) Heat Stress Program

(7) Pest Control

(8) Occupational Health Monitoring Programs

(9) Habitability

(10) Preventive Medicine Liberty Brief Items

(11) Preventive Medicine Supplies

e. Each problem listed should include the action that was taken and any recommended future course of action.

f. Items of interest that are not necessarily problems should also be mentioned. There is a good chance that if these items were of interest to you, they will be of interest to others deploying in the future.

g. Significant events encountered during deployment should be documented as soon as possible after they occur for later inclusion in the cruise report.

h. An electronic copy of the cruise report shall be sent to COMNAVAIRFOR (N01M) for further distribution. If the total size of the Cruise Report exceeds nine megabytes, the report should be delivered by compact disk. Smaller reports may be sent by e-mail.

5107. INJURY REPORTING

a. The Manual of the Judge Advocate General (JAGMAN), Part E of Chapter Two, requires a Line of Duty Determination in every injury resulting in physical inability of a member of the Naval Service to perform his/her duties for a period in excess of 24 hours or where a permanent disability may result. Refer to the ship's Legal Officer and the JAGMAN for specific guidance.

b. Medical Department personnel shall initiate a local Injury Report upon initial notification or treatment of any injured crewmember. This report shall include the diagnosis, treatment, circumstances and disposition of the patient. The original report shall be forwarded to the Commanding Officer with additional copies to those departments and divisions as directed.

c. For personnel casualty reporting messages, refer to MILPERSMAN 1770 and BUMEDINST 5360.1 (series) (Decedent Affairs Manual).

5108. THIRD PARTY LIABILITY PROGRAM. The goal of this program is to recover the cost of care rendered beneficiaries at Naval MTFs ashore or afloat when another entity (the third party) is liable for the payment of that care under the Medical Care Recovery Act Program. SMOs are directed to forward potential third party liability cases to the Naval Legal Service Office (NLSO) servicing their area when any of the following general criteria are met. (These are separate criteria; if any one is met, forward the case):

a. Any motor vehicle accident where a passenger has been injured.

b. Any case in which the emergency room, clinic, or hospital has been contacted by an attorney or insurance company requesting medical records, reports, evaluations or information.

c. Any case in which a civil lawsuit is likely, such as:

(1) Someone has assaulted or otherwise intentionally injured the patient.

(2) "Slip and fall" accidents, especially at someone else's home, in a store, or any commercial establishment.

(3) Injuries caused by products. Examples could be a foot injured by a lawnmower, an exploding Coke bottle, spoiled food, or unsafe medicines and drugs. When in doubt, call the servicing NLSO.

(4) Injuries caused by services. Examples include a hairdresser who burns a client's scalp by using the wrong chemicals, a delivery person who drops a package on your foot, etc.

(5) Any injury caused by a governmental unit, such as the police, schools, street maintenance crews, etc.

(6) Any accident on a common carrier such as trains, planes, buses, or taxis.

(7) Any medical or dental malpractice (non-federal practitioner).

(8) Negligent injury to the patient in general, especially when the patient indicates he or she will sue.

5109. BOOKS, PUBLICATIONS, INSTRUCTIONS AND NOTICES

a. Since the ship's medical library must function as a reference source for operational physicians as well as a source of specialty consultation and continuing medical education for the Medical Officers deployed, it is imperative that its maintenance receive the same attention given other areas of the Medical Department.

b. An inventory of the ship's medical library shall be accomplished annually. Medical references (textbooks and CDs) shall be replaced as new editions or more suitable volumes are published.

c. For assistance in locating additional subject titles or publisher addresses, the medical librarian of any Naval Hospital may be contacted.

d. In addition to the references required in COMFLTFORCOMINST 6820.1, the following references are required to be held by Medical departments aboard NAVAIRFOR ships:

(1) Aerospace Medicine (current edition) by DeHart

(2) U.S. Naval Flight Surgeon's Manual

(3) Normal Radiological Variants (current edition) by Keats

(4) Hospital Corpsman Navy Rate Training Manuals

(5) Standard First Aid Training Course (NAVPERS 10081)

(6) Current Authorized Minimal Medical Allowance Lists

(7) Military Radiobiology edited by James Conklin and Richard Walter, Armed Forces Radiobiological Research Institute, Bethesda, MD, Academic Press, Inc

(8) The Naval Flight Surgeon's Pocket Reference to Aircraft Mishap Investigation (current edition)

5110. MEDICAL RESEARCH ABOARD AIRCRAFT CARRIERS. All requests for medical research to be conducted onboard NAVAIRFOR vessels, or utilizing NAVAIRFOR personnel, shall be forwarded to the cognizant TYCOM Force Medical Officer for review after approval of the research protocol by an Institutional Review Board. No medical research may be conducted without specific approval of the research protocol by the TYCOM in writing.

SECTION 2 – OFF-SHIP MEDICAL CARE

5201. TRICARE. Under TRICARE, active duty personnel are assigned to a Primary Care site according to their Unit Identification Codes (UIC), based on their duty stations. Active duty personnel stationed onboard Naval vessels are assigned to their ship as their Primary Care Site. All routine care will be provided by the Primary Care Manager (PCM). PCMs will direct active duty members to a military or, in rare instances a civilian hospital or clinic, when specialty care is needed. It is important to keep the crew informed of TRICARE rules and regulations as well as how to access medical care while traveling on authorized leave or TAD.

5202. SENIOR OFFICER PRESENT AFLOAT/ASHORE (SOPA) INSTRUCTION. SOPA instructions are delineated in each ship's homeport. The Senior Medical Officer should review and ensure compliance with the medical section of the local SOPA instruction.

5203. MEDICAL CONSULTATIONS

a. Medical Consultations Ashore for Personnel Afloat. Medical consultations for shipboard personnel shall be scheduled as far in advance as practical. This advance notice will facilitate the reservation or adjustment of appointments by the shore facility to accommodate fleet personnel requiring medical consultation during a limited inport period. Consultation at a civilian medical facility may be obtained in an emergency. Except for bona fide emergency care cases, all active duty personnel reporting to military or government medical facilities for consultations shall be in the prescribed uniform of the day.

b. Request for Consultation. Patients requiring additional consultation services at other medical facilities will be referred using either a SF-513 (Military), DD Form 2161 (Civilian), or authorized electronic referral system (CHCS). The Medical Department will maintain a tickler system to track the status of all off-ship consultations. The following guidelines are general in nature and the

consultation process may vary depending on the policies of the MTF in each geographic area.

(1) Whenever possible, an electronic method should be used. An authorized CHCS remote connection can be used to request consultation services; otherwise, a properly prepared consultation sheet (SF-513) will accompany each patient referred for consultation. Contact the supporting MTF's Fleet Liaison office for local policy. The request for consultation shall include a summary of the patient's history (i.e. condition, complaints, treatment administered to date, and results of the regimen) and any other information that may be of value to the provider completing the consultation. X-rays, laboratory reports, and other pertinent information and documentation should also accompany the patient.

(2) The use of Fleet Liaison officers at medical and dental treatment facilities is strongly encouraged to ensure proper, adequate, and timely resolution of medical support problems.

(3) In general, patients should not be referred to a hospital for consultation with a specialist without first having been seen by a Medical Officer, except in emergencies or when a Medical Officer is not available and delay might jeopardize the welfare of the patient. If operating conditions dictate, direct transfer of the patient should be effected without delay.

c. Post-Medical Consultation. When crewmembers return from off-ship medical consultations, the consultation and their medical record must be reviewed by a Medical Officer or Physician Assistant who shall determine further medical care requirements (e.g., medications, physical therapy, follow-up appointments, etc.).

d. Cancellation of Appointments. If the operating schedule of the ship changes or other unforeseen incidents occur whereby appointments for consultations cannot be kept, appointments shall be cancelled or rescheduled expeditiously and as far in advance as possible.

5204. NON-MILITARY OUTPATIENT HEALTH CARE

a. When non-emergent civilian health care is required, it must be pre-arranged by the military. Active duty members who receive non-emergency medical treatment from a civilian provider without prior approval will be responsible for all costs incurred. Active duty members considering civilian care on their own must receive counseling from their PCM prior to seeking civilian care.

b. All non-military rendered care must be documented in the member's medical record. Additionally, military commands are not obliged to recognize a civilian physician's "orders" for sick leave, etc.

5205. CLAIMS FOR TREATMENT OF MILITARY PERSONNEL IN NON-FEDERAL MEDICAL FACILITIES. The process for submitting claims for payment of civilian health care bills varies by the location of the ship. The following paragraphs define the various processes based on geographic location:

a. At Homeport. When bills are incurred for civilian care of active duty members while in homeport, the bills are to be forwarded to the designated active duty claims representative for the TRICARE region where the ship is homeported. The claim form, DD Form 2642, must be completely filled out and accompanied by an itemized bill from the treating provider(s) or medical facility. Reasons for not utilizing military medical facilities should be indicated on the DD Form 2642. Data on this form must be clear and contain sufficient information upon which to make a decision regarding payment of the claim. If necessary, attach a memorandum explaining in detail why federal facilities were not used. If the care was for an injury that was from an accident or was related to off-duty employment, a "Statement of Personal Injury – Possible Third Party Liability", DD Form 2527, shall be submitted as well. The following addresses should be used based on homeport location:

(1) TRICARE North Region (North Carolina to Maine and west to Wisconsin and Illinois):

TRICARE Prime, Extra, & Standard Claims:

Where to File Claims:	Contractor Information:
North Region Claims PGBA PO. Box 870140 Surfside Beach, SC 29587-9740 http://www.mytricare.com/	Health Net Federal Services Beneficiary Services 1-877-TRICARE (1-877-874-2273) www.hnfs.net/bene/home/

TRICARE Retail Pharmacy Claims:

Where to File Claims:	Contractor Information:
Express Scripts, Inc. ATTN: TRICARE Claims P.O. Box 66518 St. Louis, MO 63166-6518	Express Scripts Beneficiary Services 1-866-DOD-TRRX (1-866-363-8779)

TRICARE Dental Claims:

Where to File Claims:	Contractor Information:
United Concordia TDP Claims Processing P.O. Box 69411 Harrisburg, PA 17106-9411	Delta Dental Beneficiary Services 1-888-838-8737

(2) TRICARE South Region (South Carolina to Florida and west to Texas):

TRICARE Prime, Extra, & Standard Claims:

Where to File Claims:	Contractor Information:
TRICARE South Region Claims Department P. O. Box 7031 Camden, SC 29020-7031 1-800-403-3950 http://www.mytricare.com/	Humana Military Healthcare Services Beneficiary Services 1-800-444-5445 http://www.humana-military.com PGBA Claims Processor 1-800-403-3950

TRICARE Retail Pharmacy Claims:

Where to File Claims:	Contractor Information:
Express Scripts, Inc. ATTN: TRICARE Claims P.O. Box 66518 St. Louis, MO 63166-6518	Express Scripts Beneficiary Services 1-866-DOD-TRRX (1-866-363-8779)

TRICARE Dental Program Claims:

Where to File Claims:	Contractor Information:
United Concordia TDP Claims Processing P.O. Box 69411 Harrisburg, PA 17106-9411	United Concordia Beneficiary Services 1-800-866-8499

(3) TRICARE West Region (Entire west coast, Alaska, and Hawaii):

TRICARE Prime, Extra, & Standard Claims:

Where to File Claims:	Contractor Information:
WPS/West Region Claims P.O. Box 77028 Madison, WI 53707-7028 https://www.triwest.com/triwest/default.html	TriWest Healthcare Alliance Beneficiary Services 1-888-TRIWEST (1-888-874-9378)

TRICARE Retail Pharmacy Claims:

Where to File Claims:	Contractor Information:
Express Scripts, Inc. ATTN: TRICARE Claims P.O. Box 66518 St. Louis, MO 63166-6518	Express Scripts Beneficiary Services 1-866-DOD-TRRX (1-866-363-8779)

TRICARE Dental Program Claims:

Where to File Claims:	Contractor Information:
United Concordia TDP Claims Processing P.O. Box 69411 Harrisburg, PA 17106-9411	United Concordia Beneficiary Services 1-800-866-8499

(4) TRICARE Western Pacific (Japan, Guam):

TRICARE Prime, Extra, & Standard Claims:

Where to File Claims:	Contractor Information:
WPS/Western Pacific Region Claims P.O. Box 7985 Madison, WI 53707-7985	(608) 301-2310

b. Away from Homeport, not Deployed. When civilian medical bills are incurred by active duty members away from homeport, but not deployed (underway for less than 30 days). Those bills should be collected and submitted to the TRICARE region processing office for the geographic region in which the ship is homeported. For example, if a ship homeported in Norfolk incurs civilian medical bills while the ship is conducting a port visit in Mayport, Florida, those bills should be submitted to the TRICARE North Region claims processing center for payment.

c. Deployed. When deployed for greater than 30 days, the TRICARE region at the ship's homeport is no longer responsible for paying for required medical care. When care is required, where the ship is located and what method is used to obtain the necessary care will determine who is responsible for payment.

(1) Deployed to an area with no MTF support. The Assistant Secretary of Defense for Health Affairs has awarded the TRICARE Global Remote Overseas Health Care Contract (TGRO) to International SOS to assist with foreign payments for urgent/emergent medical care and MEDEVAC assistance in areas without Host Nation TRICARE Contracts. When operating in areas supported by the TGRO contract, this should be used as the primary method of obtaining required civilian care. When such care is coordinated through International SOS, there will be no billing to the ship. The TGRO contract is limited to urgent/emergent care and should not be used for routine consultations. If it is necessary to get a routine consultation in an area supported by the TGRO contract, International SOS can still provide recommended sources to receive care, even if that care is not covered under the contract. In those cases, the ship is responsible for paying any associated bills. The following contact numbers are provided for International SOS (IDD = International Direct Dial Code):

(a) For support in the European and Middle East AOR:

Regional Office:	Telephone Number
International SOS Assistance (UK) Ltd Sixth Floor, Landmark House Hammersmith Bridge Road London, England W6 9DP	Admin Tel: IDD +44 (0)20 8762 8000 Admin Fax: IDD +44 (0)20 8762 8070 Alarm Tel: IDD +44 (0)20 8762 8008 Alarm Fax: IDD +44 (0)20 8748 7744

(b) For support in the Pacific AOR:

Regional Office:	Telephone Number:
International SOS Pte Ltd 331 North Bridge Road #17-00 Odeon Towers Singapore 188720	Admin Tel: IDD +(65) 6338 2311 Admin Fax: IDD +(65) 6338 7611 Alarm Tel: IDD +(65) 6338 7800 Alarm Fax: IDD +(65) 6338 7611

(c) For support in the South American AOR:

Regional Office:	Telephone Number:
International SOS Assistance, Inc. 3600 Horizon Boulevard Suite 300 Trevose, PA 19053	Admin Tel: IDD +(1) (215) 942 8000 Admin Fax: IDD +(1) (215) 942 8299 Alarm Tel: IDD +(1) (215) 942 8226 Alarm Fax: IDD +(1) (215) 354 2338

(2) Deployed to an area with MTF Support. When operating in an area served by a MTF, the MTF should be the first source for needed care. If the MTF does not have the requisite service and it becomes necessary to refer patients directly to civilian care, a provider from the MTF's preferred provider network should be used whenever possible. Close coordination with the MTF is necessary to insure that bills from network providers are forwarded to the ship in a timely manner for payment. **Payment for civilian medical care bills incurred during deployment are made using the ship's OPTAR.** Theater specific reporting or payment requirements and variations should be researched during pre-deployment briefings and may be contained in the theater in-chop message or by reviewing the ANNEX Q of the respective Fleet Surgeons Homepage.

5206. MEDICAL EVACUATION (MEDEVAC)

a. General.

(1) The Fleet concept of medical care requires the full utilization of all resources organic to the unit and Task Force prior to transfer ashore. However, since treatment capability afloat is often constrained by ship design and manning, patient transfer may be necessary and plans and procedures must exist to accomplish this procedure safely. Transfer of casualties or patients is an inherently dangerous procedure. In all cases, a risk benefit ratio must be determined to decide the best course of action to serve the patient under the present operational, geographic and environmental factors. The transfer of a patient has two major components: 1) the

uninterrupted continuation of care; and 2) the selection of a proper transportation platform. Determination of the necessary appropriate medical support personnel, supplies and equipment shall be accomplished in an expeditious and complete manner. The continuity of care requires a direct interchange of professional evaluation and information between the sending, transporting, and receiving providers.

(2) For specific guidance refer to the theater in-chop message and by reviewing the ANNEX Q of the respective Fleet Surgeons Homepage. Appendix F of this instructions contains a detailed MEDEVAC checklist for use in managing the MEDEVAC process.

(3) Each carrier medical department shall develop and publish a MEDEVAC checklist consisting of all required procedures, actions and notifications, customized for the ship's command structure and geographic AOR. Physician to physician contact by transferring and receiving facilities shall be accomplished prior to transfer if possible. A SF600 entry documenting all aspects of care and the reasons for transfer shall be entered into the medical record.

(4) A MEDEVAC request message shall be sent to the receiving medical treatment facility to document all MEDEVACs. At a minimum, the CFFC/CPF, TYCOM, Carrier Strike Group Commander and Fleet Commander shall be made information addressees on this message and any messages concerning medical emergencies occurring at sea. The message format can usually be found in the theater in-chop message. If the patient originally came from another ship or submarine, be sure to keep the parent command informed of their status. Additionally, if the patient is from a submarine, notify the submarine's Group Commander and TYCOM as well.

(5) A debrief report shall be accomplished after all MEDEVACs, as specified by the theater in-chop message.

(6) The responsibility for patients being transferred to another activity for transportation and/or treatment rests with the CO of the transferring command until the patient, with all necessary records and belongings, is safely delivered to the receiving medical facility. The transferring command is also responsible for ensuring the receiving command is fully informed as to the condition of all patients transferred, including mental competency and disciplinary status.

(7) To avoid unnecessary personal hardship on patients being medically evacuated, especially where there is any question as to the patient returning to the parent command, special precautions will be taken to ensure:

(a) Adequate uniform and other appropriate clothing and toiletry items are transferred with the patient.

(b) Records, including personnel, pay, and health, are up-to-date, properly annotated and transferred with the patient. A legible summary of care, discharge orders, enroute orders, and list of medications shall be sent with the patient.

(c) All patients who must travel to the hospital for appointments or admission will be issued 30 day funded TEMADD orders. The exception to this requirement is if the ship is in the port serviced by the hospital. When in ports other than homeport, if the ship must depart and the patient will remain for evaluation/treatment, funded orders must be issued to the patient prior to the ship's departure. The appropriate block must be checked to allow the medical facility to send the patient to another facility for further evaluation if indicated.

(8) Patients being sent for evaluation of suicide ideation, gestures, or threats must have an escort who will remain with the patient until released by the examining psychiatrist/psychologist. This escort should be an E-4 or above, and does not need to be a member of the Medical Department.

b. Transfers to U.S. Military Hospitals. Patients being transferred to a military hospital shall be accompanied by their personal effects, health record, and other personnel records as appropriate. For enlisted personnel, a statement relating to their disciplinary status shall be included except in cases of emergency in which instance the records shall be forwarded to the admitting facility as soon as possible. Ambulatory patients should be transferred in the uniform of the day.

c. Transfers to Veterans Administration Hospitals. The health record of a patient transferred to a VA hospital shall be forwarded to the appropriate authority as designated in NAVMEDCOMINST 6320.12 (series). Prior to forwarding the record, an entry shall be recorded on a SF 600 reflecting the name and location of the VA hospital to which the patient has been transferred per MANMED, Chapter 16.

d. Transfers to Non-Federal Facilities Within CONUS. A patient being transferred to a non-federal hospital for treatment shall have all his records maintained onboard unless his command is scheduled for deployment. Copies of appropriate medical record pages will accompany the patient.

e. Transfers to Hospitals of Foreign Nations.

(1) When a service member is hospitalized at a medical facility of a foreign nation, an entry shall be made in the health record. However, this entry shall not be designated as an official transfer document. The health record shall be retained onboard until the patient either returns to duty or is transferred to another U.S. Naval vessel or U.S. military activity. Copies of appropriate medical pages will accompany the patient. Upon departure of the vessel from

port, the health record will be delivered to the CO or designated representative for inclusion with the member's service record and forwarding to the nearest U.S. Embassy or Consulate. The Embassy or Consulate shall be furnished with a complete history of the reason for hospitalization and shall be requested to coordinate with the hospital, with a view toward having the member properly cared for. Upon the member's recovery, the Embassy or Consulate shall arrange for the member's transportation, with records, to the nearest U.S. Naval activity. Refer to MANMED, Chapter 16-37 for further details.

(2) In every case where Fleet personnel are admitted to a foreign medical facility, the Commanding Officer will designate a mature, responsible, Officer or Petty Officer as Medical Liaison Officer (MLO). The MLO will establish and maintain close liaison between the medical facility, the patient's attending physicians, and the ship's senior medical representative. The command must submit a Personnel Casualty Report (Hospitalization in a Foreign Medical Facility) if the ship must sail and leave the patient and MLO at the facility. As soon as the patient's condition will allow, medical evacuation will be coordinated with the appropriate commands.

(3) The patient's command, when in the port where the service member is hospitalized, will ensure the patient is visited daily by a member of the Medical Department and a daily status report will be given to the Commanding Officer.

5207. PATIENT ADMINISTRATION

a. Administrative procedures for admitting patients to the inpatient ward/intensive care unit shall abide by the requirements noted in Paragraph 7110 of this instruction and be logged in the Medical Department Journal.

b. Personnel whose illnesses or injuries are of such severity as to be life threatening (as defined by MILPERSMAN 1770-080) will be placed on the Serious List or Very Serious List with appropriate notifications made as required.

c. Sick in Quarters (SIQ) dispositions from other medical facilities should be considered as treatment recommendations. The patient's command must make the final disposition. Personnel placed on SIQ will be evaluated by the ship's Medical Department prior to being returned to full duty and appropriate health record entries will be made. The length of time an individual may be placed in this status should normally be no greater than 72 hours.

d. Military Treatment Facilities may discharge a patient to return to his or her unit and recommend convalescent leave.

Convalescent and sick leave are recommendations by an attending physician to the command and are considered as adjuncts to patient treatment. The command has approval/disapproval authority for such recommendations. The command must evaluate each recommendation based on individual case history and operational priorities. Convalescent and sick leave, when granted, do not count against annual leave. Commanding Officers of Naval Hospitals or Commanders of Naval Medical Centers may grant convalescent leave without consulting the patient's parent command according to MILPERSMAN Article 1050-180. In case of conflict over MTF recommendations it is best to discuss the recommendation with the consultant.

5208. DECEDENT AFFAIRS

a. General. Responsibilities of Commanding Officers and Medical Officers regarding deaths are set forth in the following:

- U.S. Navy Regulations, 1990, Article 0815
- NAVMEDCOMINST 5360.1 (series) (Decedent Affairs Manual)
- MARCOR Casualty Procedures Manual (MCO P3040.4 (series))

Reports and notifications are outlined in the following:

- Manual of Medical Department, Chapter 17
- MILPERSMAN Section 1770
- MCO P3040.4 (series)

b. To assure orderly compliance with current procedures in the event of deaths occurring onboard ship and deaths of personnel away from their parent command, Medical Departments shall maintain "Death Portfolios" containing a procedure check-off list and all pertinent forms. See Appendix G. This sequential, step-by-step procedure will assist in the timely submission of reports, messages, letters, forms, etc. by the command.

c. At least five "Death Portfolios" shall be available in the Medical Department at all times and are to be provided to the cognizant action officer when the need arises.

d. It is emphasized that while the Decedent Affairs Program is closely related to the Casualty Assistance Calls Program, they are separate and distinct and should not be confused with one another.

e. Decedent Affairs Procedures.

(1) Initial Report. When a death occurs within a command, the SMO will immediately furnish the Commanding Officer with a memorandum report providing the information necessary to comply with MILPERSMAN 1770-030 for Naval personnel and NAVMEDCOMINST 5360.1 (series), Decedent Affairs Manual, Chapter 3, for other than Naval personnel.

(2) Medical Department Journal. An entry will be made in the journal recording all available information concerning the death.

(3) Death Certificate. MANMED, Chapter 17 provides information concerning death certificates and submission of DD Form 2064, Certificate of Death (Overseas). Commands will ensure that an adequate supply of DD 2064s are onboard for use should deaths occur outside the United States. An American medical doctor, military or civilian must sign an OCONUS death certificate.

(4) Health Record Entries. After the required entries concerning a death have been completed and the death certificate is incorporated into the record, the health record will be closed.

(5) Disposition of Remains. As soon as possible, remains will be transferred to the nearest Naval or armed forces medical facility for further disposition. Remains must be accompanied by the following:

(a) Medical/Dental records and dental x-rays.

(b) DD Form 2064, Certificate of Death (Overseas) signed by an American physician.

(c) Two DD Form 565s, Statement of Recognition, signed by shipmates who knew the deceased, if remains are recognizable. In all cases, refer to the Decedent Affairs Manual, NAVMEDCOMINST 5360.1 (series) regarding requirements for death certificates to accompany remains. When transfer cannot be immediately accomplished, the remains will be prepared per NAVMED P-5083, placed in a body pouch, and refrigerated at a temperature of 36-40 degrees Fahrenheit to prevent decomposition. The space used must contain no other items and must be cleaned and disinfected before reuse. Remains will be identified with waterproof tags, marked with waterproof ink, and affixed with wire ties to the right great toe and to each end of the body bag. Minimum identification will include the full name, SSN, and rate. The Decedent Affairs Manual contains complete information and guidelines.

5209. REUSABLE ALUMINUM TRANSFER CASES, HUMAN REMAINS. The minimum allowance of reusable aluminum cases, human remains, for CV/CVNs is four. All units shall ensure that the current allowance is onboard. In any case where a shortage exists, a request for replacement shall be ordered immediately via the supply system.

SECTION 3 - MISCELLANEOUS

5301. DISPOSITION OF MEMBERS WHO REFUSE MEDICAL TREATMENT

a. Medical Departments may occasionally be confronted with an active duty member who refuses to submit to recommended therapeutic measures to prevent illness or injury or to remedy a defect or condition that has interfered with their performance of duty. Persons refusing treatment aboard ship may be subject to administrative or disciplinary consequences. In some cases, it will be appropriate to transfer them to a military treatment facility for further evaluation and recommendations as to disposition. The medical board process, if such is warranted, is detailed in MANMED, Change 120, Article 18-11. Submit cases up the immediate chain of command. Do not, under any circumstances, force unwanted medical procedures on a competent, aware individual.

b. Notwithstanding the above, medical treatment may be given with or without a member's consent in certain conditions. In general, these are:

(1) Emergency care required to preserve the life or health of the member.

(2) Care necessary to protect life or health of a member who is considered by a qualified medical provider to be mentally incompetent.

(3) Isolation and quarantine for cases of suspected or proven communicable disease where medically indicated or required by law.

(4) Detention on closed ward where necessary to ensure proper treatment or to protect the members or others from harmful acts.

NOTE: MANMED Article 18-22 provides guidance concerning disposition of personnel who refuse medical, surgical, or dental care or related diagnostic studies. The condition, rather than the refusal of treatment, should be the deciding factor for determining disposition.

5302. RECOMMENDATIONS FOR DISCHARGE BY REASON OF UNSUITABILITY

a. The recommendation for separation by reason of unsuitability or unsatisfactory performance due to personality disorders and disorders of intelligence should be made only in those cases in which a member has demonstrated unsuitability by unsatisfactory performance of duty or repeated disciplinary problems. The patient must demonstrate a personality disorder or other non-psychotic mental disorder as diagnosed by a psychiatrist or clinical psychologist.

b. Enlisted personnel diagnosed as having one of the below medical conditions may be processed for separation per MILPERSMAN Section 1900, SECNAVINST 1910.4 (series) and MANMED Chapter 18.

ICD-9 CODE	DIAGNOSIS
300.0-300.9	Neurotic Disorders
301.0-301.9	Personality Disorders
302.0-302.9	Sexual Deviation/Disorders
303.0-303.9	Alcohol Dependence Syndrome
304.0-304.9	Drug Dependence
305.0-305.9	Non-dependent Abuse of Drugs
306.0-306.9	Physiological Malfunctions from Mental Disorders
307.0-307.9	Special Symptoms not classified
308.0-308.9	Acute Reaction to Stress
309.0-309.9	Adjustment Reaction
311.0	Depressive Disorder, not classified
312.0-312.9	Disturbance of Conduct, not classified
315.0-315.9	Specific Delays in Development
317.0-319.0	Mental Retardation

5303. MEDICAL BOARDS. A medical board may be convened by the personnel specified in MANMED Articles 18-3 on any member of the Naval service upon recommendation of the Medical Officer of the command to which the member is attached. This article does not prevent a ship or squadron Commanding Officer from requesting a medical board for fitness for duty from authorized medical facilities. Detailed instructions on medical board procedures are in MANMED, Chapter 18.

5304. SHIPBOARD MEDICAL SPACES. Shipboard medical spaces are assigned to provide certain capabilities for care of the sick and injured consistent with size and projected employment of the ship. Shipboard medical spaces will therefore not be converted to other use. No permanent alterations of medical spaces shall be made without the submission and approval of a formal shipboard alteration request via the TYCOM and Force Medical.

5305. BERTHING OF NON-PATIENT PERSONNEL IN MEDICAL SPACES. There will be no non-patient personnel assigned berthing in Medical Department spaces per CINCPACFLTINST 5440.3 (series), Chapter 10, Article 10103 and CINCLANTFLTINST 5400.2 (series), Chapter 10, Article 10103.

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CHAPTER 6

Medical Information Systems

6101. GENERAL

a. All medical software systems will be operated on the ship's automated information system. All software must be IT-21 compliant and have been certified as a SPAWAR Approved Product. All questions concerning the installation of a specific program should be checked with the ships Combat Systems Department.

b. Any computer that is provided to the Medical Department as part of a medical equipment system shall not be re-utilized as a computer work station or removed from the equipment system. This requirement is intended to keep users from swapping their current computer with one provided as part of a medical equipment solution in order to get a better computer.

6102. SNAP AUTOMATED MEDICAL SYSTEM (SAMS)

a. SAMS is a multi-user database application that is used to automate the Medical Department's administrative functions. Installation of SAMS version 08.03.01 or higher is required aboard all aircraft carriers, and all medical personnel should be proficient in using the system. SAMS consists of eight major modules. Use of the following five modules is mandatory for all aircraft carrier Medical Departments:

(1) The Master Tickler tracks immunizations, physicals and other monitoring programs.

(2) The Radiation Health module is the only software application currently approved by NAVSEA 08 to track radiation exposure data.

(3) The Occupational Health/Environmental Health module tracks water testing, heat stress, and pest control data.

(4) The Supply module is a MILSTRIP/MILSTRAP compliant unit and automates tracking and re-order of medical supplies.

(5) The System Management section can be used to create SAMS accounts and control the level of access to the information contained in the program.

NOTE: Use of the Medical Encounter, Training Management, and Periodic Duties modules are optional.

b. To ensure a complete database of all onboard personnel, embarked airwing squadrons shall carry aboard SAMS data files for all personnel and may incorporate them into the ship's SAMS database. SAMS data for such units shall be downloaded at the time of debarkation.

c. The information contained in SAMS is protected by encryption technology and shall be maintained on a ship's server. A member of the Medical Department shall be designated and trained as the SAMS administrator. All users must be entered into the system using the Systems Management module. Use is password protected and each user should only be granted access to those modules necessary for the completion of assigned tasks. Passwords are not to be shared with other individuals. The system manager's password shall be provided to the ship's CMS/Security Manager for emergency access.

d. Back-ups of SAMS data shall be accomplished on a daily basis. A local Medical Department back-up shall be made in addition to the LAN administrator's back-up of all SAMS data. This procedure meets computer security guidelines for remote and local backups. This procedure also provides for the highest level of data protection and recovery. A minimum of seven daily back-up disks/tapes is required to be maintained in Medical at all times. Additionally, a separate set of monthly backup disks/tapes shall be maintained in Medical for the last three months. It is possible that the data may degrade over many days and the daily back-up media may not be useable. In this event, the system administrator will be required to restore one of the monthly backups and update the data from that time forward. If it is necessary to reconstruct more than three months worth of data, the department will be required to reload all medical records into SAMS.

e. SAMS Support is available from:

(1) SAMS Web Site: http://www.scn.spawar.navy.mil/med-sys

(2) For Atlantic Fleet units:

SPAWARSYSCEN NORFOLK

Letter: Commanding Officer
Space and Naval Warfare Systems Center
1837 Morris Street, Suite 3311
Norfolk, VA 23511-3432

Message: SPAWARSYSCEN NORFOLK VA//133//332

Phone: Commercial (757) 443-0741, DSN 646-0741

E-mail: sscn_samseast@navy.mil

(3) For Pacific Fleet units:

SPAWAR Systems Activity Pacific

Letter: Officer in Charge
SPAWAR Systems Activity Pacific
675 Lehua Avenue
Pearl City, HI 96782-3356

Message: SPAWARSYSCEN NORFOLK DET SAN DIEGO CA

Phone: Commercial (808) 474-3166

E-mail: sscn_samswest@navy.mil

6103. COMPOSITE HEALTH CARE SYSTEM (CHCS)

a. Onboard CHCS. CHCS2T is currently in the testing phase. A version of TMIP (Theater Medical Information Program) Block 1 was tested in 7th Fleet. TMIP Block 1 was removed due to multiple problems and is currently undergoing changes. CHCS2T and SAMS(9.0) will roll out as part of TMIP Block 1 sometime in the future.

b. Remote Access to MTF CHCS. Aircraft carriers may be able to remotely access their supporting MTF's CHCS server via telephone dial-up or over the internet. Currently, this process only requires the use of a secure internet connection. Software and hardware are being fielded to protect patient privacy. Firewall clearances must be negotiated with the ship's Combat Systems Department and the MTF's information systems manager. Use of such systems to submit electronic consults, obtain laboratory and pathology results, and order tests from the supporting MTF is encouraged.

6104. TELEMEDICINE

a. Telemedicine is the business practice of exchanging clinical information in electronic format between remote locations to facilitate clinical diagnosis, treatment, consultation or referral for the purpose of delivering health services. The word "telemedicine" has been broadly applied in the medical field to describe everything from Video-Teleconferencing, email with attachments, components of the electronic patient record, telephone consults, medical data retrieval, and medical library reference (online or CD-ROM). Examples of Telemedicine are:

(1) A telephone consult between providers, or a provider and a patient for the purpose of delivering health services.

(2) A request for medical consultation through email, with or without data attachments.

(3) A video teleconference for the purpose of conducting a patient visit/consult between providers, or provider and patient.

(4) The transmission of real-time or store & forward images to a medical facility for the purpose of medical diagnosis, treatment or disposition.

(5) A remote provider dialing into CHCS as a TELNET session to access a lab result for his/her patient.

(6) The online reference of an electronic medical library for the purpose of medical consultation and/or making a clinical diagnosis.

(7) Faxed or scanned images of medical record data transmitted between two MTF's or commands.

b. Telemedicine has two basic temporal modalities, asynchronous or "Store & Forward" (S&F), and "Real-time" (RT) interactive communication that are described as:

(1) Store & Forward. Examples of Store & Forward telemedicine communication include:

(a) Digital Camera still images (i.e., jpeg, bmp, gif)

(b) Computer Radiology still images (DICOM or JPG)

(c) Scanner (flatbed or stream feed)

(d) Internet email (text and file attachments)

(e) Voice or video messaging (voicemail or video-clips)

Store & forward methods are ideal for small or limited bandwidth situations and have found value in teleradiology, dermatology, pathology, gross medical photography (disease or wound documentation), and sharing text-based patient demographic data. S&F technology is mature, low-bandwidth, relatively low-cost, and has a high return-on-investment (ROI).

(2) Real-time. Examples of real-time telemedicine include:

(a) Video Teleconferencing (VTC)

(b) Voice (phone or radio)

(c) Ultrasound video data stream

Real-time telemedicine is ideal for large platform facilities with high bandwidth and that have time sensitive cases that can justify this allocation of high bandwidth on a contingency or routine basis. Telepsychiatry, Teleorthopedics, Teleneurology, Teleophthalmology and

other clinical specialties have demonstrated this benefit in the Navy. Technical limitations on diagnostic quality are video frames-per second and resolution coupled with available bandwidth. RT technologies like VTC are improving and have become more affordable as the cost and quality of the technology continues to evolve. As more reliable bandwidth becomes available, RT applications will have a greater applicability.

6105. MEDICAL DATA QUALITY MANAGER. Each ship shall designate one person in the Medical Department to be the Medical Data Quality Manager. It is this person's responsibility to review entries made into SAMS and other medical IT programs to ensure that the data is entered into the correct fields and use the correct format. It is difficult to produce accurate reports when there is a data mismatch. One example of an entry error could occur when several personnel enter influenza shots under the separate fields of: Influenza Adult, Influenza Whole, Influenza Split, and Influenza NOS.

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CHAPTER 7

Clinical Services

7101. MEDICAL RESPONSE TEAM

a. The Medical Response Team (MRT) is an excellent method of extending emergency room medical expertise and equipment to a patient during the first critical minutes following an accident or injury, such as electrical shock, asphyxiation, cardiac arrest, etc., whether it be on the flight deck or in an engine room. The Medical Response Team is designed for the treatment of one or two patients and is not intended for utilization in mass casualty situations. Therefore, all NAVAIRFORCE ships will develop and establish two Medical Response Teams in a manner that best suits the needs of the Medical Department and the ship. The names of MRT members shall be posted on the Watch, Quarter and Station Bill (WQS).

b. Medical Response Teams (MRT) shall be composed of a minimum of 4 personnel, three of which must be hospital corpsmen. A Medical Response Team must be present aboard ship at all times; exceptions to this policy require specific approval by the ship's Commanding Officer. The Medical Response Team must be able to provide, at a minimum, BLS level of care after hours while the ship is in homeport. While the ship is at sea, or in foreign ports where a Medical Officer's presence is required aboard, the MRT is expected to be able to provide ACLS level of care. Emergency Medical Technician (EMT) training and/or certification for Hospital Corpsmen assigned to the MRT, while not mandated, is highly recommended. Should time constraints limit the feasibility of such training, a class in Pre-Hospital Trauma Life Support (PHTLS) may serve as an acceptable alternative. Advanced Cardiac Life Support training for Corpsmen is also highly encouraged.

c. When a medical emergency is called away, the 2nd MRT team shall muster in the main medical spaces.

d. MRT drills shall be conducted according to the frequency specified in COMNAVAIRFORINST 3500.20 (series). At a minimum, each of the two Medical Response Teams should be drilled on a monthly basis. Actual responses may count as a drill as long as the event was a bona fide medical emergency, the MRT response time was immediate and the care rendered was deemed satisfactory per the Senior Medical Officer (SMO) and/or the Medical Training Team (MTT) leader.

e. Hand held radios allowing for instantaneous communication between the MRT and the Medical Department have proven invaluable in rendering quality emergency medical care. At least one hand-held radio shall be carried by the MRT during all medical emergencies. (Hand held radios are not authorized for use in Reactor Department

spaces. The Medical and Reactor Departments need to develop an effective form of communication.)

7102. MEDICAL RESPONSE TEAM EQUIPMENT

a. Each Medical Response Team shall have a full set of emergency medical equipment. Members of the MRT shall carry the following equipment, at a minimum:

(1) Oxygen/Suction/Bag-Valve-Mask device

(2) Trauma Bag (dressings/bandages, splints, gloves, IV fluids, instruments, oral/nasal airway, c-collar, etc).

(3) Defibrillator/AED

b. Once on scene, should it be determined that a higher level of care is warranted, MRT personnel will radio the Medical Department to request the assistance of a Medical Officer. The following required equipment shall additionally be carried to the scene:

(1) Stretcher

(2) Drug bag with full ACLS capability (syringes, laryngoscope, endotracheal tubes, etc).

c. MRT Equipment shall be inventoried on a daily basis and after each use. Written documentation is required. See Paragraph 13207d. for requirements on deep access rescue.

7103. CRASH CARTS

a. Three complete crash carts shall be maintained within the medical spaces. One shall be located within the Treatment Room, one in the Intensive Care Unit, and one within the Operating Room. The anesthesia cart may suffice for a dedicated crash cart as long as it contains all required items. A listing of required items is located in Appendix H. Additional items may be added if approved by the SMO. If items are added, they must be included as part of the inventory and managed accordingly.

b. Crash carts shall be inspected, with attention paid to medication expiration dates, on a monthly basis and after every use. A tamper seal shall be used to ensure the cart has not been opened between uses. Crash carts shall be checked daily to ensure that the tamper proof seal is intact. Defibrillators shall be checked on a daily basis per PMS procedures and the manufacturer’s recommendation. Written documentation of these inspections and checks is required.

7104. BEACH GUARD MEDICAL SUPPORT. Whenever the ship sets up a Beach Guard it shall be manned with medical personnel constituting a

Medical Beach Guard. The mission of a Medical Beach Guard is to supply BLS level of care capability, first aid, and safety screening of personnel before transiting to the ship. At a minimum, one Hospital Corpsman with hand-held radio contact to the ship, and supplied with IV fluids, suction device, resuscitator (ambu bag), oxygen and litters is required. Other equipment and personnel shall be available per local environmental conditions and host nation medical resources. Medical Beach Guard personnel shall be briefed on: the contact numbers for shore medical facilities and ambulance services, guidance for when to contact the duty Medical Officer, when to delay transit to the ship and when to divert patients to shore facilities (see ship's instruction on Management of Intoxicated Personnel).

7105. SICK CALL

a. Sick Call. Sick call shall be held at those times designated by the Commanding Officer. Sick call should be adjusted to fit the ship's work routine when operating under adverse or other unusual conditions so as to make the services available to each watch section. Each patient reporting to sick bay shall have an entry made in the health record on the Standard Form 600. The importance of proper legible record keeping cannot be overemphasized. Entries made in the health record shall contain the date, name of ship, vital signs, complaint and treatment rendered in "SOAP" format. All sick call medical record entries shall be signed and include the printed name, rank, corps and service of the health care provider. All non-physician health care providers who function in sick call evolutions must comply with COMNAVAIRFORINST 6320.3 (series). All health record entries of patients seen by sick call screeners must be countersigned by a credentialed health care provider or Independent Duty Corpsman (IDC). An electronic (preferred) or written log of all patients seen by the Medical Department shall be maintained.

b. Brig Sick Call. A Brig Sick Call shall be conducted twice daily when any prisoners are being detained in the brig. This sick call shall include an inspection of the sanitary conditions of the brig. The Senior HM in the duty section shall hold Brig Sick Call. A Medical Department Journal entry documenting Brig Sick Call is required. A Medical Officer shall be designated as the Brig Medical Officer, and shall be informed of any medical issues or treatment provided to prisoners.

c. Sick in Quarters (SIQ) and Light Duty. When a patient is determined to be too ill or injured to perform their regular assigned duties, a recommendation for Sick in Quarters or Light Duty shall be forwarded to the patient's chain of command. The SMO will designate which level of provider has the authority to sign a SIQ chit.

(1) A Hospital Corpsman must seek Medical Officer advice if the member cannot be returned to full duty after 72 hours due to unresolved illness.

(2) The SIQ/Light Duty Chit will contain, at a minimum, the following:

(a) Limitations that are as specific as possible.

(b) The length of time the limitations are expected to be in effect.

(c) The specified time and place of follow-up.

(d) Any special instructions to the patient.

(e) A patient signature block for the patient to acknowledge their understanding.

7106. TREATMENT ROOM

a. Treatment Room. The Treatment Room, which also functions as the Main Battle Dressing Station (BDS), shall remain open and manned continuously, except under specific approval from the ship's Commanding Officer. The function of the Treatment Room is as an emergency room during routine evolutions and as a BDS during General Quarters. The Treatment Room shall have the following equipment available and in working order at all times:

OR Table
OR Lighting
Medical Oxygen
Suction
Crash Cart
Defibrillator
Vital Signs Monitor
Sharps Containers
Main BDS Supplies

b. Antidote Locker. A separate poison control antidote locker is no longer a requirement onboard CV/CVNs. The antidote locker was originally intended for use by non-medical personnel in the event trained medical staff was not available to handle such emergencies. Antidotes for use by medical staff are now part of the AMMAL formulary. The telephone numbers for the local and national Poison Control Centers shall remain prominently posted in the Treatment Room for quick reference.

7107. SURGERY

a. Surgical Services. As a deploying warship and intensive industrial complex, the risk of traumatic injury and severe illness makes the availability of surgical services essential. Surgical services aboard, while of the highest quality available, cannot always meet the capabilities of shore-based facilities. Therefore, a risk-benefit analysis should be undertaken prior to commencing any surgical endeavor. This philosophy does not intend to prohibit the performance of minor surgery or emergency surgery where the delay incident to transfer of the patient would introduce a disproportionate risk and where a safe and reasonable capability exists. It does require, however, the surgical endeavor to be consistent with the highest standards of practice. The minimum standards that apply under emergency circumstances are not acceptable when the proposed surgery is elective. The possibility of misadventure is greatly increased when difficulties with exposure, anesthesia, blood availability, and inexperienced assistants become superimposed.

b. Action. Medical Officers are directed, whenever surgical procedures are contemplated, to carefully evaluate the aforementioned factors and to use the following guidelines:

(1) Usually, it is not advisable to perform other than minor and endoscopic procedures onboard ship while inport where more capable shore-based surgical capabilities exist.

(2) Procedures requiring general, spinal, or regional anesthesia are prohibited while the ship is in homeport or in CONUS ports, other than homeport, with a military hospital or civilian medical center. In unique situations, the need for surgery onboard should be carefully evaluated to ensure the greatest safety for the patient. IV sedation may be performed while the ship is homeported consistent with the provider’s clinical privileges and facility restrictions. Each carrier Medical Department is required to develop guidelines for the use of IV sedatives. Ensure that dental patients who are intended to recover on the ward are included in the policy.

(3) At sea, Senior Medical Officers shall discuss with their Commanding Officer his policy with respect to surgery and notification of the patient’s chain of command prior to the performance of an elective surgical procedure. The ship’s Commanding Officer shall be notified immediately of all emergency (unscheduled) surgical procedures.

(4) The SMO is charged with the ultimate responsibility for all patient care, and his explicit approval is to be obtained prior to performance of any major surgical procedure or procedure requiring the use of more than local anesthesia.

(5) Proper patient consent, documented on the applicable standard form, shall be obtained prior to all procedures.

See Appendix I for recommended forms to prepare for elective surgery.

7108. GENERAL ANESTHESIA

a. General Anesthesia. General Anesthesia administered aboard aircraft carriers shall be administered only by a Certified Registered Nurse Anesthetist (CRNA) or Anesthesiologist. General Anesthesia is discouraged for elective surgical procedures when other methods of anesthesia are available.

b. Absence of Anesthesiologist/CRNA: In the absence of a CRNA or Anesthesiologist, general anesthesia will be administered only in actual emergency situations required to save life and limb. The Ship's Surgeon and the SMO will determine if general anesthesia is required in the absence of a privileged anesthesia provider. The Oral Surgeon may administer general anesthesia in emergent situations.

c. Anesthesia Equipment and Supplies. The Anesthesiologist/CRNA assigned to the ship is responsible to the SMO to ensure that all equipment and supplies are in working order and well maintained. All shipboard anesthesia machines shall receive preventive maintenance and be certified in correct working order at least annually by a competent biomedical equipment technician or manufacturer’s representative.

d. The CRNA or anesthesiologist will be responsible for developing and updating the carrier instruction on IV sedation.

7109. INTENSIVE CARE UNIT (ICU)

a. ICU. Similar to shore-based medical treatment facilities, the ICU is intended to treat patients in a serious condition and/or requiring continuous monitoring. All personnel assisting in the care of ICU patients shall be trained in a manner consistent with their responsibilities and under close supervision of the Ship’s Nurse or Medical Officer.

b. ICU Beds. The ICU shall have three beds, to include monitors and other necessary ICU equipment, unless specifically waived by the Force Medical Officer. Whenever a patient requiring intensive care monitoring occupies a bed, a Nurse or Medical Officer must be present within the main medical spaces. Additionally, a Corpsman will be present in the ICU at all times whenever a patient is admitted to the ICU.

c. Notification. All patients admitted to the ICU are to have notification procedures accomplished as specified in Paragraph 7110 below.

d. ICU Equipment and Supplies: The Ship’s Nurse is responsible to the SMO to ensure that all equipment and supplies are in working order and well maintained. ICU ventilators shall receive preventive maintenance and be certified in correct working order at least annually by a competent biomedical equipment technician or manufacturer’s representative.

7110. INPATIENT CARE / WARD MANAGEMENT

a. The Ship's Surgeon will be assigned in writing as the Ward Medical Officer. The Ward Medical Officer will be responsible to the Senior Medical Officer for medical care and documentation thereof, including oversight of admissions, discharges, and daily patient rounds. The Ward Medical Officer shall ensure that the SMO is informed of all admissions. Admitting privileges to the Ward/ICU are limited to TYCOM-privileged medical officers. The Clinical Psychologist may admit and manage mental health patients if they hold the appropriate clinical privileges (If medications are required, supervision and co-signature of all orders by a medical officer is warranted). Other privileged allied health specialists (physician assistants, physical therapists, nurse practitioners) may assist and manage inpatient care, but a physician must countersign all notes and orders.

b. The following information is provided to assist the ship’s Medical Departments in developing and organizing an inpatient ward that will provide the best quality care for the patient.

(1) The Inpatient Ward shall be closed while the ship is homeported. When in other ports with a U.S. military hospital in close proximity, patients who require a higher level of care should be transferred to that facility. However, if the patient’s condition is improving and they are expected to return to duty in a few days, they should remain on the ship’s ward. In this circumstance, a Corpsman must remain on the ward and a Medical Officer must remain onboard with a hand-held radio or equivalent.

(2) The minimum manning which shall be maintained while the inpatient ward is open for admissions is a Medical Corps Officer and a Corpsman. Only trained and competent Hospital Corpsmen will be assigned to inpatient care duties, and they will be assigned such watch sections to ensure the ward is adequately manned 24 hours a day while the ward is in operation.

(3) The minimum number of Ward beds required on an Aircraft Carrier is 51. Specific configuration: 40 general ward beds, eight Quiet Room beds (usually this will be configured as two 4-bed quiet rooms), and three ICU beds.

(4) The SMO shall ensure that daily bedside rounds are conducted and documented. Care shall be taken to ensure that meals

are served on time, medications are administered, and other treatments are given as directed. Vital signs shall be obtained at scheduled intervals, and laboratory specimens and x-rays will be obtained as required by the attending doctor. All abnormal results will be promptly reported to the Ship's Nurse and/or Duty Medical Officer. All efforts will be made to ensure that the inpatient chart is properly maintained and is legible. Timely documentation is of the utmost importance.

(5) The following items are suggested for a check-off list of accomplishments for patient admission. These should be tailored to meet the needs of the command:

(a) Patient's Division Officer notified.

(b) The Personnel Officer shall be notified about all patients whose illnesses or injuries are of such severity as to be life threatening (as defined by MILPERSMAN Section 1770). Such patients will be placed on the Serious List or Very Serious List with appropriate notifications made to next of kin/CACO as required.

(c) Commanding Officer and Executive Officer notified.

Note: It is strongly recommended that the next of kin (NOK) be notified as soon as possible in all cases of admission. If possible, this notification should be done by the patient using POTS. If the patient is unable to notify the NOK, and it can be ascertained that they desire notification be made, it should be accomplished expeditiously. If the patient is admitted and does not desire the NOK to be notified, a written deferral should be signed and dated by the patient. This practice will resolve difficult questions that may arise following MEDEVACs, transfer admissions, etc. This written deferral shall be noted in the Nursing Notes section.

(6) Controlled Medications. Written procedures are required for the handling and dispensing of controlled substances as directed by MANMED, Chapter 21. Controlled medications will only be stocked on the ward when required for specific patient treatment. A ready stock of medications will not be maintained on the ward.

(7) Inpatient Chart

(a) All patients (Medical/Dental) requiring ongoing treatment or observation must be formally admitted to the ward. The highest possible quality of medical care shall be administered with a clear record of care and an audit trail for routine review of patient care practices. Formal written admission procedures per standard Navy medical practices, utilizing a formal chart, either long form (SF 504, 505, & 506) or short form abbreviated medical record (SF 539) format as appropriate will be utilized. The SF 539 will be utilized only in uncomplicated inpatient care of brief duration (an anticipated hospitalization of less than 48 hours). If the admission becomes

longer than 48 hours, the reason for the extended hospitalization will be documented in the Progress Notes. It is not necessary to switch to the long form admission documents. The SMO should evaluate admission trends to insure that use of the abbreviated admission format is not being abused.

(b) Upon acceptance of an individual for admission in the ward, for whatever reason, the SMO shall be immediately notified and fully informed. The Medical Officer ordering admission shall assume full responsibility for the well being of that patient until care is appropriately concluded or the patient is formally transferred to the care of another physician.

(c) In all instances, daily progress of the patient shall be documented. A complete record of care shall be maintained until discharge or transfer. All standard forms used in the inpatient record must meet the medical record criteria contained in MANMED, Chapter 16 and BUMEDINST 6300.3 (series). All inpatient record entries (nursing notes, progress notes, Medical Officer orders, etc.) must record both date and time of entry.

(d) Upon discharge or release from Medical Department cognizance, either a Narrative Summary (SF 502) or completed abbreviated form (SF 539), as appropriate, shall be included in the patient's inpatient record with a copy placed in the patient's outpatient medical record. The discharge summary must contain the following:

(1) Admission diagnosis

(2) Discharge diagnosis

(3) A brief summary of stay with justification for discharge diagnosis

(4) Instructions to patient (medications, follow-up and other instructions as necessary)

(5) Duty status

(6) Condition of patient on discharge

(e) The legibility of all written notes must be guaranteed by the SMO. When the SMO completes the final portion of the inpatient record, by signing the Inpatient Admission/Disposition Record (NAVMED 6300/5), his signature verifies the quality of care as well as completeness of the record. The SF 502, Narrative Summary, must be typewritten and signed by the discharging physician.

(f) No patient will be discharged from the ward and placed on a "No Duty" status or ordered to bed rest (SIQ).

c. Medical Hold. The unique nature of the shipboard environment is clearly recognizable. A deployed ship does not have the luxury of discharging a patient to Convalescent Leave or to a shore based medical holding (MEDHOLD) company. On occasion, ward beds are used for patients who would not otherwise require hospitalization. Due to the difficulty encountered using shipboard ladders and other potentially hazardous environmental conditions, some patients may be better cared for in Medical. The close proximity of the galley combined with the facilities on the ward allow recovering patients to provide self care in a controlled environment.

(1) The SMO has a clear obligation to provide safe and proper medical care, regardless of the medical reason for accepting a patient for berthing in the ward. Patients may be discharged to a MEDHOLD status if they no longer require any direct medical care. However, it is inappropriate to discharge patients to MEDHOLD in order to save on paperwork and avoid using the long form. It shall only be used to provide a suitable convalescent period that will allow the patient to remain onboard and return to duty as soon as practicable. If there exists any uncertainty over whether to admit a patient or place them in MEDHOLD, the patient shall be admitted. When MEDHOLD patients are on the Ward, the Ward will be staffed consistent with the requirements outlined in Paragraph 7110b(2).

(2) The Medical Department is responsible for all personnel residing in medical spaces. Whether a patient is admitted or not, the Medical Department must account for these individuals for mustering purposes. Refer to Paragraph 5305 regarding the berthing of non-patients on the ward.

7111. PHYSICAL EXAMINATIONS. The Medical Department is responsible to ensure all necessary physical exams are available, completed and submitted as required in a timely fashion and per the Manual of the Medical Department and other agencies dictating specifics (DODMERB, NASA, etc). All required follow-ups, recalls and resubmission should be completed in a timely fashion. All laboratory and radiographic results shall be reviewed and initialed by a licensed clinical provider.

7112. AVIATION MEDICINE. All aviation medicine procedures will be accomplished per the NATOPS General Flight and Operating Instructions Manual, OPNAVINST 3710.7 (series), and Chapter 15, Section 65 of the MANMED. Direct oversight of operations, including review of physical examinations, waivers and submissions, will be the role of the SMO and Carrier Air Wing Flight Surgeons as directed by the SMO. The Flight Deck BDS will be manned per ship's policy by trained and competent personnel, and per Paragraph 4104d. The SMO, or assigned CVW Flight Surgeons, shall provide oversight of Flight Deck BDS operations.

7113. SUBSTANCE ABUSE REHABILITATION PROGRAM. The Substance Abuse Rehabilitation Program (SARP) serves to prevent and treat alcohol abuse and dependence. The SARP director reports clinically to the Clinical Psychologist, and administratively to the Medical Department LCPO and Medical Division Officer. The SARP should work closely with the command DAPA to ensure expeditious evaluation and treatment as necessary. The SARP shall be run and services provided per BUMEDINST 5353.4 (series), to include preceptor and reporting requirements. "Performance Indicator Surveys" shall be distributed and collected from all patients. Other utilization of the SARP should be based on local needs and capabilities of personnel (Stress/Anger Management, Suicide Prevention Programs, etc.).

7114. CLINICAL PSYCHOLOGY. Clinical Psychology services are an effective asset to the Medical Department and crew on a platform with an inherently stressful environment. The various preventive and treatment options made available should serve to improve working conditions and morale, as well as reduce the need for administrative separations and MEDEVACS for mental health reasons. The Clinical Psychologist will report to the SMO, and follow all applicable instructions and directives, including COMNAVAIRFORINST 6320.3 (series), Non-Physician Health Care Providers. The Quality Assurance program applies to assigned Clinical Psychologists. The Clinical Psychologist shall be well integrated into the Medical Department and crew and provide high quality care within the parameters of their credentials. The Clinical Psychologist should be utilized in Health Promotion activities (Stress/Anger Management, Suicide Prevention, etc.) and for SARP oversight as assigned by the SMO. Psychiatric Technicians will report clinically to the assigned Clinical Psychologist. The Clinical Psychologist may manage mental health admissions to the Medical Ward/ICU that do not require medication if they have the required clinical privileges. If medications are involved supervision by a Medical Officer is required. The Clinical Psychologist will be responsible for developing and updating the carrier instruction on Critical Incident Stress Debriefing and on the Management of Personnel with Suicidal Ideation.

7115. PHYSICAL THERAPY. Physical Therapy services are an effective asset to the Medical Department and crew on a deploying warship/industrial complex. The various preventive and treatment modalities made available should serve to prevent injuries, decrease lost work days, improve morale and decrease the need for MEDEVACs due to musculo-skeletal injuries. The Physical Therapist will report to the SMO and follow all applicable directives and instructions, including COMNAVAIRFORINST 6320.3 (series), Non-Physician Health Care Providers. The Quality Assurance program applies to assigned Physical Therapists. The Physical Therapist shall be well integrated into the Medical Department and crew and provide high quality care within the parameters of their credentials. The Physical Therapist should be utilized in Health Promotion (Healthy Back, Injury Prevention, etc.) and other activities as assigned by the SMO. Physical Therapy

Technicians will report clinically to the Physical Therapist. Medical Ward/ICU admissions related to musculo-skeletal injuries, while followed closely by the Physical Therapist, shall be made by a Medical Officer. The Physical Therapist shall be responsible to the SMO for currency and maintenance of PT supplies and equipment (PT AMMAL).

7116. WOMEN'S HEALTH ISSUES

a. It is incumbent on medical personnel to ensure quality preventive medicine and treatment services for women are readily available aboard ship. All medical staff members should be familiar with COMNAVAIRFORINST 6320.1 (series), provision of standbys During medical examinations, and cognizant of the privacy and sensitivity issues involved.

b. Annual Health Maintenance Examination for Women. An annual health maintenance examination is required for all active duty women. The annual examination includes, but is not limited to the following:

(1) Pelvic examination, to include Papanicolaou (PAP) smear and Chlamydia screening

(2) Breast and thyroid examination

(3) Vital signs, to include blood pressure measurement

(4) Mammography. A baseline at age 40 (sooner based on family history and breast examination) and screening shall be offered every 1-2 years, until age 50, then annual screening at nearest shore based MTF.

(5) Family planning, contraceptive counseling, STD prevention, and general health promotion shall be a component of every annual examination.

c. Due to inherent delays in PAP smear evaluations during deployments, **all attempts should be made to complete the annual examination prior to deployment.** Every effort will be made to provide patients with the results of their PAP smear within 30 days. The components of the annual examination will be evaluated by Force Medical during Birth Month Medical Surveillance Inspections (BMMSI).

d. The references for the pregnancy policy are OPNAVINST 6000.1B of 04 March 2003 and CNO NAVADMIN 060.94 DTG 151726Z APR 94. The NAVAIRFORCE pregnancy policy for all carriers has remained the same since 1994:

(1) Pregnant women are prohibited from being onboard during routine underway periods if the time required for medical evacuation to emergency OB/GYN care exceeds six hours. This six hour rule is not intended to allow pregnant women to routinely operate at sea, but

rather to provide the Commanding Officers flexibility during short underway periods such as changes in ship's berth, ammo/stores/training anchorages, transits to and from local shipyards, etc.

(2) Servicewomen who are confirmed to be pregnant during operations at sea shall be sent TAD to the closest U.S. military facility that can provide OB/GYN care at the earliest opportunity.

7117. CLINICAL INSTRUCTIONS. Each carrier shall develop written guidance for handling the following events:

a. MANAGEMENT OF ALLEGED RAPE VICTIMS. Plans, policies and procedures shall be developed and implemented in a shipboard instruction per OPNAVINST 1752.1 (series).

b. MANAGEMENT OF INTOXICATED PERSONNEL. Although not all inclusive, the following checklist represents the minimum criteria that should be established in the management of intoxicated personnel:

(1) Shipboard guidelines for Command Duty Officers (CDO) on handling intoxicated personnel.

(2) Medical Departmental SOP for handling intoxicated personnel, to include:

(a) Beach Guard HM guidelines in foreign ports

(b) Ward management

(3) Documented training for all Medical Department personnel for screening intoxicated personnel.

c. COMPETENCY FOR DUTY EXAMINATIONS. Competency for duty examinations will be performed per BUMEDINST 6120.20 (series). The purpose of competency for duty examinations is to determine whether an individual who shows signs of intoxication to medications, alcohol or illicit drugs, is competent to perform duty, to operate a motor vehicle, or to perform other official functions or risk the safety of themselves or others. The authority and signature for requesting a competency for duty examination must be given by the CO/XO/CDO or Department Head, as delegated by CO. Unless laboratory testing is specifically requested, a clinical evaluation should suffice in determining competency. Competency for duty examinations shall be performed by a medical officer and completed on NAVMED 6120/1 form.

d. MANAGEMENT OF PERSONNEL WITH SUICIDAL IDEATION. Personnel with suicidal ideation shall be managed per BUMEDINST 6520.1 (series). Plans, policies and procedures shall be developed and implemented through a shipboard instruction.

e. CRITICAL INCIDENT STRESS DEBRIEFING. Early intervention and counseling has proven very effective when contact with the patient is initiated early after a significant event/disaster. Each ship shall make plans for debriefing critical incidents including the use of indigenous assets, and off-ship assets such as SPRINT Teams.

f. IV SEDATION. Each carrier Medical Department is required to develop guidelines for the use of IV sedatives. Ensure that Dental patients who are intended to recover on the ward are included in the policy.

CHAPTER 8

Ancillary Services

SECTION 1 - PHARMACY

8101. DEFINITIONS. Alcohol, barbiturates, hypnotics, stimulants, narcotics, and other substances requiring special custodial care are collectively called controlled substances. Controlled medicinals are defined as a drug or other substance determined by the Director, Drug Enforcement Administration, Department of Justice, to be designated Schedule Symbols II, III, IV, or V, as defined in the Controlled Substances Act, effective 1 May 1971, and other items requiring security storage.

8102. GENERAL RESPONSIBILITY. Responsibility for the receipt and custody of controlled medicinals is assigned to the Controlled Substances Bulk Custodian. Additionally, the Senior Medical Department Watchstander is charged with the custody of and accountability for the contents of the emergency breakout locker for use after normal working hours.

a. Each ship must maintain detailed records. The purpose of these records and procedures is to fix accountability for receipt, custody, transfer, survey, dispensing, loss, and to prevent the unauthorized use of controlled medicinals.

b. The SMO will be responsible to the Commanding Officer for requisitioning, dispensing, survey, loss, and procedures pertaining to usage of all controlled medicinals.

8103. CONTROLLED SUBSTANCE CUSTODIANS

a. An officer shall be designated as the Controlled Substances Bulk Custodian. This position will normally be assigned to a Medical Department officer who does not provide primary care to patients, such as the MAO. The Bulk Custodian shall not be a Medical or Dental Department Officer with prescribing authority or a Supply Corps Officer. The Bulk Custodian shall be appointed in writing by the current Commanding Officer per MANMED, Chapter 21. An example of the appointment letter is provided in Appendix J. A copy of the letter shall be maintained in the Medical Department.

Note: Only the Bulk Custodian or the SMO is authorized to sign for receipt of controlled medicinals arriving onboard.

b. The Pharmacy Technician (NEC 8482) will normally be the custodian of the working stock. The Working Stock Custodian will hold the combination of the working stock safe. The Working Stock Custodian shall be appointed in writing by the current Commanding

Officer per MANMED, Chapter 21. An example of the appointment letter is provided in Appendix J. A copy of the letter shall be maintained in the Medical Department

8104. CONTROLLED SUBSTANCES INVENTORY BOARD (CSIB)

a. A three member Controlled Substances Inventory Board shall be appointed in writing by the current Commanding Officer. An example of the appointment letter is provided in Appendix J. At least two of the three members shall be commissioned officers. At the discretion of the Commanding Officer, the third member may be a senior enlisted other than a Hospital Corpsman or Dental Technician in pay-grade E8 or E9. No member of the board may be responsible for either the control or custody of the substances being inventoried (i.e., a Custodian shall not be a member of the CSIB that inventories the controlled medicinals). MANMED, Chapter 21 provides detailed guidelines, and the CSIB members shall familiarize themselves with this reference.

b. An inventory will be conducted at least quarterly, per MANMED, Chapter 21. Additional inventories will be conducted when the Custodian or the Pharmacy Technician is relieved, or upon the direction of higher authority. Controlled substances records will be reconciled between the bulk, working and emergency stock quantities to ensure that proper accounting procedures are in effect. (NOTE: The use of facsimile stamps is prohibited on all controlled medicinal records. A signature is required on prescriptions, receipts, vouchers and issue documents except where authorized deviations (i.e., initials) are allowed by MANMED, Chapter 21.

c. A copy of the letter appointing the Inventory Board shall be maintained in the Medical Department.

8105. CONTROLLED SUBSTANCES INVENTORY REPORTS. The senior member of the Controlled Substances Inventory Board will submit letter reports to the Commanding Officer upon completion of an inventory of each site. The suggested format is located in Appendix J.

8106. SECURITY. Strict security measures are required to protect controlled medicinals. Only the Bulk Custodian shall have the combination to the Bulk safe. The Working Stock Custodian will provide administration of Working Stock records. The working stock safe's combination shall be known only to those persons whose official duties demand access and have been authorized by the SMO. The combination of both safes shall be changed upon assuming custody, at the time any person having knowledge of the combination transfers from the command or is relieved of duties requiring access to controlled substances, and at least every 12 months. Records of combinations shall be recorded on the Classified Container Information Form OPNAV 5511/30 and placed in the "Combination Change Envelope" OPNAV 5511/2 (Rev. 8-62) and placed in the custody of the Registered Publications Officer.

8107. DISPENSING AND TRANSFER OF CONTROLLED MEDICINALS. The dispensing of controlled substances for other than medical purposes is strictly prohibited. A loose-leaf binder shall be used for the bulk, working, and emergency records of controlled substances. Use a Perpetual Inventory of Narcotics, Alcohol, and Controlled Drugs (NAVMED 6710/5) for each individual substance. These records shall be retained for three years, after which they are destroyed at the beginning of a new calendar year, per SECNAVINST 5212.5 (series). Example: On 1 January 2005, all controlled substance records and prescriptions issued prior to and including 31 December 2001 will be destroyed.

a. Transfer from Bulk Stock to Working Stock

(1) Transfer shall be made per current supply procedures and in whole units only.

(2) Enter transfer on the Perpetual Inventory of Narcotics, Alcohol, and Controlled Drugs (NAVMED 6710/5).

(3) Prepare a dated receipt in duplicate. Place one copy inside an envelope attached to the corresponding drug record index sheet in the bulk stock record binder. The other copy will be placed inside the envelope in the working stock binder.

(4) Make necessary entries on the record page to account for bulk to the working stock transfer.

b. Transfer from Working Stock to Bulk Stock

(1) Transfer shall be made in whole units by complying with the same procedures as outlined for transactions between the bulk stock and the working stock.

(2) Enter transfer on Perpetual Inventory of Narcotics, Alcohol, and Controlled Drugs (NAVMED 6710/5).

c. Transfer from Working Stock to Emergency Stock

(1) Small quantities of controlled substances may be transferred from the pharmacy working stock to the emergency break-out locker. Appropriate security will be provided.

(2) Transfer from working stock to emergency stock, or vice versa, will follow the same procedures as outlined in MANMED, Chapter 21.

d. Dispensing from Working Stock

(1) Enter transfer on the Perpetual Inventory of Narcotics, Alcohol, and Controlled Drugs (NAVMED 6710/5).

(2) Dispensing from working stock will be made only on a properly prepared and signed prescription form DD 1289.

(3) Prescriptions shall be assigned a control number prefixed with a letter to identify the particular class of controlled substance being issued. A consecutive number will be assigned to each prescription written. The prefixed letters are:

"A" for alcohol
"N" for narcotics
"C" for other controlled substances

(For example: Alcohol, ethyl = A-001, A-002, etc.)

(4) Upon dispensing the controlled medicinal, the prescription is filed in the card index box in sequential order by the drug type as identified in Paragraph 8107d(3) above.

(5) Only a Medical Officer or Dental Officer will sign prescriptions for controlled medicinals.

(6) All controlled medicinals dispensed shall bear a label as specified in MANMED, Chapter 21.

e. Dispensing from Emergency Stock

(1) Dispensing from emergency stock will be made only on a prescription form DD 1289 following the procedure outlined for dispensing from working stock.

(2) The purpose of the emergency stock is to provide the Senior Duty Section Watchstander with a small quantity of controlled substances separate from the working stock. The Senior Medical Officer will specify the quantity and type of controlled substances held in emergency stock.

(3) The Senior Duty Section Watchstander shall ensure all appropriate entries are made on the NAVMED 6710/1's and NAVMED 6710/4's during their watch. The custodian of the working stock shall ensure the accuracy and completeness of all pertinent DD form 1289s and NAVMED 6710/1s. Senior Medical Officers, or their appointed representatives, shall assure the accuracy and completeness of all NAVMED 6710/4's by visual and physical accounting when deemed necessary.

(4) No controlled substance prescriptions will be filled unless there is a bona fide signature card on file in the pharmacy for the Medical or Dental Officer writing the prescription.

(5) Upon relieving the watch, a physical inventory of the controlled breakout substances is accomplished between the off going and relieving Senior Watchstanders. The keys to the emergency stock

shall remain in the custody of the Medical Department Duty Section Senior Watchstander ONLY.

8108. WARD ISSUE

a. In order to maintain a clear and concise audit trail, all controlled medicinals for ward use shall be accompanied by a properly prepared Narcotic and Controlled Drug Account Record (NAVMED 6710/1). Additionally, the Ward shall maintain a Controlled Drug Log containing the Narcotic and Controlled Drug Account Record (NAVMED 6710/1) and Narcotic and Controlled Drug Inventories (NAVMED 6710/4).

b. Audit trails must be clear and concise. Entries on the NAVMED 6710/1 shall have corresponding substantiating entries on the Medication Administration Record (MAR, NAVMED 6550/8) and on the Nursing Notes (SF 510) of the inpatient record. The doctor's orders shall also indicate the date, time and quantity ordered and the date and time the medication was discontinued. The Controlled Substances Inventory Board shall include the ward as part of the quarterly inventory.

c. Pharmacy, Ward and Nursing personnel shall be familiar with and comply with the requirements of MANMED, Chapter 21.

8109. LOSS OR THEFT

a. Upon discovery of loss or theft, the Commanding Officer shall be immediately notified and the CSIB shall conduct a complete inventory. In the case of loss of controlled substances, the Bulk Custodian and the Senior Member of the CSIB will determine if the loss constitutes a significant loss. In the event of theft or significant loss, the following agencies must be notified per MANMED Chapter 21: the Naval Criminal Investigative Service (NCIS), the TYCOM, and the Drug Enforcement Administration (DEA). A DEA Form 106 shall be filed when quantities of controlled substances have been stolen, or a significant amount has been lost.

b. If the loss is determined to be an insignificant amount, the loss will be documented in the CSIB report to the Commanding Officer and the stock records will be adjusted to reflect the actual quantities on-hand.

8110. DISPOSAL OF EXCESS QUANTITIES OR DETERIORATED ITEMS. Excess or deteriorated quantities of controlled substances requiring special custodial care will be disposed of per MANMED, Chapter 21, the Afloat Medical Waste Management Guide (OPNAV P-45-113-3-99) and Paragraph 16306 of this manual.

8111. RESERVE STOCK. Controlled medicinals held onboard as integral parts of Class 6545 (Sets, Kits, and Outfits) will be placed in the custody of the Bulk Custodian and safeguarded per MANMED, Chapter 21. Appropriate entries will be made in the Custodian's record.

8112. DISPERSAL PRIOR TO COMBAT OR EMERGENCY SITUATIONS. Planning is an important factor. The decision to distribute controlled medicinals to the BDS safes rests upon the Commanding Officer. This action shall be considered when a combat or emergency situation is imminent. The Custodian/Senior Medical Officer should have written guidance defining distribution procedures and responsibilities in the event controlled medicinals need to be dispersed for an emergency situation/combat.

8113. REQUISITIONING, RECEIPT, AND EXPENDITURE OF CONTROLLED MEDICINALS. The requisitioning, receipt, expenditure, survey, or other issuance of controlled medicinals is directly related to the financial management of Medical Department funds. The stock records, therefore, must be presented to the inventory board monthly for comparison with total quantities contained in bulk, working, and emergency stock against the total quantities received and expended. The total quantities "on-hand" recorded on the stock record card must equal the total quantities, in whole units or unit of issue (NEVER broken units), carried in the bulk, working, and emergency stock records. To facilitate reconciliation of stock record cards with quantities on-hand of controlled medicinals, the stock records are to be maintained separately in stock number sequence or in the sequential order of the records in which the drugs are contained. Whole units of controlled medicinals are expended from the stock records only when dispensing whole units or otherwise changing the "unit of issue." Broken units remaining are accountable in each individual record under the appropriate column.

8114. CONTROLLED SUBSTANCES SURVEILLANCE PROGRAM. The ordering of controlled drugs not listed on the AMMAL requires prior approval by the Force Medical Officer.

8115. PRESCRIPTION DISPENSING POLICIES/LIMITATIONS. The following is a listing of policies pertaining to the operation of pharmacies onboard aircraft carriers. These policies are the most frequently asked about and the most common cause of concern. It is not intended as a listing of all policies and procedures relating to the pharmacy. Refer to MANMED, Chapter 21, for additional information. Normally, the medications maintained in the ship’s pharmacy are intended to support the ship’s company and embarked personnel.

a. Prescriptions from civilian providers will not be filled onboard. CV/CVN prescribers will not countersign, initial or rewrite civilian prescriptions. An appropriate evaluation and SF-600 entry shall be made prior to prescribing medications on the advice of a civilian provider.

b. No person will prescribe or furnish a controlled substance to themselves or members of their immediate family.

c. All military prescriptions require the printed name and signature of the prescriber. Prescriptions for controlled substances

additionally require the prescriber's Drug Enforcement Agency (DEA) number and branch of service. If the prescriber does not have a DEA number, the Social Security Number may be used instead. Prescriptions not meeting this requirement will be returned to the prescriber.

d. Telephoned or oral prescriptions will not be accepted.

e. Prescriptions for animals will not be filled.

f. Prescriptions will not be dispensed by mail.

g. Regular prescriptions must be filled within 30 days of the date written. Schedule II prescriptions must be filled within seven days of the date written. Schedule III-V controlled prescriptions must be filled within 30 days of the date written.

h. The maximum quantity of non-controlled drugs which should be dispensed at one time is a 90 day supply. However, birth control pills and hormonal replacement therapy (e.g., Premarin and Provera) can have a maximum quantity of 180 days. The maximum quantity for Schedule II-V pharmaceuticals is a seven day supply unless the prescription is cosigned by the Senior Medical Officer.

i. All dispensed drugs must be labeled properly with an appropriate health record entry per MANMED, Chapters 16 and 21.

j. The CV/CVN Core formulary is included as Appendix K. While this formulary was current as of the date of publication of this instruction, it is subject to change. For the latest version of the Core Formulary, contact Force Medical. In addition to this formulary, each ship will develop a local formulary, listing all medications stocked aboard ship (AMMAL and non-AMMAL). This local formulary shall be published and made available to all Medical and Dental providers with authorization to prescribe medications. This formulary shall also contain a listing of medications that can be prescribed by IDCs. This formulary shall be reviewed and updated at least annually.

8116. PRESCRIPTION REQUIREMENTS. Prescriptions must be written in ink, or typewritten and must show the following:

a. Patient's full name.

b. Date prescription was written.

c. Patient's age or date of birth and weight (if 12 years or younger). If a prescriber omits the child's age, the pharmacy may record the child's age on the prescription.

d. Full name of drug, form of drug, dosage size or strength written in the metric system and quantity to be dispensed. Prescriptions should be written generically.

e. Complete directions for the patient. ("Take as directed," in most circumstances, is not considered adequate instruction and must be avoided.)

f. The prescriber's name, stamped, typed or hand printed on the prescription and signature is required.

g. Refill authorization. If none, specify “no refills”.

h. Additional requirements for controlled substances include:

(1) Prescriptions for controlled substances must be written in ink, or typewritten. Duplicate, carbon, photographic, printed, rubber-stamped or addressographed orders are not valid prescriptions for controlled substances.

(2) Command, department, and division of the person for whom the prescription is written (may be supplied by the patient or the agent at the time of dispensing).

(3) The legible signature, DEA number (or SSN) and service (e.g., USN) of the authorized prescriber. In addition, the name of the prescriber must be stamped, typed or hand printed on the prescription.

(4) Erasure or line-outs on prescriptions for controlled substances are prohibited unless initialed by the prescriber.

i. Practitioners using prescriber order entry electronic pharmacy systems are exempt from the signature requirement and the written prescription requirement for non-controlled substances and for controlled substances in Schedule III-V. However, if a patient must have a prescription filled in a community pharmacy, the physician is required to write a traditional prescription and sign it as required by 21 CFR 1305.05(a).

8117. OVER THE COUNTER MEDICATIONS. In order to expedite the treatment of minor injuries and illnesses, an Over the Counter (OTC) Medication program is authorized aboard aircraft carriers.

a. Quantities dispensed are limited to one treatment regimen or a few days supply for relief of minor medical conditions.

b. OTC items must be labeled appropriately and provide adequate directions to the patient for safe and effective use, and also provide warnings and cautions against misuse.

c. OTC medications will be entered into the patient’s medical record, and an OTC log shall be maintained to prevent abuse of the service. Use of a SF 600 overprint is preferred to document the encounter in the patient’s record, see Appendix J for a sample.

d. The patient should be cautioned that some or all OTC medications may be inappropriate for personnel on special duty status, especially for those on flight status.

e. Further guidance on OTC dispensing and the elements of a dispensing request form may be found in MANMED Chapter 21, Article 5.

8118. AMMAL ADDITIONS/DELETIONS. As therapeutic modalities change, the medications on the AMMAL need to be updated. Several factors determine which medications are stocked onboard. The Force Medical Officers determine what is authorized on the AMMAL based upon level of care, Specialty Advisor recommendations, Prime Vendor contracts, and DoD Pharmaco-Economic Board input. Any staff Medical or Dental Officer can request that a drug be added or deleted from the AMMAL by providing written justification, to include drug, nomenclature, cost, and clinical benefit. This justification shall take into account that the AMMAL change will apply to all aircraft carrier Medical Departments. Refer to chapter 10 for AMMAL Change request procedures.

8119. PRE-DEPLOYMENT MEDICATION ANALYSIS AND REPORTING TOOL (P-MART)

a. The Pharmacoeconomic Center (PEC) provides operational forces with a medication management tool called P-MART. Upon receiving an alpha roster of Sailors aboard the ship, this tool can provide a medication use profile for each sailor. The profile includes medications obtained at any Navy MTF, any DOD facility, or any pharmacy in USA. In addition, the profile can be viewed based on type of medication, including high risk, chronic, etc.

b. To access P-MART, go to the Pharmacoeconomic Center website at www.pec.ha.osd.mil, then click on Readiness/P-MART and follow the instructions.

c. Carrier medical departments are expected to obtain a P-MART print-out on the ship’s crew three months prior to a major deployment.

8120. TRICARE MAIL ORDER PHARMACY (TMOP). The TMOP will be used to obtain a six month supply of any nonformulary medications, required by members of the crew, and not available from the local MTF, prior to deployment. The process must be completed at least 14 days before deployment in order to obtain the medication in a timely manner. This process may also be used to replenish required medications should the deployment be extended beyond the initial six months.

a. **Pre-Deployment Refill Process** (Medical Management for Service Members deployed on Navy Ships):

(1) It is not necessary for the Service Member to register with TMOP to receive medications through this program as long as all requirements listed in item 2 below for each prescription are met.

(2) The following information will be clearly written on the prescription:

(a) Patient information:

(1) First name, middle initial, and last name

(2) SSN

(3) Date of Birth

(4) Gender

(5) Allergy information

(6) Ship's FPO address

(b) Medication information:

(1) Drug name, strength, and form

(2) Quantity for 180 day supply

(c) Provider information

(1) Provider name (printed or stamped)

(2) DEA number

(3) Provider signature

(3) The prescriptions must be mailed or faxed to the PDTS Customer Service Support Center (CSSC) at the PEC. Fax 210-221-8131. DSN 471-8131.

(a) Mailing address:

DOD PHARMACOECONOMIC CENTER
PDTS/TMOP TEAM LEAD
2421 DICKMAN RD STE 81
FT. SAM HOUSTON, TX 78234-5081

(b) Fax numbers:

(1) Commercial: (210) 221-8131

(2) DSN: 471-8131

(4) In the event of an urgent order the Medical Officer can call in a prescription directly at:

(1) CONUS: 877-283-3858

(2) OCONUS: 602-225-0005 ext 436914

(5) To facilitate the delivery of any feedback information (shipment date, non-availability, etc.) and to provide for rapid resolution of any problems, provide the e-mail address of either the prescriber or a point of contact within the ship's Medical Department.

b. Smoking cessation products can be ordered in conjunction with the smoking cessation program. Requirements for these products need to be coordinated in advance with the CSSC manager.

Note: Medical personnel authorized to write prescriptions must, provide items listed above in step (2) for every prescription. OTC supplements are not authorized to be dispensed by the TMOP. Prescriptions written for OTC Prilosec 20mg will need to be written for legend Prilosec that requires a prescription.

c. CSSC POCs:

rosemary.gonzalez@amedd.army.mil	TMOP Team Lead	866-275-4732 ext 3006
teresa.dowell@amedd.army.mil	Asst. TMOP Team Lead	866-275-4732 ext 3016
hector.morales2@amedd.army.mil	PDTS/CSSC Manager	comm. 210-221-8443 DSN 471-8443

SECTION 2 – LABORATORY

8201. BLOOD BANK

a. The Carrier Blood Bank program is optional and not mandatory. Carrier medical departments choosing to use this program, must comply with the requirements listed below.

b. The carrier Blood Bank program is authorized to deploy with 20 units of packed red blood cells and eight units of fresh frozen plasma. The red blood cell inventory will include 17 units of O-Positive and three units of O-Negative. The fresh frozen plasma will consist of four units of AB and 4 units of A. A deployment requiring this level of blood support is for a duration of 30 days or greater.

c. Coordinate with the local MTF 15-30 days before deployment. Red blood cell units must arrive at the designated carrier within seven days of collection. Fresh frozen plasma must arrive within three months of collection.

d. Coordinate OCONUS resupply requests via message to the closest Area Joint Blood Program Office (AJBPO), U.S. Naval Hospital, or other

designated blood supply source five to ten days before arrival or close transit. Blood supply source locations will be designated by the Combatant Command Joint Blood Program Office (JBPO)in coordination with the Navy Component Command depending on the area of operation.

e. Ships must have an approved blood bank refrigerator and freezer. It is imperative that carriers receive and document blood bank technical assist visits. The visit should be conducted at the request of the carrier by the supporting Naval hospital laboratory officer approximately 90-120 days before deployment.

8202. WALKING BLOOD BANK (WBB)

a. General. Every effort should be made to use other intravenous solutions, when feasible, in place of whole blood for resuscitation. However, whole blood transfusions may be required in an emergency situation. The WBB will be used in a mass casualty situation, when the refrigerated blood supply has been exhausted.

b. Donors. WBB donors should only be used in a true emergency when the delay necessary to transfer a patient to a shore-based medical facility would be detrimental to a critical patient. To qualify as a donor, personnel must be screened by the Medical Department and determined to be healthy. They shall meet all screening criteria, including: having a normal temperature, free of acute respiratory disease and, as can be determined from the donor's history, free of disease transmissible by blood transfusion (viral hepatitis, malaria, syphilis, HIV, etc.). DD Form 572 will be completed and updated prior to each major deployment (30 days or greater) but no less than annually, by each member of the WBB. It is highly encouraged that all WBB members donate blood, or the laboratory Petty Officer coordinated a ship wide blood drive with the local MTF Blood Bank, prior to deployment so that a complete serological/ virological screening can be performed. However, separate serological/ virological testing is not required.

c. Aircrew Personnel will be handled per OPNAVINST 3710.7 (series).

d. Tickler File. The SMO, in coordination with the Senior Dental Officer, will designate a Medical or Dental Officer to be the Walking Blood Bank Officer (WBBO). The WBBO will report the status of the WBB to the General Surgeon on at least a monthly basis, or more frequently as determined by the General Surgeon. The General Surgeon will exercise overall program management responsibility and will provide guidance and direction to the WBBO as necessary. The General Surgeon will report the status of the WBB to the SMO prior to any underway periods. The WBBO shall establish and maintain a listing of all personnel eligible as blood donors (walking blood bank). This file shall include the person's full name, rate/rank, SSN, division, telephone extension and blood type. The file shall be updated on a

monthly basis. A minimum file of 10 percent of the ship's company will be maintained.

e. If blood donor units are collected and transfused, the following must take place:

(1) A plasma sample must be collected from the donor and recipient, properly labeled and frozen. Upon arrival at the nearest military medical facility with a blood donor center, submit the samples for the current battery of blood donor tests approved by the FDA and American Association of Blood Banks. The recipient must be tested again at three months, six months and at one year.

(2) Ensure procedures are in place, which allows for the identification and tracking of all blood products (received from off the ship or emergency onboard collections) to final disposition of the product (destroyed, transfused, or transported off the ship). Ensure receiving and shipping documents, blood donation records, and transfusion records are permanently maintained. Forward copies of all shipboard transfusions and collections to the Navy Blood Program Office. For east coast carriers, the address is:

Laboratory Medicine Service Line &
Fleet Forces Command Liaison
Naval Medical Center Portsmouth
6200 John Paul Jones Circle
Portsmouth, VA 23708-2197

COMM: 757-953-1709/DSN 377-1709

For west coast carriers, the address is:

Director Western Area Blood Systems
Head Blood Bank
Naval Medical Center San Diego
34800 Bob Wilson Drive
San Diego, CA 92134-5000

COMM: 619-532-9240/DSN 522-9240.

Copies of all blood bank records will be maintained by the ship’s laboratory indefinitely.

8203. QUALITY ASSURANCE

a. The DoD Clinical Laboratory Improvement Program (CLIP), as described in AFIP Pamphlet 40-24 of 8 Jul 96, mandates that deployable medical units performing laboratory testing on a routine basis meet the following minimum requirements:

(1) Maintain verification of training and competency of laboratory personnel per Chapter 11 of AFIP Pamphlet 40-24.

(2) Maintain a SOP for each test performed.

(3) Maintain and document quality control, quality assurance, and maintenance programs.

(4) Validate all procedures with a supporting MTF laboratory.

(5) Participate in continuing education offered by the supporting MTF laboratory.

(6) It is imperative that carriers receive and document laboratory technical assist visits. A copy of the laboratory assessment, with documentation of corrective action, must be kept on file with the ship's Medical Department.

b. The supporting MTF is required, at a minimum, to:

(1) Assign a technical consultant to the ship.

(2) Conduct an annual and/or predeployment assessment of the shipboard laboratory using the current Fleet Laboratory Assessment Form. A copy of the form will be provided by the technical consultant. The assessment results will be submitted to the SMO, who is responsible for taking corrective action as required. A copy will be maintained in the supporting MTF laboratory. In addition, a copy will be forwarded to Force Medical and to the Clinical Laboratory Improvement Program Office (CLIP) at Center for Clinical Laboratory Medicine, 6825 16th Street, NW Bldg 54, Washington, DC 20306-6000, 202-782-2467/DSN 662-2467.

(3) Providing laboratory training as required.

(4) Establishing internal proficiency testing as needed.

(5) Verifying the ability to perform all shipboard laboratory procedures.

8204. REPORTING OF LABORATORY RESULTS

a. Laboratory Log. A log of all laboratory tests performed must be kept, containing at a minimum the following data elements: Name, SSN last 4, date, test performed, technician. A separate log shall be maintained for all specimens sent off the ship for testing, including the basic elements listed above plus the following: Facility submitted to, date received, and result. A copy of the laboratory results will be maintained by the laboratory for not less than two years.

b. Filing of Laboratory Results. All laboratory tests performed shall be entered into the medical record in a timely fashion after review by a medical provider. Documentation of this review shall be accomplished by the provider placing their initials on the lab chit.

SECTION 3 – RADIOLOGY

8301. TERMINOLOGY

a. **Conventional,** or Film-Based Radiology involves the capture of a radiographic image onto photographic film, which is then developed via a wet chemical process in order to produce a viewable image.

b. **Computed Radiography (CR)** is a method of capturing a radiographic image on a phosphorous plate, which is inserted into a standard X-Ray cassette as a replacement for film. This plate is processed through a digital laser reader that produces a digital image.

Note: CR does not involve any wet film processing and CR can be utilized in a local setting without involving Teleradiology.

c. **Direct Radiology (DR)** is a method of capturing images on an X-Ray sensitive detector, which produces a direct digital image. Note: There are no cassettes, readers or scanners involved in DR.

d. A **Film Digitizer (FD)** is a device that scans X-Ray film into a digital format output.

Note: FD implies that you are still processing the traditional wet films. FD allows for the transmission of the X-Rays thereby enabling teleradiology.

e. **Teleradiology (TR)** is the transmission of a radiographic image from a remote site to a facility that can receive and interpret the image to render diagnosis and or recommendations for treatment. Note that TR can involve images that are acquired by either a CR unit, DR unit or a film digitizer.

8302. QUALITY ASSURANCE. Regardless of the imaging method used, radiographs will be monitored on an ongoing basis for quality by a member of the medical staff. A complete log must be kept listing all x-ray exposures, and must contain the following elements: date of exposure, patient name, patient SSN, type of study, technician name, ordering provider, date sent for radiologist review, date returned from radiologist review, and verification radiologist result placed in outpatient chart.

8303. X-RAY EQUIPMENT TESTING. BUMEDINST 6470.22 (series) provides guidelines regarding diagnostic x-ray equipment. Of particular note, each medical and dental x-ray machine requires performance testing every two years. A list of approved surveyors may be obtained from NEHC. Retain all copies of performance testing onboard for three years. Operation of x-ray equipment without a current letter of certification requires a waiver from the TYCOM.

8304. REPORTING OF RADIOLOGY RESULTS. Senior Medical Officers shall ensure that the results of radiology studies performed are entered into the medical record in a timely fashion after review by a medical provider. Documentation of this review shall be accomplished by the provider placing their initials on the x-ray report.

8305. DISPOSITION OF X-RAY STUDIES. Shipboard x-ray studies must be maintained onboard for five years. After that time they may be disposed per SECNAVINST 5212.5 (series). This requirement applies to both film-based studies and digital radiology files.

8306. COMPUTED RADIOLOGY SYSTEM.

a. A Computed Radiography System has been installed on all Aircraft Carriers. Computed radiology systems shall be configured as indicated in figure 8-1.

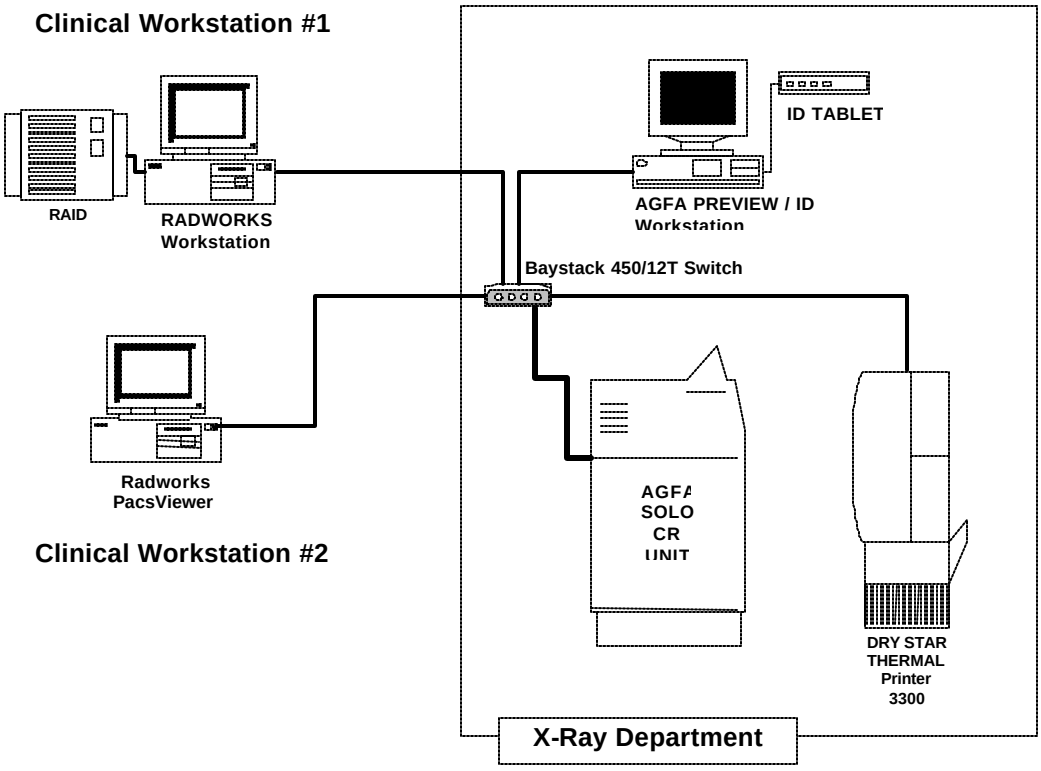

Figure 8-1. CV(N) Computed Radiology configuration

b. Support, Repair and Maintenance procedures for the CR system are provided via a two-tier process as listed below. This plan is current as of the time of this instruction revision:

(1) Tier 1 Support – Ship. The ship's Bio-Medical Equipment Technician (BMET) evaluates the situation and attempts to fix the problem.

(a) Hardware. Warranty information must be carefully evaluated before any repairs are attempted, since working on the item without manufacturer approval may invalidate the warranty. The BMET may receive assistance from the ship's Electronic Technicians if the Electronics Maintenance Officer determines that they are qualified to work on the CR equipment. Hardware replacement costs may be accrued by the ship, if the warranty no longer applies. In this case, the ship will utilize repair money for CR parts on the Approved Parts List (APL). Fleet Technical Support Center (FTSC) LANT and NAVMEDLOGCOM (NMLC) will develop the Preventive Maintenance Schedule (PMS) for CR systems. The ship submits an OPNAV 4790/7B "Feed Back Report" to Navy Inventory Control Point – Mechanicsville (NAVICP-M). NAVICP-M places the equipment on a PMS card and sends it to the ship when preventive maintenance is due. If PMS requirements change, the ship must submit a new OPNAV 4790/7B. Equipment maintenance information can be found in the vendor-supplied manuals.

(b) Software. If the Ship's ADP staff have attended CR System Administrator Training, the ADP staff attempts to restore the Radworks system to it's original configuration.

(c) AGFA software or application configuration issues cannot be addressed by the Ship CR System Administrator. Such issues need to be routed directly to the Navy Telemedicine Business Officer (NTBO) Telemedicine Technical Support Center (TTSC) for timely assistance, as per manufacture warranty, which states that only certified maintenance technicians can configure software.

(2) Tier 2 – Vendor. In the event vendor support is needed to resolve a problem, the ship's BMET will contact the vendor. Vendor assistance may be provided by:

(a) Assistance through references or trouble shooting via the vendor's web site.

(b) Remote trouble shooting assistance from a vendor representative. The vendor may provide shipboard assistance, if requested and funded by the carrier. In this situation, the carrier will also release a CASREP to the TYCOM and the appropriate Fleet.

c. APL. NMLC and NAVICP-Mechanicsburg are responsible for developing the CR APL. NAVICP-M will complete the APL process and ensure the

approved (populated/non-populated) APL is introduced to the CV(N) Weapons System File and the class Configuration Manager.

8307. TELERADIOLOGY

a. General. Teleradiology (TR) involves the electronic transmission of digitized x-ray images from one location to another for interpretation by a radiologist. The purpose of TR is to provide timely expert x-ray interpretation to the remotely located health care provider to facilitate clinical management and thus improve patient care. National Naval Medical Center (NNMC) Bethesda and Naval Medical Center San Diego (NMCSD) are the currently designated Navy "catcher's mitt" sites responsible for providing TR interpretations.

b. Access To X-Ray Interpretation. In general, East Coast ships will send TR studies to the National Naval Medical Center, Bethesda, MD, and West Coast ships will send TR requests to the Naval Medical Center, San Diego, CA.

c. The specific procedures for obtaining interpretations are dependant upon the urgency of the need, whether STAT (immediate), priority, or routine. The provider requesting film interpretation will determine the level of urgency required, using the following guidelines:

(1) **STAT Interpretation:** Upon notification by the site requesting a STAT x-ray interpretation, the TR interpretation site will provide a report by telephone (if possible) and will generate an electronic interpretation within one hour of receipt of the x-ray image AND notification of the STAT TR request.

(2) **PRIORITY Interpretation:** Some x-rays do not require a STAT interpretation, but a radiologist's interpretation is desired more urgently than the ROUTINE designation might provide. Images that fall in this category may be transmitted on a daily basis if bandwidth is available. The TR interpretation site will read transmitted images at regularly scheduled intervals and will generate an electronic interpretation within 24 hours of receiving the image.

(3) **ROUTINE Interpretation**: CD-R files can be hand-delivered (by inport ships) to the MTF for interpretation or mailed (by underway ships) for interpretation of images when bandwidth is limited or not available for routine studies. The site requesting interpretation will transfer digitized x-rays to a CD-R using a "lossless" compression or uncompressed format on a weekly or bi-weekly schedule, depending on volume, urgency, and mail routing availability. To avoid duplication, send only files that have not been previously transmitted for PRIORITY or STAT interpretations. The TR interpretation site will send an electronic report or mail a paper report within one week of receipt of the x-ray studies.

d. Communication. Effective communication between transmitting referral sites and the consultation sites is crucial to the successful deployment of TR. Specific information on how to access resources, including telephone numbers, e-mail addresses, Points of Contact (POC) and Internet interfaces, must be readily available to all participants and should be acquired and tested before the ship gets underway.

e. Documentation. Documentation includes providing timely permanent reports for the individual patient's medical record, local temporary image back-up, permanent storage (archive) of the digital (filmless) x-ray images, and accurate workload capture:

(1) **Reports:** The MTF providing the interpretation will generate a report for permanent documentation in the patient's medical record. The facility receiving the TR service is responsible for assuring that a report is received for every image and that the report is entered into the patient's medical record. The requesting site and the MTF consultation center providing study interpretations shall coordinate business rules to ensure the reports are delivered electronically or by regular mail, depending on the capabilities and/or limitations of the communicating medical sites.

(2) **Archives:** The MTF that provides the x-ray interpretation shall provide for the permanent archive function either onsite or at a central designated location. Carrier medical departments shall backup the image and report files locally, and are required to maintain the image files onboard for five years.

f. TR Quality Processes. Each aircraft carrier requesting TR services will establish a procedure (SOP) to: (1) monitor x-ray quality, (2) ensure timely delivery of images to the MTF by TR electronic direct transmission or CD-R removable media, (3) maintain temporary local backup libraries until the MTF has received and reported the final interpretation, and (4) enter the final report into the patient's medical record. Problems with service will be addressed initially with the TR coordinator at the consultation site.

SECTION 4 - OPTOMETRIC SERVICES

8401. GENERAL

a. Optometric services will be provided to active duty personnel of the uniformed services per BUMEDINST 6810.1 (series), and BUMEDNOTE 6810.

b. Spectacle Prescription, DD Form 771, shall be used for requesting spectacles or repairs. Special requests will be documented in the "Special Lenses or Frames" block. Examples are tinted lenses due to topside watches, or Frames of Choice (FOC). Refer to BUMEDNOTE 6810 of 22JUL02 for guidelines on FOC.

c. Per BUMEDINST 6810.1 (series), air controllers or flight deck personnel shall not be issued flight goggles. Flight deck personnel should be issued spectacles per Paragraph 2-7 of the above instruction. However, under the FOC program they may choose to receive one pair. Note that tinted lenses are authorized for flight deck, air controller personnel, and others whose duties require them to stand topside watches.

d. Hospital Corps personnel qualified to perform refractions, shall have a Page 13 entry signed by the SMO and filed in the individual's personnel record.

e. Optometric supplies (frames and lens blanks) may be received by carrier medical departments on a no-cost basis from NOSTRA. Carriers desiring to receive such supplies must report optometric production metrics to NOSTRA on a monthly basis via email no later than the 15th of each month. The spreadsheet format for reporting optometric production metrics is available in electronic format from the TYCOM or NOSTRA.

SECTION 5 – STERILE SUPPLIES

8501. EVENT-RELATED STERILIZATION

a. Several studies have been conducted and determined that once an object is sterile it will remain so until a pathogen is introduced. A pathogen is presumed to have been introduced if the integrity of the protective wrapping has been compromised. Therefore, sterility is related to an event vice being related to time.

c. Standard sterile processing procedures will be followed, to include: proper hand washing, strict cleanliness of the processing room, controlling traffic through the processing room, no use of rubber bands, and not carrying sterile items under arms or in unsanitary containers. Double wrappers are required. If linen wrappers are used, an extra Blue polyethylene wrapper must be added. NSNs for the wrappers are 6530-00-127-6612 for the 24x24 wrapper, and 6530-01-086-2464 for the 54x54 wrapper. Both of these wrappers are on the AMMAL. In addition, if the item is to be stored outside of the Main Battle Dressing Station, it must be plastic wrapped with double heat seal. For single items, double peel pack with double heat seal is authorized. In all cases, ensure proper drying and cooling to prevent rust and contamination from condensation.

d. After an item has been sterilized, it must be labeled with a sticker, which states, “STERILE Unless Package Opened or Damaged, Check Before Use.” The sticker must also be labeled with the date sterilized and the batch number. A sterilization log must be kept and will contain the date processed, item sterilized, batch number, temperature of sterilizer, amount of time sterilized, and biological

indicator results. Biological indicators should be run daily, but, at a minimum, will be run once a week.

e. Sterile items should be stored in closed cabinets whenever possible. Otherwise, they will be stored on open shelves and must not be within 12 inches of the deck or overhead. Sterile items shall not be stored within 2 inches of walls or bulkheads, unless they are properly lagged and in good repair. Under no circumstances will sterile items be stored next to bulkheads that have been known to form condensate. Sterile items stored on open shelves more than one year require dust covers. Ideal storage conditions are 64-72 degrees with 35-70% humidity. Under these conditions the heat-sealed plastic cover will provide the necessary protection for sterile items. Sterile items exposed to temperature above 80 degrees or humidity greater than 80% will be re-sterilized. Each space where sterile gear is stored on open shelves will be cleaned at least weekly. Sterile gear will be rotated so that the oldest gear will be used first. New items are placed in the back, and old items are placed in the front.

f. Sterile items shall be inspected before use. They will also be inspected during the semi-annual BDS and Mass Casualty Box inventories. Look for damage to the outer wrapper. Damage is defined as a hole or tear in the package, wet or moist package, dropped on floor or otherwise compromised, unsealed/broken seal or tape. Damaged items must be re-sterilized. When in doubt, remove the package from service and submit it for re-sterilization.

g. After each extended yard period in excess of 90 days, all sterile gear will be opened, inventoried, and re-sterilized. This requirement is geared toward accountability vice sterility concerns.

8502. STERILIZATION RECORDS. A record of sterilizer use shall be maintained, and shall include the following information:

a. Sterilizer number or ID

b. Sterilization load number in the format DDMMMYY-## (i.e. 23JAN01-01). The first load of every day is load # 01, and loads are consecutively numbered thereafter for that 24-hour period.

c. List of items/packs in the sterilizer load

d. Length of exposure time of load

e. Maximum temperature of sterilization for exposure

f. Results of biological indicator testing with each load

8503. STERILIZER TESTING

a. In addition to maintenance per PMS requirements, all sterilizers on aircraft carriers will be tested, on a minimum of a

weekly basis, with a biological indicator. Follow the manufacturer's directions for processing the biological test. Ensure that testing is completed on all sterilizers, and not just the steam sterilizers.

b. Results of testing are to be recorded in the sterilization record and will be maintained for a minimum of two years.

CHAPTER 9

Radiation Health Protection

9101. GENERAL. Radiation health is the continued assessment of an individual's exposure to ionizing radiation and its effect on physical well being. The application, interpretation, and documentation of exposure data provide the basic tools for an effective Radiation Health Program. Thermoluminescent dosimetry is the primary means of measuring exposure to ionizing radiation. The Radiation Health Program is to be administered per the Radiation Health Manual NAVMED P-5055 and COMNAVAIRFORINST 6470.4 (series). The Senior Medical Officer is responsible for the Radiation Health Program except for those aspects of dosimetry, designated by the above references, which are assigned to other departments. The Radiation Health Officer (RHO) will administer the Radiation Health Program per current publications and directives.

9102. PERSONNEL EXPOSURE

a. In the event of accidental overexposure, any exposure deemed emergent in nature, or any actual contamination of personnel involving direction or reporting to higher authority, COMNAVAIRPAC or COMNAVAIRLANT will be an info addressee.

b. Procedures in the event of an overexposure or emergency are contained in NAVMED P-5055 Radiation Health Protection Manual and BUMEDINST 6470.10 (series) Initial Management of Irradiated or Radioactively Contaminated Personnel.

9103. DOSIMETRY

a. Calcium Fluoride (CaF) TLD. These TLDs are used in the Naval Nuclear Propulsion Program. The CaF TLDs are evaluated onboard and the results forwarded to the Medical Department in support of the Radiation Health Program. The CaF TLD program is to be maintained per Radiological Controls for Ships NAVSEA S9213-33-MMA-000(series).

b. Lithium Fluoride (LiF) TLD. These TLDs are used to monitor personnel for exposure to ionizing radiation who are not required to be monitored using CaF TLDs per chapter 2 of COMNAVAIRFORINST6470.4 (series). LiF TLDs are submitted to the Naval Dosimetry Center, Bethesda, Maryland for evaluation and the results are returned to the command. The LiF TLD program is to be maintained per NAVMED P-5055.

9104. TRAINING. On CVs, radiation health training is usually the responsibility of the Medical Department. On CVNs, training in radiation health will be jointly performed by both the Medical and

Reactor Departments. Normally, these requirements will be fulfilled during familiarization and indoctrination courses. Training requirements for the Radiation Health Program are delineated in chapter 2 of COMNAVAIRFORINST6470.4 (series).

9105. HEALTH RECORDS. Health records of all personnel exposed to ionizing radiation shall be strictly maintained per NAVMED P-5055 and article 15-68 of NAVMED P-117 (Manual of the Medical Department (MANMED)).

9106. PHYSICAL EXAMINATIONS/QUALIFICATIONS

a. Physical examination periodicity requirements and physical standards for occupational exposure to ionizing radiation are specified in chapter 2 of NAVMED P-5055 and article 15-68 of MANMED. Each Ionizing Radiation Medical Examination (6470/13) shall be completed in strict compliance with the instructions contained in NAVMED P-5055.

b. All physical examinations finding a member Not Physically Qualified for occupational exposure to ionizing radiation, all situational examinations, and specific findings in the medical history require forwarding of the examination to BUMED (MED-21) for review by the Radiation Effects Advisory Board as delineated in section 2-7 of NAVMED P-5055, article 15-68 of MANMED and BUMEDINST 6470.21 (series). All submissions to BUMED will be forwarded via the TYCOM.

9107. AUDITS. Audits for CVNs are detailed in COMNAVAIRFORINST 6470.4 (series). One external audit must be conducted annually by the TYCOM with the participation of the Executive Officer. Two internal audits will be conducted semi-annually by the Executive Officer (XO) and the Reactor Officer (RO). If the XO participates in the external audit, it may also count as one of the internal audits. Copies of external audits shall be forwarded to COMNAVAIRFOR Codes N01M and N9. CVs will be audited per NAVMED P-5055. At a minimum, CVs will receive one annual external audit by personnel trained in Radiation Health.

9108. RADIOACTIVE MATERIALS. Radioactive material not associated with the Naval Nuclear Propulsion or Nuclear Weapons programs shall be handled per NAVSEA SO420-AA-RAD-010.

9109. REQUIRED REPORTS

a. Annual Report of Personnel Exposure to Ionizing Radiation. This report will be sent to the Naval Dosimetry Center on magnetic media with a printed copy of the report prior to the second calendar quarter or **within thirty days of the receipt of the final exposure**. Submit the results to the Officer in Charge, Naval Dosimetry Center, Navy Environmental Health Center Detachment, Bethesda, MD 20889-5614. The Annual Report must be signed by the Radiation Health Officer then reviewed and approved by the Commanding Officer using a cover letter.

(1) The format for this report is the NAVMED 6470/1.

(2) This report will only include those personnel onboard as of 31 December and who have been monitored for ionizing radiation during the calendar year.

(3) All exposures must be reported, including those that are 00.000.

(4) All pages of the Annual Report must be signed by both the Radiation Health Officer and the responsible Radiation Health Technician.

(5) All previous Annual Reports must be kept on file indefinitely per NAVMED P-5055, art 5-13(5).

b. Summary of Personnel Annual Exposure to NAVSEA 08 (NAVSEA 211.1). This report must be **received at NAVSEA by 31 January**. If the results of the Lithium Fluoride TLD's are not available, send a preliminary report using available data. The final report will be submitted within 30 days of receiving the results that were not available on the preliminary report. This report is sent to Naval Sea Systems Command, Code 08, 2531 Jefferson Davis Hwy, Arlington, VA 22242-5160. **NOTE: A preliminary report must identify the number of personnel and the monitoring period for which complete data is not available.**

c. Report to Personnel (RCFS 211.5). Annually, a report will be provided to each person who has been monitored during the previous calendar year and who is still attached to the command at the end of the year. The report will contain, at a minimum the following:

(1) The year for which the report applies.

(2) The annual whole body dose received.

(3) The cumulative whole body dose.

(4) The date and results of the last internal monitoring if performed during the year.

This report will be forwarded to all personnel prior to 15 February of the calendar year after the report year.

d. Termination Letters (RCFS 211.7, NAVMED P-5055 5-11). If radiation workers are released, retired, or terminate employment and request a copy of their exposure information, they will be provided with a statement of their total occupational radiation exposure received during their period of employment or service with the Navy or Marine Corps. All personnel who are separating, retiring, or terminating from the Naval service will be afforded the opportunity to

request a Termination Letter. The Termination Letter will be submitted within 30 days of the receipt of the individual's final exposure or determination that the individual will no longer be monitored for exposure. Copies of this report are not forwarded to NAVSEA. The letter will include:

(1) Name, social security number, and date of birth

(2) Dates of employment

(3) Name of activities at which exposure occurred

(4) Exposure Information

(a) Current year's exposure by quarter

(b) Prior years exposure listed by year

NOTE: Refer to NAVMED P-5055, 5-11 for calculating exposures prior to January 1993 and the format for the termination letter.

(5) The following statements will be included on the form or letter provided:

(a) "This report is submitted per NAVMED P-5055, Radiation Health Protection Manual."

(b) "You should preserve this report for future reference. If you should seek future employment involving occupational exposure to ionizing radiation, your employer will want this information. As a point of reference as to the significance of your exposure, the average exposure to a member of the United States population is approximately 300 mrem (3mSv) per year from natural background radiation. Federal radiation exposure limits are 5 rem (0.05 Sv) per year, total effective dose equivalent. No adverse observable effect is expected at exposure levels below the Federal limits."

e. Commanding Officer's Monthly Report of Ionizing Radiation Exposure. The Commanding Officer will receive a monthly report of radiation exposure and the status of the Radiation Health Program. This report is submitted by the RHO and CRA to the Commanding Officer via the SMO, RO, and XO.

(1) At a minimum, the following information will be included:

(a) Exposure summaries for Calcium Fluoride TLD's

(b) Exposure summaries for Lithium Fluoride TLD's

(c) Dose estimates completed since the last report.

(d) Visitors since the last report

(e) Personnel on the Alert List

(f) Discrepancies on the 15A Cards

(g) Status of the Radiation Health Program

(2) Radiation Health Physicals that are due

(3) Status of any outstanding audits

(4) Any audits that are coming due

(5) Any corrective actions which are outstanding

f. Situational Report (NAVMED P-5055, 5-12(2)).

(1) If a monitored individual is transferred, retires or terminates employment, prior to 31 December, a Situational Report of Personnel Exposure (NAVMED 6470/1) will be forwarded to the Naval Dosimetry Center. **This report must be submitted within 30 days of receipt of the final exposure**. All Situational Reports must be kept on file indefinitely, per (NAVMED P-5055, 5-13(5)).

(2) If a visitor from an activity that does not report to the Naval Dosimetry Center is monitored at a NAVAIRLANT/NAVAIRPAC command, a Situational Report must be **submitted within 30 days of receipt of the final exposure**. All pages of the Situational Report must be signed by the RHO and the Radiation Health Technician.

(3) The acceptable format for the Situational Report is on 3.5 inch magnetic media with a printed hard copy.

(4) All Situational Reports will be forwarded to the Naval Dosimetry Center with a cover letter signed by the Commanding Officer.

(5) All 6470/1's are generated by the SAMS computer program.

g. Forwarding of Personnel Exposure (NAVMED P-5055, 5-3(e)). When an individual from another command is monitored at a NAVAIRFOR command for exposure to ionizing radiation, their exposure information will be furnished to the custodian of the individual's medical record. This information will be forwarded at least quarterly and **within 30 days of receipt of the final exposure information**. If the member is still onboard, it is permissible to have them hand carry their exposure information back to their command. If the member is from a non-reporting command, their exposure information will be forwarded to the Naval Dosimetry Center via a Situational Report.

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CHAPTER 10

Medical Supply

10101. GENERAL. The Senior Medical Officer (SMO) is responsible for all items listed under the Operating Space Items (OSI) portion of the Authorized Minimal Medical Allowance List (AMMAL). The Supply Officer is responsible for all items listed as Store Room Items (SRI). The Medical Department needs to coordinate with the Supply Department to ensure that essential medical items will be available at all times.

10102. CUSTODY OF MEDICAL MATERIAL

a. Responsibility for custody of medical supplies is equal to the responsibility for custody of equipment. Custodians of medical material shall not permit waste or abuse of medical supplies or equipment.

b. In company with the outgoing SMO, the new SMO shall review the status of medical material management and equipment prior to assuming duty. At a minimum, this procedure shall include:

(1) Ensure that all items of durable medical equipment required by the AMMAL are onboard.

(2) Ensure that the inventory management control system for OSI is current through the use of SAMS.

10103. MEDICAL MATERIAL REQUIREMENTS

a. Authorized Minimal Medical Allowance List (AMMAL). The medical material requirements for aircraft carriers are stated in the Authorized Minimal Medical Allowance List. The AMMAL is controlled by Commander, Fleet Forces Command (CFFC) and managed by the Naval Medical Logistics Command (NAVMEDLOGCOM).

(1) Each ship must maintain at a minimum the quantity of medical supplies and durable medical equipment listed in the current AMMAL. The AMMAL is divided into two portions. The Operating Space Items (OSI) are those durable and ready use items that will be maintained in Medical Department operating spaces and/or medical-owned storerooms. Store Room Items (SRI) shall be managed by the Supply Department, maintained in supply-owned storerooms and are funded by the Navy Working Capital Fund (NWCF). Procurement of OSI items are financed by Medical Department Operating Target (OPTAR) funds. During extended overhaul, the Supply Department is authorized to off-load part or all of the SRI stores.

(2) Recommendations for changes to the ship's AMMAL must be submitted via an AMMAL Change Request Form (Appendix L) to CNAF Force Medical. An AMMAL Change Request Form is a recommendation to change the allowance for all carriers, and should not be used to request items of personal preference.

b. Revisions to the AMMAL are based on changes to the Federal supply system and professional reviews and recommendations from Fleet units. Any Medical or Dental Officer can request that a drug be added or deleted from the AMMAL by providing written justification, to include drug, nomenclature, cost and clinical benefit. This justification shall take into account that the AMMAL change will apply to all aircraft carrier Medical Departments. Submit this information on an AMMAL Change Request Form to the TYCOM Force Medical Officer, via the Senior Medical Officer. AMMAL change requests may be submitted electronically. Changes to the AMMAL are disseminated monthly and are downloaded. The Summary of Changes and electronic files are available from the Naval Medical Logistics Command web site (http://www-nmlc.med.navy.mil/).

c. COSAL. The COSAL is an authoritative document that lists:

(1) The equipment/components verified by Ships Configuration and Logistics Support Information System (SCLSIS) Configuration Data Manager (CDM) to be installed on a ship to perform its operational mission.

(2) The repair parts and special tools required for the operation, overhaul, and repair of equipment/components.

d. Allowance Parts List (APL) and Allowance Equipage List (AEL). Spare parts and consumables required to support medical equipment are listed on the APL/AEL. The APL/AELs are developed and managed by NAVMEDLOGCOM and are submitted to the Naval Inventory Control Point Mechanicsburg (NAVICP-M) to establish Coordinated Shipboard Allowance List (COSAL) support. The APLs list both the technical characteristics of a particular piece of equipment and it’s logistic and supply information. APLs also identify all maintenance significant repair parts associated with the equipment. Each repair part listed has potential to fail during normal operation and is a possible allowance item. However, only those with sufficiently high predicted failure rates, or actual replacement rates, and items required for planned maintenance, or safety of the ship’s personnel/mission will normally be authorized and listed in the COSAL. Force Medical in conjunction with Force Supply will review and designate items that will be carried at all times, except during major overhaul.

e. Deployment Augmentation Requirements. The individual ship’s Senior Medical Officer shall determine these requirements. These items are needed to meet known or anticipated requirements during a

specific deployment. The SMO shall review the proposed ship's schedule to determine the potential requirement for prophylaxis and treatment of endemic diseases. The SMO and/or supply PO should liaison with the ship's Supply Department in order to ensure that adequate stock inventories, based upon historical usage rates and anticipated needs (i.e., cold meds, STD items and lab reagents, etc.), are available for the entire duration of the deployment.

10104. MEDICAL DEPARTMENT SUPPLY PETTY OFFICER. Each carrier Medical Department shall assign a Supply Petty Officer (E-5 or above). They shall be responsible for management of OSI AMMAL items and reorder of supplies. The supply management module of SAMS shall be used to maintain the OSI portion of the AMMAL. The Supply PO in conjunction with the MAO and LCPO shall liaison with the Supply Department to provide technical expertise in the management of medical shelf life items contained in the SRI. The Management Training and Assistance Team (MTAT) at Force Supply provides training for the Medical Department Supply Petty Officers. The MTAT conducts the Supply Petty Officer course, and quotas may be obtained from them. Obtain a training quota for the Supply Petty Officer as soon as feasible after being assigned supply duties. A schedule of available supply courses on both the east and west coasts can be accessed from the menu tab at the following website https://www.pst.govapps.com/pst.nsf. It is also possible to reserve a seat for the desired class at this website. Supply Petty Officers can also be trained onboard by the ship's Supply Department.

10105. AUTHORIZED MINIMAL MEDICAL ALLOWANCE LIST (AMMAL). The Authorized Minimal Medical Allowance Lists for NAVAIRFOR Aircraft Carriers is contained in Appendix M.

10106. QUALITY CONTROL OF MEDICAL MATERIAL

a. Each NAVAIRFORCE ship shall maintain a strict quality control program for all medical material onboard. This program shall consist of frequent inspection, examination, and rotation to ensure the highest possible quality of medical material. The ship's Supply Officer is responsible for maintaining quality control surveillance over medical material within Supply storerooms. The ship's Senior Medical Officer is responsible for maintaining quality control surveillance over medical material contained within the medical operating spaces.

b. Potency dated material is material having a definite storage period (expiration date) determined by empirical and technical test data. When an expiration date is given as month and year only, the material is considered to expire on the last day of the month. Type I potency dated material is non-extendable. Type II potency dated material is extendable when satisfactory results are obtained upon prescribed testing, as approved by the FDA.

c. Both the Medical Department (OSI/AMMAL) and the Supply Department (SRI) shall maintain a Medical Material Quality Control Program in place that consists of:

(1) Shelf-Life Management. The following minimum procedures will be established:

(a) A cyclic routine for removing expired Type I material from stock, surveying and ordering replacement material prior to the expiration date.

(b) A cyclic routine for quality control surveillance of other material having an estimated storage life, including action on requesting shelf life extensions, surveying and replacing as indicated.

(c) A standard policy to issue and use expiration dated material on a "first to expire" basis.

(d) An arrangement, where possible, to turn in expiration dated materials prior to the end of it's potency period to shore-based medical treatment facilities in exchange for like material bearing a longer potency period.

(2) Medical Material Information Management. The following minimum procedures will be established:

(a) A system to manage and verify compliance with all DOD and NMLC medical material information notices, including drug and equipment recalls, suspensions, and shelf-life extensions.

(b) A records accounting system that adjusts promptly to reflect the results of material requisitions, receipts, and dispositions (including surveys and exchanges).

10107. REPORTING DEFECTIVE OR UNSATISFACTORY MEDICAL MATERIAL

a. Upon the receipt or discovery of defective/unsatisfactory medical material, all NAVAIRFOR ships shall suspend all stocks involved from issue and use. Reports shall be made per the provisions of BUMEDINST 6710.63 (series).

b. Type I material includes equipment which has been determined to be harmful or defective to the extent that use has already or may cause death, serious injury, or illness. Type II material includes medical items, other than equipment, which is suspected of being harmful, defective, deteriorated, or otherwise unsuitable for use. Type III complaints involve equipment that is determined to be unsatisfactory due to malfunctions, design, or defects caused by faulty material, workmanship, quality inspection, or performance.

c. Type I complaints shall be sent by priority message to the Defense Personnel Support Center/Directorate of Medical Material. Telephone calls are acceptable, but must be followed immediately by written detailed letter report.

d. Type II & III complaints require original and four copies of a letter report to the Defense Personnel Support Center/Directorate of Medical Material (Code ATQ). One additional copy of the report shall be furnished to both the Naval Medical Logistics Command, Fort Detrick, Frederick, MD; and Defense Medical Standardization Board (DMSB), Fort Detrick, Frederick, MD 21701.

e. Copies of the report shall be provided to the TYCOM Force Medical Offices on both coasts.

f. Prior to submission of a report, the inadequacy or unsuitability of the item shall be thoroughly evaluated by medical, supply, and/or maintenance personnel. Only items that are considered to be injurious or unsatisfactory due to inherent characteristics shall be reported. Items involving idiosyncrasies or sensitivities of individual patients shall not be reported.

10108. SURVEY. Detailed instructions on how to survey medical items are contained in NAVSUP P-485, Chapter 5.

a. Disposal of Medical Material (Medicinals). All Medical Department personnel are cautioned that medical material should be disposed of in a manner as to ensure the medical material is rendered non-recoverable for use and harmless to the environment. As stated in DOD Manual 4160.21-M, Defense Utilization Disposal Manual, "Destruction will be complete, to preclude use of the drug or any portion thereof." Security of all medicinals shall be maintained to ensure inaccessibility by non-medical personnel.

b. The following guidelines shall be used when disposing of medicinals:

(1) Tablets, Capsules, Powders. Remove from the original container, crush or break tablets and capsules, and flush into the sewage (CHT) system. Flush in small quantities to ensure that you do not plug the CHT piping system.

(2) Injectibles/Parenterals. Remove the stoppers from the bottle, injectors, or open vials as directed, then express contents into the CHT system. Dispose of needles in sharps container.

(3) Auto Injectors. Offload in bulk as medical waste.

(4) Biologicals. Whether dried or suspended in liquid, these materials must be (1) incinerated, (2) injected with enough sterilizing agent to kill the live biological agent, or (3) pressure

steam sterilized. If one of the latter procedures is used, the sterilized contents of the containers should be emptied into the CHT system and the containers disposed of in a Bio-Hazard bag.

c. AT NO TIME SHALL MEDICINALS BE DISPOSED OF "OVER-THE-SIDE, WHOLE OR IN PART."

d. Each Pharmacy will maintain a "Survey/Destruction Log" for non-controlled substances. The log will indicate: Name, Nomenclature, NSN, Lot No., Manufacturer, Expiration Date, Amount, Date, Method of destruction and Signature of Pharmacy Technician.

e. Survey and destruction of controlled substances, narcotics and alcohol must follow the guidelines of paragraph 8110 of this instruction.

f. Destruction of the above materials should be accomplished in a well ventilated and secure area. In addition, when working with liquid substances subject to absorption through the skin, the wearing of neoprene rubber gloves is advised; and thorough hand washing should follow in every case. Wearing of protective goggles may also be indicated.

10109. INVENTORY MANAGEMENT SYSTEM. NAVAIRFORCE ships will use the medical supply module of SAMS for inventory management of OSI medical supplies. RSUPPLY will be used by Supply to manage SRI medical supplies. The Supply Department will be responsible for the management of shelf life, lot numbers, expiration dates, recalls and shelf life extension of all SRI items. The comments field in RSUPPLY shall be used to document shelf life in the following manner: 0612, where 0612 represents an expiration date of 2006 Dec.

10110. MEDICAL INVESTMENT EQUIPMENT FUNDING

a. Shipboard Equipment Installation Process. The Shipboard Equipment Replacement Program (SERP) is the process to modernization of major fleet medical equipment. For Fleet aircraft carriers, AMMAL items with a cost over $5000 are eligible to be replaced utilizing Fleet funding.

b. All medical departments are to maintain and periodically validate SERP inventories on file with Force Medical to allow for proper funding and planning to modernize Fleet medical equipment. It is essential that SERP lists in Force Medical are kept up to date to ensure future funding is available. All newly received equipment needs to be reported to Force Medical via the Monthly Medical Report and entered in the ships OMMS-NG to ensure repair support is available.

c. To support the Fleet Response Plan (FRP), equipment that requires major installation (i.e. Audiobooth, x-ray systems, etc.)

need to be planned for and conducted during shipyard maintenance periods. All departments need to ensure they plan major installs during these maintenance periods, to include OMMS-NG entries requesting the installation.

d. TOB Medical - Dental Requisitions. Per NMLC FT DETRICK MD, TOB funding is authorized for initial outfitting ADDITIONS to the authorized medical allowance list or authorized dental allowance list (AMAL-ADAL). These items are identified with allowance type code A2 in the monthly AMAL/ADAL download into SAMS from SPAWAR/NMLC. THIS DOES NOT INCLUDE REPLACEMENT ITEMS FOR AN OLD NSN THAT WAS ON YOUR AMAL/ADAL. Any requisition for other than A2 coded items submitted citing TOB funding will be canceled.

e. Annual CBR Inventories and Shelf-Life Extension Program (SLEP) Testing Process. The DoD SLEP has been critical in the testing and extension of large amounts of high cost pharmaceuticals, primarily the CBR medications. The testing process can last up to 18 months. Each ship is required to contact and register a SLEP coordinator by contacting the SLEP Program Manager via e-mail at: DMSBDOD-FDASLEP@DETRICK.ARMY.MIL. Once registration is complete, the SLEP Coordinator is responsible for ensuring all SLEP NSNs (generally CBR medications) are loaded into the DOD/FDA SLEP system to include on-hand quantities, lots and manufacturers. The coordinator shall also monitor e-mail for SLEP notices and actions, and comply with DOD/FDA system instructions regarding suspending, destroying or re-labeling material. Each ship is required to validate SLEP on-hand quantities at a minimum annually in the 4th fiscal quarter.

10111. MEDICAL/DENTAL OPERATING TARGET AMOUNTS. The budget submission of the Medical OPTAR should be calculated by taking into consideration the ship's schedule, average of the OPTAR amounts for the previous three years and consideration for inflation. These amounts are not intended to limit the maximum/minimum obligations for requirements. All medical/dental equipment not funded by CINCPACFLTINST/CINCLANTFLTINST 4235.7 (series) shall be procured through the ship's regular OPTAR.

10112. MEDICAL SUPPLY PROCEDURES:

a. REQUISITION PRIORITY. The ship’s Supply Department will normally provide guidance regarding which priority or urgency of need designators to use. The priority will determine how quickly supplies are procured and delivered. Specific guidance on the priority of requisitions may be found in the MILSTRIP/MILSTRAP manual, and the NAVSUP P-485.

b. MILSTRIP/MILSTRAP. All items on the AMMAL that have a National Stock Number (NSN) assigned must be ordered using the standard MILSTRIP/MILSTRAP process. However, if the item does not have an NSN assigned, has a local NDN assigned, or has an acquisition advice code of L, it may be procured by using the Open Purchase process. A local NSN is easily identified by the letters contained

within it. Acquisition advice code L means that the item is authorized for local procurement.

c. OPEN PURCHASE. An Open Purchase is accomplished by completing and submitting a NAVSUPP 1149 or by using the command's Impact Card. The Impact Card is used similar to a credit card. Specific guidelines exist for the use of an Impact Card. Check with your Supply Department for guidance on the use of these cards.

d. OPTAR LOG. The OPTAR log is a ledger style accounting for all supply requisitions. The SAMS Supply module has an OPTAR log and is the preferred method to track supply requisitions. If the use of SAMS is not feasible, or if the Command requires the use of another medium, this requirement shall be waived.

e. REPORT 21. The Report 21 is a report generated by the Supply Department that shows requisition status and actual cost of items charged for a specific item. This report is to be used like a bank statement to reconcile and balance the OPTAR log.

f. INVENTORY PERIODICITY. An on-going process of equipment and supply inventory management is required. As supplies are stocked and issued, an ongoing validation shall insure that the data in the SAMS supply database is updated and kept current. This is accomplished by conducting local spot-checks while in storerooms and workspaces. In addition, the following inventory periodicity will be followed:

(1) SMO Turnover. At turnover of the SMO a complete equipment inventory will be accomplished and reconciled. The incoming SMO will acknowledge the inventory of equipment on-board and the outgoing SMO will resolve any missing equipment issues prior to departure.

(2) Equipment: An annual equipment inventory will be conducted and reconciled each year. Missing equipment will be identified, investigated, and surveyed as appropriate.

(3) Supplies: A wall-to-wall inventory of OSI supplies shall be accomplished six months prior to a planned deployment. Additionally, all AMMAL items will be inventoried at least annually. This may be accomplished by a one-time wall-to-wall inventory or by inventorying 10 percent of line items each month. These inventories are intended to only count those items that have not been expended for use within the department. All inventories are to be reconciled with SAMS upon completion and inventory documentation will be maintained for two years.

g. MEDICAL PHARMACEUTICAL PRIME VENDOR PROGRAM. Defense supply center Philadelphia periodically awards fleet pharmaceutical prime vendor (PPV) contracts. These contracts allow RSUPPLY unit level ships to web order pharmaceutical items. RSUPPLY force level ships can utilize this program for direct turnover (DTO) requisitions only

(using OPTAR funding). Force level ships must complete technical edit of PPV DTO requisitions to ensure available SRI stock is used prior to ordering DTO material from the PPV. MILSTRIP requisitions can still be passed to order material using either OPTAR or SRI as appropriate. At sea, you must use SRI first before ordering from the Prime Vendor.

h. PHARMACEUTICAL GUARANTEED RETURNS PROGRAM. The guaranteed returns program is utilized to receive partial credit for returning expired pharmaceuticals to the manufacturers. Dependent on market conditions, a partial monetary credit can be applied to PPV accounts to be utilized for future spending, dependent on current contract specifications. Contact force medical or fleet industrial supply center liaisons for specific information on current program guidelines and training opportunities.

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CHAPTER 11

Facilities and Equipment Maintenance

11101. MEDICAL EQUIPMENT MAINTENANCE AND REPAIR PROGRAM

a. NAVAIRFOR ships will comply with CINCLANTFLTINST/ CINCPACFLTINST 4235.7 (series) and OPNAVINST 4790.4 (series) for equipment management and maintenance.

(1) When new equipment arrives onboard an Work Candidate must be entered into the Organizational Material Management System – Next Generation (OMMS-NG) to update the ship's records. A separate Work Candidate must be submitted to remove the old unit. This process does several things. It provides an accurate listing in the Ship's Master System Weapons File and the Configuration Data Manager's Database – Open Architecture (CDMD-OA) database. It also drives spare parts provisioning through the Coordinated Shipboard Allowance List (COSAL) system. These procedures are all defined in OPNAVINST 4790.4 (series). To submit the Work Candidate you will need to provide the APL and AEL numbers for the new piece of equipment. These numbers shall be obtained from NAVMEDLOGCOM.

(2) To update the maintenance procedures, a Feedback Report (FBR) must be submitted to add the new piece of equipment and remove the old one. Follow the manufacturer's recommendations for preventive maintenance until the actual Planned Maintenance System (PMS) cards arrive.

(3) A NAVMED 6700/3, Medical/Dental Equipment Maintenance Record, is not required for equipment on fleet units.

(4) If equipment malfunctions, and is beyond the BMET's ability to repair it, the ship shall submit a Casualty Report (CASREP) per OPNAVINST 4790.4 (series). Contact the ship's Maintenance Officer for assistance in submitting the CASREP. Ensure that Force Medical, CFFC/CPF Medical, and NAVMEDLOGCOM are informed on the CASREP message. The CFFC/CPF Ship's Equipment Replacement Program (SERP) account supports medical equipment CASREPs per CINCLANTFLTINST/CINCPACFLTINST 4235.7 (series). NAVMEDLOGCOM will assist in coordinating a qualified BMET or a company technician to conduct repairs.

(5) Equipment that is no longer serviceable or is being upgraded may be sent to DRMO for reutilization or disposal.

11102. RADIATION PROTECTION SURVEY AND EQUIPMENT PERFORMANCE TEST OF DIAGNOSTIC X-RAY EQUIPMENT

a. Applicability. The Navy Environmental Health Center (NEHC) is responsible to coordinate listings of surveys and corrective action reports for diagnostic X-ray equipment per COMNAVMEDCOM ltr 6470/11 Ser 21/0383 of 31 Jul 85.

b. References. BUMEDINST 6470.22 (series) identifies procedures for periodic equipment performance tests and radiation protection surveys of medical and dental diagnostic X-ray equipment.

c. Responsibilities. The SMO must ensure that X-ray equipment is periodically checked per BUMEDINST 6470.22 (series) and that surveys and corrective action reports are forwarded to Force Medical and NEHC.

11103. OXYGEN HANDLING AND STORAGE

a. At least one oxygen cylinder shall be available for ready use in the Treatment Room, ICU, and each BDS (i.e., with regulators installed at all times). Note that installing regulators will change the frequency of PMS pressure checks.

b. Oxygen cylinders will be mounted off the deck and stowed according to grade B shock mounting and OPNAVINST 5100.19 (series). Oxygen cylinders will be mounted in permanent storage racks.

c. Empty cylinders shall never be stowed in the storage racks provided for the full cylinders. Cylinders will be filled to capacity, and ready for immediate use. Empty cylinders are to be filled at the earliest opportunity.

d. Great care must be used in handling oxygen delivery equipment to prevent contact with oils, greases, organic lubricants, rubber or other flammable materials. The following Oxygen handling and stowage regulations, based on those of the Compressed Gas Association, shall be observed and posted in each area where medical oxygen tanks are used/stored.

(1) Oxygen cylinders, meeting 3A or 3AA DOT standards, shall be hydro-statically tested and stamped at least every ten years per Naval Ship’s Technical Manual (NSTM) Chapter 550.

(2) Never permit oil, grease or readily flammable materials to come in contact with oxygen cylinders, valves, regulators, gauges, or fittings.

(3) Never lubricate regulators, gauges or fittings with oil or other flammable substances.

(4) Never handle oxygen cylinders or equipment with oily hands, greasy gloves or rags.

(5) Always clear the particles of dust and dirt from cylinder valve openings by slightly opening and closing the valve before applying any fitting to the cylinder.

(6) Open the high-pressure valve on the oxygen cylinder before applying the equipment to the patient.

(7) Open the cylinder valve slowly, with the face of the regulator gauge away from all personnel.

(8) Never drape an oxygen cylinder with any materials such as hospital gowns, masks or caps.

(9) Never use oxygen fittings, valves, regulators or gauges for anything other than oxygen.

(10) Never mix gases of any type in an oxygen bottle or any other cylinder.

(11) Always use a pressure regulator to administer oxygen from a cylinder.

(12) Never attempt to use regulators that need repair or have valves that do not work properly.

(13) Defective oxygen equipment should always be repaired or replaced by the manufacturer or his authorized agent.

Note: All oxygen cylinders shall have a medical warning tag (DD 1191) affixed.

11104. MAINTENANCE CONTRACTS. Each carrier is allowed to establish maintenance contracts to perform specific maintenance, calibration, or certifications for medical equipment. These contracts will be funded from the ship's OPTAR. Individual visits may be funded by submitting an 1149 Open Purchase document. Specific pieces of equipment that may require this level of support are: anesthesia machine, chemistry analyzer, computed radiography unit, ventilators, and the audio booth. Force Medical may negotiate Force wide contracts if there is some benefit such as a quantity discount. Check with Force Medical to see if there is already a contract in place before negotiating a new contract. Also, check with your Supply Department for the proper procedures to ensure that you do not obligate yourself to an unauthorized commitment.

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CHAPTER 12
Medical Training

SECTION 1 - GENERAL

12101. LONG-RANGE TRAINING PROGRAM. Naval Medical Education & Training Command (NMETC) promulgates an annual list of required training topics via Naval message. These topics include medical training for the crew. A separate Long-Range Training Plan (LRTP) is not required, although many ships continue to use one as a management tool. If your unit continues to use a LRTP, the Medical Department should ensure that all medical training requirements for the ship are included in the LRTP.

12102. MEDICAL DEPARTMENT REQUIRED TRAINING

a. Required training for individual Medical Department Personnel is outlined in Appendix N. The Ship's Training Officer will track these requirements through the Navy Training Management and Planning System (NTMPS). Specific training requirements (i.e. SWMDOIC, SWMOIC, Fire-fighting, etc.) shall be completed en route to the ship or shortly after the member reports onboard pending course availability.

b. In addition to training required by higher authority, the topics below shall be provided to all Medical Department personnel.

(1) Bloodborne Pathogens. All Medical Department personnel shall complete annual training regarding the hazards and protective measures to prevent transmission of disease due to blood and human body fluids.

(2) All Medical Department personnel shall be instructed regarding the provisions and guidelines set forth in the command's instructions. Templates for the below instructions are available at the TYCOM level but must be tailored to the specific command. Training shall be conducted as often as needed to ensure that all medical personnel are familiar with the command's policies and required actions for the following:

(a) Management of Intoxicated Personnel

(b) Needle Sticks

(c) Management of Rape and Alleged Rape Cases

(d) Competence for Duty Examinations

(e) Management of Personnel with Suicidal Ideation

(f) Critical Incident Stress Debriefing

(3) BLS, ACLS, ATLS

(a) All Medical Department physicians will maintain currency in BLS, ACLS, and ATLS. This is a training requirement and it is not intended to be a prerequisite for privileges. If ACLS or ATLS expires during deployment, the physician must attain currency upon return to homeport.

(b) COMFLTFORCOMINST 6400.3 outlines the policy on the management, certification and training for use of the automatic external defibrillator (AED). All CV(N) medical department personnel are required to be qualified in BLS and use of the AED. A qualified BLS Instructor-Trainer will serve as the director for the program. The Program Director will ensure all aspects of training, monitoring and evaluation are conducted per the Military Training Network (MTN) and American Heart Association (AHA) guidelines.

(4) CBR. All Medical Department Officers shall complete training in recognizing and treating casualties from Chemical, Biological, and Radiological Warfare Agents. This course is available through Navy Knowledge Online at the following website https://www.nko.navy.mil.

(5) Radiation Protection Training. All personnel shall receive radiation protection training commensurate with their duties and per federal regulations, Department of the Navy directives, program radiological controls manuals, and the radiation health protection manual.

12103. TRAINING AIDS. The following items should be available to assist in the Medical Department's training efforts:

a. Moulage Set, War Wounds

b. Manual of Preventive Medicine (NAVMED P-5010)

c. Manual of the Medical Department (NAVMED P-117)

d. DVD, VHS or CD programs for closed circuit TV. For a list of available programs, contact the Naval Medical Education and Training Command (NMETC), Bethesda, MD or order online at http://nshs.med.navy.mil/VID/.

e. Resuscitation training manikin

SECTION 2 – CORPSMAN TRAINING

12201. TRAINING OF HOSPITAL CORPSMEN. The SMO is responsible for all care rendered onboard the carrier. It is his/her responsibility

to ensure that Hospital Corpsmen are trained and competent to perform the tasks assigned. Specific utilization of Hospital Corpsmen is outlined in COMNAVAIRFORINST 6320.3 (series), Non-Physician Health Care Providers.

12202. PERSONNEL QUALIFICATION STANDARDS. The SMO may develop a local training and certification program for duties as an HM. This program shall follow the guidelines for a Job Qualification Requirement (JQR). NAVEDTRA 43100-2B of NOV 2001 is the PQS Model Managers Guide. It outlines the requirements for developing a JQR. It also requires a local JQR to be submitted to the relevant TYCOM for possible Fleet-wide applicability. If applicable, the TYCOM shall submit it to Commander, Naval Education and Training Command for Navy wide review and implementation.

12203. SICKCALL SCREENER PROGRAM

a. The Sickcall Screener Program shall be accomplished per COMNAVAIRFORINST 6320.3 (series).

b. Each Hospital Corpsman who functions as a non-physician health care provider per the Sickcall Screener Instruction must be certified by the SMO prior to evaluating or treating patients.

12204. ROTATION OF HOSPITAL CORPS PERSONNEL. The SMO shall provide for the rotation of Hospital Corps personnel through assignments in order to ensure thorough indoctrination in all phases of their duties. (Refer to OPNAVINST 3120.32 (Navy SORM) and OPNAVINST 3500.34 (PQS Program) (series)). Many areas, (lab, pharmacy, X-ray, and others) may need to be covered through On the Job Training (OJT). While there is no requirement to have a certified technician operating these areas at all times, OJT Corpsmen will be expected to deliver the same standard of care. The SMO is responsible for developing and implementing additional safeguards to insure quality patient care is maintained. Each carrier should benefit from their training and expertise by rotating and training additional Corpsmen to cover each ancillary service. The overall benefit is a medical staff that is much more capable and experienced. Additionally, a service may have to be covered by an OJT tech if a designated technician becomes an unplanned loss. It must be recognized, however, that use of OJT Corpsmen to cover in high-risk areas (e.g. Pharmacy) constitutes an increased risk of adverse events.

12205. STRIKERS. The SMO shall ensure that, prior to accepting an individual as a striker, they meet the requirements set forth in BUMED/BUPERS directives for duties as a Hospital Corpsmen. Hospital Corps strikers should not be retained in striker status for an inordinate length of time. Six months is considered an adequate appraisal period to make a determination whether action should be instituted for Hospital Corps School attendance or return to other duties. In difficult situations, a division may not be able to

release an individual to work in the Medical Department full time as a Striker. A member does not have to work in the department to get a Medical Officer's letter of recommendation for HM "A" School. Strikers will not provide direct patient care or perform medical related activities (i.e. filling prescriptions, performing lab work, seeing patients, taking vital sign, etc.) unless directly supervised by qualified medical staff.

12206. IDC CONTINUING EDUCATION. Per OPNAVINST 6400.1 (series) IDCs are required to get a minimum of 12 Continuing Education Units (CEUs) annually. This requirement may be fulfilled on a one-for-one basis with Continuing Medical Education (CME) credits. There are other methods of obtaining CEUs than resident courses. Articles in PA journals and other pubs offer CME if the IDC reads the articles and answers the questions. The IDC's Physician Supervisor has the authority to award this type of CEU without sending to BUMED for approval. Refer to the OPNAV Instruction for further guidance.

12207. EAWS/ESWS PROGRAMS

a. Enlisted Aviation Warfare Specialist (EAWS) Program. OPNAVINST 1414.2 (series) establishes policy and guidelines for the EAWS Program. EAWS is the primary warfare specialty for AVTs and other enlisted personnel assigned to aviation squadrons.

b. Enlisted Surface Warfare Specialist (ESWS) Program. OPNAVINST 1414.1 (series) establishes policy and guidelines for the ESWS Program. This warfare specialty is considered the primary specialty for all Medical Department enlisted personnel permanently assigned to a CV/CVN. All Medical Department enlisted personnel may enroll into the EAWS program upon completing their ESWS Program.

12208. CORRESPONDENCE COURSES. Navy Education and Training Professional Development Center (NETPDC) publishes NAVEDTRA 12061, "Catalog of Nonresident Training Courses" and is available on the Internet at https://www.advancement.cnet.navy.mil. In addition to the rating courses, i.e., Hospitalman (NAVEDTRA 14295), many other correspondence courses are available. The following courses developed by Naval School of Health Sciences (NSHS) are available on the Internet at https://www-nshspts.med.navy.mil/ Courses/Catalog.htm. Additions and deletions may occur at any time.

CORRESPONDENCE COURSE	NAVEDTRA #
Blood Component Therapy	13121
Clinical Aspects of Cold Weather	13147
Combat Casualty Care for IDC's	13132
Combat Casualty Care for Nurses	13131
Control of Communicable Diseases in Man	13111
Decedent Affairs	13154
Drug Alcohol Abuse Prevention & Control	13125

CORRESPONDENCE COURSE	NAVEDTRA #
Environmental Health & Safety	13126
Exceptional Family Member	13123
Family Advocacy Program	13134
Fleet Hospital	13117
Food Service Sanitation	13100
Heat Stress	13128
Immunizations Program	13152
Medical & Dental Material Management	13120
Medical Regulating	13113
Naval Command & Control	13161
Naval Intelligence	13159
Naval Planning	13160
Operational OB/GYN	13109
Physical Examinations	13148
Preventive Medicine for Ground Forces	13112
Principles of Epidemiology	13123
Sexual Assault Victim Intervention (SAVI)	13137
Standard First Aid	13119
Treatment of Chemical Agent Casualties	13116

12209. SENIOR ENLISTED LEADERSHIP TRAINING. The Executive Medical Department Enlisted (EMDEC) Course is the course in the Medical Department Senior Enlisted's Learning Continuum. This course is designed to prepare Medical Department Senior Enlisted personnel for increased responsibilities as senior enlisted leaders who understand the "practice and business" of Navy Medicine in both the operational and MTF settings. This course is offered at NMETC in Bethesda, Maryland.

SECTION 3 – OFFICER TRAINING

12301. SURFACE WARFARE MEDICAL DEPARTMENT OFFICER (SWMDO) DESIGNATION. OPNAVINST 1412.8 (series) contains the standards and procedures for active duty Medical Department Officers to qualify as a SWMDO. A Medical Department Officer shall not be required to become part of any shipboard watch bill to pursue qualification as a SWMDO; and qualification shall not interfere with the duties assigned in the Medical Department.

12302. CONTINUING MEDICAL EDUCATION (CME). CME shall be reported on the Monthly QA Report. BUMED funding may be available to support obtaining required CME. Procedures to submit for BUMED/NMETC funding are contained in BUMEDINST 4651.3 (series).

12303. CORRESPONDENCE COURSES. Medical Officers are encouraged to take advantage of this training opportunity. Most of the courses grant CME credit for Medical Officers upon satisfactory completion of the course. See paragraph 12208 for a list of available courses.

12304. JOINT MEDICAL EXECUTIVE SKILLS INSTITUTE (JMESI). In 1992, Congress mandated that commanders of military treatment facilities possess certain administrative competencies before assuming their command positions. In 1996 and in 1998, that guidance was expanded to include prospective Deputy Commanders, Lead Agents, and Managed Care Coordinators. The JMESI and the Joint Medical Executive Skills Program (JMESP) are now in place to help candidates meet those requirements. Forty competencies in eight major areas have been identified and make up the professional skills list. In addition to overseeing the 40 competencies, JMESI publishes a catalog of executive medical courses offered by each service and the Department of Defense. The catalog describes available courses taught within the Military Healthcare System and identifies which of the 40 competencies each course covers. JMESI may be accessed at www.jmesi.org.

12305. MEDICAL DEPARTMENT OFFICER'S LEARNING CONTINUUM

a. The Basic Medical Department officer Course (BMDOC) is the first course in the Medical Department Officer's Learning Continuum. The purpose of the BMDOC is to increase junior officer awareness for all aspects of Naval Medicine including: Medical Treatment Facility operations; Operational Medicine and Health Service Support; and Homeland Defense. All those in ranks 0-1 to 0-3 are required to complete this online course, which is available on Navy E-Learning.

b. The Advanced Medical Department Officer (AMDOC) Course is the second course in the Medical Department Officer's Learning Continuum. This course is designed to prepare Medical Department Officers at the 0-4 to 0-5 level for increased responsibilities as senior officers and leaders who understand the "practice and business" of Navy Medicine in both the operational and MTF settings. This course is offered at NMETC in Bethesda, Maryland.

SECTION 4 – CREW TRAINING

12401. TRAINING OF NON-MEDICAL PERSONNEL

a. COMNAVAIRFOR considers that a comprehensive program in first aid, self-aid, buddy-aid and the medical aspects of CBR warfare is essential to maintaining a high level of combat readiness. Such training is recognized as a potentially critical factor for casualty reduction and in minimizing adverse effects on combat effectiveness in modern warfare. Training of this nature will enhance the successful management of mass casualties in any disaster, whether in peace or war.

b. The eight basic War Wounds or "GITMO Wounds" are Amputated Hand, Burns, Electrical Shock, Compound Fracture of the Lower Extremity, Fracture of the Jaw with Facial Injury, Open Abdominal Wound with Extruded Viscera, Smoke Inhalation, and Sucking Chest

Wound/Pneumothorax. The ship's crew should receive war wound training, CPR, and stretcher bearer training at every available opportunity such as during GQ drills and the ship's indoctrination course.

c. The SMO will ensure a continuing, standardized, regularly scheduled program of instruction for the officers and crew in first aid, self-aid and the medical aspects of CBR warfare. Utilization of the ship's entertainment system (TV, videotapes, etc.) is encouraged.

12402. BLS TRAINING. All CV(N)s will have a qualified BLS instructor-trainer onboard to serve as Affiliate-Faculty and effectively manage a BLS training program.

a. Information on Heart Saver CPR, Heart Saver AED, and Health Care Provider courses is available from local chapters of the American Heart Association, local medical treatment facilities, and the Military Training Network (MTN) website at www.usuhs.mil/mtn/ or:

Military Training Network for Resuscitative Medicine
Uniformed Services University of the Health Sciences
F. Edward Herbert School of Medicine
4301 Jones Bridge Road, Bethesda, MD 20814-4799
Commercial (301)-295-2282, DSN 295-2282

b. Each Medical Department shall:

(1) Establish an approved BLS program with appropriate documentation of such training. The Heart Saver CPR program shall be incorporated into the command indoctrination for all hands. Healthcare Provider training shall be incorporated into the Medical/Dental Department orientation programs.

(2) Maintain current Healthcare Provider qualifications, at a minimum, for all Medical/Dental Department personnel.

(3) Maintain current Heart Saver CPR qualification for the following groups:

(a) All personnel in the electrical and electronic associated ratings.

(b) All gas free engineers designated as rescue personnel for engineers working in confined spaces.

(c) All members of CV/CVN master-at-arms force and brig personnel.

12403. ADVANCED TRAINING OF REPAIR PARTY, STRETCHER BEARER PERSONNEL AND BOAT CREWS. The training program for these personnel shall include all subjects applicable to the crew, with special

emphasis and additional training in first aid procedures, methods of resuscitation, self-aid in chemical warfare, casualty evacuation and transportation of casualties. The names and assignments of stretcher bearers shall be posted on the Medical Department Watch, Quarter and Station Bill.

12404. MEDICAL TRAINING TEAM (MTT)

a. All aircraft carriers will establish a Medical Training Team (MTT). This team will be responsible to the SMO for the proper training of medical personnel and ship's company in all aspects of first aid, medical response team performance, war wound and mass casualty treatment. Paragraph 2305 of this instruction outlines the mission area training exercises as required by COMNAVAIRFORINST 3500.20 (series).

b. The MTT will be comprised of personnel with the requisite knowledge, background and training to ably facilitate medical training. The team leader will be the Ship's Nurse, leading a team made up of at a minimum, one Medical Officer, the Leading Chief Corpsman, and one Independent Duty Hospital Corpsmen. MTT members will be Personnel Qualification Standards (PQS) or Job Qualification Requirements (JQR) qualified and designated in writing by the Commanding Officer or their designated approving authority. Either the MTT leader or the Medical Department LCPO will also be a member of the Damage Control Training Team (DCTT).

c. In order to facilitate collaboration and integration among all the ship's training teams, it is recommended that each member of the MTT carry a secondary training team assignment. For example, one MTT IDC is also assigned to the Air Department Training Team (ADTT). This secondary assignment fosters improved communication between the training teams by offering MTT presence during drill planning and at drill briefs and debriefs.

d. The MTT will observe, grade and critique all medical (FSO) exercises and report the results to the Commanding Officer. Whenever possible, members of the MTT should make use of standard grade sheets when carrying out their duties. Prior to any medical drill/evolution the MTT leader will conduct a brief, utilizing a timeline drill package that outlines the objective of the drill, timeline, personnel assignments, lessons learned (from previous drills) and safety concerns (utilizing Operational Risk Management). Following the drill, a debrief shall be conducted with the MTT and other personnel involved with the drill. The drill package and debrief will be routed via the chain of command for the Commanding Officer's approval.

CHAPTER 13

Battle Readiness

SECTION 1 – GENERAL

13101. BATTLE BILL. Each carrier will have a ship's bill or instruction that addresses the location and quantity of emergency medical supplies located throughout the ship. It shall also outline the roles and responsibilities of Medical Department personnel during emergency and special evolutions. A sample Battle Bill is provided in Appendix O.

13102. BATTLE DRESSING STATIONS (BDS)

a. A minimum of six BDSs shall be provided and shall be located in areas affording maximum protection consistent with the availability of care for the injured. The BDS contained within the Medical Department shall be classified as the primary (main) BDS. Since it is co-located with the operating room and has ancillary support, it is best suited to care for the critically injured.

b. In addition to the main BDS, a minimum of five additional BDSs are required for CV/CVN type ships: one forward, one aft, two auxiliary BDSs, and one in close proximity to the flight deck.

c. BDSs shall not be utilized as auxiliary storerooms. Stowage of personal gear within the BDS is not authorized.

d. Each BDS shall be outfitted per the current BDS AMMAL, 0955. They will also have adequate operational readiness equipment, including a potable water tank with gravity feed piping, proper lighting and a securable table suitable for the treatment of casualties.

e. A roster of all personnel assigned shall be maintained in each BDS including stretcher bearers and phone talkers. All BDS personnel shall be incorporated into the Medical Department's Watch, Quarter and Station Bill.

f. Per NWP 3-20.31, each ship will assign a minimum of four stretcher bearers to support each active BDS. Stretcher bearer personnel may be provided from Damage Control personnel or from outside the DC organization. Ships shall have as many personnel trained to function as stretcher bearers as deemed necessary to handle mass casualties. They shall be trained in advanced first aid and casualty handling techniques and shall be capable of training other crewmembers in self-aid and buddy-aid. Each Stretcher Bearer Team shall be equipped with a First Aid Kit, Gun Crew (Gun Bag).

g. All Hospital Corpsmen will be assigned General Quarters (GQ) stations in a BDS, a repair locker, or in Main Medical. Per COMNAVAIRFOR 3500.20 (Series) a corpsman and four stretcher bearers will be assigned to each repair locker. In the event of significant battle casualties, Main Medical must remain fully functional. This requires the lab, x-ray, pharmacy and the ward to be fully staffed.

13103. MAINTENANCE AND ROTATION OF SUPPLIES. Provisions shall be made for permanent stowage and adequate security of medical supplies at the BDSs. The SMO shall ensure that each BDS is equipped with the necessary miscellaneous items (e.g., flashlights, head and hand lantern, batteries, etc.). Prescribed surgical packs must be readily available and serviceable should the need arise. Senior Medical Officers shall inspect these facilities and supplies upon reporting for duty, and are encouraged to recommend changes to the TYCOM on the basic contents of the sterile packs and associated supplies. Additional supplies may be added to the minimum requirements if approved by the SMO. If added, they will be included on the inventory and managed the same as the required items. An inventory list utilizing the SAMS database shall be kept of all emergency medical supplies dispersed throughout the ship. Rotation of shelf life supplies is mandatory. Newly requisitioned supplies are to be rotated into reserve stock and older stock utilized in sick bay. This process provides the opportunity for use prior to expiration. Defective material will be surveyed and destroyed per current directives. When an expiration date is given as month and year only, the material is considered to expire on the last day of the month. Type II potency dated material may be extended when satisfactory results are obtained upon prescribed testing. NAVMEDLOGCOM provides specific guidance based on the manufacturer and individual lot number.

13104. ADDITIONAL SUPPLIES FOR BATTLE DRESSING STATIONS. The AMMAL 0955 contains the minimum requirements for BDSs on all CV/CVNs. A complete inventory of all BDSs shall be accomplished semi-annually, and the inventory list signed and dated at the time the inventory is conducted. The replacement of material shall occur as part of the regular semi-annual inventory. Items that will expire prior to the next scheduled inventory shall be replaced during the inventory.

13105. BATTLE DRESSING STATION ACCESSORY ITEMS. The following accessory items shall be maintained in a state of operational readiness in each BDS:

a. Lighting. BDSs shall have at least one surgical light and four relay type toggle switch battle lanterns installed.

b. Each BDS shall have the capability to administer oxygen. In each BDS, oxygen cylinders shall be available for ready use (e.g., with regulators installed, one resuscitator and oxygen attachments to provide six hours of continuous service at a flow rate of six liters

per minute) at all times. The BDS ready tank shall not be allowed to fall below 1000 PSI unless treating actual casualties.

c. Water Supply. Provisions for potable water supply for BDSs shall comply with ship's design and class specifications. A diagram and operating instructions for the gravity fed potable water system shall be posted in the immediate vicinity. The potable water gravity tank shall be labeled "Drain, flush and refill every three months." It shall be the responsibility of the Medical Department to empty, flush and refill the emergency fresh water tanks. All tanks shall have water samples taken monthly to determine chlorine/bromine and bacterial content per current 3-M and Preventive Medicine directives. The date and result of the most recent chlorine/bromine residual and bacteriological test shall be posted on or near the potable water tanks.

13106. ROUTE AND ACCESS MARKINGS

a. Routes to BDSs shall be marked on interior and exterior bulkheads throughout the ship per the Navy Ship’s Technical Manual (NSTM), Volume 2, Chapter 079.

b. Each hatch and door leading directly to a BDS shall be fitted with a metal label plate with the inscription "ACCESS BATTLE DRESSING STATION" engraved thereon in 1/2 inch letters and filled with red baked enamel.

c. When establishing and marking the routes to the various BDSs throughout the ship (interior and exterior), the markers shall be located frequently enough to enable the person(s) following the route to have a clear view of the next marker.

13107. SURGICAL PACKS AND TRAYS. Surgical instrument trays, anesthesia trays, minor surgical sets, suture sets and items that are routinely stocked at BDSs shall be prepared per this instruction.

a. Specific trays or sets shall be prepared and maintained sterile. Surgical knife blades are to be included with surgical instrument trays with the foil wrapping intact to prevent rusting. Sutures packaged in plastic packets are desirable, but are not to be autoclaved due to the deteriorating effect of heat to plastic. Paper foil wrapped sutures may be autoclaved. Assorted suture materials will be made readily available and shall be armed with a needle. Pre-packaged sterile knife blades and suture materials can be placed in the plastic dust cover with the sterile packs. A piece of tape should be placed on the outside of the plastic cover indicating the expiration date of the suture material inside.

b. The following sterile packs and trays shall be maintained in accordance with current sterilization procedures and located in each

BDS. See Chapter 8, Section 5 of this instruction for guidelines on Event Related Sterilization.

REQUIRED PACKS FOR BATTLE DRESSING STATIONS		
Nomenclature	**U/I**	**QTY**
Tracheotomy Tray	EA	1
Chest Tube Tray	EA	1
Minor Instrument Set	EA	4
Sterile Linen Pack	EA	1
Sterile Sheet Pack	EA	2

(See Appendix P for set definitions)

SECTION 2 - FIRST AID BOXES, FIRST AID GUN BAGS, & PORTABLE SUPPLIES

13201. GENERAL

a. Ship's personnel must understand the lifesaving value of the emergency medical supplies and facilities located throughout the ship. They must also be instructed not to open these supplies and spaces except in actual emergencies. First aid boxes, gun bags and mass casualty boxes are to be marked with a red cross (each bar to be 2" X 6"). However, manufacturer applied red crosses are acceptable until they are no longer legible.

b. Maintenance and Security of Supplies. Supplies stored in emergency medical units (i.e., first aid boxes, mass casualty boxes, gun bags, etc.) must be protected from weather and pilferage. The contents will be wrapped in clear plastic bags. All first aid kits that are intended for use by the crew will be sealed with a plastic anti-pilferage seal or anti-tamper tape that can be broken with little effort. The Medical Department will conduct semi-annual inspections/ inventories of emergency medical units, and signed, dated entries will be made on the inventory list of each emergency unit. Locations of all emergency medical kits will be listed in the Medical Department Battle Bill for easy location. All sets will have a list of the contents and an inventory signature page in each individual set. The signature page will list more than one inventory to document a history of inventory.

13202. FIRST AID BOXES

a. First aid boxes (NSN 1H 2090-00-368-4792) will be stocked in compliance with AMMAL 0927 and distributed throughout the ship per the Ship’s Battle Bill. The minimum number of First Aid Boxes for all CV/CVN ships is 90. The recommended location for these boxes is contained in Appendix Q, however, these locations may be altered as necessary to better meet the needs of the individual ship. The requirements listed in this document supercede those outlined in

GENSPECS 652 until it is updated to reflect these requirements. The location of each first aid box will be documented in the Battle Bill.

b. First aid boxes will be maintained per paragraph 13201b of this instruction; and the contents will be divided into three equal portions to represent three separate first aid kits. They will be sealed in a plastic bag or placed inside the heat-sealed plastic tubing. Each First Aid Box will be marked with a Red Cross (2" X 6") and labeled "For Emergency Use Only."

13203. FIRST AID KIT GUN CREW (GUN BAGS)

a. Each repair party locker and BDS will be provided one gun bag for utilization by each stretcher bearer team. The location of each gun bag will be documented in the Battle Bill.

b. Each gun bag will be maintained per paragraph 13201b of this instruction.

c. The contents of each gun bag will consist of the following:

GUN BAG CONTENTS		
Nomenclature	**U/I**	**QTY**
Inventory List	EA	1
Povidine Iodine Sol, 10%, 15ML	BT	6
Dressing, First Aid Field, Individual Troup, 4″ x 7″	EA	4
Bandage, Gauze, Compressed, 2″ x 6″	EA	3
Bandage, Gauze, Compressed, 3″ x 6″	EA	5
Bandage, Muslin, Compressed, 37″ x 52″	EA	1
Dressing, First Aid Field, 7½″ x 8″	EA	2
Dressing, First Aid Field, 11¾″ Square	EA	2
Compress and Skill Cap, Head Dressing	EA	1
Gauze, Petrolatum, 3″ x 18″, 12s	PG	1
Gauze, Absorbant, 18″ x 36″, 2s	PG	4
Tape, Surgical, Adhesive, 1″ x 5 Yards	SL	2**
Bandage, Adhesive, ¾″ x 3″, 300s (Bandaids)	BX	18/300
Tourniquet, non-pneumatic, 1½″ x 42″	EA	2
SAM Splint, Universal	EA	2
** AUTHORIZED SUITABLE SUBSTITUTIONdc		
Add the following additional items (Not included in Standard Kit)		
Oral Pharyngeal Airway Set	EA	1
Pocket Mask	EA	1
Roller Gauze, Kerlix	EA	4
Sponge, Surgical 4″ x 4″	EA	20
Skin Marker	EA	01
Bandage, Cotton Elastic, Rubber Wrap Threads, 3″ x 4 ½ YDS, 12’s	PG	3/12

13204. MASS CASUALTY BOXES. Mass Casualty Boxes provide portable medical supplies in the event of a mass casualty. Refer to AMMAL 0963 for a listing of required box contents.

13205. JUNIOR EMERGENCY RESPONSE KIT (JERK). Each carrier will maintain a minimum of five of these units to support special evolutions such as Sea and Anchor Detail, and Underway Replenishment. They will be maintained as outlined in paragraph 13201b of this instruction. Refer to AMMAL 0944 for a listing of the JERK contents.

13206. LIFEBOATS, MOTORBOATS, WHALEBOATS & LIFE RAFT FIRST AID KITS

a. Lifeboats, motorboats, whaleboats, gigs, etc., shall each be provided with a First Aid Kit, General Purpose (NSN 6545-01-459-1115). Life rafts shall be provided with First Aid Kit, Life Raft (NSN 6545-00-168-6893). The contents to these kits are to be maintained per FSC Class 6545, Components of Sets, Kits and Outfits (C-6545-IL, Volume 2).

b. All General Purpose First Aid Kits shall be inspected semi-annually by Medical Department personnel and maintained per Paragraph 13201b of this instruction. The components of these First Aid Kits shall be encased in plastic bags before placement in the First Aid Kit containers. These kits will be listed in the Battle Bill.

c. Life Raft First Aid Kits will be inspected in conjunction with the regular PMS. They do not require inventory by Medical Department personnel.

13207. STRETCHERS/LITTERS

a. The type and quantity of the various stretchers shall be per CV/CVN AMMALs and this instruction, and will be listed in the Battle Bill. The recommended location for the stretchers is contained in Appendix Q, however, these locations may be altered as necessary to better meet the needs of the individual ship. Consideration will be given to the nature of extrication required when selecting the type of stretcher for that area of the ship. Stretchers will not normally be stowed in locked spaces that are difficult to access. Determination of the type of stretcher/litter to be used for personnel casualty transfer shall be based on the condition of the casualty and environmental factors; however, safety shall be paramount.

b. Serviceability, inspection criteria and accountability for all stretchers/litters shall be per the current 3-M system. All stretchers/litters will be stenciled with the ship's name and compartment number. The stenciling shall be located in such an area that it can be readily viewed when the stretcher/litter is in its normal storage position. Locations and types of all

stretchers/litters will be included in the Medical Department's Battle Bill.

c. Handling lines will be maintained in BDSs and with the MRT gear. They will consist of at least 25 feet of line, and shall have a snap-hook or locking D-ring spliced to one end of the line with a minimum of five tucks on the splice. If a modern synthetic double-weave line is used, it will be tied to the ring with a bowline and two half hitches. Handling lines should be maintained in a pouch for easy stowage and transport. The purpose of the handling line is to belay a patient in a litter down a ladder. Historically, the lines spliced on a stretcher were difficult to maintain and became a significant trip hazard after they were used. If a patient must be transported down a ladder, the line will be removed from the pouch, snapped onto the stretcher, and then restowed at the bottom of the ladder. Three handling lines will be maintained in each BDS and one for each MRT set. Handling lines with a pouch are commercially available through EMS distributors. The locking D-rings and Snap rings shall be rated for a minimum breaking strength of 5000 pounds.

d. Deep Access Rescue and Extraction

(1) It is not normally the function of the Medical Department to rig the extraction equipment for rescue from a deep space or void. Riggers have the requisite knowledge to perform this hazardous evolution safely. Each ship will designate and train a Medical Extrication Team who will rig the equipment necessary to extricate the patient, while the medical personnel treat the patient and prepare them for transport.

(2) Handling lines of sufficient circumference and length will be provided to permit efficient and safe handling. 1/2" nylon handling lines or equivalent synthetic lines are required.

(a) The line shall be of sufficient length to allow the litter to be lowered into the required space with enough line remaining to pass through the pad eye or block over the hatch and take three turns around a stanchion.

(b) An additional line of suitable length shall be available for attachment to the lower end of the litter to stabilize it during the extraction process.

(c) The Medical Extrication Team shall maintain both lines along with any other specialized equipment.

e. Sea-Air Rescue (SAR) Litters. NWP 3-50.1 requires at least two SAR MEDEVAC litters for boat and deck recovery be maintained aboard aircraft carriers. NWP 3-50.1 also requires a rail assembly and a rescue litter sling assembly when using these litters for a SAR helicopter or deck recovery. Assemblies must be ordered separately: Trail Line Pack, 1 each, NSN 4010-01-312-4854 and Sling, Rescue

Helicopter, 2 each, NSN 1680-01-226-5300. The Medical Department's responsibility is to maintain the SAR litters in a state of readiness at all time.

f. Army Pole Litters. Army Pole Litters are to be utilized for moving patients on the ward and to support mass casualty requirements. They shall not be utilized to transport patients up or down ladders.

SECTION 3 – CHEMICAL, BIOLOGICAL & RADIOLOGICAL PREPAREDNESS

13301. CBR DEFENSE RESPONSIBILITY

a. The SMO shall ensure all providers have a thorough knowledge of CBR medical treatment regimens. Courses are available through the local Environmental Preventive Medicine Unit, on-line, and through other government agencies. The following references are recommended for self-study and reference:

(1) NSTM 070 Radiological Recovery of Ships After Nuclear Weapons Explosions

(2) NMETC-CBRNE-CC-2.0, CBRNE EMPRC Clinicians Course

(3) NAVPERS 10899-B, Disaster Control (Ashore and Afloat)

(4) NWP 3-20.31 Surface Ship Survivability

(5) NSTM 470 Shipboard BW/CW Defense and Countermeasures

(6) NAVMED P-5041, Treatment of Chemical Agent Casualties

(7) NAVMED P-5042, Treatment of Biological Agent Casualties

(8) BUMEDINST 6470.10 (series), Initial Management of Irradiated or Radioactively Contaminated Personnel

(9) BUMEDINST 3400.1 (series), Operational Concept for Medical Support and Casualty Management in the Chemical and Biological Warfare Environment

(10) Medical Management of Biological Casualties by U.S. Army Medical Research Institute of Infectious Diseases, Ft. Detrick MD. (Second edition)

(11) Medical Management of Chemical Casualties by Medical Research Institute of Chemical Defense, Aberdeen Proving Grounds (second edition)

13302. CBR DEFENSE BILL. The SMO shall be familiar with the ship's CBR defense bill, which establishes CBR defense organization within the ship's damage control organization. The CBR defense bill will outline the battle and administrative responsibilities of the Medical Department during and after CBR attack.

13303. CBR DEFENSE MATERIAL

a. The Medical Department shall be responsible for the maintenance of medically oriented decontamination supplies. Any CBR supplies that are carried in Supply shall remain part of the Navy Working Capital Fund (NCFW) until used. The Supply Officer shall be responsible for maintaining these items.

b. Ships and operating units shall provide adequate protective measures for Atropine and 2-PAM CL auto-injectors to prevent loss from pilferage or misuse. Adequate storage is considered to be a locked cabinet, locked medical locker, or locked storeroom that is not readily accessible to all hands. Controlled medicinals included in the CBR block will be included in the Controlled Medicinals program and will be included in the quarterly program audits. The entire stock of the controlled medicinal can be secured with tamper evident seals to allow for quick inventory. When the ship is cruising in Condition III or higher, the CBR block shall be distributed to each BDS. A plan for distribution of CBR defense medications shall be developed by each carrier and documented in the ship’s Battle Bill/SORM.

13304. DECONTAMINATION STATIONS. Personnel decontamination stations shall be established per NWP 3-20.31, NSTM 470 and BUMEDINST 6470.10 (series). The following CBR defense materials are required by BUMEDINST 6470.10 (series). The Medical Department shall provide them in the indicated quantity and they shall be stowed in a suitably mounted cabinet or chest near each decontamination station. Semi-annual inventories of decontamination stations will be documented and signed. Dated entries shall be made on the inventory list of each DECON locker.

NSN	NOMENCLATURE	U/I	QTY
5120-00-545-4268	Retrieving Tool, Magnetic	EA	1
6505-00-480-7216	Aluminum Hydroxide Gel 12 oz	BT	2
6505-01-072-3623	Magnesium Sulfate, 8 oz	BT	2
6505-00-246-0142	Water for Irrigation	BT	8
6510-00-782-2698	Sponge, Surg, 4" X 4", 8 Ply	PG	2
6510-00-890-1371	2" Surgical Tape	PG	1
6510-00-890-1370	3" Surgical Tape	PG	1
6508-00-852-6597	Soap, Antiseptic, Cake	EA	200
6515-01-234-6838	Applicator, Disp Sq Tip 100's	PG	2
6530-00-772-5935	Brush, Surgical Scrub, Nylon	EA	50
8520-00-550-6417	Soap, Grit, 4.5 oz, Cake	EA	50

NSN	NOMENCLATURE	U/I	QTY
8520-00-965-2109	Cleaner, Hand Anti-Microbial Laundry Detergent	TU	2
6530-00-075-6636	Specimen Cup, Urine, 500s, PG	EA	20*
6505-01-116-8198	Potassium Iodide Tabs	BT	6000**

*Package contains 500 urine cups; distribute 20 each to each DECON station.

**Distribution is one bottle per crewmember and is listed in the 7025 AMMAL. Maintain entire quantity in Supply until needed. This requirement is applicable to nuclear power vessels only.

13305. BW/CW MEDICAL MATERIAL

a. The following CBR defense items are required as specified in AMMAL 1031:

NSN	NOMENCLATURE	QTY
6505-00-009-5063	Doxycycline Hyclate Capsules, 100mg, 500 Capsules Per Bottle	168
6505-00-926-9083	Atropine Injection, Aqueous Type, 0.7ml, Syringe with Needle Auto Injector	18000
6505-01-125-3248	Pralidoxime Chloride Injection, 300mg/ml, 2ml, Auto Injector	18000
6505-01-178-7903	Pyridostigmine Bromide Tablets, 30mg I.S., 210 Tablets/Package	1200
6505-01-274-0951	Diazepam Injection, 5mg/ml, 2ml, Syringe-Needle Unit	6000
6505-01-333-4154	Ciprofloxacin Tablets, 500mg, 100 Tablets/Bottle	1200

(2) Specific medications and treatment protocols may be found in the references listed in Paragraph 13301.

SECTION 4 - BW AGENT CONFIRMATORY LABORATORY GUIDANCE

13401. GENERAL. To provide guidance to Naval units outfitted with confirmatory laboratories for use of equipment described herein and for receiving, sampling, testing, reporting, packaging and transport of suspected BW samples. This pertains to all deployed ship platforms currently outfitted with confirmatory labs aboard. The confirmatory laboratory uses highly reliable PCR technology to confirm or discount presumptive Hand Held Assay (HHA) results. Testing a presumptive HHA sample with a second independent method leads to a very high level of certainty for sample identification. This uniquely layered approach to Bio-Defense leads to highly reliable BW agent identification.

13402. DEFINITIONS

a. POLMERASE CHAIN REACTION (PCR) TESTING: Confirms the presence of the DNA of a specific BW agent. PCR equipment is deployed as part of the confirmatory laboratory.

b. PCR INSTRUMENT - LIGHTCYCLER OR R.A.P.I.D.: Laboratory instrument used to conduct PCR testing.

c. DIRTY AREA: The dirty area is the portion of the confirmatory laboratory where positive control standards and suspect samples are prepared for PCR testing.

d. CLEAN AREA: The portion of the confirmatory laboratory where PCR reagents and negative controls are prepared for PCR testing.

e. PCR REAGENTS: Materials required for PCR testing.

f. QUALITY CONTROL PROGRAM: Monthly testing program established to maintain the proficiencies of PCR trained laboratory technicians.

g. REACHBACK: Protocols established to contact subject matter experts at the Biological Defense Research Directorate (BDRD). Reachback is the definitive third component of the Navy's robust layered approach to BW Agent detection.

h. BIOSAFETY CABINET (BSC): Specialized laboratory equipment used to keep potentially biohazardous materials isolated. Confirmatory laboratories utilize the BSC to safely manipulate suspect BW agent samples.

i. RECEIVING PARTY: Person or persons responsible for receiving and transporting suspect package to it's next destination.

13403. ENVIRONMENTAL SAMPLING. NAVAIRFOR carriers are outfitted with environmental sampling protocols and equipment to sample for the presence of aerosolized BW agents and suspicious powders and liquids in letters and parcels. Upon the detection of a suspect BW agent, Navy units are trained in the proper procedures to safely package and ship a sample of the suspect BW agent to the nearest confirmatory laboratory. All carriers have received confirmatory testing capabilities. These capabilities include the confirmatory PCR laboratory equipment, microbiology area, and HHA capabilities. The confirmatory laboratory is staffed to deliver a second opinion on a positive environmental sample or a suspicious letter/parcel sample.

13404. CONFIRMATORY PCR LABORATORY SET UP

a. The confirmatory PCR laboratory consists of five components. These components include a Clean area, a Dirty area, a Biosafety cabinet (BSC), a PCR instrument (either a R.A.P.I.D. or a

Lightcycler), and a set of reagents and standards. The Clean Area must be set up in an area where potential biological sample contaminations are not present. All reagents and negative PCR control standards are set up in the clean area. The Dirty Area may be set up in the standard medical laboratory. Positive controls and samples are set up in the Dirty area. The BSC is co-located with the Dirty area. While manipulating suspect samples within the BSC, in order to prevent DNA contamination of the Clean and Dirty areas, the PCR instrument must be set up in a separate area from the Clean/Dirty areas. The reagents and standards must be stored in a manual defrost freezer maintained at negative 20 degrees Celsius. Freeze/thaw cycles are detrimental to these reagents and standards.

b. CONFIRMATORY MICROBIOLOGICAL LABORATORY: The Microbiological laboratory consists of standard plating techniques for bacterial samples.

c. HHA's: The HHA is repeated in the confirmatory laboratory setting. This verifies the HHA result from the field.

13405. CONFIRMATORY LABORATORY OPERATIONS. UPON NOTIFICATION OF INBOUND PRESUMPTIVE BW AGENT SAMPLES: The SMO directs PCR qualified laboratory technician to prepare for receipt of samples, and to prepare the confirmatory laboratory. The SMO initiates reachback communication with Bio-Defense Research Development (BDRD).

13406. RECEIVING PRESUMPTIVE BW AGENT PACKAGE

a. Commander of affected unit utilizes chain of command to arrange for safe transport of decontaminated package containing the presumptive BW agent sample to the carrier lab. The carrier Commanding Officer alerts the lab that a suspect package is inbound. The carrier lab prepares for receipt of suspect package.

b. Suspect package is received, while maintaining chain of custody procedures.

c. Receiving party escorts suspect package to confirmatory laboratory for testing while maintaining chain of custody procedures.

d. The SMO or Lab tech receives package while maintaining chain of custody procedures.

e. Confirmatory Laboratory Tech opens BW agent package within BSC and ensures integrity of sample container. The primary container is removed, decontaminated with a hype-wipe, and the sample is prepared for testing.

f. Lab Tech runs confirmatory tests including HHA, PCR, and microbiological analysis as appropriate.

13407. CONFIRMATORY LABORATORY TESTING AND RESPONSES FOR NEGATIVE HHA

a. If receiving a suspicious letter/parcel sample with a previously negative HHA test result:

(1) The SMO instructs confirmatory Lab Tech to repeat a complete HHA panel to verify negative HHA result, perform microbiological analysis on Blood Agar or MacConkey's media as available, and conduct PCR testing. Conduct reachback for specific agent test procedures.

(2) Results of all confirmatory tests will be verified via reachback consultation with BDRD.

(3) The SMO directs medical monitoring of "at-risk" personnel until Lab clears sample (i.e. No Growth on blood Agar or MacConkey's media after the appropriate time period and/or PCR testing negative) or as deemed appropriate by the SMO (No clinical cases observed following an anticipated agent-specific incubation period).

(4) If sample is determined negative by confirmatory testing:

(a) Alert Chain of Command of negative result.

(b) Chain of Command issues follow-on messages as appropriate.

(c) Chain of Command will determine further treatment of the sample(s) and follow-on action. If sample is shipped from the confirmatory laboratory, package as a Class 6.2 Infectious Substance but label and ship as an "Environmental Sample". Engage local shipping experts for further detail.

(5) If sample is determined positive for a BW Agent by confirmatory laboratory testing:

(a) The SMO directs medical treatment appropriate to BW agent detected. Since multiple agents could be present in a positive sample, engage reachback subject matter experts at BDRD for instruction on additional testing of the sample.

(b) Chain of Command issues follow-on messages as appropriate.

(c) Chain of Command will determine further treatment of the sample(s) and follow-on action. If sample is shipped, package and ship as a Class 6.2 Infectious Substance. Engage local shipping experts for further detail.

13408. CONFIRMATORY LABORATORY TESTING AND RESPONSES FOR POSITIVE HHA

a. If Confirmatory Laboratory is receiving a sample that has tested positive via the HHA:

(1) The SMO directs Laboratory Technician to conduct confirmatory tests including a complete HHA panel, PCR testing for the BW agent identified, and microbiological analyses (as available) for the BW agent identified. Since multiple agents could be present in a positive sample, engage reachback subject matter experts at BDRD for instruction on additional testing of the sample.

(2) The SMO directs medical monitoring of "at-risk" personnel until lab clears sample (i.e. No growth on blood Agar or MacConkey's media after 72 hours and PCR testing negative) or as deemed appropriate by SMO (No clinical cases observed following an anticipated agent-specific incubation period).

(3) If Lab confirms presence of BW agent, the SMO reports positive results and recommends appropriate medical course of action to CO.

(4) If after consultation with BDRD reachback, the confirmatory laboratory determines that the sample is negative (i.e. No BW agent detected):

(a) The SMO reports negative result to CO.

(b) CO initiates appropriate follow on message traffic.

(c) Chain of Command will determine further treatment of the sample(s) and follow-on action. If sample is shipped, package as a Class 6.2 Infectious Substance but label and ship as an "Environmental Sample." Engage local shipping experts for further detail.

13409. PCR QUALITY CONTROL PROGRAM

a. PCR quality control reagents (unknown samples) are deployed to confirmatory laboratories.

b. Confirmatory laboratories are instructed to conduct PCR quality control testing on a monthly basis.

c. PCR quality control testing consists of periodically analyzing a set of unknowns, and completing the BW report form. Send results via unclassified internet to BDRDBW@NMRC.NAVY.MIL for reachback analysis and confirmation.

13410. CERTIFICATION OF CONFIRMATORY LABORATORY BIOLOGICAL HOODS

a. The Biological Defense Research Directorate (BDRD) of the Naval Medical Research Center (NMRC) requires that the biological hoods of the confirmatory labs on Navy ships be certified annually.

b. Certification may be obtained by civilian contractor. Contact Force Medical for specific guidance.

13411. TECHNICAL REACHBACK POC INFORMATION. Naval Medical Research Center, BDRD watch stander pager numbers:

Primary 877-243-1528
Secondary 877-243-1531
STU III DSN 285-7509 COM: 301-319-7509
EMAIL: NIPR: BDRDBW@NMRC.NAVY.MIL
SIPRNET BDRD.OPS@INTECWASH.NAVY.SMIL.MIL

CLASSIFIED MESSAGE TRAFFIC PLAD: NAVMEDRSCENTER SILVER SPRING MD
NMRC OFFICER OF THE DAY
DSN: 285-9053
COM: 301-526-1649
Inform the NMRC OOD that you need the BDRD watch stander paged; provide contact information to the OOD.

13412. CONFIRMATORY LABORATORY INVENTORIES

a. Inventory checklists are included in the Dirty and Clean laboratory boxes.

b. Questions regarding inventory components may be addressed through reachback to BDRD.

SECTION 5 - MASS CASUALTY PLANNING

13501. DEFINITION OF MASS CASUALTY. The Mass Casualty Bill shall be activated any time when personnel casualties exceed the capabilities of the Medical Department personnel on the scene. In this situation, all of the medical personnel and material resources will need to be mobilized in an effort to render aid to the greatest number of casualties possible. The keys to successful execution of the Mass Casualty Bill are flexibility, good communication, and sound leadership as manifest through efficient utilization of resources to (1) return the greatest number of personnel casualties to fight the ship, and (2) provide care to the greatest number of remaining casualties. Although triage will vary according to the ship’s tactical situation and the total number of casualties sustained, the categories remain consistent. There should be no hesitancy in calling “Mass Casualty” as this action mobilizes many functional areas of the

ship in addition to Medical (i.e. Dental, Supply, Weapons, AIMD, Air Department, and Security). The exact method of notification should be outlined in the Mass Casualty Bill. The Medical Department shall develop, implement and regularly review the Mass Casualty Bill. Mass Casualty drills are required, and the periodicity is outlined in the Readiness and Training Manual COMNAVAIRFORINST 3500.20 (series).

13502. TRIAGE CATEGORIES. Triage is necessary in order to determine priority for treatment as well as returning the greatest number of personnel to fight the ship. Depending upon the tactical situation, emphasis will be placed predominantly on the Immediate Category or on the Walking Wounded Category. Assignment of a triage category is a continuously evolving process and should be repeated frequently, and, at a minimum, following each intervention. The triage categories are:

a. **Immediate (Red).** Life or limb-saving measures are required in order to have any reasonable expectation for survival.

b. **Delayed (Yellow).** Cases in which some surgical intervention will be required, but can be safely delayed until after the Immediate category have been treated.

c. **Minimal** (**Walking Wounded) (Green).** Those who not only can ambulate without assistance to receive care, but who can be tended to most rapidly and then returned to their duty station.

d. **Expectant (Black).** Those whose injuries are so severe that survival is either not expected or would consume so many personnel and material resources that many other casualties would suffer as a consequence.

Triage categories may be assigned differently depending upon the total number of casualties suffered, the number and expertise of medical providers, the amount of medical supplies and the urgency with which casualties must be returned to duty. Depending upon the situation, it may be more important to retain a large number of casualties in the Holding Area where the Surgeon and Anesthetist are able to assist multiple casualties, rather than getting the first case to the Operating Room.

13503. MASS CASUALTY AREAS. The exact location of the following areas will vary depending upon the location of the casualties and the nature of the event resulting in the casualties, in addition to what tactical evolution the ship is in at the time. If the ship is in blue water flight ops, the prime consideration will be to clear the flight deck expeditiously without contributing further FOD hazards. This evolution can be accomplished by rapid movement of casualties to another location with movement of minimal, if any, supplies onto the flight deck.

a. Initial Triage and Collecting Area. This area may be one in the same, and merely be an area for collecting as many casualties as possible before movement to a safe location (i.e. deck edge elevator prior to movement to the Hangar Bay). If this area is on the Flight Deck, it may be just one or two corpsmen doing initial triage and informing other department personnel of the nature and extent of injuries. A Flight Surgeon and 1–2 corpsmen will be in the Flight Deck BDS to render aid to walking wounded (to expeditiously return them to the fight) or possibly render the beginning of ATLS protocols, depending upon the situation.

b. Triage Area. This area is the first location where a concerted triage effort is conducted, and depending upon timing and numbers, the first ATLS measures. The primary Triage Officer should be located here. Walking wounded should be directed to the designated treatment area, often an Auxiliary BDS or a separate location on the Hangar Bay. Expectant and dead casualties should be moved to other locations on the Hangar Bay.

c. Holding Area. This area is the one in which the greatest amount of care can be rendered to the greatest number of casualties with the fewest personnel because of the more open spaces. This area is for the gathering of casualties for definitive resuscitation and temporary observation prior to orderly movement to the Main BDS. Often, this area will be the Forward or Aft Mess Decks on the Second Deck. One should not rush to move large numbers of casualties to the Main BDS because the configuration in the Main BDS is such that it takes more providers to render care in that area. Depending upon the total number of casualties, you may move 2-3 of your most critical casualties plus a surgical case to the Main BDS. Remember, though, you cannot afford to commit too many personnel to just a few casualties if the total casualty count is high.

d. Main BDS. All litter casualties will eventually be moved to this location. Walking Wounded casualties will be treated and returned to duty to support the ships evolution.

13504. LOCATION OF PROVIDERS. Distribution of providers is as critical as distribution of supplies and space. The location of all providers for mass casualty response shall be listed in the Watch, Quarter, and Station Bill. Resist the temptation to “jump into the fray” or commit providers to a hazardous location. Personnel resources are limited and the Medical Department cannot afford to have any of them become casualties themselves. Crash Fire and Rescue personnel, other fire fighters, and repair locker personnel are trained in the recovery, extraction, and removal of casualties. Stretcher bearers will then bring the casualties to the providers. The Dental Department shall be utilized to provide additional resources under the direction of the SMO. Dental Officers will assist in triage or in treatment of casualties as appropriate. Dental technicians are trained in basic medical techniques and shall be fully

integrated into the Medical organization. Because the greatest amount of care can be provided to the greatest number of casualties in the Holding Area, this area may be the best location for initial utilization of the General Surgeon, Oral Surgeon and Anesthetist. Like all other facets of the mass casualty scenario, distribution of personnel must remain flexible and well thought out in terms of safety and effectiveness.

13505. MASS CASUALTY SUPPLIES. Seven Mass Casualty Sets will be used to provide mass casualty medical supplies. These sets will be stocked in compliance with AMMAL 0963. These sets must be strategically pre-staged and remain portable to support a variety of contingencies. The seven Mass Casualty Sets shall be maintained with one in each Hanger Bay, two on the Forward Mess Decks and two on the Aft Mess Decks. Conventional aircraft carriers with only two hangar bays shall maintain two sets in the Forward Hangar Bay, and one set in the Aft Hangar Bay. These supplies shall be inventoried as outlined in Paragraph 13201b of this instruction. The Supply Petty Officer must work closely with the Supply Department to rapidly replenish the supplies once they are depleted from the Mass Casualty Sets and other locations.

13506. COMMUNICATION. Each carrier shall establish an effective mass casualty communication system that allows for alternate methods of communication in the event that the primary means is lost through an equipment casualty. Hand held radio systems are the most efficient and are preferred over sound powered phones, or messengers, however, all three methods of communication should be drilled. The number and type of casualties is critical for efficient management of the situation, and must eventually be reported to the chain-of-command. The SMO must retain a capability of overseeing the entire evolution and an understanding of the "big picture." This understanding is necessary in order to apply his/her expertise and experience to the overall directing of events. The MAO or a Chief Petty Officer should be assigned to Damage Control Central for communications control and medical coordination. This individual accumulates casualty information and directs the flow of casualties, personnel, equipment, and supplies throughout the ship. They determine safe routes based on information from the Damage Control Assistant and provide casualty information to the Damage Control Officer. They are the "controllers" of the flow of casualty care and medical responses throughout the ship.

13507. PREPARATION. Planning for a wide variety of scenarios is key to being well prepared. Although history has long taught us to plan for the Flight Deck or Hangar Bay mishap, there are numerous other events and locations that could produce mass casualties, at sea or in port. The Medical Department and the ship should train for as many variations as possible. Although the Mass Casualty Bill is not executed during General Quarters, plan for the management of numerous casualties during General Quarters, and for the eventual movement of

casualties as the GQ situation evolves or the ship stands down from GQ. A script cannot possibly be written for every possible scenario. One must comprehend these guidelines, practice as many different scenarios as possible and rely on creating order out of chaos through effective communication and efficient utilization of resources.

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CHAPTER 14

Carrier Strike Group Operations

14101. STRIKE GROUP MEDICAL OFFICER RESPONSIBILITIES. The SMO embarked on the CV/CVN is usually designated the Carrier Strike Group Medical Officer (CSGMO) while the Carrier Strike Group (CSG) is deployed. The CSGMO is the Senior Medical Authority afloat and advises the Strike Group Commander on all matters pertaining to health care of the Strike Group.

14102. MEDICAL LIAISON WITH SHIPS IN COMPANY. Carrier Medical Departments are the medical resource center of typical task force operations. Support within the strike group is more readily met if all parties are fully cognizant of each other's capabilities and general operating procedures. Ships in company have called upon Carrier Medical Departments for assistance in a variety of circumstances, including:

a. Operational emergencies involving personnel casualties

b. Medical and surgical consultative services

c. Supply, X-ray and Laboratory services

d. Evacuation services

e. Sanitary and epidemiological support

f. Ophthalmic support

g. Medical equipment repair support

h. Mental health and substance abuse consultation, evaluation, and treatment

14103. STRIKE GROUP PRE-DEPLOYMENT PLANNING. To optimize medical support within the CSG, all NAVAIRFOR Carrier Medical Departments, prior to commencement of task force operations or operational deployments, shall accomplish the following:

a. Establish communications between the carrier and commands in company at least 90 days prior to deployment.

b. Hold pre-deployment briefs to assure the understanding and coordination of mission requirements and CSG policies and procedures by medical representatives of all participating units. The CSGMO shall provide sufficient notice and lead time to allow attendance by all Medical Department Representatives at these work-up phase

meetings. At a minimum, the following issues should be discussed: medical capabilities within the CSG, quality assurance, medical intelligence, medical evacuation (MEDEVAC) procedures, grounding and clearing of flight crew personnel and medical guard ship duty.

c. Physically visit, where possible, Medical Departments of ships which will be in company.

d. Invite Medical Department Representatives of commands which will be in company to visit the Carrier Medical Department for indoctrination.

e. Provide a written protocol describing, at a minimum:

(1) Medical services available and capabilities

(2) Procedures for patient referral or transfer

(3) Other information as desired by the Carrier Strike Group Medical Department or SMO, such as medical supply material carried on board

(4) Indoctrination on helicopter MEDEVAC methods, limitations, hazards and environment. Additionally, ascertain whether the sending ship is capable of receiving a helicopter on deck

(5) The information should also be provided to additional ships which join the task force or operational group during the deployment. Info the TYCOM on all correspondence and messages.

14104. SURFACE FORCE IDC QUALITY ASSURANCE. Although not required elsewhere, during the deployment the GMO or one of the Flight Surgeons should periodically go aboard the IDC escort ships. They can conduct a Medical Officer Quality Assurance review and assist with any difficult medical cases.

14105. PRE-DEPLOYMENT CHECKLIST. All Medical Departments will utilize the checklist in Appendix R when preparing for extended deployment.

CHAPTER 15

Health Promotion

15101. GENERAL

a. Health Promotion is a combination of health education and related organizational, social, economic, and health care interventions designed to improve or protect health. A Health Promotion program should encourage healthy lifestyles, increase organizational and individual readiness, and concentrate on increased individual fitness by identifying and minimizing health risks and disabilities.

b. Approximately 50 percent of all deaths and illnesses in the United States relate to unhealthy lifestyle habits: poor diet, lack of exercise, alcohol abuse, tobacco abuse, and unmanaged stress. Additional compromises to health and productivity result from undiagnosed or inadequately controlled hypertension, elevated cholesterol levels, and lower back injuries. Positive lifestyle and behavioral changes should result in optimal health, an enhanced quality of life and improved combat readiness of Sailors and Marines so they are physically and mentally ready to carry out their mission worldwide.

c. The Commanding Officer is responsible for ensuring that a command Health Promotion program is implemented. The command Health Promotion program must promote optimal wellness through various educational and intervention programs.

d. Program requirements for NAVAIRFOR ships are outlined in COMNAVAIRFORINST 6100.1 (series). Additional information on Health Promotion programs can be found in OPNAVINST 6100.2 (series) and BUMEDINST 6110.13 (series).

e. The Medical Department serves a vital role in the establishment and overall maintenance of the command Health Promotion program.

15102. HEALTH PROMOTION PROGRAM GOALS

a. Available to all crew/staff

b. High participation and satisfaction rate

c. Increase awareness of healthier lifestyles and behaviors

d. Improve readiness

e. Increase command fitness

f. Assist in risk reduction

g. Encourage individual responsibility

h. Enhance productivity and morale

i. Improve quality of life

j. Emphasize healthy people leading indicators:

(1) Physical activity

(2) Overweight and obesity

(3) Tobacco use

(4) Substance abuse

(5) Responsible sexual behavior

(6) Mental health

(7) Injury and violence

(8) Environmental health

(9) Immunizations

(10) Access to health care

15103. HEALTH PROMOTION COORDINATOR QUALIFICATIONS. The Health Promotion Coordinator (HPC) must have the following qualifications:

a. A genuine interest in health promotion and helping to increase the knowledge of the crew in health promotion topics for a healthy lifestyle.

b. A non-smoker.

c. Within the height/weight standards and physically fit.

15104. COURSES FOR HEALTH PROMOTION COORDINATOR

a. Contact Naval Environmental Health Center (NEHC) and the local hospital/clinic for courses on Health Promotion Programs.

b. The HPC shall attend the Navy Health Promotion Director and Marine Corps Semper Fit Coordinator Training and Certification Courses given by NEHC.

c. The HPC should attend the combined DoD Population Health & Health Promotion Conference at the Navy Environmental Health Center (NEHC) Navy Occupational Health and Preventive Medicine Workshop, which is held each year.

15105. HEALTH PROMOTION PROGRAM MARKETING

a. A yearly calendar of events/classes shall be published and distributed throughout the ship. This calendar shall contain the Health Promotion events sponsored by the ship and the local area hosts when pier side. Many classes are taught in the local area that the ship can utilize. Contact the Force Environmental Health Officer or the local hospital or clinic Health Promotion Department for more information.

b. The ship's closed circuit TV should be used to air the events calendar and show educational videos on the different Health Promotion programs.

c. Conduct health fairs to expose the crew to current health topics and allow them to interact with health care professionals on an informal basis. Contact the local Navy Environmental and Preventive Medicine Unit for info/help with the health fairs.

d. The ship's newspaper, Plan of the Week/Day, bulletin boards and promotion posters should be used to promote the Command's Health Promotion Program.

15106. PROGRAM SELF EVALUATION

a. The Health Promotion Coordinator shall oversee a health assessment on each command member at least annually. This assessment is to ensure the Health Promotion Program is meeting the needs of the crew. To conduct the assessment, the Health Risk Appraisal (HRA) form or the Health Enrollment Assessment Review (HEAR) form can be used. For the fleet, the HRA is normally used. To obtain information on the HRA and HEAR go to the NEHC web-site: http://www-nehc.med.navy.mil/hp/index.htm. The local supporting Navy Environmental and Preventive Medicine Unit can help you compile the HRA data sheets.

b. The HPC should develop a survey/evaluation form that can be used to evaluate the Health Promotion classes given at the command. At the end of all Health Promotions classes, a survey should be provided to participants in order to evaluate and make changes to improve the class. All class participants should be encouraged to fill out an evaluation form/survey.

15107. HEALTH PROMOTION AWARD. NEHC offers a Health Promotion award called the Command Excellence in Health Promotion. This award recognizes commands for their excellence in Navy and Marine Corps Health Promotion programs. The non-competitive Award for Command

Excellence in Health Promotion is represented on three levels, including Gold, Silver and Bronze. Commands submit an awards package that reflects the level of development of the command's Health Promotion Program. All Navy Health Promotion and Marine Corps Semper Fit Programs are eligible for this award. For more information contact NEHC or check their health promotion website at: http://www-nehc.med.navy.mil/hp/index.htm.

CHAPTER 16

Preventive Medicine and Environmental Health

SECTION 1 - GENERAL

16101. INTRODUCTION. This chapter addresses policies that promote the health, welfare, and comfort of the personnel stationed aboard NAVAIRFOR carriers. The SMO is responsible for implementing Preventive Medicine, Occupational Medicine and Environmental Health programs and advising the Commanding Officer of all conditions affecting the health of the crew. These programs include:

a. Birth Month Medical Surveillance Program and Preventive Health Assessments

b. Communicable Disease Control and Immunization Tracking Program

c. TB Surveillance Program

d. Food Safety Program

e. Potable Water and Ice Surveillance Program

f. CHT System and Solid Waste Surveillance

g. Pest Control Program

h. Habitability

i. Medical Waste Program

j. Bloodborne Pathogen Program

k. Heat Stress Program

16102. INSPECTIONS AND REPORTS

a. Inspections

(1) The SMO or their Preventive Medicine Representative must conduct routine sanitation and habitability inspections to identify health threats and other detrimental conditions that are potentially degrading to the health and well being of the ship’s crew.

(2) Findings must be documented and reported to the Commanding Officer with copies provided to cognizant Department Heads, Division Officers or Leading Chief Petty Officers.

(3) Inspection frequency is determined by published guidelines and instructions, Commanding Officer's direction, workload considerations, potential for illness or injury, and degree of compliance with published health standards.

b. Preventive Medicine/Occupational Health Reporting

(1) Pertinent aspects from the Preventive Medicine and Occupational Health Program will be submitted in the monthly Medical Quality Assurance (QA) report. The monthly report format for the Occupational Health and Preventive Medicine information is contained within Appendix E of this instruction.

(2) The compliance goal for each program area is 90 percent. The achieved compliance score should be documented for each program, including an explanation of deficiencies and corrective action.

SECTION 2 - PREVENTIVE MEDICINE

16201. DISEASE REPORTING

a. The Medical Event Report (MER) is the primary method of reporting various medical events; including communicable diseases, injuries and outbreaks; to the Chain of Command and appropriate medical authorities. Reporting requirements and guidelines for preparation and submission of MERs are provided in BUMEDINST 6220.12 (series).

b. Submit routine MERs using SAMS on the first of the month when a reportable medical event is suspected or confirmed. Urgent MERs shall be reported within 24 hours of suspected diagnosis followed up by a final MER when diagnosis is confirmed. Specific reporting timeframes for each reportable disease are contained in BUMEDINST 6220.12 (series).

c. Contact the TYCOM Force Environmental Health Officer (EHO) and cognizant NAVENPVNTMEDU via telephone and e-mail in the event of suspected disease outbreak, unusual conditions, or high interest diagnoses (i.e., Unit SITREP).

d. Commands are required to report as necessary to various local, state, or federal health authorities via fax or e-mail. The TYCOM Force EHO as well as the local MTF Preventive Medicine Department can be contacted for assistance and advice with local/state reporting requirements and methods. SAMS generated reports may be acceptable to local and state authorities.

e. The Medical Department Sick Call Log must be reviewed daily for tracking potential disease trends and follow-up on reportable

diseases and injuries. Gastroenteritis/diarrhea and upper respiratory infection rates should be tracked on a regular basis to monitor overall disease threat/trends to the crew.

16202. COMMUNICABLE DISEASE CONTROL

a. Immunizations

(1) Ship's company and embarked squadron personnel shall be immunized and re-immunized, as applicable, per BUMEDINST 6230.15 (series) and the current BUMEDNOTE 6230, Immunization Requirements and Recommendations. Squadron personnel should be fully immunized by their cognizant shore-based MTF prior to deployment. In the event that significant numbers of squadron personnel arrive not fully immunized, the specifics of the immunization shortfall should be reported to the appropriate Force Medical staff in the monthly Quality Assurance report.

(2) Preventive Medicine must provide program oversight to ensure that required immunizations are administered and documented correctly. Medical personnel administering immunizations must receive annual training in the current policies and procedures.

(3) Immunization Tracking Requirement

(a) All commands are required to utilize the SAMS database system for tracking and reporting all routine immunizations IAW SECNAVINST 6230.4 (series).

(b) Electronic transfer of all immunization data is required weekly to the Naval Medical Information Management Center (NMIMC). The preferred method of doing so is via the Navy Medicine Online Website. SAMS data may be submitted via floppy disk if electronic transfer is not possible.

(c) Accurate documentation in the database and individual medical records is critical. Entries for each vaccine or toxoid administered on SF 601 shall include: date given, manufacturer, lot number, dose given, route of administration, and name, address, and title of the provider.

(1) Storage and shelf life requirements must be closely monitored.

(2) The temperature of all refrigerators storing vaccines must be checked and documented twice a day.

b. Tuberculosis Control

(1) Navy policies governing tuberculosis control, treatment and case management are detailed in BUMEDINST 6224.8 (series).

Specific program guidance may be obtained from either the TYCOM or the cognizant NAVENPVNTMEDU.

(2) An annual summary report must be sent to the cognizant NAVENPVNTMEDU with a copy to COMNAVAIRFOR no later than 28 February of each year using the format in BUMEDINST 6224.8 (series).

(3) All operational personnel must have a PPD administered and read annually. All previous PPD reactors must be evaluated annually with a screening questionnaire. This shall be documented in the individual medical record.

(4) A Preventive Medicine Technician (PMT) must evaluate all PPD reactors, regardless of induration. A Medical Officer or Physician Assistant must see all reactors prior to instituting a course of Isoniazid (INH) preventive therapy. A second opinion is required from a Preventive Medicine physician or Infectious Disease specialist if an initial reactor who meets the guidelines of BUMEDINST 6224.8 (series) is not started on INH.

(5) Patients placed on INH therapy must be seen monthly by Preventive Medicine until successful completion of treatment as prescribed in BUMEDINST 6224.8 (series). A final follow-up visit is also required after the completion of INH therapy and the patient is placed in the annual follow-up program.

c. Sexually Transmitted Disease (STD) Program

(1) Navy guidance for the diagnosis and treatment of STDs is provided in BUMEDINST 6222.10 (series). The most current Centers for Disease Control and Prevention (CDC) treatment guidelines must be available and utilized for STD patient management and treatment.

(2) A STD log or database must be maintained to track the overall management of patients being evaluated and treated for STDs. SAMS shall be used to meet this requirement.

(3) All STD patients must be directed to Preventive Medicine for contact interviews to fulfill various reporting requirements per BUMEDINST 6220.12 (series) and BUMEDINST 6222.10 (series). SAMS can be used to track required patient follow-up and MER reporting.

(4) A Medical Event Report (MER) must be submitted for any case of chlamydia, gonorrhea, or syphilis (all stages), and Hepatitis-B. Contact the cognizant NAVENPVNTMEDU or local MTF Preventive Medicine Department for guidance with various local/state reporting requirements, methods, and forms as other communicable diseases that do not require a MER may require a report to the local health authority.

(5) All patients evaluated for a STD must be tested for syphilis and HIV.

(6) Hepatitis-B vaccine must be administered to all patients evaluated for a STD per the current BUMEDNOTE 6230, Immunization Requirements and Recommendations. When STD patients return for their third dose of the HBV vaccine (i.e., 6 months) they should also be offered follow-up HIV testing.

d. Rabies Prevention and Control

(1) Follow guidance per SECNAVINST 6401.1 (series) and BUMEDINST 6220.13 (series). In addition, cognizant NAVENPVTMEDU or the local MTF Preventive Medicine Department must be contacted for current treatment protocols and guidance with various local/state reporting requirements, methods, and forms.

(2) All animal bite cases must be individually evaluated for possible rabies vaccine administration. In most cases, rabies vaccine should be administered when patients cannot provide adequate information for local authorities to locate the suspect animal.

e. Malaria Prevention and Control

(1) Chemoprophylaxis and treatment protocols are defined in the current edition of the Navy Medical Department Pocket Guide to Malaria Prevention and Control, NEHC-TM PM 6250.1 (series) and NAVMEDCOMINST 6230.2 (series).

(2) Medical intelligence sources, such as the Armed Forces Medical Intelligence Center (AFMIC) MEDIC CD-ROM, provide information on current malaria threats and recommendations.

(3) Chemoprophylaxis drug quantities and shelf life must be verified prior to deployment.

f. Hand Washing Techniques and Control

(1) In order to decrease the spread of communicable diseases through direct and non-direct hand contact, the usage of waterless hand sanitizers shall be implemented.

(2) Waterless hand washing stations shall be located at various key locations throughout the ship and must be conspicuously mounted to the bulkhead. Specifically, they must be located at the following locations:

(a) Entrance to all galley food service lines

(b) Snack food vending stations

(c) Medical spaces (to include patient waiting areas)

(d) Liberty brows (ideally, to be used primarily during foreign port call visits)

(e) Gym facilities

(f) Any other area as deemed necessary by the Senior Medical Officer.

(3) The Supply Department will be responsible to ensure that adequate supplies are present for the waterless hand washing stations. During their scheduled inspections, Preventive Medicine will inspect the hand washing stations for functionality and will conduct appropriate awareness training to the ship to ensure maximum utilization. Individual departments who have the waterless hand sanitizer stations are responsible to keep them stocked.

(4) Design and manufacturer of the waterless hand sanitizing stations shall be left to the discretion of the Supply Department with guidance from the Senior Medical Officer. Specific guidance may be obtained from either the Force Environmental Health Officer or the Navy Environmental Health Center.

16203. MEDICAL INTELLIGENCE/HEALTH THREAT BRIEFS

a. Information concerning endemic diseases and vectors in potential ports of call is available from NAVENPVTMEDUs and Navy Disease Vector Ecology Control Centers (DVECCs). The phone numbers and website addresses are as follows:

UNIT	COMM	DSN	FAX	WEB ADDRESS
NEPMU2	(757) 444-7671	564-7671		http://www-nehc.med.navy.mil/nepmu2/nepmu2_index.htm
NEPMU5	(619) 556-7070	526-7070	(619) 556-7071	www.nosc.mil/usn/nepmu5/
NEPMU6	(808) 473-0555	473-0555	(808) 473-2754	http://nepmu6.med.navy.mil/
NEPMU7	011-39-095-56-4101	624-4101	011-39-095-56-4100 or 624-4100	http://www.sicily.navy.mil/nepmu7/
DVECC JAX	(904) 542-2424	942-2424		http://dvecc-jax.med.navy.mil/DefaultHtml.htm
DVECC Bangor	(360) 315-4450	322-4450		

b. Another source of medical intelligence is the Armed Forces Medical Intelligence Center, Fort Detrick, MD. They provide medical, environmental, and disease intelligence and monthly worldwide disease occurrence reports. The AFMIC phone numbers and web address to get a

new account and medical intelligence are: Comm: (301) 619-7574, DSN: 343-7574, and http//mic.afmic.detrick.army.mil.

c. The most current version of the MEDIC CD-ROM must be maintained in Preventive Medicine. This CD-ROM is produced by AFMIC and as such is considered an intelligence product. For assistance in getting a copy, contact the command Intelligence Officer.

d. The Port Directory Guide for Visiting Ships is another valuable source of medical information.

e. The SMO, as Carrier Strike Group (CSG) Medical Officer, should request a pre-deployment brief from the supporting NEPMU prior to a major deployment for all CSG medical representatives.

f. Health threat education briefs must be provided to the crew prior to port calls while on overseas deployment.

16204. BIRTH MONTH MEDICAL SURVEILLANCE PROGRAM GUIDELINES

a. All personnel must be seen annually by the Medical Department. In addition, personnel checking in and out of the command must process through the Medical Department. The Birth Month Medical Surveillance Program (also known as Birth Month Recall Program) has proven to be effective and efficient in maintaining overall medical readiness. The program requires command-wide support.

b. Once on board, each crewmember must report to Medical annually during their respective birth month. The PHA Form 2766 replaces the Birth Month Recall forms and should be printed out from SAMS and reviewed annually for accuracy and completeness. See paragraph 16205 of this instruction for information regarding the Preventive Health Assessment (PHA).

c. The goal of the Birth Month Recall (BMR) program is 90% or better compliance at all times. Recognize that Birth Month Recall is only a tool to help achieve medical readiness. An individual is only considered to be in compliance when all Birth Month Recall program requirements are completed (i.e., the patient must have their PPD read and HIV test results recorded on PHA Form 2766 before they may be considered to have completed the Birth Month Recall process).

d. Department heads will be notified prior to the beginning of each birth month of personnel requiring annual medical readiness verification. Department heads will also be notified of personnel failing to complete their birth month medical evaluation and verification. Each department aboard the ship shall assign a Birth Month Recall Liaison representative to facilitate the completion of all medical requirements.

e. The SAMS program must be used to track and manage all medical readiness and immunization requirements for all command personnel. Using the BMR indicators (routine immunizations, PPD, HIV, DNA, audiogram, physical exam, and annual verification), a monthly summary of the overall crew medical readiness will be generated and reported in the monthly Medical Quality Assurance report.

f. Force Medical will conduct a Birth Month Medical Surveillance Inspection (BMMSI) annually. When applicable the BMMSI will be conducted in conjunction with the Medical Readiness Inspection. BMR indicators will be evaluated based on a review of approximately 120 randomly selected medical records.

16205. PREVENTIVE HEALTH ASSESSMENTS (PHA)

a. Navy policies directing Preventive Health Assessments are detailed in OPNAVINST 6120.3 (series). Specific guidance may be obtained from either the TYCOM or the Navy Environmental Health Center (NEHC).

b. The purpose of the PHA is to consolidate medical, occupational health and risk screening services, medical record review, preventive counseling, and risk communication under one annual assessment for all active duty service members.

c. All service members will receive their PHA on an annual basis. It is suggested that commands complete their assessments during the individual's birth month. Commands may elect to follow another mechanism of ensuring annual assessment. The PHA does not replace or modify the full periodic physical examination.

d. Documentation of the PHA will be placed on the DD Form 2766. Units are encouraged to utilize the electronic version of DD Form 2766, which automatically populates about 70 percent of the fields.

SECTION 3 - ENVIRONMENTAL HEALTH

16301. FOOD SAFETY

a. Applicability. This section applies to galleys, bake shops, meat processing areas, sculleries, food storage spaces, mess decks, ice cream and soda messes, first class petty officer messes, chief petty officer messes, wardrooms, Commanding Officer and Flag messes, vending machines, and other areas where food is stored, prepared, served or consumed.

b. Responsibilities

(1) The SMO or the PMT will conduct a formal food safety inspection of each food service space at least once a month.

(2) All cited critical violations must be corrected at the time of the inspection or within ten days of initial inspection. Formal inspection reports must be routed via the chain of command to the Commanding Officer.

(3) Informal walk-through assessments are highly encouraged. A minimum of weekly walk-through assessments of the galleys and wardrooms should be conducted.

c. Communicable Disease Occurrences

(1) If communicable disease outbreak occurs which has direct impact on food service operations, e.g. viral gastroenteritis (VGE) or norovirus; the Senior Medical Officer will notify the Commanding Officer and the Supply Department to inform them of the disease threat.

(2) In order to eradicate the spread of disease via respiratory discharge and hand contact, the following processes will be imposed:

(a) Self service at the galleys will cease (exception would be for wrapped or prepackaged food items and beverage stations). All food will be dispensed by galley personnel until disease threat has been confined as determined by the Senior Medical Officer.

(b) Hand-rails of ladder wells will be disinfected by wiping them with a sanitizing solution. Hand-rails should be wiped at least twice a day until disease rates have lowered.

(c) Preventive Medicine will regularly monitor hand washing stations to enforce and educate the crew on the significance of hand washing. They will properly educate the crew concerning hand washing techniques.

d. References. The Manual of Naval Preventive Medicine, Chapter 1 (NAVMED P-5010-1) is the Navy basic guidance document. In addition the most current version of the U.S. Public Health Service, Food and Drug Administration "Food Code" provides a frequently cited reference source for established food safety principles and practices and NAVSUP Pubs 421 and 486.

e. Medical Screening. All personnel working in foodservice must be initially evaluated by Medical. A screening questionnaire will be administered and completed by all foodservice workers prior to commencing duties in any food preparation area per NAVMED P-5010-1.

f. Training

(1) All foodservice workers must receive a minimum of four hours of food safety and sanitation training. Temporary foodservice

workers (less than 30 days) must receive a minimum of two hours training.

(2) Any foodservice worker designated as a supervisor or person in charge must receive 18 hours of supervisor/manager foodservice sanitation training. Completion of this training also certifies supervisors to teach the 4-hour foodservice worker training.

(3) Preventive medicine must provide oversight for the Food Safety and Sanitation Training program. If galley personnel conduct food service training, Preventive Medicine staff should routinely audit the training sessions to determine the validity and effectiveness of the training curriculum. Foodservice management personnel and/or the Preventive Medicine Technicians will conduct training of foodservice workers. Training of foodservice workers designated as supervisors or a person in charge will usually be provided by the supporting NEPMU.

16302. POTABLE WATER SANITATION

a. Responsibility

(1) Each ship must have a Water Sanitation Bill that delineates all policies and procedures for the provision and monitoring of potable water.

(2) The Engineering Officer or Reactor Officer, as appropriate, is responsible for supply and treatment of potable water.

(3) The SMO is responsible for conducting a comprehensive medical surveillance program of the potable water system including adequacy of disinfection procedures, collection of samples for bacteriological analysis, and daily halogen residuals from the potable water distribution system.

b. References. Naval Ships Technical Manual (NSTM) Chapter 531; NSTM Chapter 533; Manual of Naval Preventive Medicine, Chapter 6 (NAVMED P-5010-6); BUMEDINST 6240.10 (series).

c. Surveillance

(1) Preventive Medicine must conduct a comprehensive potable water system inspection on a quarterly basis. The inspection should include a review of deck risers, hoses, hose lockers, sounding tubes, sounding tapes, halogen storage, batch chlorination procedures and the brominators, chlorinators or Electrolytic Disinfectant Generators as applicable. A search for submerged potable water outlets and other existing or potential cross-connections must be included. A copy of the inspection must be routed via the chain of command to the Commanding Officer.

(2) Daily halogen residuals must be taken from 12 sampling sites, which are varied and represent all parts of the potable water distribution system. Engineering/Reactor Departments will be notified daily of the sampling results. Free available chlorine or bromine residuals will be maintained as prescribed by current directives. Trace halogen residuals may be permitted underway and in CONUS but must be supported by consistently negative bacteriological test results. Daily halogen residuals may be reduced to once per week while conducting bacteriological quality of potable water when the ship is connected to shore potable water supply in homeport.

(3) Bacteriological quality of potable water and ice must be tested weekly, unless otherwise noted, following the procedures provided in NAVMED P-5010-6. Sampling sites shall conform to the following:

(a) Water samples from 12 sites that are varied and represent all parts of the distribution system

(b) Water samples from 1/4 of all potable water tanks

(c) Ice samples from all operating ice making/dispensing machines (monthly)

(d) Emergency Potable Water Tanks/Battle Dressing Stations (monthly)

(1) A water log shall be maintained that documents the source and location the sample was taken from and the results of all daily halogen and all weekly bacteriological testing.

(2) A weekly potable water bacteriological testing report that documents location and test results must be submitted to the Commanding Officer.

d. Training. Engineering personnel responsible for processing, treatment and distribution of potable water are encouraged to attend a one-half day basic or refresher Water Sanitation Afloat Class (COIB-322-2120) offered by Navy Environmental Health and Preventive Medicine Units. The ship's PMT should provide the training if it is not available locally or readily accessible.

16303. COLLECTION, HOLDING AND TRANSFER (CHT) SYSTEM and SOLID WASTE SURVEILLANCE

a. Responsibilities. The Engineering Officer is responsible for operating and maintaining the CHT system. The SMO is responsible to ensure all CHT personnel are trained in the medical aspects of marine sanitation devices and for conducting periodic medical surveillance inspections of the CHT system.

b. References. OPNAVINST 5090.1 (series) establishes Navy policy concerning environmental and natural resource protection. NAVMED P-5010-7 and Naval Ships Technical Manual (NSTM), Chapter 593 provide guidelines concerning safe and efficient operation of the CHT system.

c. Surveillance. Preventive Medicine must conduct a comprehensive CHT system inspection on a quarterly basis. The inspection should include a review of pump rooms, comminuter spaces, spill lockers, and deck risers for safety, health, and sanitation concerns. A copy of the inspection must be routed via the chain of command to the Commanding Officer.

d. Medical Screening. All CHT workers must be evaluated and have their immunization status reviewed on an annual basis. A current roster of all personnel who have been screened and trained to respond to CHT spills shall be maintained in Preventive Medicine.

e. Training

(1) Preventive Medicine must provide annual training to all personnel who operate or maintain the CHT system and its components as well as personnel assigned to clean up CHT spills. The topics should include, but not be limited to: infectious diseases associated with human waste, the hazards of hydrogen sulfide and other gases, personal hygiene, personal protective equipment, and proper clean-up of spills and disinfection procedures.

(2) Engineering personnel responsible for the operation, maintenance and clean-up of spills are encouraged to complete the course in Health Aspects of Marine Sanitation Devices via the Navy E-Learning website.

f. Solid Waste Collection Sites. Preventive Medicine must inspect all solid waste collection and processing sites for overall cleanliness and sanitation on a monthly basis. All plastic waste processing areas must also be included in the monthly sanitation inspection.

16304. PEST CONTROL PROGRAM

a. Responsibilities

(1) The Medical Department is responsible for performing pest surveys and conducting or supervising safe pest control operations. An Integrated Pest Management approach must be followed and the indiscriminate use of pesticides is prohibited.

(2) The SMO must be delegated by the Centers for Disease Control and Prevention Quarantine Division as the ship’s U.S. Public Health Service Officer for granting Derat certificates to other U.S.

Navy vessels. The process for obtaining a seal is described in BUMEDINST 6250.14 (series).

(3) PMTs and all Medical Department personnel who assist with pest control must maintain a current shipboard pest management certification.

(4) PMTs must also maintain current DoD Category 8 Pest Control certification per BUMEDINST 6250.12 (series).

(5) The Supply Department is responsible for funding and procuring pest control supplies and equipment and preparing their spaces properly for pesticide applications.

(6) Other departments requiring pesticide applications must ensure their spaces are prepared properly for the pesticide treatment.

(7) The SMO should contact the regional NEPMU to determine any unique host nation entry requirements prior to making a port visit.

b. References. SECNAVINST 6210.2 (series) "Medical Service Quarantine Regulations of the Armed Services," provides quarantine regulations. OPNAVINST 6250.4 (series) establishes Navy policy for implementing pest management programs. The Manual of Naval Preventive Medicine, Chapter 8 (NAVMED P-5010-8) and the Navy-Wide Shipboard Pest Control Manual (a DVECC publication) discuss Navy policies for a safe and effective pest control program. BUMEDINST 6250.12 (series) establishes procedure for pesticide applicator training and certification for Medical Department personnel. BUMEDINST 6250.14 (series) provides guidelines for procurement of derating/derating exemption certificates.

c. Derating/Derating Exemption Certification

(1) Deployable vessels must maintain a current derating or derating exemption certificate. To be valid, the certificate must have been issued within the preceding six months. Ships with a Medical Officer holding a seal must obtain inspection and certification from another command.

(2) Certificate service is available through U.S. quarantine stations in major ports of the United States, including Puerto Rico and the Virgin Islands, and by NEPMUs, DVECCs, Naval Hospitals, and ships with Medical Officers designated as Public Health Service Officers. Should operational commitments preclude obtaining a quarantine inspection prior to expiration of the current certificate one 30-day extension may be granted by the issuing authority.

d. Surveillance and Treatment

(1) Monthly surveys of all food storage and service areas are required to actively search for signs of insect infestations. Active

infestations will require frequent follow-up. All incoming provisions also need to be assessed for potential insect infestation. A comprehensive surveillance program will include the use of sticky traps and flushing agents.

(2) A pest control log must be maintained that documents all surveys and pesticide applications.

(3) In the event of an insect or rodent infestation, the ship's certified pest control personnel must initiate prompt and appropriate control measures. NEPMUs or DVECCs should be contacted for technical assistance as needed.

(4) The application of pesticides without correcting sanitation discrepancies and eliminating insect harborages is not approved, as it is ineffective in achieving long-term control over pests.

e. Pest Control Training

(1) OPNAVINST 6250.4 (series) states that medical personnel can be trained to apply pesticides aboard ship. Individuals certified in shipboard pest control are restricted to using only those procedures, equipment, and pesticides approved for shipboard use. Annual certification training is required for all medical personnel who procure and apply standard stock pesticides. The NEPMUs and DVECCs provide this training.

(2) EPA Pesticide Applicator Category 8 certification must be maintained by PMTs as part of their basic 8432 NEC qualification per BUMEDINST 6250.12 (series). The certification is initially issued upon graduation from PMT "C" School and is effective for three years. Recertification can be attained at any point before the three years expires by attending a recertification course sponsored by DVECC, Jacksonville or Bangor. This course is also offered every year at the NEHC Conference. Both DVECCs are authorized to extend the expiration date by 12 months if operational commitments interfere with recertification efforts. If an individual's certification has expired, the member must repeat the entire 4-week Pesticide Applicator course at DVECC, Jacksonville or Bangor. There are no exceptions since this training certification process must comply with strict federal EPA pesticide regulations.

(3) Medical and Supply Department personnel are selectively encouraged to assist with the pest control program, under the supervision of a PMT, by attending a one-day Shipboard Pest Management Course (CANTRAC Course B-322-1075) offered by NEPMUs.

16305. HABITABILITY INSPECTIONS

a. Responsibilities. The SMO or Preventive Medicine representative must conduct periodic sanitation inspections of berthing areas, heads, shower rooms, laundry, dry cleaning plants, confinement facilities (brig), gyms, barbershops, and ship stores. The Commanding Officer must be advised of conditions that are harmful to the health and morale of the crew.

b. References. Shipboard habitability standards are prescribed in OPNAVINST 9640.1 (series). The Manual of Naval Preventive Medicine, Chapter 2 (NAVMED P-5010-2) provides guidelines concerning sanitation of living spaces and related facilities.

c. Inspections

(1) All berthing spaces and heads are required to be inspected for general sanitation and cleanliness on a quarterly basis. The inspection plan should focus on a randomly selected sample of berthing compartments and heads by the Medical Department under the supervision of Preventive Medicine.

(2) Barbershops, the ship’s laundry and dry cleaning plant, the ship’s store, gym, and the ship’s brig are to be inspected on a quarterly basis.

d. Medical Screening. All barbers and laundry workers must be medically screened and have current immunizations prior to commencing their duties. The supervisor of the laundry facility shall maintain copies of the certifications and each barber shall display their medical certificate at their workstation.

16306. MEDICAL WASTE MANAGEMENT PROGRAM

a. Applicability. Infectious medical waste requires special handling, sterilization, storage and disposal by Medical Department personnel.

b. Responsibilities. The Commanding Officer shall ensure that no medical materials are disposed of in a manner that poses a risk or perception of a risk to public health and welfare or the marine environment. Disposal of medical materials must also comply with existing state and local regulations or Status of Forces Agreements (SOFA).

c. References. OPNAVPUB P-45-113-3-99 supplements and implements the policies established for shipboard medical waste in Chapter 19 of OPNAVINST 5090.1 (series) plus BUMEDINST 6280.1 (series), “Management of Infectious Waste”.

d. State Medical Waste Requirements

(1) Inport, potentially infectious medical waste from ships shall be delivered to a designated Navy Branch Medical Clinic or turned over to an authorized PWC contractor.

(2) Any attempt to list specific rules and regulations for every county, state and country where NAVAIRFOR maintains a homeport would be exhaustive and incomplete. Each CV/CVN shall ensure compliance with their respective municipalities' regulations regarding disposal of medical waste. Local guidance shall be obtained from the supporting MTF, NEPMU or PWC Environmental staff.

e. Foreign Countries. For foreign countries, the packaging, handling, storage, transportation, treatment and disposal of infectious waste shall be consistent with standards to protect public health and the environment as prescribed by applicable SOFAs and international agreements. If no SOFA or international agreement exists, infectious waste shall be disposed of as specified by the cognizant Fleet commander.

f. Record Keeping. Tracking, storage and disposal of shipboard infectious medical waste will be recorded in the Shipboard Medical Waste Storage and Disposal Record.

g. Training. All medical personnel will receive infectious medical waste training annually.

h. Program Oversight. Preventive Medicine will evaluate overall compliance with the Medical Waste Program on a monthly basis.

CHAPTER 17

Occupational Health and Safety

SECTION 1 – GENERAL

17101. INTRODUCTION

a. Background. The safety and health of Navy personnel is an integral responsibility of the command and is achieved through the integration of safety and health into all aspects of Naval operations. The Navy Occupational Safety and Health (NAVOSH) program will be carried out through the chain of command, with assistance from safety and health personnel. Specific emphasis is required by supervisory personnel to ensure NAVOSH hazards are identified and corrected, and that personnel are aware of hazards associated with their work and the means to prevent accidents and illnesses.

b. Purpose. The core of the NAVOSH program is training and the identification, risk assessment and elimination or control of safety and health hazards. The occupational health element is primarily concerned with more insidious health effects, which are usually produced by long term (chronic) exposures to toxic chemicals or harmful physical agents (e.g., noise, radiation, etc.) and the treatment of work related injuries.

(1) The occupational health program element is divided into two major subspecialties - industrial hygiene and occupational medicine. Each of these subspecialties has, as one of its major functional components, a long-term surveillance program.

(a) Industrial hygiene involves the surveillance of the work place and the anticipation, recognition, identification, evaluation, and control of any health hazards.

(b) Occupational medicine focuses on the medical surveillance of personnel potentially exposed to the hazards identified during the industrial hygiene work place evaluation, and the diagnosis and treatment of occupational injuries and illnesses.

c. Responsibility. The Safety Department is responsible for the overall NAVOSH Program. All medical surveillance and examination requirements are the responsibility of the Medical Department.

17102. COMMAND OCCUPATIONAL HEALTH INSPECTIONS

a. OPNAVINST 5100.19 (series) requires that a baseline industrial hygiene survey be conducted for each ship. An update of the baseline survey is necessary when system, equipment, or load out changes significantly affect the onboard hazard and or risk. As part of the

operational risk management responsibilities the Commanding Officer is required to identify potential hazards, assess the risks presented by the hazards, and provide controls to prevent exposures to personnel. An essential risk management tool is the industrial hygiene survey. The Safety Department will ensure that the baseline industrial hygiene survey is completed and will advise the Commanding Officer on the need for updates to the baseline survey.

b. The baseline and periodic industrial hygiene surveys will be conducted by the Assistant Safety/Industrial Hygiene Officer assigned to the CV/CVN. The CV/CVN IHO may request assistance from their respective Force Industrial Hygiene Officer (IHO).

c. The Safety Department shall provide the Medical Department with a copy of the baseline and periodic industrial hygiene survey results, including specific medical surveillance requirements. The Medical Department will permanently maintain copies of all baseline and subsequent industrial hygiene surveys.

d. The Medical Department may request industrial hygiene evaluation of any work procedures or processes suspected as occupational hazards based on health complaints or diagnosis.

17103. WORK PLACE MONITORING

a. The IHO shall conduct work place monitoring as indicated by the baseline or periodic industrial hygiene survey. If the IHO is unable to accomplish the work place monitoring, their respective Force IHO will be notified and assistance will be arranged.

b. The Medical Department shall be responsible for reviewing heat stress surveys from engineering and non-engineering spaces prior to submission to the CO/XO.

17104. MEDICAL SURVEILLANCE

a. General

(1) The Safety Department has the primary responsibility to inform department heads of operations identified in the industrial hygiene survey, which may potentially expose personnel to health hazards.

(2) Occupational medical surveillance examinations are designed to produce specific information upon which decisions may be based regarding the adequacy of protective measures used to prevent hazardous exposures, and to verify that personnel have not received dangerous exposures to chemical, physical, or biological hazards.

(3) The Medical Department will provide surveillance examinations as required by OPNAVINST 5100.19 (series) for those work

centers identified by the Safety Department as requiring medical surveillance. It is the responsibility of the individual's department to ensure the individual presents to the Medical Department for examinations. The Safety and Medical Departments will monitor compliance.

b. Medical Surveillance Examinations

(1) The latest Industrial Hygiene survey identifies those positions that are required to be in various medical surveillance programs. The Industrial Hygiene Officer shall provide rosters of individuals occupying those positions to the Medical Department. The Medical Department is then responsible for entering these people into the appropriate Medical Surveillance program.

(2) The results of all occupational health medical surveillance examinations shall be reviewed by an appropriately privileged medical provider to ensure that all aspects of the examination have been completed, and that appropriate actions have been initiated for all abnormal examination results. Note: Personnel should not be in Medical surveillance if the IHO has not recommended placement.

SECTION 2 – OCCUPATIONAL HEALTH PROGRAMS

17201. PERSONNEL PROTECTIVE EQUIPMENT

a. General. Operations for which respiratory protection or protective eyewear are required shall be identified during the industrial hygiene survey of work centers. A listing of operations for which respirators are required, and the types of respirators required for each, shall be provided to department heads and maintained by the Safety Department for TYCOM and INSURV review.

b. Respirator User Medical Screening

(1) Individuals required to use respirators shall be identified in the industrial hygiene survey. The individual's department is responsible for the presentation of the individual for medical examination. The Respirator Program Manager (RPM) will be responsible for the program's management.

(2) Personnel who are required to use respirators shall be scheduled for a medical examination at the following frequency unless these personnel are exposed to lead, asbestos, or other dangerous materials requiring more frequent screening:

(a) Below age 35: Every 5 years

(b) Age 35 to 45: Every 2 years

(c) Over age 45: Annually

(3) A medical questionnaire, as outlined in the current OPNAVINST 5100.19 (series), shall be completed for each individual during the medical examination. Conditions disqualifying personnel for respirator use can often be identified by this questionnaire. Note: Regardless of amplifying information the four part questionnaire must be filled out for all respirator users.

(4) The Medical Officer's evaluation of suitability of the individual examinee for respirator use shall be based on knowledge of the workplace and tasks and results of the medical questionnaire and evaluation. The Medical Officer shall classify the examinee in a category and report those findings to the cognizant division officer on the medical clearance request in the current OPNAVINST 5100.19 (series) with a copy to the RPM.

c. Sight Screening

(1) The Safety Department, as part of the industrial hygiene survey, shall provide a list of all eye hazardous areas and processes to the cognizant department. All personnel, prior to the onset of exposure to eye-hazardous processes or operations or those exposed as a result of an emergency, shall be referred for a sight screening examination. It is the responsibility of the individual's department to identify individuals at risk and send those individuals to the Medical Department. The Safety Department will oversee the Sight Conservation Program. Per OPNAVINST 5100.19 (series), the usual physical examination cycle includes sight testing for all personnel and shall be used as the baseline eyesight screening examination. These screenings shall be a part of the individual's medical record. Individuals whose visual acuity is insufficient to meet the requirement of the job shall be referred for refractive lenses for their protective eyewear.

(2) The Medical Department shall validate the prescription and facilitate procurement of required prescription safety glasses.

(3) Issue and maintenance of sight protective equipment shall be per OPNAVINST 5100.19 (series).

17202. HEARING CONSERVATION PROGRAM

a. General. The definitive source documents for hearing conservation are DODINST 6055.12 and OPNAVINST 5100.19 (series). They provide guidance for the establishment and implementation of an occupational noise control and hearing conservation program elements. The goal is to prevent occupational hearing loss and assure auditory fitness for duty of all Navy personnel.

b. Audiometry. Personnel exposed to potentially hazardous noise shall receive periodic hearing testing to assess the effectiveness of noise reduction measures and personal protective equipment.

(1) Reference Audiogram. All military personnel shall have a reference audiogram. OPNAVINST 5100.19 (series) requires that reference audiograms be recorded on DD Form 2215 (NSN 0102-LF-002-2150). The audiogram performed at the Armed Forces Entrance and Examining Station (AFEES) may not be used as a reference audiogram or transcribed to a DD 2215.

(2) Monitoring Audiogram

(a) Procedures for conducting monitoring hearing tests are outlined in detail in OPNAVINST 5100.19 (series). Monitoring audiograms shall be recorded on DD Form 2216 (NSN 0102-LF-002-2160).

(b) The monitoring audiogram shall be compared to the most current reference audiogram to determine if a significant threshold shift (STS) has occurred. Procedures for STS evaluations are outline in OPNAVINST 5100.19 (series), VOL 1, Appendix B4-A.

c. Audiometric Test Booths. The IHO or local NEPMU shall annually certify the audiometric booth per NEHC Technical Manual, TM-6290.91-2, Rev. B. Coordinate with the 3M A-1 for annual maintenance.

d. Personal Hearing Protection Devices

(1) Personnel working in or entering designated hazardous noise areas or utilizing noise hazard tools or equipment shall have hearing protective devices available at all times, and wear them without consideration of duration of exposure. A qualified professional must document exceptions to this requirement.

(2) Every effort shall be made to issue personnel hearing protective devices suited to the location and duration of usage following the guidance contained in OPNAVINST 5100.19 (series), VOL I, Appendix B4-D.

e. Training

(1) All personnel included in the hearing conservation program shall receive training relative to hearing conservation prior to working in noise hazardous areas or with noise hazardous equipment and annually thereafter. Initial training topics include:

(a) The elements and rationale for hearing conservation including the effects of noise on hearing.

(b) Designated noise hazardous areas and equipment.

(c) Proper use and maintenance of hearing protective devices, including the advantages and disadvantages of each type of device.

(d) The necessity for periodic hearing testing, and a description of test procedures.

(e) Mandatory requirement to wear assigned protective equipment, and the administrative actions that may result from failure to comply.

(f) Off duty hearing health hazards.

(g) The effects of hearing loss on career longevity, promotion, and retention.

(2) Refresher training for the hearing conservation enrolled personnel will be performed in conjunction with the annual audiogram.

f. Record Keeping. The Medical Department shall maintain a current roster of personnel who routinely work in designated noise hazardous areas and shall update this roster semi-annually. They shall also upload audiometeric information utilizing the Defense Occupational Health Readiness System-Hearing Conservation (DOHRS-HC) as directed by the regional occupational audiologist.

17203. HEAT STRESS MONITORING PROGRAM

a. Responsibilities. The Medical Department is responsible for performing heat stress surveys as assigned by the Commanding Officer. Reactor and Engineering Departments are responsible for monitoring and surveying their own spaces. A command instruction is required.

b. References. OPNAVINST 5100.19 (series) and NAVMED P-5010 provide guidance for the implementation of the Heat Stress Program.

c. Surveys

(1) The Medical Department must assess individual spaces for heat stress conditions and stay times when dry bulb (DB) temperatures exceed the following limits:

(a) Physiological Heat Exposure Limit (PHEL) I through III

(1) Watch/work length 4 hours or less DB => 100 degrees F

(2) Watch/work length greater than 4 hours DB => 90 degrees F

(b) PHEL IV through VI DB => 85 degrees F

(2) All Medical Department personnel who perform heat stress surveys must be appropriately trained and competent in the operation and calibration of Wet Bulb Globe Thermometers (WBGT).

d. Record Keeping. The Medical Department shall maintain a complete file of all heat stress survey reports performed during the previous 12 months. In addition, the Medical Department shall periodically audit non-Medical Departmental heat stress monitors and provide necessary direction to ensure satisfactory performance.

e. Required reports/inquiries. All heat stress related injuries shall be reported on Heat Injury Report forms (NAVMED 6500/1). This form must be signed by the Commanding Officer and forwarded to NEHC (Code 35) with a copy to the appropriate COMNAVAIRFOR Force Medical office. If a heat injury results in one or more lost workdays, a mishap Report (Report Control Symbol OPNAV 5102-1) must be submitted per OPNAVINST 5102.1 (series).

f. Training. All personnel must receive annual heat stress training that covers heat stress health hazards and related injuries.

17204. BLOODBORNE PATHOGEN PROGRAM

a. Applicability. A Bloodborne Pathogen Program is required for all commands that have personnel who potentially have an occupational exposure to bloodborne pathogens. All Medical and Dental department personnel aboard ship are considered potentially exposed to bloodborne pathogens. In addition, Security personnel and others who can reasonably anticipate occupational exposure to blood shall be included in this monitoring program. These individuals and the particular function shall be identified in the ship’s Bloodborne Pathogen instruction.

b. Responsibilities

(1) Each carrier is required to have a written Bloodborne Pathogen Control Plan which is reviewed annually. The command is responsible for providing appropriate Personnel Protective Equipment.

(2) The Infection Control Officer shall serve as the Bloodborne Pathogen Program Coordinator, and should be familiar with procedures and practices to reduce bloodborne pathogenesis.

c. References. OPNAVINST 5100.23 (series).

d. Exposures

(1) An exposure incident review procedure must be implemented and reviewed annually to identify processes or mechanisms leading to exposures and to develop courses of action to prevent bloodborne pathogen exposure reoccurrence.

(2) In the event of a bloodborne pathogen exposure, such as a needlestick, both the victim, normally a healthcare provider, and the source patient need to be screened and evaluated. Included in this evaluation would be screening for both HIV and HBV.

(3) Guidance for initiating chemoprophylaxis is contained in Appendix S. The Centers for Disease Control website, www.cdc.gov, should be consulted for the latest information and any updates to treatment protocols. Additionally, a CDC telephone hotline is available at (888) 448-4911.

(4) Personnel who receive an occupational exposure to known HIV infected blood or other body fluids must be evaluated promptly and must start chemoprophylaxis. Treatment should be initiated within 1 to two hours and no later than 72 hours. If treatment is initiated, a DoD Infectious Disease physician must be consulted. Do not delay treatment if timely contact of an Infectious Disease physician is not possible. A Medical Event Report must be submitted in the event of an occupational exposure requiring chemoprophylaxis initiation.

(5) A physician’s written opinion and record of counseling regarding the risk of developing a bloodborne pathogen disease shall be placed in the patient’s record. There must also be a documented medical follow-up within six months.

(6) Each incident requires that a permanent individual case file be maintained by the Medical Department with all supporting documentation. Additionally, a Safety Department Accident and Injury report shall be initiated following any used needlestick or sharps injury.

e. Training. Initial and annual training must be provided to individuals identified in the command’s Bloodborne Pathogen instruction. Training must be documented.

f. Medical Screening. Medical and Dental Department personnel must be screened annually to ensure that they have received the Hepatitis B vaccine and are current for MMR, annual HIV screening, and annual PPD screening.

17205. ASBESTOS MEDICAL SURVEILLANCE PROGRAM (AMSP)

a. Per OPNAVINST 5100.19 (series), the Medical Department representative will determine placement of personnel in the AMSP using the NEHC medical surveillance procedures manual and medical matrix.

b. An updated "Medical Surveillance Questionnaire," OPNAV 5100/15, shall be obtained from all personnel reporting aboard. A determination as to the placement of the individual in the AMSP must be indicated in Part II of the Medical Surveillance Questionnaire.

Personnel placed on the AMSP at any time in their career shall remain in the AMSP for the duration of their career in the Navy.

c. Asbestos medical surveillance examinations shall be conducted in accordance with OPNAVINST 5100.19 (series).

17206. LEAD MEDICAL SURVEILLANCE PROGRAM (LMSP)

a. Personnel are included in the LMSP when industrial hygiene surveys indicate that they perform work or are likely to be in the vicinity of an operation which generates airborne lead concentration at or above the action level more than 30 days a year. The program includes:

(1) Pre-placement medical evaluation prior to assignment involving potential exposures to lead that equals or exceeds the action level.

(2) Follow-up medical evaluation on blood lead analysis.

(3) Notification of personnel concerning the results of their blood lead levels.

(4) Counseling of individuals with abnormalities detected during medical evaluation.

(5) Removal of personnel from work with exposure to lead in certain specified situations.

b. Personnel who are expected to be assigned to duties or likely to be in the vicinity of an operation involving exposure to lead concentrations greater than 30 micrograms lead per cubic meter of air (ug/m^3), as an 8-hour time-weighted average (TWA), for more than 30 days per year, shall be scheduled for a pre-placement medical evaluation per the current OPNAVINST 5100.19 (series).

c. Personnel who are or may be exposed to 8-hour TWA concentrations of lead greater than 30 ug/m^3 for more than 30 days per year must be scheduled for blood lead monitoring every six months. They shall be scheduled for blood lead monitoring every two months when their blood lead levels exceed 30ug/100gm of whole blood. The medical surveillance requirements for personnel will be based on industrial hygiene evaluations. Identification of personnel at risk and requiring medical surveillance is the responsibility of the cognizant department head in consultation with the Safety Department. Responsibility for the presentation of the individual to the Medical Department for evaluation is the responsibility of the individual's department.

d. An individual shall be medically removed from lead work if their blood lead concentration equals or exceeds 60 ug/100 gm or the

average of the last three blood lead concentrations equals or exceeds 50 ug/100 gm.

(1) Blood lead concentrations of personnel medically disqualified for lead work shall be monitored monthly until the individuals last two consecutive results are below 40 ug/100 gm. At this point the individual may be medically requalified for lead work.

(2) When an individual's blood lead concentration is between 30 and 40 ug/100 gm, blood lead concentrations shall be monitored every two months until the last two consecutive blood lead test results are less than 30 ug/100 gm.

e. Follow-up medical evaluations shall be conducted in accordance with OPNAVINST 5100.19 series for all personnel found to have a blood lead concentration at or above 30 ug/100 gm.

f. An industrial hygiene evaluation shall be requested of the Safety Department to determine the cause and necessary corrective action of each blood lead level at or above 30 ug/100 gm.

g. Removal from the LMSP is indicated when an individual's current work no longer requires the individual to perform a lead-exposed job. The IHO should make this assessment.

CHAPTER 18

Quality Assurance and Risk Management

18101. POLICY. COMNAVAIRFOR is committed to providing the highest quality medical care to our forces given the constraints of the operational environment. We fully support the principle that the quality of health care is steadily improved through effective programs of quality assurance (QA), risk management (RM), continuing education, and utilization review. This can be confirmed when the care rendered is measured against clinically valid, measurable and predetermined criteria. A pattern of serious and/or frequent patient care errors will be handled per BUMEDINST 6320.67 (series).

18102. SCOPE. This program is applicable to all health care services and health care providers assigned to NAVAIRFOR CV(N) medical departments. Dental QA programs are not covered by this instruction except for inpatient care by the Oral Surgeon.

18103. QA PROGRAM OBJECTIVES

a. Evaluate the quality and appropriateness of patient care on an ongoing basis

b. Identify opportunities to improve patient care

c. Reduce risk to patients and staff thereby reducing exposure to liability

d. Document the resources required to maintain acceptable standards of patient care services

e. Communicate important QA/RM information to effect sound clinical management and decision-making at all levels of care

f. Integrate, track and trend QA/RM data to identify problems that require focused review or intervention

g. Support credentials and privileging activities in accordance with OPNAVINSTs 6320.7 (series) and 6400.1 (series), and BUMEDINSTs 6320.66 (series) and 6320.67 (series)

h. Identify education and training requirements for both staff and patients

18104. ORGANIZATION AND RESPONSIBILITY

a. COMNAVAIRFOR. Commander, Naval Air Forces is the privileging authority for all CNAF providers.

b. COMNAVAIRFOR Surgeon. The Force Surgeon is delegated authority and responsibility for implementing and maintaining the QA program and shall:

(1) Review and act for the Commander in the granting of clinical privileges for all CNAF healthcare providers.

(2) Review and monitor the implementation of QA programs by each Medical Department and provide technical assistance as required. This shall be accomplished by:

(a) Site visits and Medical Readiness Inspections

(b) Review of the Monthly QA Report, weekly SITREPS from deployed carriers and routine correspondence such as Preventive Medicine reports.

c. COMNAVAIRFOR Force Medical Officers. The Force Medical Officer (Atlantic and Pacific) shall chair the Executive Committee of the Medical Staff (ECOMS) on each coast. The ECOMS shall be composed of all available Senior Medical Officers holding privileges and such other privileged providers as designated by the Force Medical Officer. The ECOMS duties are defined in OPNAVINST 6320.7 (series) and BUMEDINST 6010.13 (series).

d. CV(N) Commanding Officers. The Commanding Officers are ultimately responsible for their ship’s Medical QA program and shall:

(1) Designate, in writing, the ship’s Senior Medical Officer (SMO) as the QA Program Manager.

(2) Direct the SMO to establish a QA Committee to develop and implement criteria for monitoring and evaluation, conduct peer reviews, and act on privileging requests. Membership shall include all health care providers, the Medical Professionals Credentials Coordinator, the Quality Assurance Coordinator (QAC), and others as designated by the SMO. This committee shall meet at least monthly.

e. Senior Medical Officer. The SMO shall ensure overall QA program implementation, and will appoint, in writing, a QAC and a QA Physician Advisor (QAPA). In addition, the SMO shall:

(1) Act as chairperson of the QA Committee.

(2) Schedule QA Committee meetings monthly, or more often if necessary.

(3) Review and approve the agenda for the monthly meetings.

(4) Participate in scheduled meetings of the TYCOM ECOMS consistent with the ship’s schedule.

f. Quality Assurance Coordinator. Responsibilities of the QAC include:

(1) Collect all data to complete the Monthly QA Report and submit it up the Chain of Command.

(2) Electronically send Monthly QA Report to the appropriate COMNAVAIRFOR Force Medical office (Atlantic or Pacific) by the 15th of the month following the period of the report.

(3) The signed hard copy of the Monthly QA Report is to be sent to COMNAVAIRFOR by the 30th of the month following the period of the report.

(4) Maintain a hard copy file of QA reports onboard ship for five years. Discard after five years per SECNAVINST 5212.5 (series).

(5) Prepare agenda for monthly meetings and submit to SMO for approval.

(6) Coordinate review of medical records; assign each provider with a designated number of records to review based on total number of new patient visits for the month.

g. Quality Assurance Physician Advisor. Responsibilities of the QAPA include:

(1) Principal advisor to the SMO and other health care providers on matters related to health care quality assurance.

(2) Assist the QAC in data collection, enforcement of the required number of provider record reviews, and tracking problem resolution.

(3) Review and endorse the Monthly QA Report.

18105. MEDICAL RECORDS REVIEW

a. Review of the inpatient and outpatient medical records must include participation by all healthcare providers, Nursing staff, and Medical Records personnel. The medical record review shall include:

(1) Adequacy of the records as a primary document reflecting the care and treatment of the patient

(2) Adequacy of the record as a medico-legal document

(3) Timely completion of the record

(4) Confidentiality, custody and proper release of information from the record

(5) Standardization and use of medical record forms

(6) Appropriate use of symbols and abbreviations, including signature with name, rank, corps, and service stamped or neatly printed below the signature

(7) Legibility

b. Inpatient Medical Records Review

(1) All active duty military inpatient medical records shall be maintained as outlined in the Manual of the Medical Department, Chapter 16.

(2) All inpatient medical records shall be reviewed upon patient discharge using the Inpatient Record Review Form contained in Appendix T. The Ship's Nurse will perform these record reviews.

c. Outpatient Medical Records Review

(1) All active duty military outpatient medical records shall be maintained as outlined in the Manual of the Medical Department, Chapter 16.

(2) It is recommended that the following routine be carried out at the end of each month:

(a) The number of new patient visits is determined for each provider.

(b) The number of records to be reviewed is determined by multiplying each provider's new patient visit total by 10 percent and rounding up to the next whole number. For example, if the Physician Assistant saw 143 new patients during the month, 15 of those records are to be reviewed.

(c) A Medical Records technician shall randomly "pull" the designated number of records for each provider.

(d) The QAC disseminates the "pulled" records out to the providers so that there is fair and equal distribution and also ensures that each provider does not review their own records.

(e) The Outpatient Medical Records will be reviewed using the Outpatient Record Review Forms contained in Appendix U. These forms are intended for review of privileged providers. In addition to the form for general outpatient records, specialized forms are provided for Clinical Psychologists (CP) and Physical Therapists (PT).

(f) Due to the nature of their specialties, the Physical Therapist and Clinical Psychologist records may benefit from specialty

peer review at the local MTF. When the ship is inport, the local MTF should be requested to perform a review of the CP and PT records. When the ship is at sea or deployed, the SMO will conduct these reviews. The Physical Therapist records should be reviewed using the Physical Therapist Record Review Form and the Clinical Psychologist records may be reviewed using the Clinical Psychologist Record Review Form contained in Appendix U.

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APPENDIX A

Acronyms

3-M	Material and Maintenance Management System
ACLS	Automated Carrier Landing System
ACLS	Advanced Cardiac Life Support
ADCON	Administrative Control
ADDU	Additional Duty
ADP	Automated Data Processing
ADTT	Air Department Training Team
AFFF	Aqueous Film Forming Foam
AIMD	Aircraft Intermediate Maintenance Department
AMMAL	Authorized Minimum Medical Allowance List
AOR	Area of Responsibility
ASFP	At Sea Fire Party
ATG	Afloat Training Group
ATLS	Advanced Trauma Life Support
ATO	Air Transport Officer
ATO	Air Tasking Order
AW	Air Warfare
BDS	Battle Dressing Station
BFIMA	Battle Force Intermediate Maintenance Activity
BG	Battle Group
BLS	Basic Life Support
BMMSI	Birth Month Medical Surveillance Inspection
BUMED	Bureau of Medicine and Surgery
C4ISR	Command, Control, Communications, Computer and Intelligence, Surveillance, Reconnaissance
CART	Command Assessment of Readiness and Training
CASREP	Casualty Report
CASCOR	Casualty Correction Report
CBR	Chemical, Biological, Radiological
CBRNE	Chemical, Biological, Radiological, Nuclear and Explosives
CCA	Contamination Control Area
CCOL	Compartment Check-Off Lists
CDC	Combat Direction Center
CFFC	Commander, Fleet Forces Command
Chem/Radcon	Chemical Radiological Control
CHENG	Chief Engineer
CHT	Collection, Holding and Transfer
CIN	Course Identification Number
CIS	Contaminated Injured Sailor
COMPEX	Competitive Exercises
COMPTUEX	Composite Training Unit Exercise
COMSEC	Communications Security
CONUS	Continental United States
COSAL	Coordinated Shipboard Allowance
CSG	Carrier Strike Group
CSG	Commander Strike Group
CSIB	Controlled Substances Inventory Board
CSTT	Combat Systems Training Team
CVOA	Carrier Operating Area
CVW	Carrier Air Wing
DC	Damage Control

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DCA	Damage Control Assistant
DCPO	Damage Control Petty Officer
DCTT	Damage Control Training Team
DESRON	Destroyer Squadron
DNBI	Disease and Non-Battle Injury
DPIA	Docking Planned Incremental Availability
DSPO	Division Safety Petty Officer
EAWS	Enlisted Aviation Warfare Specialist
ECOMS	Executive Committee of the Medical Staff
EEBD	Emergency Escape Breathing Device
EMCON	Emission Control
EOOW	Engineering Officer of the Watch
EPW	Enemy Prisoner of War
ESG	Expeditionary Strike Group
ESWS	Enlisted Surface Warfare Specialist
ETT	Engineering Training Team
FAF	Floating Accommodation Facility
FBP	Final Battle Problem
FEP	Final Evaluation Period
FLEETEX	Fleet Exercise
FOD	Foreign Object Damage
FPTT	Force Protection Training Team
FRP	Fleet Response Plan
FRSCQ	Fleet Reserve Squadron Carrier Qualification
FXP	Fleet Exercise Publication
GMT	General Military Training
GQ	General Quarters
HAZMAT	Hazardous Material
HMC&M	Hazardous Material Control and Management
HICS	Hazardous Material Inventory Control System
IDC	Independent Duty Corpsmen
IDRC	Inter-Deployment Readiness Cycle
ICAV	Inspections, Certifications, Assessments, and Visits
INSURV	Board of Inspection and Survey
ISEA	In-Service Engineering Activity/Agent
ISIC	Immediate Superior in Command
ITT	Integrated Training Team
JBD	Jet Blast Deflectors
JQR	Job Qualification Requirement
JTF	Joint Task Force
JTFEX	Joint Task Force Exercise
LOA	Light-Off Assessment
MAO	Medical Administrative Officer
MANMED	Manual of the Medical Department
MAV	Medical Assist Visit
MEDEVAC	Medical Evacuation
MEU	Marine Expeditionary Unit
MMR	Main Machinery Room
MRC	Maintenance Requirement Card
MRI	Medical Readiness Inspection
MSC	Maintenance Support Center
MSC	Military Sealift Command
MTF	Military Treatment Facility
MTT	Medical Training Team
MTT	Mobile Training Team
NATOPS	Naval Air Training and Operations Procedures Standardization Program

NAVEDTRA	Naval Education and Training
NAVOSH	Navy Occupational Safety and Health
NETPDTC	Naval Education and Training Professional Development and Technology Center
NETC	Naval Education and Training Command
NOBC	Navy Officer Billet Code
NOFORN	Not Releasable to Foreign Nationals
NPEB	Nuclear Propulsion Examining Boards
NPMTTNR	Nuclear Power Mobile Training Team, Nuclear Reactors
NRTC	Nonresident Training Courses
NSN	National Stock Number
NWP	Naval Warfare Publication
O2N2	Oxygen-Nitrogen
OJT	On-the-Job Training
OOD	Officer of the Deck
OPCON	Operational Control
OPREP	Operations Report
OPSEC	Operational Security
OPTEMPO	Operations Tempo
OR	Operating Room
ORM	Operational Risk Management
ORSE	Operational Reactor Safeguards Examination
PEB	Propulsion Examining Board
PEB	Physical Evaluation Board
PIA	Planned Incremental Availability
PMS	Planned Maintenance System
POM	Pre-Overseas Movement
PORSE	Post-Overhaul Reactor Safeguards Examination
PQS	Personnel Qualification Standards
PRD	Projected Rotation Date
PSA	Post Shakedown Availability
QA	Quality Assurance
QAPA	Quality Assurance Physician Advisor
RCOH	Refueling Complex Over-Haul
ROC/POE	Required Operational Capabilities/Projected Operating Environment
ROH	Regular Overhaul
RSE	Reactor Safeguards Examination
SAMS	SNAP (Shipboard Navy Automated Support) Automated Medical Support
SAR	Search and Rescue
SAREX	Search and Rescue Exercise
SARP	Substance Abuse Rehabilitation Program
SATCOM	Satellite Communications
SBTT	Shipboard Training Team
SCBA	Self-Contained Breathing Apparatus
SCD	Ship Change Document
SERP	Shipboard Equipment Replacement Program
SHIPMAIN	Ship Maintenance
SITREP	Situational Report
SLEP	Service Life Extension Program
SMA	Supply Management Assessment
SMI	Supply Management Inspection
SNDL	Standard Navy Distribution List
SNTT	Seamanship/Navigation Training Team
SOE	Schedule of Events
SOP	Standard Operating Procedure

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SORM	Ship’s Organization Regulations Manual
SORTS	Status of Resources and Training System
SRA	Selected Restricted Availability
SWMDO	Surface Warfare Medical Department Officer
TACON	Tactical Control
TAO	Tactical Action Officer
TAV	Technical Assist Visit
TMIP	Theater Medical Information Program
TRMS	TYCOM Readiness Management System
TSTA	Tailored Ships Training Availability
TYCOM	Type Commander
UIC	Unit Identification Code
UNREP	Underway Replenishment
VERTREP	Vertical Replenishment

APPENDIX B

Crew Certification Report Sample

CREW CERTIFICATION
REPORT OF FINDINGS
USS NEVERSAIL (CVN-00) PHASE __ CREW CERTIFICATION

DEPARTMENT EVALUATED: Medical

STRENGTHS:

_____
_____
_____

WEAKNESSES:

_____
_____
_____

DISCREPANCIES:

SPECIFIC: (Restrictive, Major, or Minor)

_____
_____

RECOMMENDATION:

_____
_____
_____

REFERENCE:

_____

NOTE:

Restrictive = Discrepancies which would preclude safe operation of the ship and must be corrected prior to fast cruise.

Major = Discrepancies which could hinder proper operation of the ship and must be corrected prior to getting underway.

Minor = Discrepancies which do not affect proper operation of the ship.

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APPENDIX C

Generic CV/CVN Medical Department Manning

Description	SUB SPEC	AQD	Grade/ Rate	NEC/NOBC	
PREVMED AERO	15A1J	6AG	2102H	0163	
GENERAL SURGEON	15C0J		2100I	0214	
CRITICAL CARE NURSE	1960E		2900J	0904	
HEALTH CARE ADMIN	1801S		2300J	0800	
PHYSICIAN ASSISTANT	0893E		2300J	0113	
GENERAL MED OFF *			2100J		
CLIN PSYCHOLOGIST			2300J		
PHYS THERAPIST			2300J		
RAD HEALTH (CVN ONLY)			2300J		
NRS ANESTH (CVN 76 ONLY)	1972P		2900J		
HOSPITAL CORPSMAN			HMCS	0000	LCPO
ALCOHOL COUNSELOR			CPO	9519	SARP Director
DRUG & ALCH INTERN			PO1	9522	SARP Intern
HOSPITAL CORPSMAN			HMC	8432	Prev Med Tech
HOSPITAL CORPSMAN			HM1	8478	Adv BMET
HOSPITAL CORPSMAN			HM1	8432	Prev Med Tech
HOSPITAL CORPSMAN			HM1	8425	Surf IDC
HOSPITAL CORPSMAN			HM1	8406	Aero Med Tech
HOSPITAL CORPSMAN			HM1	8466	PT Tech
HOSPITAL CORPSMAN			HM1	8485	Psych Tech
HOSPITAL CORPSMAN			HM2	8463	Optician Tech
HOSPITAL CORPSMAN			HM2	8432	Prev Med Tech
HOSPITAL CORPSMAN			HM2	8425	Surf IDC
HOSPITAL CORPSMAN			HM2	0000	Gen Duty HM
HOSPITAL CORPSMAN			HM2	8407	Rad Hlth Tech
HOSPITAL CORPSMAN			HM2	8406	Aero Med Tech
HOSPITAL CORPSMAN			HM3	8506	Adv Lab Tech
HOSPITAL CORPSMAN			HM3	8483	Surg Tech
HOSPITAL CORPSMAN			HM3	8482	Pharmacy Tech
HOSPITAL CORPSMAN			HM3	8452	Adv X-Ray Tech
HOSPITAL CORPSMAN			HM3	8407	Rad Hlth Tech
HOSPITAL CORPSMAN			HM3	0000	Gen Duty HM
HOSPITAL CORPSMAN			HM3	0000	Gen Duty HM
HOSPITAL CORPSMAN			HM3	0000	Gen Duty HM
HOSPITAL CORPSMAN			HM3	0000	Gen Duty HM
HOSPITALMAN			HN	8483	Surg Tech
HOSPITALMAN			HN	0000	Gen Duty HM
HOSPITALMAN			HN	0000	Gen Duty HM
HOSPITALMAN			HN	0000	Gen Duty HM
HOSPITALMAN			HN	0000	Gen Duty HM
HOSPITALMAN			HN	0000	Gen Duty HM
HOSPITALMAN			HN	0000	Gen Duty HM

*Effective October 2005, GMOs will be replaced by Family Practitioners as they rotate off the ship.

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APPENDIX D

TAD Support Request Messages

TAD Message Request Format For Anesthesia Support

********** (CLASSIFICATION AS REQUIRED) **********

R 191436Z AUG 01
FM USS (YOUR SHIP)
TO (SUPPORTING MTF PER BUMED MSG)
INFO COMNAVAIRFOR SAN DIEGO CA//N01M//
COMNAVAIRLANT NORFOLK VA//N01M//
COMFLTFORCOM NORFOLK VA//N01M// (or CINCPACFLT as appropriate)
CNO WASHINGTON DC//N931//
BUMED WASHINGTON DC//M3F/M3M//
BT
UNCLAS (OR CLASSIFIED AS REQUIRED) //N06010//
MSGID/GENADMIN/CVN XX MED//
SUBJ/ANESTHESIA PROVIDER AUGMENTATION//
REF/A/MSG/BUMED WASHINGTON DC/092221ZMAR04//
AMPN/REF A IS BUMED MSG DIRECTING ANESTHESIA SUPPORT TO
AIRCRAFT CARRIERS//
RMKS/1. (C) REF A DIRECTS ANESTHESIA SUPPORT FROM YOUR CMD TO ORIGINATOR.
REQUEST YOU SUPPLY ANESTHESIA PROVIDER FOR THE FOLLOWING PERIODS:

U/W PERIOD	REPORT NLT
27 AUG 05 - 12 SEP 05	2000, 25 AUG 05
06 OCT 05 - 22 OCT 05	2000, 04 OCT 05
10 NOV 05 - 18 DEC 05	2000, 08 NOV 05

MESSING AND BERTHING WILL BE AVAILABLE ONBOARD ORIGINATOR. ANY MODS TO THIS
SKED WILL BE FORWARDED TO YOU AS SOON AS PRACTICABLE.
2. (U) REQUEST YOU ENSURE YOUR ASSIGNED PERSONNEL RECEIVE THE FOLLOWING
ESSENTIAL INFORMATION FOR AUGMENTEES:
(A) LONG SLEEVED SHIRTS ARE REQUIRED TO BE WORN WHEN UNDERWAY.
LEATHER SHOES/BOOTS (STEEL-TOED) ARE REQUIRED.
(B) PERSONNEL ON SPECIALIZED MEDICATIONS SHOULD BRING SUFFICIENT
QUANTITIES FOR THE DURATION OF THE UNDERWAY EVOLUTION.
(C) LIBERTY ATTIRE POLICY PROHIBITS T-SHIRTS AND REQUIRES THAT
PERSONNEL DEPARTING ON LIBERTY PRESENT A NEAT AND MODEST APPEARANCE.
3. (U) PLEASE ENSURE A CREDENTIALS TRANSFER BRIEF (CTB), IAW BUMEDINST
6320.66 SERIES IS FWD TO COMFLTFORCOM NORFOLK VA (N02M) ON ALL YOUR TAD
PERSONNEL.
4. (U) REQUEST RESPONSE BY MSG. THANK YOU FOR YOUR SUPPORT.
5. (U) POC: LT , MSC, USN, AT (XXX)XXX-XXXX.//
BT

Customize this message to meet individual ship's requirements.

TAD Message Request Format For Other Medical Support

********** (CLASSIFICATION AS REQUIRED) **********

R 231200Z AUG 05
FM USS (YOUR SHIP)
TO COMNAVAIRFOR SAN DIEGO CA//N01M// (or COMNAVAIRLANT as appropriate)
INFO COMPACFLT PEARL HARBOR HI//N01M// (or COMFLTFORCOM as appropriate)
CNO WASHINGTON DC//N931//
BUMED WASHINGTON DC//M3F/M3M//
BT
UNCLAS (OR CLASSIFIED AS REQUIRED) //N01331//
MSGID/GENADMIN//
SUBJ/REQUEST FOR GENERAL SURGEON SUPPORT// (OR OTHER AS APPROPRIATE)
POC/(AS APPROPRIATE)//
RMKS/1. (C) REQUEST GENERAL SURGEON SUPPORT FOR FOLLOWING AT SEA PERIOD: 10-12 OCT 05. SURGEON WILL NEED TO MEET SHIP BY 09 OCT DURING HER PORT VISIT TO FT LAUDERDALE FL. MEMBERS ARE INSTRUCTED TO REPORT ONE DAY PRIOR TO THE UNDERWAY PERIOD.
2. (U) NORMALLY ASSIGNED SURGEON WILL BE INVOLVED WITH NATIONAL BOARDS REVIEW AND EXAM.
3. (U) REQUEST YOU ENSURE YOUR ASSIGNED PERSONNEL RECEIVE THE FOLLOWING ESSENTIAL INFORMATION FOR AUGMENTEES:
    (A) LONG SLEEVED SHIRTS ARE REQUIRED TO BE WORN WHEN UNDERWAY. LEATHER SHOES/BOOTS (STEEL-TOED) ARE REQUIRED.
    (B) PERSONNEL ON SPECIALIZED MEDICATIONS SHOULD BRING SUFFICIENT QUANTITIES FOR THE DURATION OF THE UNDERWAY EVOLUTION.
    (C) LIBERTY ATTIRE POLICY PROHIBITS T-SHIRTS AND REQUIRES THAT PERSONNEL DEPARTING ON LIBERTY PRESENT A NEAT AND MODEST APPEARANCE.
4. (U) PLEASE ENSURE A CREDENTIALS TRANSFER BRIEF (CTB), IAW BUMEDINST 6320.66 SERIES IS FWD TO COMNAVAIRFOR SAN DIEGO CA (N02M) ON ALL YOUR TAD PERSONNEL.
5. (U) REQUEST RESPONSE BY MSG. THANK YOU FOR YOUR SUPPORT.
6. (U) POC: LT   , MSC, USN, AT (XXX)XXX-XXXX.//

BT
NNNN

Please note that this is a request and may not be filled. The TYCOM will see if temporary assets are available. If they are not available, then they will forward to the Fleet Commander for action. If they do not have available assets, they will forward to CNO who will task BUMED to support. Note that the requesting command is responsible for funding all expenses associated with the TAD support! The only exception is for Anesthesia support due to a special arrangement with BUMED.

Customize this message to meet individual ship's requirements.

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APPENDIX E

Monthly Report Format

6000
Ser
Date

From: Commanding Officer, USS **AIRCRAFT CARRIER** (CV**N XX**)
To: Commander, Naval Air Forces, (N01M)

Subj: MONTHLY MEDICAL QUALITY ASSURANCE REPORT FOR **MONTH YEAR**

Ref: (a) COMNAVAIRFORINST 6000.1

Encl: (1) Monthly Medical Quality Assurance Report

1. Per reference (a), enclosure (1) is submitted.

Charles Oscar

Copy to:
file

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FIRST ENDORSEMENT on Monthly Medical Quality Assurance Report

From: Quality Assurance Physician Advisor
To: Commanding Officer
Via: Senior Medical Officer
Executive Officer

Subj: MONTHLY MEDICAL QUALITY ASSURANCE REPORT

1. Concur/Do not concur with minutes as submitted.

2. Comments:

I. M. QAPA

SECOND ENDORSEMENT on Monthly Medical Quality Assurance Report

From: Senior Medical Officer
To: Commanding Officer
Via: Executive Officer

Subj: MONTHLY MEDICAL QUALITY ASSURANCE REPORT

1. Concur/Do not concur with minutes as submitted.

2. Comments:

I. B. SMO

THIRD ENDORSEMENT on Monthly Medical Quality Assurance Report

From: Executive Officer
To: Commanding Officer

Subj: MONTHLY MEDICAL QUALITY ASSURANCE REPORT

1. Concur/Do not concur with minutes as submitted.

2. Comments:

I. M. XO

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MEDICAL DEPARTMENT
USS **AIRCRAFT CARRIER** (CV[N] **XX**)
FPO A**X XXXXX-XXXX**

From: Medical Quality Assurance Coordinator
To: Commanding Officer
Via: (1) Quality Assurance Physician Advisor
(2) Senior Medical Officer
(3) Executive Officer

Subj: MONTHLY MEDICAL QUALITY ASSURANCE REPORT FOR **MONTH YEAR**

Ref: (a) BUMEDINST 6010.13
(b) COMNAVAIRFORINST 6000.1

Encl: (1) Quality Assurance Committee Meeting Attendance Roster
(2) Opportunity Summary List
(3) Monthly Medical Volume Indicators
(4) Preventive Medicine Section
(5) Post Deployment Health Assessment (PDHA) Report
(6) Authorized Minimum Medical Allowance Status
(7) Medical Equipment Report
(8) Medical Provider Outpatient Record Review Report
(9) Medical Department Roster
(10)Any Other Enclosures

1. In accordance with the requirements set forth in references (a) and (b), the Monthly Medical Quality Assurance Report is submitted.

2. Administrative Announcements:

a. **Date of Monthly QA Meeting.** See Enclosure (1).

b. **Note gains, losses, and TAD personnel.**

c. **Other administrative announcements.**

3. Old Business.

a. **Commanding Officers Comments and Follow-up, if applicable.**

b. COMNAVAIRFOR Carrier Medical Department Monthly Report Review Sheet Comments and Follow-up.

c. Quality Assurance Opportunity Summary List Follow-up Comments. See Enclosure (2).

4. New Business

a. Volume Indicators, Preventive Medicine Data, and PDHA: Data reflects USS **AIRCRAFT CARRIER** (CV**(N) XX**) medical activity from **DDMMYY to DDMMYY.** See Enclosures (3) through (5).

b. AMMAL Status: See Enclosure (6).

c. Medical Equipment: See Enclosure (7).

d. Occurrence Screens: **Discuss medical errors, needlestick injuries. Use the following format**:

1) CASE #**0001: Include in Enclosure (10)**
2) Recommendations: **(Also indicate Category I-III)**
3) Actions: **(List each and who has for action)**
4) Follow-up: **(Briefly discuss plan to avoid problem)**

5. Medical Staff Monitors

a. Medical Record Review

1) Outpatient Record Review: See Enclosure (8).

2) Inpatient Record Review: **Comment on number of charts reviewed and problems, if applicable.**

b. Ancillary Services:

(1) Pharmacy: **Comment on type and amount of thrombolytics on board and expiration dates; problems in drug availability; changing patterns of drug usage; cost factors; use of mail order pharmacy; use of pharmo-economic council (PEC) in preparation for deployment, if applicable; issues with Pharmaceutical Prime Vendor (PPV), etc.**

(2) Laboratory: **Comment on last PCR sample submitted and results, status of HIV mail-outs, other laboratory send-outs and limitations in the laboratory, etc.**

(3) Radiology: **Comment on issues with transmitting images, number of images sent out via CD, receipt of radiologist interpretation, etc.**

c. Risk Management

(1) JAGMANS & Congressional Inquiries: **Comment if applicable.**

(2) Patient Satisfaction: **Discuss satisfaction survey results and actions to improve customer service. (Report Annually)**

(3) Infection Surveillance: **Discuss outbreaks such as VGE and any cases of reportable communicable diseases; inpatient nosocomial infections as applicable; measures to reduce incidence of infection (i.e. use of waterless hand sanitizers, crew training, etc.)**

(4) Safety: **Comment on departmental and crew training, if applicable.**

d. Credentials/Licensure

(1) Credentials Status: **"All providers properly credentialed and licenses current". Comment if not current.**

(2) BLS/ACLS/ATLS/CME Status: **Comment if any deficiencies and plan for corrective action.** See Enclosure (9).

(3) Performance Appraisal Report (PAR): **Document completion of and transmittal of PARs.**

(4) PA/IDC/HN Clinical Supervision: **Document completion of appointment letter and supervisor status, i.e. "LT 210X is the primary PA supervisor in Sickcall with (SMO) as secondary supervisor."**

6. Health Promotion Activities: **Discuss educational presentations; counseling sessions; health fairs; tobacco cessation classes; number of PRT failures and body composition assessment failures for spring/fall PRT cycles; discuss plan for improving physical fitness among crew; and health promotion plan in preparation for deployment, etc.**

Respectfully submitted,

I. M. QAC

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MEDICAL DEPARTMENT
USS **AIRCRAFT CARRIER** (CV[N] **XX**)
FPO A**X XXXXX-XXXX**

QUALITY ASSURANCE COMMITTEE MEETING ATTENDANCE ROSTER												
KEY: P- PRESENT E- EXCUSED A- ABSENT L- LEAVE T- TAD												
	JAN **YEAR**	FEB **YEAR**	MAR **YEAR**	APR **YEAR**	MAY **YEAR**	JUN **YEAR**	JUL **YEAR**	AUG **YEAR**	SEP **YEAR**	OCT **YEAR**	NOV **YEAR**	DEC **YEAR**
NAME SMO												
NAME GMO: QAPA												
NAME NURSE: QAC												
NAME PA												
NAME MAO												
NAME PT												
NAME CP												
NAME RHO												
NAME SURGEON												
NAME LCPO												
NAME IDC												
NAME IDC												
NAME												
NAME												

Enclosure (1)

OCT 21 2005

MEDICAL DEPARTMENT
USS **AIRCRAFT CARRIER** (CV[N] **XX**)
FPO A**X XXXXX-XXXX**

QUALITY ASSURANCE OPPORTUNITY SUMMARY LIST *(FORMERLY PROBLEM SUMMARY LIST)*					
NUMBER	**DATE**	**DESCRIPTION**	**ACTION OFFICER**	**FOLLOW-UP DATE**	**RESOLUTION DATE**
#001	*01JAN05*	*BIRTH MONTH RECALL*	*LT XXXXXX*	*01MAR05*	
#001					

Enclosure (2)

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USS (AIRCRAFT CARRIER) CV[N] (XX) MONTHLY MEDICAL VOLUME INDICATORS FOR (MONTH YEAR)				1
MONTH/YEAR:	**XXX**	**XXX**	**XXX**	**COMMENTS**
PATIENT VISITS				
Sick Call				*Number Reporting For Health Care During Sick Call Hours*
Other Acute Care / Appointments				*Number Reporting Outside of Designated Sickcall Hours, for Emergencies, Follow-up Visits, & Appointments*
Physical Exams				*Number Completed During the Month*
Birth Month Recall				*Number Reporting for BMR; Place Asterisk & Comment if under 90%*
Preventive Medicine				*Number Screened or Treated by PrevMed Techs; BMR not Included*
Physical Therapy				*Number Seen by Physical Therapist & Physical Therapy Tech*
Psychology				*Number Seen by CP & Psych Tech; Include Group Therapy Patients*
General Surgery				*Number Seen by General Surgeon Outside of Sickcall*
SARP				*Number Screened, Attending Classes, & Attending Group Sessions*
TOTAL OUTPATIENT VISITS				*Total Number of Previous 9 Sections*
PHYSICAL EXAMS				*Total Number for Each Category During the Month*
Flight PE				
Periodic (5yr)				
Separation/Retirement				
Flight Deck Screen				
Radiation Health				
Other				*Use for Exams Not Covered Such as Diving, Commissioning, etc.*
SURGICAL PROCEDURES				*Number for Each Category; Comment on Unusual or Major Cases*
Minor Surgical Procedures				*Number of Procedures Using Local Anesthesia*
Outpatient				*Number of Procedures Using Conscious Sedation*
Inpatient				
Surgical Procedures at local MTF				*Number of Major & Minor Surgical Procedures Performed by Ship's Surgeon at Local Military Treatment Facility While in Port*
INPATIENT SERVICES				
Admissions				*Patients Admitted for Less than 24 Hours are Also Included Here*
Total Inpatient Days				
Average Inpatient Days				*Divide Number of Total Inpatient Days By Number of Admissions*
Med Hold Admissions				*Number of Patients Held on Ward But Not Admitted*

Enclosure (3)

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USS (AIRCRAFT CARRIER) CV[N] (XX) MONTHLY MEDICAL VOLUME INDICATORS				2
MONTH/YEAR:	**XXX**	**XXX**	**XXX**	**COMMENTS**
ANCILLARY SERVICES				*Total Number for Each Category During the Month*
X-ray Exposures				
Technically UNSAT Rate				*Comment if >1% on Films by Rad Tech & if >3% for OJT Personnel*
Lab Procedures				
Pathology Specimens				
Pharmacy Prescriptions				
Over the Counter Medications				
Optical Fabrications				
Audiograms				
Annual				
Follow-up/Re-test				
Referrals to audiologist				*Number Sent to a Definitive Medical Treatment Facility*
ADMINISTRATION				
Medical Screening				*Number of Screenings During the Month; Includes Firefighting, Security Clearance Reviews, Overseas Screenings, etc.*
Civilian Billings				*Number of Claims for Civilian Care*
Other Limited Services				*Number of Other Items Not Covered in Previous 2 Categories*
MEDICAL EVACUATIONS				
Incoming				*Number of Patients Received from Other Units*
Outgoing				*Number Sent To a Medical Treatment Facility*
OTHER				*Number for Each Category During the Month*
Number of Consults				
Consults Pending				
Personnel Lost to Medical Board				
Accident/Injury Reports				
PREGNANCY INCIDENCE				
Positive HCGs				*Number of New Cases for the Month*
Female Crew Size				*Includes those Embarked for Deployment*
Pregnancy Incidence Rate				*Divide the Number of New Pregnancies During the Month by the Number of Females Assigned to the Ship, & Multiply by 100*

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USS (AIRCRAFT CARRIER) CV[N] (XX) MONTHLY MEDICAL VOLUME INDICATORS				3
MONTH/YEAR:	**XXX**	**XXX**	**XXX**	**COMMENTS**
SARP				*Number of Patients (Not Number of Sessions) for Each Category*
Screened				
IMPACT				
Level I (Outpatient)				
Level II (Intensive Outpatient)				
Continued Care Support Group				
Other				*Include ADAMS for Managers/Supervisors*
WALKING BLOOD BANK				
Number Enrolled in Program				*Total Number of Crewmembers Registered, Screened, & Completed DD Form 572; Comment if <10% of Ship's Company*
MEDICAL DRILLS & RESPONSES				*Enter Number for Each Category During the Month*
Actual Medical Responses				*Comment on Problems Encountered*
Medical Response Team Drills				
Mass Casualty Drills				
Other Drills				*i.e. Contaminated Injured Man/Sailor, Deep Trunk Rescue*
CONTROLLED SUBSTANCES INVENTORY				*Enter Date of Most Recent CSIB Inventory Performed*
Quarterly Inventory Completed				*Comment on Unusual Findings or Any Discrepancies*
SEMI-ANNUAL HEALTH RECORD INVENTORY				
Health Record Inventory				*Enter the Date of the Last Health Record Inventory; Comment on Discrepancies Between the Wall-to-Wall Inventory & the Alpha Roster*

USS (AIRCRAFT CARRIER) CV[N] (XX) PREVENTIVE MEDICINE SECTION				1
MONTH/YEAR:	**XXX**	**XXX**	**XXX**	**COMMENTS**
MEDICAL & DENTAL PERSONNEL				*Enter the Percent Readiness by Using the SAMS Inquiry Module Readiness (%) = "Each Item Current" Divided By "Each Item Required", Multiply Results by 100; Comment if Any Category < 100%*
Hepatitis A				
Hepatitis B				
HIV				
MMR				
PPD				
# OF MED/DENT PERSONNEL				*Enter Total Number of Medical & Dental Personnel During the Month*
CREW READINESS				*Enter the Percent Readiness by Using the SAMS Inquiry Module Readiness (%) = "Each Item Current" Divided By "Each Item Required", Multiply results by 100; Comment if Any Category < 90%*
Hepatitis A				*If TwinRx – Must Have 3 Shot Series*
Hepatitis B				*If Started, Must Complete 3 Shot Series*
MMR				*Documented Receipt of Vaccine at or After Age 12*
Tetanus				
Yellow Fever				
Typhoid				
Anthrax				
Smallpox				
PPD/Converter Screen				
Influenza				*Include Date Immunizations Completed for Entire Crew*
DNA				*Comment if < 100%*
HIV				*HIV neg result documented in record within 60 days of blood draw*
Physical Examination				*Every 5 Years For Age <50; Every 2 Years For 50-59; Annually >60*
Reference Audiogram				
Women's Health Exam				
OVERALL MEDICAL READINESS				*Average of All Categories Above*
TOTAL CREW SIZE				*Enter Total Crew Size During the Month*

Enclosure (4)

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USS (AIRCRAFT CARRIER) CV[N] (XX) PREVENTIVE MEDICINE SECTION				2
MONTH/YEAR:	**XXX**	**XXX**	**XXX**	**COMMENTS**
SEXUALLY TRANSMITTED DISEASES				*Enter Number of New Cases & Calculate the STD Incidence Rate*
Gonorrhea				
NGU				
Chlamydia				
Syphilis				
Other				
STD Incidence Rate				*Comment on Incidence Rate if Exceeding 0.50%*
TUBERCULOSIS CONTROL PROGRAM				*Enter Number for Each Category During the Month*
New Reactors Identified				*If Converters >2.5%; Comment on Findings of Investigation*
Old & New Reactors Onboard				
# on INH Therapy				
REPORTABLE DISEASES				*Enter Number Submitted During the Month*
Medical Event Reports				
FOOD SERVICE INSPECTIONS				*Comment on Current Month's Critical Violations & Any Repeat Non-Critical Violations*
EXAMPLE	*1C/0NC*	*2C/3NC*		*Report Total Critical (C) & Non-Critical (NC)Violations For Each Month*
CO's Galley				
CPO Mess				
Enlisted Galley-Aft				
Enlisted Galley-Fwd				
Flag Mess				
Wardroom I & II				
Wardroom III				
PEST CONTROL				*Enter Number for Each Category During the Month*
Total Surveys				
Infestation				
Treatment				
WATER TESTING				*Enter Number for Each Category During the Month*
Total Halogen Samples				
Total Negative Halogen Residual				
Total Water Cultures				
Total Positive (Coliform) Cultures				

USS (AIRCRAFT CARRIER) CV[N] (XX) PREVENTIVE MEDICINE SECTION		3
OTHER INSPECTIONS/QUALIFICATIONS- CY XXXX		
QUARTERLY	**DATE PERFORMED**	**COMMENT**
CHT system		
Barber Shops		
Laundry		
Dry Cleaning		
Storerooms		
Brig		
Berthing/Heads		
Gymnasiums		
SEMI-ANNUALLY	**DATE PERFORMED**	**DUE DATE**
De-Rat Certificate		
PEST CONTROL OPERATORS	**DATE CERTIFIED**	**DUE DATE**

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USS (AIRCRAFT CARRIER) CV[N] (XX) PREVENTIVE MEDICINE SECTION				4
BIRTH MONTH RECALL- CY XXXX				
MONTH	**# DUE**	**# DONE**	**% DONE**	**COMMENT IF BELOW 90%**
January				
February				
March				
April				
May				
June				
July				
August				
September				
October				
November				
December				
OCCUPATIONAL HEALTH MONITORING				
OCCUPATION	**# IN PROGRAM**	**# CURRENT**	**PERCENT**	**COMMENTS**
Asbestos				
Cadmium				
Cholinesterase				
CHT Worker				
Explosive Driver				
Forklift Driver				
Hearing Conservation				
Isocyanates				
Laser				
Lead				
Otto Fuel				
Respirator				
Tetrachloroethylene				
Welder				

USS (AIRCRAFT CARRIER) CV[N] (XX) POST DEPLOYMENT HEALTH ASSESSMENT REPORT				
MONTH/YEAR:	**XXX**	**XXX**	**XXX**	**COMMENTS**
POST DEPLOYMENT HEALTH ASSESSMENT				*These Numbers Reflect Personnel Due for Birth Month Recall and are Not a Reflection of the Entire Ship's Crew*
Personnel Deployed				*Enter Number Currently Deployed*
Personnel Redeployed				*Enter Number who Deployed and Returned During the Past Year*
Personnel Completing DD 2796 Form				*Enter Number Redeployed, who Completed the DD 2796 Form*
Personnel Completing a Post-Deployment Blood Draw				*Enter Number Redeployed, who Completed the Post Deployment Blood Draw*
Personnel Requiring a Referral/Consult as a Result of PDHA Screening				*Enter Number Redeployed, who Required a Referral/Consult as a Result of the PDHA*
Personnel Completing Initial Referral Evaluation				*Enter Number Requiring a Consult, who Completed the Initial Referral*
DD 2796 Forms Forwarded to the Army Medical Surveillance Activity				*Enter Number of Completed DD 2796 Forms, which were Forwarded to the Army Medical Surveillance Activity*

Enclosure (5)

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USS (AIRCRAFT CARRIER) CV[N] (XX) AUTHORIZED MINIMUM MEDICAL ALLOWANCE STATUS					
MONTH/YEAR:		**XXX**	**XXX**	**XXX**	**COMMENTS**
TITLE	**OSI**	**% ON BOARD**			*Enter AMMAL Percentage For Each Month*
Computed Radiography	905				
Basic Antidote Locker	925				
First Aid Box	927				
BMET Afloat	937				
Junior Emergency Response Kit	944				
Battle Dressing Station	955				
Mass Casualty Box	963				
Optician Allowance	1012				
Core	1013				
Supplemental	1014				
Laboratory Core	1015				
Laboratory Supplemental	1016				
Women at Sea	1017				
Physical Therapy	1028				
Force Health Protection	1031				
Actual % Of Total Quantity On Board:					

Enclosure (6)

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USS (AIRCRAFT CARRIER) CV[N] (XX) MEDICAL EQUIPMENT REPORT - CUMULATIVE CY XXXX							
EQUIPMENT UNDER REPAIR							
AMMAL	RIN (Repair ID #)	NSN	NOMENCLATURE	MAKE/MODEL	SERIAL NUMBER	DATE DOWN	COMMENTS
	From OMMS-NG						
NEW EQUIPMENT RECEIVED							
AMMAL	RIN	NSN	NOMENCLATURE	MAKE/MODEL	SERIAL NUMBER	DATE RECEIVED	COMMENTS

Enclosure (7)

OCT 21 2005

USS (AIRCRAFT CARRIER) CV[N] (XX) MEDICAL PROVIDER OUTPATIENT RECORD REVIEW FOR (MONTH YEAR)			
PROVIDER	**NEW PATIENT VISITS**	**RECORDS REVIEWED (10% of New Patient Visits)**	**COMMENTS**
CDR X. X. XXXXXXXX Senior Medical Officer			

Enclosure (8)

USS (AIRCRAFT CARRIER) CV[N] (XX) MEDICAL DEPARTMENT ROSTER									1
RANK/ RATE	LAST NAME	FIRST NAME	DESIGNATOR NEC	LICENSE EXPIRE	PRD	**BLS EXPIRE	**ACLS EXPIRE	**ATLS EXPIRE	CME TO DATE

**Provide comments in Administrative Announcements if Provider's certifications are expired and explain plan for recertification.

Enclosure (9)

USS (AIRCRAFT CARRIER) CV[N] (XX) MEDICAL DEPARTMENT ROSTER									2
RANK/ RATE	LAST NAME	FIRST NAME	DESIGNATOR NEC	LICENSE EXPIRE	PRD	BLS EXPIRE	ACLS EXPIRE	ATLS EXPIRE	CME TO DATE

APPENDIX F

Medical Evacuation Checklist

USS ALWAYS AT SEA (CVN xx)
MEDICAL EVACUATION (MEDEVAC) CHECKLIST

Patient Name:	**Unit:**	**Date:**	**MEDEVAC #:**

Points of Contact List

Duty Flight Surgeon		Flight Deck BDS	
Ship's CO		Flight Deck Control	
Ship's XO		Cognizant HOD	
HEC		TFCC	
Strike OPS		TAO	
Gun Boss		DESRON COS; CAG or DCAG	
Ordnance Control		TYCOM	

Referring Clinician

1	Contact SMO and MAO	Complete ☐
2	Contact receiving physician at MTF (with assist of MAO as needed)	Complete ☐
3	Give name of receiving physician and hospital location to MAO	Complete ☐
4	Prescribe transport meds for Nurse	Complete ☐
5	Fill out consultation form	Complete ☐
6	Finish paperwork (History and Physical, orders, etc)	Complete ☐
7	Ensure patient knows the plan (receiving MD, location)	Complete ☐

Nurse

1	Coordinate with clinician for enroute meds/equipment	Complete ☐
2	Copy all orders and paperwork	Complete ☐
3	Give the COPIES of the orders/paperwork and the ORIGINAL CHART to the flight surgeon for transport to MTF (We keep the ORIGINALS of the orders/paperwork)	Complete ☐
4	Give medications and equipment to the flight surgeon (medications the clinician ordered).	Complete ☐
5	Gather the patient chart, the copies of the orders/paperwork, and contact information; place with the patient	Complete ☐
6	Check: a. Clothes/bag with essential belongings packed and available in the medical department? If no, contact Medical LCPO b. TAD orders? If no, contact MAO c. Direct the patient to bring medical record back from MTF? d. Ensure patient has: contact information, phone number of main medical, instructions post evaluation	Complete ☐ Complete ☐ Complete ☐ Complete ☐

MAO

1	Establish communications with hospital for clinician.	Complete ☐
2	Notify ATO	Complete ☐
3	Complete ATO request	Complete ☐
4	Complete Aeromedical clearance	Complete ☐
5	Ships Company: TAD orders full cost 30 days – Training Officer	Complete ☐
6	For CVW personnel : TAD orders full cost 30 days – Squadron AO	Complete ☐
7	Landing zone preparation COD: coordinate beach detachment transport HELO: coordinate MTF landing pad preparations	Complete ☐
8	Instruct patient in reporting procedures post release	Complete ☐
9	Write and send notification message	Complete ☐

LCPO

1	For ship's company, notify CMDCM	Complete ☐
2	For embarked personnel, notify CMDCM	Complete ☐
3	For ship's company, notify cognizant LCPO	Complete ☐
4	Notify originating unit/department of need for sea bag	Complete ☐
5	Form a team to transport patient from medical to ATO staging area or Flight Deck BDS	Complete ☐

Flight Surgeon

1	For CVW personnel: a. Notify Squadron CO/XO b. Notify CAG or Deputy CAG	Complete ☐
2	Check Aeromedical suitability	Complete ☐
3	Ensure records and appropriate gear onboard for transport	Complete ☐
4	Advise and assist transport patient from medical to receiving hospital (as necessary.)	Complete ☐
5	Ensure receiving clinician receives medical documentation / records	Complete ☐

Flight Deck BDS

1	SMO should brief flight deck medical and Flight Deck Control on the upcoming MEDEVAC, time, etc. All transportation via any elevators should have been arranged prior to times of transport and briefing.	Complete ☐
2	Receive notice from Main medical on the patient with all patient information and status and expected time for departure.	Complete ☐
3	Notify flight deck control and Handler on patient and expected time and route of receiving patient, either ambulatory or upper stage elevator, etc.	Complete ☐
4	Gather flight deck stretcher-bearers for transport and have them standing by at the proper location.	Complete ☐
5	Make sure all necessary equipment is ready to go or gather up any additional equipment that may be required.	Complete ☐
6	Patient should be received and escorted by either ATO to Flight deck BDS or by an escort from Medical, which does a turnover with a flight deck HM.	Complete ☐
7	When patient arrives, give them a flight deck safety	Complete ☐

	brief, time of departure, and address concerns they may have or issues we need to address with them.	
8	Notify Flight deck control and HANDLER that the patient has arrived and is standing by in Flight deck BDS. Flight deck control should be notified on the status and condition and any special instructions that may be needed or required from the flight deck HM.	Complete ☐
9	Flight deck HM's will ensure that all gear and patient belongings go with the patient, and ensure that the patient is stable and ready for transport.	Complete ☐
10	Once cleared for transport, 1 or 2 flight deck HM'2 will escort the patient with flight deck stretcher bearers to the COD or HELO, and ensure that they are secured and all safety precautions are taken and that any special equipment…(O2, Meds, etc) are secured and with the patient.	Complete ☐
11	Once the patient is loaded and secured, Flight deck medical will notify HANDLER and Flight deck control that the patient has been turned over to the COD or HELO Crew. Flight deck medical will call main medical and give a final status that the patient has been turned over and is departing.	Complete ☐

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APPENDIX G

Decedent Affairs

CONTENTS OF THE "DEATH PORTFOLIO"

1. The following items are to be maintained in each "Death Portfolio".

   a. Check List for Completion of Death Procedures

   b. Brief Summary of Decedent Affairs Program benefits when NOK (next of kin) prepares own arrangements

   c. Sample- Receipt for Remains of the Deceased Letter

   d. Remains Identification Tag

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CHECK LIST FOR COMPLETION OF DEATH PROCEDURES					
Name (Last, First, Middle)					
Rate/Rank		**SSN**			
Division/Squadron					
Time/Date of Death					
				YES	**NO**
Notify Commanding Officer (Medical Officer)					
Notify Executive Officer (Medical Officer)					
Notify Disbursing Officer (Personnel Officer)					
Notify NCIS Agent (OOD/Medical)					
Information provided to Personnel Officer: Initiates priority Personnel Casualty Report message to BUPERS					
Death Certificate roughed out (Medical Officer) **CONUS – Civil Death Certificate **OCONUS - DD 2064					
Remains tagged and wrapped (Medical Department)					
Receipt for remains obtained (if civilian, funeral home picks up remains aboard ship)					
Information provided for appropriate entries in ship's log (Medical)					
Inventory personal effects (Division Officer)					
** Signed copy of NAVSANDA 29 sent with effects					
** Signed copy of NAVSANDA 29 retained on file					
Complete ten (10) copies of DD 2064 or Civil Death Certificate for distribution (Medical Department)					
Certified copy of civil death certificate obtained (if applicable) (Personnel/Casualty Assistance Calls Officer)					
Commanding Officer's letter of condolence to next of kin (BUPERSMAN 4210140) (Personnel Office)					
Terminate Health Record (Medical Department)					
Terminate Service Record (Personnel Office)					
Initial brief to escort (Personnel Officer/Medical Admin. Officer)					
Provide copy of escort manual to escort (Personnel Officer/Medical Admin. Officer)					

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Brief Summary of Decedent Affairs Program benefits when NOK makes own arrangements:

Reference: BUMEDINST 5360.1 (series), Decedent Affairs Manual

1. Reimbursement for expenses in an amount not to exceed the appropriate authorized allowance, as follows:

a. Preparation and encasement of the remains:

(1). Where an Armed Forces contract or mortuary is not available, an amount not to exceed $750.00.

(2). What procurement would have cost the Navy in an area where an Armed Forces contract or mortuary is available but not utilized in accordance with the wishes of the NOK. The CACO shall obtain a signed statement from the NOK refusing the Armed Forces contract or mortuary services.

b. Transportation: Reimbursement may be made in an amount not to exceed the amount transportation would have cost the Government.

c. Funeral and burial expenses:

(1). Where burial is made in a private cemetery, an amount not to exceed $900.00.

(2). Where remains are consigned to a funeral director designated by NOK prior to burial in a national cemetery or burial at sea, an amount not to exceed $475.00.

(3). Where remains are consigned directly to a national cemetery or to a naval activity or ship for burial at sea, an amount not to exceed $75.00.

NOTE: DD Form 1375, Request for Payment of Funeral and/or Internment Expenses, should be used by the NOK for submitting a claim for reimbursement or payment of primary expenses, transportation and secondary expenses when services of the Government were not utilized. The DD 1375 will be provided by the CACO. BUMEDINST 5360.1 (series), Section 11.

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Sample- Receipt for Remains of the Deceased Letter

From: (Full name and business address of civilian mortuary)

To: Commanding Officer, USS ALWAYS SAIL, Norfolk, Virginia

Subj: RECEIPT FOR REMAINS

1. Receipt is acknowledged of the remains of the late

_____
(Full name, rank/rate, service/file number of deceased)

_____
(Signature of mortuary representative)

_____
(Printed full name and position of representative signing receipts)

WITNESS:

_____
(Signature of command representative)

_____
(Printed rank/rate, name and position)

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REMAINS IDENTIFICATION TAG

First	**Middle**	**Last Name in Full**
Rank/Rate		**Branch of Service**
SSN		

A heavy duty string tag shall be affixed to the right great toe of remains and both outside ends of transfer case, legibly inscribed with required complete identification.

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APPENDIX H

Crash Cart Contents

1. At a minimum, crash carts shall contain the following medications:

Medication	NSN	Quantity
Adenosine 6mg/2ml	6505-01-518-4153	3 syringes
Albuterol Inhaler Soln	6505-01-258-0960	3 ampules
Amiodarone HCL 150mg/3ml	6505-01-423-2851	8 ampules
Ammonia Inhalents	6505-00-106-0875	8 ampules
Aspirin 325 mg tabs	6505-00-153-8750	1 bottle
Atropine 1mg/10cc	6505-01-094-6196	4 bristojets
Calcium Chloride 10%	6505-00-865-2401	5 vials
Calcium Chloride	6505-00-139-4548	3 bristojets
Dexamethasone 4mg/ml 5 ml	6505-01-522-5164	1 vial
Dextrose 50% 25gms/50ml	6505-01-501-5408	1 bristojet
Digoxin 2ml	6505-00-531-7761	2 ampules
Diltiazem HCL 5mg/ml 10 ml	6505-01-353-9827	2 vials
Diphenhydramine 50mg/ml	6505-00-148-7177	2 tubex
Dopamine 800mcg/ml, 250 ml	6505-01-148-0288	1 bottle
Enoxaparin Inj 30mg/3ml	6505-01-377-1444	10 syringes
Epinephrine 1:10,000 10 ml	6505-01-093-2384	6 bristojet
Epinephrine 1:1000 1ml	6505-00-299-8760	5 ampules
Esmolol Hydrochloride	6505-01-520-7737	2 vials
Furosemide 10mg/ml	6505-00-157-5117	2 ampules
Glucagon Kit	6505-01-466-7505	1 kit
Heparin 50,000u/ml, 500cc	6505-01-377-0444	1 bag
Heparin 1000u/ml	6505-01-515-3167	2 vials
Heparin 20,000 u/ml	6505-01-331-3039	1 vial
Labetalol 5mg/ml 20ml	6505-01-244-7982	4 vials
Lidocaine 5%, 250 ml	6505-01-194-7266	1 bag
Lidocaine 100mg/5cc	6505-01-277-5724	4 bristojets
Magnesium Sulfate 1gm/2ml	6505-01-301-8175	3 vials
Mannitol 25% 50ml	6505-01-125-3253	2 vials
Methylprednisone 1000mg	6505-01-108-0808	1 CO
Metoprolol 5mg/5ml	6505-01-309-2742	3 vials
Naloxone 0.4 mg/ml	6505-00-079-7867	10 ampules
Nitroglycerine 250 ml	6505-01-343-2489	1 bag
Nitroglycerine Lingual	6505-01-486-0542	1 bottle
Nitroglycerine Ointment	6505-01-008-3401	1 tube
Phenylephrine Hydrochloride	6505-00-104-9320	8 vials
Phenytoin Sodium 50mg/ml	6505-01-332-9024	1 vial
Procainamide 500mg/ml	6505-00-153-3842	2 vials
Propranolol 1mg/ml 1 ml	6505-00-106-7394	2 vials
Sodium Bicarb 8.4% 1meq/ml	6505-00-139-4561	2 bristojets
Sodium Chloride Inj 10 ml	6505-00-287-0626	5 vials
Sodium Nitroprusside 50mg/2ml	6505-01-009-5019	1 bottle
Terbutaline Sulfate, 1mg/ml	6505-01-013-9941	2 ampules
Vasopressin 20units/ml	6505-00-684-8625	2 vials
Verapamil 5mg/2ml	6505-01-131-3855	5 ampules

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2. At a minimum, crash carts shall contain the following medical equipment and supplies:

ACLS Algorithms			
Ambu-bag	6515-01-061-7812	1	
Anesthesia Cart	6530-01-294-3297	1	
Adhesive tape, 2 inches	6510-00-926-8883	2	rolls
Adhesive tape, 2 inches	6510-00-926-8882	2	rolls
Arterial Catheter, radial	6515-01-376-7473	1	kit
Arterial Pressure tubing	6515-01-271-5678	1	ea
Administration set, IV	6515-01-519-9210	2	sets
Administration set, IV macro	6515-00-117-9021	2	sets
Alcohol pads	6510-00-786-3736	1	box
Benzoin Tincture applicator	6510-01-240-4514	1	pkg
Basin, Emesis	6530-00-770-9220	1	
Batteries, “D” cell	6135-00-985-7845	2	
Blade, surg knife #1	6515-00-660-0010	1	
Bite block	6515-01-164-2820	1	
Blood Gas Kit	6550-01-294-3297	1	
Catheter, Introducer	6515-01-181-8239	1	
Carbon Dioxide Detector	6515-01-369-7974	2	
Catheterization kit	6515-01-260-6698	1	
Catheter Kit, urethral	6515-00-149-0104	1	
Connection tubing, oxygen	6515-01-520-8791	2	
Connection tubing, suction	6515-01-370-3201	1	
Connector, tube	6515-01-926-9201	5	
Cricothyrotomy Set	6515-01-459-4834	1	
Defibrillator Pad	6651-01-443-0565	1	
Dextrose, 250ml bag	6505-01-462-1912	1	
ECG electrode pads	6515-01-377-3836	5	ea
Electrode Gel	6515-01-085-8035	1	tube
Extension Set, IV	6515-01-377-3836	2	
Forceps, Magill	6515-00-332-3300	1	
Gloves, Sterile, 6.5	6505-01-149-8839	2	Pr
Gloves, Sterile, 7.0	6505-01-149-8840	2	Pr
Gloves, Sterile, 8.0	6505-01-149-8842	2	Pr
Gloves, non-sterile, Med	8415-01-352-6553	1	box
Handle, knife, surgical	6515-00-344-7820	1	
Holder, Tracheal Tube	6515-01-245-2115	1	
Infuser, Pressure, blood-IV	6515-00-128-2150	1	
IV Catheter, 16 ga	6515-01-337-3681	5	
IV Catheter, 18 ga	6515-01-336-5874	5	
IV Catheter, 20 ga	6515-01-337-3582	5	
Lab tube, 7ml, red	6630-00-145-1137	3	
Lab tube, lavender	6630-01-061-2282	3	
Lab tube, blue	6630-01-343-7521	3	
Lactated Ringers 1000ml	6505-01-462-3025	1	
Laryngoscope, Macintosh	6515-00-656-5052	1	
Laryngoscope, bulb, extra	6515-01-360-5822	1	
Lubricant, Surgical	6505-00-153-8809	1	tube
Miller Blade #3.0	6515-01-264-0365	1	
Miller Blade #4.0	6515-01-527-2286	1	
Mask, non-rebreathing	6515-01-164-3755	2	ea
Nasal Cannula	6515-01-473-7526	1	
Nasogastric Sump	6515-00-917-1912	1	
Nasopharyngeal airway, 28	6515-01-180-0467	2	
Nasopharyngeal airway, 34 F	6515-01-125-0121	2	

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Nebulizer, plastic	6515-01-267-1490	1
Needle, hypodermic, 18ga	6515-00-754-2834	5 ea
Needle, hypodermic, 21ga	6515-00-754-2838	5 ea
Needle, hypodermic, spinal	6515-00-209-1197	1 ea
Needle, particulate, filter	6515-01-114-1101	1 ea
Oral Airway, 70mm	6516-01-344-6118	1
Oral Airway, 90mm	6515-01-240-3851	1
Provodone Iodine solution	6505-00-491-7557	1 bottle
Scissors, bandage	6515-00-935-7138	1
Sharps Container	6530-01-172-6992	1
Sodium Chloride, 100ml bags	6501-01-462-2118	2
Sodium Chloride, 250 ml bags	6501-01-462-2432	2
Sodium Chloride, 1000 ml bags	6501-01-462-2436	2
Sphygmomanometer	6515-01-039-4884	1
Stethoscope	6515-01-314-6694	1
Stopcock, 3-way	6515-01-035-7962	1
Stylet	6515-01-394-8327	1
Suction catheter, 10 Fr	6515-00-458-8413	2
Suction catheter, 18 Fr	6515-00-458-8416	2
Suture, nonabs 2-0	6515-01-075-8288	2
Syringe & Needle, 23ga/3cc	6515-00-149-1206	5
Syringe & Needle, insulin	6515-00-172-1090	5
Syringe & Needle, tuberculin	6515-00-982-4205	5
Syringe, 5cc	6515-00-754-0406	5
Syringe, 10cc	6515-00-754-0412	5
Syringe, irrigating, 60ccc	6515-01-500-9382	1
Tongue Depressors	6515-00-324-5500	1
Tracheal Tube 7.0	6515-01-105-0744	2
Tracheal Tube 7.5	6515-01-233-4365	2
Tracheal Tube 8.0	6515-01-105-0759	2
Tracheal Tube 8.5	6515-01-023-0860	2
Tube, Penrose	6515-01-385-1697	2
Tubing, oxygen, connection	6515-00-562-8308	1
Tubing, blood administration	6515-01-519-9210	2
Yankaur	6515-00-137-1584	1

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APPENDIX I

SAMPLE SURGICAL FORMS

1. Major Surgical Procedure. The following forms will be used to document a major surgical procedure:

e. Consent Form: Use SF-522

f. Informed Consent Note: Use SF-509

g. Abbreviated Medical Record: Use SF-539

h. Doctor’s Orders: Use SF-508

2. Minor Operative Procedure: The following forms will be used to document a minor surgical procedure:

b. Consent Form: Use SF-522

3. Upper GI Endoscopic Procedure. The following forms will be used to document an upper GI endoscopic procedure:

d. Consent Form: Use SF-522

e. Abbreviated Medical Record: Use SF-539

f. Doctor’s Orders: Use SF-508

4. Lower GI Endoscopic Procedure. The following forms will be used to document a lower GI endoscopic procedure:

b. Modified Duty Authorization Chit.....I-6

c. Elective Surgery Memorandum.....I-7

d. Consent Form: Use SF-522

e. Abbreviated Medical Record: Use SF-539

f. Doctor's Orders: Use SF-508

5. Vasectomy Procedure. The following forms will be used to document a vasectomy procedure:

a. Surgical Site Verification Checklist.....I-3

b. Anesthesia Questionnaire.....I-4

c. Modified Duty Authorization Chit.....I-6

d. Elective Surgery Memorandum.....I-7

e. Consent Form: Use SF-522

f. Surgical Sterilization Counseling Form.....I-11

g. Vasectomy Operation Report.....I-12

f. Informed Consent Note: Use SF-509

g. Abbreviated Medical Record: Use SF-539

h. Doctor's Orders: Use SF-508

SURGICAL SITE VERIFICATION CHECKLIST

PreOP RN: Complete 1-5

1. Name _____ 2. Surgeon _____

3. DOS _____ 4. Procedure _____

LEFT _____ **RIGHT**

anatomic site

5. Verify the presence of the following documents:

__ H&P SF 600
__ Consent for Operation/Procedure
__ Anesthesia Preop Note
__ Perioperative Nursing Note
__ Imaging Studies (as indicated)

PLEASE ATTEST THAT THE PROPOSED PROCEDURE AND SITE ARE CORRECTLY INDENTIFIED:

6. Patient _____ Date & Time _____

7. RN _____ Date & Time _____

8. Anesthesia _____ Date & Time _____

9. Primary Surgeon _____ Date & Time _____

Notes

Addressograph

ANESTHESIA QUESTIONNAIRE Planned Day of Surgery: _____ Page 1

Modern anesthesia is very safe, but like any medical procedure there are risks. Major problems, even death or major disability can occur even in the best situations, but are very rare. Before surgery, an anesthesia provider will interview you and at that time the risks and benefits of the types of anesthesia will be fully discussed with you and a final choice made. Feel free to ask questions about your anesthesia care.

Please complete and sign the following questionnaire. This will be reviewed by the Anesthesia staff and will be very helpful in determining the most appropriate anesthetic for you.

Name	Age	Height (Inches)	Weight (Pounds)	Telephone #

Planned Surgical Procedure	Any allergies (Medications, Foods, Latex)?
	If Yes, type of Reaction

LIST PREVIOUS SURGERIES / TYPES OF ANESTHESIA

Date (Approximate)	Procedure (If not sure, what part of body)	Anesthetic (general, Spinal, etc.)	Problems, if any with anesthesia or surgery?

Has anyone in your family had problems with anesthesia? ___ YES ___NO If yes, what type: _____

Do you or have you ever smoked? __YES __ NO How Much _____ Pk/day, Years _____ Quit? Y N When? _____

How many alcoholic drinks:(Average per week): _____

Have you ever had a blood transfusion? __ YES __ NO If Yes, Any Reaction? _____

Have you had a cough or cold in the last 2 weeks? __ YES __ NO _____

What medication do you take regularly? (Include eye drops, aspirin, Motrin, birth control pills, vitamins, herbal remedies)

_____

_____

In the last 6 months have you taken steroid medications (Prednisone Hydrocortisone, ACTH, etc.)? __Yes __No

What medications and When? _____

Physical Activity: __ Limited __ Moderate __ Very Active

Type of exercise (if any)- Walking Swimming Running Other: _____

Addressograph Imprint

ANESTHESIA QUESTIONNAIRE Planned Day of Surgery: _____ Page 2

PATIENT TO COMPLETE TOP PART OF PAGE

MEDICAL HISTORY- Have you ever had?

High Blood Pressure (2)	⌊YES	⌊NO	Back Pain/Neurological Symptoms(2)	⌊YES	⌊NO
Heart Disease / Heart Attack (5)	⌊YES	⌊NO	Stroke (5)	⌊YES	⌊NO
Chest Pain / Angina (5)	⌊YES	⌊NO	Epilepsy / Seizures (2)	⌊YES	⌊NO
Heart Failure (5)	⌊YES	⌊NO	Head Injury/Loss Consciousness	⌊YES	⌊NO
Irregular Heart Beat	⌊YES	⌊NO	Rheumatoid Arthritis (4)	⌊YES	⌊NO
Rheumatic Fever	⌊YES	⌊NO	Bleeding Tendencies (3)	⌊YES	⌊NO
Pneumonia within past year (3)	⌊YES	⌊NO	Anemia within last year (2)	⌊YES	⌊NO
Emphysema/ Chronic Bronchitis (4)	⌊YES	⌊NO	Thyroid Problems (2)	⌊YES	⌊NO
Asthma/ Wheezing (3)	⌊YES	⌊NO	Diabetes (5)	⌊YES	⌊NO
Sleep Apnea (2)	⌊YES	⌊NO	Kidney Disease (3)	⌊YES	⌊NO
Jaundice/ Hepatitis (2)	⌊YES	⌊NO	Mental Illness/ Depression (1)	⌊YES	⌊NO
Stomach/ Duodenal Ulcers (1)	⌊YES	⌊NO	Alcohol or Drug Dependency (2)	⌊YES	⌊NO
Hiatal Hernia/ Acid Reflux (1)	⌊YES	⌊NO	Difficult Intubation (Breathing Tube) (5)	⌊YES	⌊NO
Cancer/Chemotherapy/Radiation (3)	⌊YES	⌊NO	Other Problems (Specify)	⌊YES	⌊NO

SIGNATURE (Patient, Parent or Legal Guardian)	Pre-OP Consultant (If Applicable)	Date:

ANESTHESIA STAFF TO COMPLETE SECTION BELOW

Anesthesia Pre-op Assessment

Review of Medical History/Problem List:	Vital Signs: BP P RR Temp SpO2	Studies: EKG: CXR:

Laboratory Findings	HCG ⌊ Pos ⌊Neg ⌊N/A	Physical Status: Physical Exam: 1 2 3 4 5 E NPO _____	Heart: Lungs:	Airway: MP: Dental: ROM:

The patient verbalizes understanding of the information that was presented to them.
Barriers to learning: None Physical

Emotional Cognitive

Identity Confirmed. NPO Status verified. Patient evaluated and records reviewed without contraindications to surgery noted or significant interval history elicited.

Informed Consent: I have discussed the risks and benefits, potential complications, alternatives, potential for failure, consequences of non-treatment, and potential problems related to recovery with the patient (or guardian) and they accept these risks and desire to proceed.

The anesthetic plan is:

SIGNATURE Date_____ Time _____

USS XXX (CV(N)-XX)
MEDICAL DEPARTMENT

Modified Duty Authorization Chit

This is a recommendation to your Division Officer/Department Head. You must take this form to your Division before commencing Modified Duty or SIQ status. Misuse or fraudulent use of this chit may result in disciplinary action. Unless otherwise directed, all Modified Duty chits expire in 72 hours. SIQ recommendations must be reviewed by a Medical Officer every 24 hours except as noted below.

From: Medical Department USS **CARRIER (CV(N) XX)**
To: _____ Department Head/Division Officer

Subj: _____ _____ _____
Name Rate SSN

1. The above named individual is recommended for:
   A. _____ SIQ for _____ hours.
   B. _____ Modified Duty for _____ days.

2. Modified duty with the following recommendations:
   _____ Prolonged standing not to exceed _____ hours in a 4-hour period.
   _____ Prolonged walking not to exceed _____ hours in a 4-hour period.
   _____ No running
   _____ No squatting
   _____ No kneeling
   _____ No carrying anything > _____ pounds
   _____ No pushing/pulling anything > _____ pounds
   _____ Other: _____

   This change of full duty status begins _____ and ends _____

_____
Medical Department Representative Signature Date

1. SIQ is defined as: The above named member is confined to quarters.
2. When SIQ is recommended for more than 24 hours, the member is responsible for mustering with their Department/Division.
3. SIQ chits issued by Hospital Corpsmen after normal working hours will expire the following day.

I have read and understand the above SIQ/Modified Duty policies fully and will comply with them.

_____
Patient's name Signature Date

OCT 21 2005

DATE: _____

Elective Surgery MEMORANDUM

From: _____
To: _____

Subj: REQUEST FOR ELECTIVE SURGERY ICO _____

Ref: COMNAVAIRFORINST 6000.1

1. Per reference (a), this memo is submitted for your approval.

2. _____ has requested elective surgery. Provided they obtain permission from their Division Officer or Department Head, we would like to schedule their surgery at _____
on _____ .

3. The procedure we plan to perform may require either placement on the Sick in Quarters list for _____ hours, or admission to the Medical Ward. If you cannot afford to lose this person for the period of time indicated, please indicate an appropriate time frame that you desire, in the space provided below. Indicate your approval or disapproval by signing in the space provided. Without your approval, we will not proceed.

_____
(SURGEON)

FIRST ENDORSEMENT

From: _____
Senior Medical Officer

To:

1. _____ (APPROVED / DISAPPROVED) Circle Choice.
(Division Officer)

2. _____ (APPROVED / DISAPPROVED) Circle Choice.
(Department Head)

3. (If disapproved): The time frame we desire for this procedure is from _____ to _____.

USS XXX (CV(N)-XX)
MEDICAL DEPARTMENT
MINOR OPERATIVE PROCEDURE REPORT

DATE: _____

HISTORY: _____
_____
_____

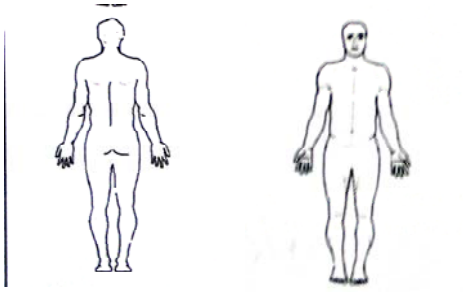
PHYSICAL FINDINGS: _____
_____

PREOP DIAGNOSIS: _____

PROCEDURE: Excision of _____

POST OP DIAGNOSIS: _____ Epidermal Inclusion Cyst
_____ Lipoma
_____ Fat Necrosis
_____ Nevi
_____ Other: _____

SURGEON:



ANESTHETIC: 1% Lidocaine w/Epinephrine 0.25% Marcaine

PROCEDURE: The lesion was identified by inspection by inspection and palpation. The skin surrounding the lesion was prepped and draped in standard sterile fashion. Local anesthetic was infiltrated in the skin and subcutaneous tissue. After adequate analgesia was assured:

_____ an incision was made over the mass. The mass was sharply excised from the subcutaneous fat and passed off as a specimen. The wound was inspected and no residual mass was identified.

_____ an elliptical incision was made to include the lesion and a 1 to 2 mm border of normal skin. The full thickness of skin was sharply excised from the underlying fat. The lesion was passed off as a specimen.

Adequate hemostasis was observed.
The skin edges were reapproximated with: _____
The incision was dressed with:
_____ Bacitracin/bandaid _____ steri-strips _____ gauze

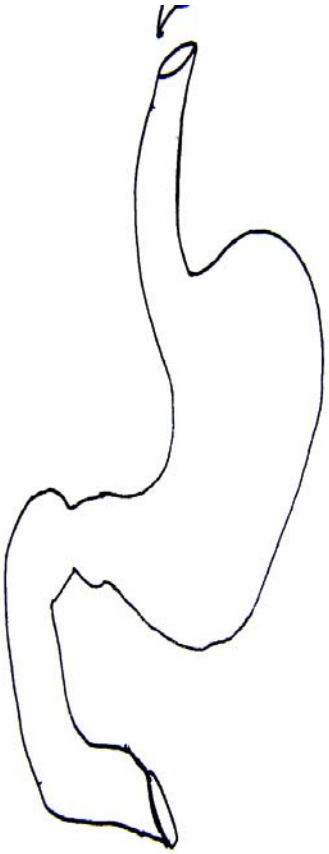
The patient tolerated the procedure well. He/she was instructed to keep the incision clean and dry. May shower in 24 hours. Return to Medical if any redness, drainage, swelling, or bleeding occurs. Return for suture removal in _____ days. Take Tylenol as needed for discomfort.

Signature of Surgeon: _____ Date: _____

Addressograph

USS XXX (CV(N)-XX)
MEDICAL DEPARTMENT

UPPER GI ENDOSCOPY REPORT



Patient: _____

Date: _____ Time: _____

Endoscopist:_____

Indication: _____
_____
_____
_____

Premedication: _____
_____

Findings:

Oral Cavity/Hypopharynx: _____
_____
_____

Esophagus: _____
_____
_____

Stomach:_____
_____
_____
_____

Duodenum: _____
_____

Diagnosis: _____
_____

Recommendations: _____
_____
_____
_____

_____ _____
Endoscopist's Signature Date

Addressograph

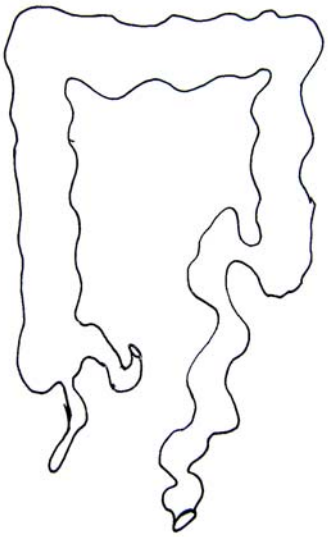
USS XXX (CV(N)-XX)
MEDICAL DEPARTMENT

COLONOSCOPY/SIGMOIDOSCOPY REPORT

Patient: _____

Date: _____ Time: _____

Endoscopist:_____



Indication: _____
_____
_____
_____

Premedication: _____
_____

Findings:
Anal Canal: _____
_____
_____
Rectosigmoid: _____
_____
_____
Descending Colon: _____
_____
Transverse Colon: _____
_____
Ascending Colon: _____
_____
Diagnosis: _____
_____
Recommendations: _____
_____
_____
_____

_____ _____
Endoscopist's Signature Date

Addressograph

SURGICAL STERILIZATION COUNSELING FORM

(To be printed on STANDARD FORM 600)

USS XXXX (CV(N)-XX)
MEDICAL DEPARTMENT

COUNSELING NOTE:

I am a ____ year old male, father of ____ children, and I desire a vasectomy for elective, permanent sterilization.

I have received information verbally and in writing describing the indication for elective, permanent sterilization, alternative forms of birth control, potential risks and complications (including, but not limited to, pain, bleeding, infection, and failure of the procedure to obtain the desired, permanent sterilization), and post procedure precautions and wound care instructions.

In addition, I have been briefed on the need to continue using alternative forms of birth control until my semen has been analyzed and found to be free of sperm on two occasions, at least six weeks and/or 15 ejaculations, following the vasectomy.

PATIENT: _____ WITNESS: _____

This ____ year old male, father of _____ children, desires a vasectomy for elective, permanent sterilization. I have described the procedure, its permanent nature, and potential complications of pain, bleeding, infection, and failure of the procedure to provide permanent sterility.

VASECTOMY SCHEDULED FOR (MM/DD/YY): _____

COUNSELING PHYSICIAN: _____

USS XXX (CV(N) - XX)
Medical Department

VASECTOMY OPERATION REPORT

PREOPERATIVE DIAGNOSIS: Undesired Fertility DATE: _____

OPERATIVE PROCEDURE PERFORMED: Bilateral Trans-Scrotal Vasectomy

SURGEON: _____ASSISTANT:_____

TECHNICIAN: _____

ANESTHETIC: _____ OPERATIVE DIAGNOSIS: SAA

DESCRIPTION OF PROCEDURE: The scrotum was prepped and draped in the usual sterile manner. The vas deferens were isolated subcutaneously in the scrotum. The skin and spermatic cord were infiltrated with local anesthetic solution. A 1cm skin incision was made down to the spermatic cord, and the vas was isolateD from the surrounding tissue. The vas was then grasped with an Allis Clamp and delivered through the skin incision. The vas was then further isolated and skeletonized with a hemostat. A 1cm segment of the vas was sharply excised. Each specimen was then placed in a labeled specimen cup filled with Buffered

Formalin, and forwarded to the Pathology Department at _____.

Additional Steps in the Procedure:

1. Number of skin incisions: _____
2. Hemostasis was obtained with:
   ___ Suture ligation. ___ Cautery. ___ Pressure.
3. The ends of the vasa were:
   ___ Ligated with _____ suture.
   ___ Clipped with Titanium liga clips.
   ___ Cauterized.
   ___ Buried in separate facial layers.
   ___ Folded over and secured with _____ suture.
4. The skin incision(s) were:
   ___ Closed with _____ suture.
   ___ Closed by hemostat pressure.
5. The incision(s) was/were dressed with:
   ___ Bacitracin ointment. ___ Zeroform gauze. ___ Plain gauze.

COMMENTS: The patient was instructed that he is NOT FERTILE and to continue using Birth Control methods until a NEGATIVE semen analysis result is obtained (AZOOSPERMIA), following 6 weeks and/or 15 ejaculations. Use of a Jock Strap is recommended; place an Ice Pack on the effected area for the first 24 hours; take only Tylenol 325mg (2 tabs every 4 hours) as needed for pain. Post-operative instructions were given orally and in a written form.

MODIFIED DUTY RECOMMENDED: Patient assigned 48 hours SIQ with 14 days light duty.

SIGNATURE OF SURGEON: _____DATE: _____

Addressograph

APPENDIX J

Controlled Medicinals – Sample Letters

Controlled Medicinals Bulk Custodian Appointment Letter

Date

From: Commanding Officer, USS
To:

Subj: APPOINTMENT AS BULK STORES CUSTODIAN FOR CONTROLLED MEDICINALS

Ref: (a) Manual of the Medical Department (NAVMED P-117), Chapter 21
(b) COMNAVAIRFORINST 6000.1

1. You are hereby appointed as Bulk Stores Custodian for the controlled medicinals on board this ship, as defined in references (a) and (b).

2. You shall read and become familiar with parts of references (a) and (b) which concern your duties as Bulk Custodian.

3. You shall maintain the necessary accounting records and documents as set forth in reference (a) to show the proper receipt and expenditure of items in your custody.

4. You shall ensure that the proper security is maintained for items in your custody and that the combination of the safe containing the bulk stock items is changed at least every 12 months in accordance with existing regulations.

5. An inventory of all drugs in your custody will be held by the Controlled Substance Inventory Board (CSIB) appointed for this purpose quarterly or more frequently, if necessary.

6. Ensure that an OPNAV 5511/2 (Rev. 8-62) "Combination Change Envelope" has been placed in the custody of the Security Manager.

SIGNATURE (Commanding Officer)

Copy to:
Medical Department File
Commanding Officer's file
Each member of the CSIB

I have read and understand the provisions of references (a) and (b).

SIGNATURE (Bulk Custodian)

OCT 21 2005

Controlled Medicinals Working Stock Custodian Appointment Letter

Date

From: Commanding Officer, USS
To:

Subj: APPOINTMENT AS WORKING STOCK CUSTODIAN FOR CONTROLLED MEDICINALS

Ref: (a) Manual of the Medical Department (NAVMED P-117), Chapter 21
(b) COMNAVAIRFORINST 6000.1

1. You are hereby appointed as Working Stock Custodian for the controlled medicinals on board this ship, as defined in references (a) and (b).

2. You shall read and become familiar with parts of references (a) and (b) which concern your duties as Working Stock Custodian.

3. You shall maintain the necessary accounting records and documents as set forth in reference (a) to show the proper receipt and expenditure of items in your custody.

4. You shall ensure that the proper security is maintained for items in your custody and that the combination of the safe containing the working stock items is changed at least every 12 months in accordance with existing regulations.

5. An inventory of all drugs in your custody will be held by the Controlled Substance Inventory Board (CSIB) appointed for this purpose quarterly or more frequently, if necessary.

6. Ensure that an OPNAV 5511/2 (Rev. 8-62) "Combination Change Envelope" has been placed in the custody of the Security Manager.

SIGNATURE (Commanding Officer)

Copy to:
Medical Department File
Commanding Officer's file
Each member of the CSIB

I have read and understand the provisions of references (a) and (b).

SIGNATURE (Working Stock Custodian)

Controlled Medicinals Inventory Board Appointment Form Letter

From: Commanding Officer, USS
To: A Commissioned Officer (Other than the Bulk Stores Custodian)

Subj: APPOINTMENT TO THE CONTROLLED SUBSTANCES INVENTORY BOARD

Ref: (a) Manual of the Medical Department (NAVMED P-117), Chapter 21
(b) COMNAVAIRFORINST 6000.1

1. You are hereby appointed as Senior Member of the Controlled Substance Inventory Board (CSIB) as described in Article 21-24(1)(b) of reference (a). In addition, (A Commissioned Officer) and (another member E-7 or above) will serve as members of this board.

2. All members shall become thoroughly familiar with the parts of references (a) and (b) which concerns the duties of the CSIB.

3. You will cause a physical inventory to be held of all narcotics, alcohol, alcoholic beverages and other controlled medicinals on board this ship as soon as possible after the last day of each quarter in compliance with references (a) and (b). A written report of each inventory conducted shall be promptly submitted to the Commanding Officer as required by Article 21-47 of reference (a).

4. In your report to the Commanding Officer, you shall include the following information:

a. Discrepancies noted in checking all receipt and expenditure vouchers, prescriptions (DD Form 1289) and NAVMED 6710/5, perpetual inventory forms, showing the receipt and expenditure of all drugs inventoried. Losses, thefts or irreconcilable differences shall be reported in accordance with Article 21-25 of reference (a).

b. If all prescribed accounting records were properly prepared as set forth in references (a) and (b).

c. If seals on the closures of vials, bottles and other containers inspected were damaged or tampered with.

d. Security of spaces where inventoried drugs are stowed and recommendations, if any, to enhance the security of such spaces.

e. Any item which shows signs of damage, expired potency date, or deterioration. Recommend action for disposal of any such item listed in accordance with Article 21-26 of reference (a).

SIGNATURE OF COMMANDING OFFICER

Copy to:
Each Board Member
Medical Department File

Controlled Medicinals Inventory Report Format

Date

From: Senior Member, Controlled Substances Inventory Board
To: Commanding Officer

Subj: CONTROLLED INVENTORY REPORT (BULK OR WORKING STOCK); FOR THE MONTH OF

Ref: (a) Manual of the Medical Department (NAVMED P-117), Chapter 21

1. In accordance with reference (a), a controlled medicinal inventory was conducted with the following results:

Drug Name	Unit of Issue	Strength	NSN	Amount Remaining Last Report	Quantity Received	Quantity Expended	Balance On Hand

2. Discrepancies noted are as follows: (either state "none" or list each discrepancy with a corresponding explanation.)

Very respectfully,

Senior Member

Copy to:
Board Members
Bulk/Working Stock Custodian

Sample OTC Pharmacy program
(Customize per SMO's direction)

MEDICAL DEPARTMENT USS _____ CV(N) XX FPO AE _____

OVER-THE-COUNTER MEDICATION REQUEST
(Please Print Clearly)

PATIENT'S NAME: _____ PATIENT'S SSN: _____

J-DIAL: _____ ALLERGIES: _____

SYMPTOMS BEING TREATED: _____

By signing, I certify the following:

1. I understand that the medication is for use in minor illnesses or conditions and that if symptoms worsen or do not improve within 48 hours, I should be seen by a medical provider.

2. I am NOT pregnant. I am NOT on Flight Status at the time.

3. I also understand that this service is available to me only TWICE PER MONTH.

4. If I become dizzy, drowsy, or suffer from any other undesirable side effects, I will discontinue the medication and report to the Medical Department.

5. Up to (3) items may be selected, but NO MORE THAN ONE ITEM FROM EACH CATEGORY.

SIGNATURE AND DATE_____

PAIN/FEVER
( ) Tylenol 325mg (12 tabs)
( ) Motrin 400mg (12 tabs)
( ) Asprin 325mg (12 tabs)

TOPICALS
( ) Chapstick
( ) Hydrocortisone 1% Cream
( ) Sunscreen

SORE THROAT
( ) Cepacol Lozenges (9 tabs)

ANTACIDS
( ) Maalox Suspension

COUGH/CONGESTION
( ) Humabid LA #12 tabs

ANTIFUNGALS
( ) Antifungal Foot Powder
( ) Mycelex 1% Cream

UPSET STOMACH/DIARRHEA
( ) Pepto Bismol #12 tabs

SEA SICKNESS
( ) Meclizine 25mg (12 tabs)

ANTIHISTAMINES/DECONGESTANT
( ) Sudafed 60mg (12 tabs)

PARENT COMMAND (CHECK BOX)

‰ **CV(N) XX**	‰ **CCG X**	‰ **CVW X**	‰ **SEAL TEAM X**
‰ **HS X**	‰ **VAQ XXX**	‰ **VAW XXX**	‰ **VF XX**
‰ **VFA XX**	‰ **VFA XXX**	‰ **VMFA XXX**	‰ **VS XX**

‰ **OTHER (specify TAD, CV(N)XX, etc)**_____

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APPENDIX K

Formulary

AMMAL Description	Drug Class
Analgesics	
DIAZEPAM INJECTION USP 5MG/ML 2 ML UNIT 10 PER PACKAGE	Analgesic / AntiAnxiety / Benzodiazepines
DIAZEPAM TABLETS USP 5MG 100 TABLETS PER BOTTLE	Analgesic / AntiAnxiety / Benzodiazepines
BUTALBITAL ACETOMINOPHEN AND CAFFEINE TABLETS 100 TABLETS PER BOTTLE	Analgesic / Barbiturate
CYCLOBENZAPRINE HYDROCHLORIDE TABLETS USP 10MG 100TABLETS/BOTTLE	Analgesic / Muscle Relaxant
DANTROLENE SODIUM FOR INJECTION 20 MG VIAL 6 VIALS PER PACKAGE	Analgesic / Muscle Relaxant
CODEINE PHOSPHATE AND ACETAMINOPHEN TABLETS 100 TABLETS/BT	Analgesic / Narcotic Analgesic Combinations
OXYCODONE AND ACETAMINOPHEN TABLETS USP 100 TABLETS PER BOTTLE	Analgesic / Narcotic Analgesic Combinations
FENTANYL CITRATE INJ USP .05MG EQUIV INTRAVENOUS 2ML AMPUL 10S	Analgesic / Narcotics
MEPERIDINE HYDROCHLORIDE INJECTION USP 100MG/ML 1ML UNIT 10/BOX	Analgesic / Narcotics
MORPHINE SULFATE INJECTION USP 10MG/ML 1 ML UNIT 10 PER PACKAGE	Analgesic / Narcotics
ASPIRIN TABLETS USP 0.324 GM 1000S	Analgesic / Non Steroidal Antiinflammatory
IBUPROFEN TABLETS USP 400 MG 500 TABLETS PER BOTTLE	Analgesic / Non Steroidal Antiinflammatory
IBUPROFEN TABLETS USP 800 MG 500 TABLETS PER BOTTLE	Analgesic / Non Steroidal Antiinflammatory
INDOMETHACIN CAPSULES USP 25MG 1000 CAPSULES PER BOTTLE	Analgesic / Non Steroidal Antiinflammatory
KETOROLAC TROMETHAMINE INJECTION USP 30MG/ML 1ML UNIT 10/PACKAGE	Analgesic / Non Steroidal Antiinflammatory

AMMAL Description	Drug Class
NAPROXEN SODIUM TABLETS USP 275MG 100 TABLETS PER BOTTLE	Analgesic / Non Steroidal Antiinflammatory
ACETAMINOPHEN SUPPOSITORIES 650MG ADULT RECTAL I.S. 12/PACKAGE	Analgesic / Non-Narcotic
ACETAMINOPHEN TABLETS USP 0.325GM 1000S	Analgesic / Non-Narcotic
TRAMADOL HYDROCHLORIDE TABLETS, 50 MG 100 TABLETS PER BOTTLE	Analgesic / Non-Narcotic
Anesthetic	
ONDANSETRON HYDROCHLORIDE (ZOFRAN) 2MG/ML 2ML VIAL TRAY OF 5S	Anesthetic / Antinausea
KETAMINE HYDROCHLORIDE INJECTION USP 10ML VIAL 10 VIALS/PG	Anesthetic / General / Induction
PROPOFOL INJECTION 10MG/ML 20ML VIAL 20 VIALS PER PACKAGE	Anesthetic / General / Induction
PROPOFOL INJECTION 10MG/ML 50ML VIAL 20 VIALS PER PACKAGE	Anesthetic / General / Induction
THIOPENTAL SODIUM FOR INJECTION USP 500MG VIAL 25 VIALS/PACKAGE	Anesthetic / General Anesthetics / Barbiturates
ISOFLURANE USP 100ML BOTTLE 6 BOTTLES PER PACKAGE	Anesthetic / General Anesthetics / Gases
NITROUS OXIDE USP SIZE D CYLINDER 250GL	Anesthetic / General Anesthetics / Gases
MIDAZOLAM HYDROCHLORIDE INJECTION 5MG/ML 1ML VIAL 10/PACKAGE	Anesthetic / General Anesthetics / Sedation
BUPIVACAINE HCL IN DEXTROSE INJ STERILE USP 2ML AMPUL 10/PG	Anesthetic / Local Anesthesia / Injectable
BUPIVACAINE HYDROCHLORIDE INJECTION USP .50% 30ML VIAL 10S	Anesthetic / Local Anesthesia / Injectable
CHLOROPROCAINE HYDROCHLORIDE INJECTION USP 20ML VIAL	Anesthetic / Local Anesthesia / Injectable
LICOCAINE HCL AND DEXTROSE INJECTION 250ML 24S	Anesthetic / Local Anesthesia / Injectable
LIDOCAINE AND EPINEPHRINE INJECTION USP 1:100,000 20 ML VIAL	Anesthetic / Local Anesthesia / Injectable
LIDOCAINE HYDORCHLORIDE INJECTION USP 20ML VIAL	Anesthetic / Local Anesthesia / Injectable

AMMAL Description	Drug Class
LIDOCAINE HYDROCHLORIDE AND DEXTROSE INJECTION USP 2ML AMPUL 25S	Anesthetic / Local Anesthesia / Injectable
LIDOCAINE HYDROCHLORIDE INJECTION USP 1.0%/ML 50ML BOTTLE	Anesthetic / Local Anesthesia / Injectable
LIDOCAINE HYDROCHLORIDE INJECTION USP 5 ML UNIT 10 PER PACKAGE	Anesthetic / Local Anesthesia / Injectable
TETRACAINE HYDROCHLORIDE INJECTION USP 2ML AMPUL 25 PER PACKAGE	Anesthetic / Local Anesthesia / Injectable
LIDOCAINE HYDROCHLORIDE TOPICAL SOLUTION USP 100ML BOTTLE	Anesthetic / Local Anesthesia, Topical
LIDOCAINE HYDROCHLORIDE TOPICAL SOLUTION USP VISCOUS 4% 50 ML	Anesthetic / Local Anesthesia, Topical
PANCURONIUM BROMIDE INJECTION 2MG/ML 5ML VIAL 25 VIALS/PACKAGE	Anesthetic / Paralysis
ROCURONIUM BROMIDE INJECTION 10MG/ML 5ML VIAL 10 PER PACKAGE	Anesthetic / Paralysis
SUCCINYLCHOLINE CHLORIDE INJECTION USP 100MG/ML 10ML VIAL 25S	Anesthetic / Paralysis
SUCCINYLCHOLINE CHLORIDE INJECTION USP 20MG/ML 10ML VIAL 25/PG	Anesthetic / Paralysis
VECURONIUM BROMIDE FOR INJECTION 10 MG 10ML VIALS 10/PKG	Anesthetic / Paralysis
PHYSOSTIGMINE SALICYLATE INJECTION USP 1MG/ML 2ML 10 AMPULES/PG	Anesthetic / Paralysis / Reversal
Antibiotics	
CEFAZOLIN SODIUM INJECTION USP 1GM/GM CEFAZOLIN 10ML VIAL 25S	Antibiotic / 1st generation Cephalosporins
CEPHALEXIN CAPSULES USP EQUIVALENT TO 500 MG 100 PER BOTTLE	Antibiotic / 1st generation Cephalosporins
CEFOTETAN DISODIUM STERILE 2GM VIAL 40S	Antibiotic / 2nd generation Cephalosporins
CEFTRIAXONE SODIUM STERILE USP 2 GM SINGLE DOSE VIAL 10S	Antibiotic / 3rd generation Cephalosporins

AMMAL Description	Drug Class
CEFTRIAXONE SODIUM STERILE USP 250MG VIAL 10 VIALS PER PACKAGE	Antibiotic / 3rd generation Cephalosporins
GENTAMICIN SULFATE INJECTION USP 40MG EQUIV/ML 2ML VIAL 25/PG	Antibiotic / Aminoglycosides
ISONIAZID TABLETS USP 300 MG 100S	Antibiotic / Antituberculosal Agents
RIFAMPIN CAPSULES USP 300MG 100 CAPSULES PER BOTTLE	Antibiotic / Antituberculosal Agents
CIPROFLOXACIN HYDROCHLORIDE IN DEXTROSE INJECTION 200ML BAG 24S	Antibiotic / Fluoroquinolones
CIPROFLOXACIN HYDROCHLORIDE OPHTHALMIC SOLUTION 5ML BOTTLE	Antibiotic / Fluoroquinolones
CIPROFLOXACIN TABLETS USP 500MG 100 TABLETS PER BOTTLE	Antibiotic / Fluoroquinolones
LEVOFLOXACIN INJECTION 25MG/ML 20ML SINGLE DOSE VIAL	Antibiotic / Fluoroquinolones
LEVOFLOXACIN TABLETS 500 MG 50 TABLETS PER BOTTLE	Antibiotic / Fluoroquinolones
AZITHROMYCIN TABLETS 250MG 30 TABLETS PER BOTTLE	Antibiotic / Macrolide
CLARITHROMYCIN TABLETS 500MG 60S BT	Antibiotic / Macrolide
ERYTHROMYCIN LACTOBIONATE FOR INJECTION USP 1GM VIAL 10/PACKAGE	Antibiotic / Macrolide
ERYTHROMYCIN TABLETS USP 250 MG 100S	Antibiotic / Macrolide
AZTREONAM FOR INJECTION USP 1GM VIAL 10 VIALS PER PACKAGE	Antibiotic / Other Antimicrobial
CHLORAMPHENICOL SODIUM SUCCINATE STERILE USP 1 GRAM VIAL 10/BOX	Antibiotic / Other Antimicrobial
CLINDAMYCIN INJECTION USP 150MG/ML 6ML VIAL 25 VIALS/PACKAGE	Antibiotic / Other Antimicrobial
CLINDAMYCIN PHOSPHATE TOPICAL SOLUTION USP 10MG/ML 60ML BOTTLE	Antibiotic / Other Antimicrobial
METRONIDAZOLE INJECTION 100 ML BAG 24 BAGS PER PACKAGE	Antibiotic / Other Antimicrobial
METRONIDAZOLE INJECTION USP STERILE 5MG/ML 100ML BAG 24/PACKAGE	Antibiotic / Other Antimicrobial

AMMAL Description	Drug Class
METRONIDAZOLE TABLETS USP 250MG 250 TABLETS PER BOTTLE	Antibiotic / Other Antimicrobial
NITROFURANTOIN EXTENDED-RELEASE CAPSULES 100MG 100 CAPS/BOTTLE	Antibiotic / Other Antimicrobial
VANCOMYCIN HYDROCHLORIDE STERILE USP 500MG VIAL 10 PER PACKAGE	Antibiotic / Other Antimicrobial
VANCOMYCIN HYDROCHLORIDE STERILE USP 500MG VIAL 10 PER PACKAGE	Antibiotic / Other Antimicrobial
AMOXICILLIN CAPSULES USP 500 MG 500 CAPSULES PER BOTTLE	Antibiotic / Penicillins
AMPICILLIN SODIUM STERILE USP POWDER FORM 1GM BOTTLE 10/PG	Antibiotic / Penicillins
PENICILLIN G BENZATHINE SUSPENSION STERILE USP 4ML UNIT 10/PG	Antibiotic / Penicillins
PENICILLIN G POTASSIUM FOR INJECTION USP 20000000 UNITS	Antibiotic / Penicillins
PENICILLIN V POTASSIUM FOR ORAL SOL USP 16000000UNITS IN200ML BT	Antibiotic / Penicillins
PENICILLIN V POTASSIUM TABLETS USP 400000 UNITS 100 TABLETS/BT	Antibiotic / Penicillins
AMOXICILLIN AND CLAVULANATE POTASSIUM TABLETS USP 875 MG 100S BT	Antibiotic / Penicillins / Penicillinase-Resistant Penicillins
AMPICILLIN SODIUM AND SULBACTAM SODIUM STERILE 3GM VIAL 10S	Antibiotic / Penicillins / Penicillinase-Resistant Penicillins
DICLOXACILLIN SODIUM CAPSULES USP 250 MG 100 CAPSULES PER BOTTLE	Antibiotic / Penicillins / Penicillinase-Resistant Penicillins
NAFCILLIN FOR INJECTION USP 1GM VIAL 10 VIALS PER PACKAGE	Antibiotic / Penicillins / Penicillinase-Resistant Penicillins
SULFAMETHOXAZOLE AND TRIMETHOPRIM INJECTION 5ML VIAL 10/PACKAGE	Antibiotic / Sulfonamides
SULFAMETHOXAZOLE AND TRIMETHOPRIM TABLETS USP 100 TABLETS/BOTTLE	Antibiotic / Sulfonamides

AMMAL Description	Drug Class
DOXYCYCLINE HYCLATE CAPSULES USP 100MG 500 CAPSULES PER BOTTLE	Antibiotic / Tetracycline
DOXYCYCLINE HYCLATE FOR INJECTION USP 100MG BOTTLE 5 PER PACKAGE	Antibiotic / Tetracycline
Anticoagulants	
ENOXAPARIN INJECTION 80MG IN 0.8ML WATER FOR INJECTION 10s	Anticoagulant
HEPARIN LOCK FLUSH SOLUTION USP 1ML CARTRIDGE NEEDLE UNIT 50/PG	Anticoagulant
HEPARIN SODIUM IN DEXTROSE INJECTION 500ML BAG 18 PER PACKAGE	Anticoagulant
HEPARIN SODIUM INJECTION 25S	Anticoagulant
HEPARIN SODIUM INJECTION USP 20000 UNITS/ML 1ML VIAL 25 VIALS/PG	Anticoagulant
WARFARIN SODIUM TABLETS USP 2MG 100 TABLETS PER BT	Anticoagulant
PROTAMINE SULFATE INJECTION USP 10MG/ML 25 ML VIAL	Anticoagulant
THROMBIN USP 5000 UNITS THROMBIN & 5ML ISOTONIC SODIUM CHLORIDE	Anticoagulant
Antidotes	
ANTIDOTE TREATMENT KIT CYANIDE	Antidote
DIMERCAPROL INJECTION USP 100MG/ML 3ML AMPUL 10 PER PACKAGE	Antidote
CHARCOAL ACTIVATED SUSPENSION 50 GM 240 ML TUBE 12S	Antidote
FLUMAZENIL INJECTION 0.1MG/ML 10ML VIAL 10 VIALS PER PACKAGE	Antidote
IPECAC SYRUP USP 7% 30ML	Antidote
NALOXONE HYDROCHLORIDE INJECTION USP 0.4MG/ML 1ML AMPUL 10/BX	Antidote / Narcotic Antagonists
AMYL NITRATE INHALANT USP 0.300ML AMPUL 12 PER PACKAGE	Antidote / Cardiovascular / Nitrate

AMMAL Description	Drug Class
ACETYLCYSTEINE SOLUTION USP 20% 30ML BOTTLE 3 PER PACKAGE	Antidote / Contrast Media / Pulmonary
PHYTONADIONE INJECTION USP 10MG/ML 1ML AMPUL 25 AMPULS PER PG	Antidote / Vitamins / Fat Soluble Vitamins
Antifungals	
ITRACONAZOLE CAPSULES 100MG 30 CAPSULES PER BOTTLE	Antifungal / Oral
TERBINAFINE HYDROCHLORIDE TABLETS 250MG 100 TABLETS PER BOTTLE	Antifungal / Oral
Antihelmintics	
MEBENDAZOLE TABLETS USP 100MG I.S. 12 TABLETS PER PACKAGE	Antihelmintics / Benzimidazoles
PRAZIQUANTEL TABLETS 600MG 6 TABLETS PER BOTTLE	Anthelmintics
THIABENDAZOLE TABLETS USP 500MG INDIVIDUALLY SEALED 36 TABS/PG	Antihelmintics / Benzimidazoles
Antihistamines	
DIPHENHYDRAMINE HYDROCHLORIDE CAPSULES USP 50MG 100 CAPS/BOTTLE	Antihistamine
DIPHENHYDRAMINE HYDROCHLORIDE INJ USP 50MG/ML 1ML SYRINGE 10/BX	Antihistamine
FEXOFENADINE HYDROCHLORIDE TABLETS 60MG 100 TABLETS PER BOTTLE	Antihistamine
HYDROXYZINE HYDROCHLORIDE INJECTION USP 50 MG PER ML 10 ML	Antihistamine
HYDROXYZINE HYDROCHLORIDE TABLETS USP 25MG 500 TABLETS/BOTTLE	Antihistamine
LORATADINE TABLETS 10 MG 10 TABLETS PER CARD 10 CARDS/PACKAGE	Antihistamine
Antimalarias	

AMMAL Description	Drug Class
CHLOROQUINE PHOSPHATE TABLETS USP 0.5GM 500 TABLETS PER BOTTLE	Antimalaria
MEFLOQUINE HYDROCHLORIDE TABLETS 250MG I.S. 25 TABLETS/PACKAGE	Antimalaria
PRIMAQUINE PHOSPHATE TABLETS USP 15MG 100 TABLETS PER BOTTLE	Antimalaria
Antivirals	
ACYCLOVIR TABLETS 800 MG 100 TABLETS PER BOTTLE	Antiviral
LAMIVUDINE AND ZIDOVUDINE CAPSULES 60 CAPSULES PER BOTTLE	Antiviral / Anti-HIV
AMANTADINE HYDROCHLORIDE CAPSULES USP 100MG 100 CAPSULES/BOTTLE	Antiviral
Cardiovascular	
ENALAPRIL MALEATE TABLETS USP 5MG 100 TABLETS PER BOTTLE	Cardiovascular / ACEI
LISINOPRIL TABLETS 20 MG 100S BT	Cardiovascular / ACEI
CLONIDINE HYDROCHLORIDE TABLETS 0.1MG 100 TABLETS PER BOTTLE	Cardiovascular / Antiadrenergic Agent
ADENOSINE INJECTION USP 2ML SINGLE DOSE VIAL 10 PER PACKAGE	Cardiovascular / Antiarrhythmic
AMIODARONE HYDROCHLORIDE INJECTION 50MG/ML 3ML AMPUL 10/PACKAGE	Cardiovascular / Antiarrhythmic
ATROPINE SULFATE INJ USP .4000MG PER ML 20ML 10S	Cardiovascular / Antiarrhythmic
ATROPINE SULFATE INJECTION USP 0.1MG/CC 10ML BOTTLE 10 PER BOX	Cardiovascular / Antiarrhythmic
ATROPINE SULFATE INJECTION USP 1ML VIAL 25 VIALS PER PACKAGE	Cardiovascular / Antiarrhythmic
DIGOXIN INJECTION USP 0.25MG/ML 2ML AMPUL 10 AMPULS PER PACKAGE	Cardiovascular / Antiarrhythmic
DIGOXIN TABLETS USP 0.25MG 100 TABLETS PER BOTTLE	Cardiovascular / Antiarrhythmic

AMMAL Description	Drug Class
PROCAINAMIDE HYDROCHLORIDE INJECTION USP 500MG/ML 2ML VIAL	Cardiovascular / Antiarrhythmic
QUINIDINE GLUCONATE INJECTION USP 80MG/ML 10ML VIAL	Cardiovascular / Antiarrhythmic
QUININE SULFATE CAPSULES USP 325MG 1000 CAPSULES PER BOTTLE	Cardiovascular / Antiarrhythmic
LABETALOL HYDROCHLORIDE INJECTION USP 5MG/ML 20ML VIAL	Cardiovascular / Beta- Alpha Blocker
ATENOLOL TABLETS USP 50MG 100 TABLETS PER BOTTLE	Cardiovascular / Beta Blocker
METOPROLOL TARTRATE TABLETS 50 MG 100S BT	Cardiovascular / Beta Blocker
ESMOLOL HYDROCHLORIDE INJECTION STERILE 10MG/ML 10ML VIAL 25S	Cardiovascular / Beta Blocker IV
METOPROLOL TARTRATE INJECTION USP 1MG/ML 5ML AMPULE 12S	Cardiovascular / Beta Blocker IV
PROPRANOLOL HYDROCHLORIDE INJECTION USP 1MG/ML 1ML AMPUL 10/BX	Cardiovascular / Beta Blocker IV
DILTIAZEM HYDROCHLORIDE INJECTION 5MG/ML 10ML VIAL 6 VIALS/PG	Cardiovascular / Calcium Channel Blocker
DILTIAZEM HYDROCHLORIDE TABLETS 120MG 100 TABLETS PER BOTTLE	Cardiovascular / Calcium Channel Blocker
NIFEDIPINE CAPSULES USP 10MG 100 CAPSULES PER BOTTLE	Cardiovascular / Calcium Channel Blocker
VERAPAMIL HYDROCHLORIDE INJ USP 5MG/2ML 2ML VIAL 5/PACKAGE	Cardiovascular / Calcium Channel Blocker
LOVASTATIN TABLETS 20MG 60 TABLETS PER BOTTLE	Cardiovascular / Cholesterol Lowering
SIMVASTATIN 20 MG 90S BT	Cardiovascular / Cholesterol Lowering
ACETAZOLAMIDE TABLETS USP 250MG 100 TABLETS PER BOTTLE	Cardiovascular / Diuretic
FUROSEMIDE INJECTION USP 10MG/ML 2ML AMPUL 25 PER PACKAGE	Cardiovascular / Diuretic
HYDROCHLOROTHIAZIDE TABLETS USP 25 MG 1000S	Cardiovascular / Diuretic
HYDROCHLOROTHIAZIDE TABLETS USP 50 MG 1000S	Cardiovascular / Diuretic
MAGNESIUM SULFATE USP CRYSTAL FORM 16 OZ CONTAINER	Cardiovascular / Intravenous Nutritional Therapy/Minerals

AMMAL Description	Drug Class
TENECTEPLASE FOR INJECTION SINGLE-BOLUS TISSUE PLASMINOGEN	Cardiovascular / Thrombolytics
NITROGLYCERIN IN DEXTROSE INJECTION 250ML BAG 12 BAGS/PACKAGE	Cardiovascular / Vasodilators / Nitrates
NITROGLYCERIN INJECTION USP 50MG 10ML VIAL 25 VIALS PER PACKAGE	Cardiovascular / Vasodilators / Nitrates
NITROGLYCERIN LINGUAL AEROSOL 14.49GM CONTAINER	Cardiovascular / Vasodilators / Nitrates
NITROGLYCERIN OINTMENT 2% 60GM COLLAPSIBLE TUBE	Cardiovascular / Vasodilators / Nitrates
SODIUM NITROPRUSSIDE STERILE USP 50 MG	Cardiovascular / Vasodilators / Nitrates
DOBUTAMINE INJECTION USP 12.5MG/ML 20ML VIAL 10 VIALS/PG	Cardiovascular / Vasopressor
DOPAMINE HYDROCHLORIDE INJECTION USP 5ML VIAL 25 PER PACKAGE	Cardiovascular / Vasopressor
EPHEDRINE SULFATE INJECTION USP 50MG/ML 1ML AMPUL 50 PER PACKAGE	Cardiovascular / Vasopressor
EPINEPHRINE INJECTION USP 1ML AMPUL 10 AMPULS PER PACKAGE	Cardiovascular / Vasopressor
EPINEPHRINE INJECTION USP AQUEOUS 1ML AMPUL 25 AMPULS/PG	Cardiovascular / Vasopressor
EPINEPHRINE INJECTION USP0.1MG PER ML SYRINGE-NEEDLE UNIT10ML10S	Cardiovascular / Vasopressor
PHENYLEPHRINE HYDROCHLORIDE INJECTION USP 1% 1 ML 25S	Cardiovascular / Vasopressor
VASOPRESSIN INJECTION USP 1ML VIAL 10 VIALS PER PACKAGE	Cardiovascular / Vasopressor
Contrast Media Radiography Contrasts	
IOVERSONL INJECTION 50 ML SYRINGE 20S	Contrast Media / IV / OPTIRAY 320
DIATRIZOATE MEGLUMINE 66%/DIATRIZOATE SODIUM 10% ORAL SOLUTION 120ML BT 12S	Contrast Media / Oral / Gastrografin

AMMAL Description	Drug Class
Dermatologicals	
LUBRICANT SURGICAL 4 OZ (113.4 GM)	Dermatological
SILVER NITRATE APPLICATORS 6 INCH 100S	Dermatological
BENZOYL PEROXIDE GEL USP 10% 3OZ OR 85GM TUBE	Dermatological / Acne
TRETINOIN CREAM USP 0.05% 20 GRAM TUBE	Dermatological / Acne
TRETINOIN CREAM USP 20 GRAM TUBE	Dermatological / Acne
BENZOIN TINCTURE COMPOUND USP 0.6ML CRUSHABLE AMPUL 100/PACKAGE	Dermatological / Adhesive
BACITRACIN OINTMENT USP 500UN/GM .87GM PACKET I.S. 144PACKETS/PG	Dermatological / Antibiotic
BACITRACIN OINTMENT USP 7100 UNITS 0.5OZ TUBE 12 TUBES/PACKAGE	Dermatological / Antibiotic
MUPIROCIN OINTMENT 1 GRAM TUBE 10S	Dermatological / Antibiotic
CLOTRIMAZOLE CREAM USP TOPICAL 1% 15GM	Dermatological / Antifungal
CLOTRIMAZOLE TOPICAL SOLUTION USP 1% 10 ML	Dermatological / Antifungal
UNDECYLENIC ACID AND ZINC UNDECYLENATE POWDER 45GM	Dermatological / Antifungal
UNDECYLENIC ACID AND ZINC UNDECYLENATE POWDER 45GM	Dermatological / Antifungal
SELENIUM SULFIDE LOTION USP 2.5% TOPICAL 118ML BOTTLE	Dermatological / Antipsoriatic Agents
HEXACHLOROPHENE CLEANSING EMULSION USP 1GL OR 3.780LI	Dermatological / Antiseptic
HYDROGEN PEROXIDE TOPICAL SOLUTION USP 1PINT (473 ML)	Dermatological / Antiseptic
ISOPROPYL RUBBING ALCOHOL USP 1 PT (473 ML)	Dermatological / Antiseptic
POVIDONE-IODINE CLEANSING SOLUTION USP 7.5% 4 FL OUNCES OR 118ML	Dermatological / Antiseptic
POVIDONE-IODINE TOPICAL SOLUTION USP 1GL (3.780 LITER)	Dermatological / Antiseptic
POVIDONE-IODINE TOPICAL SOLUTION USP 4FL OZ BOTTLE W/DISPENSER	Dermatological / Antiseptic
SKIN CLEANSER MEDICATED 1PT BOTTLE	Dermatological / Antiseptic

AMMAL Description	Drug Class
PODOFILOX TOPICAL SOLUTION 3.5ML BOTTLE	Dermatological / Anti-Viral
ALUMINUM ACETATE TABLETS FOR TOPICAL SOLUTION 100 TABS/PACKAGE	Dermatological / Astrigent
OATMEAL COLLOIDAL CONCENTRATE 30GM PACKET 8 PACKETS/PACKAGE	Dermatological / Bath
SULFADIAZINE SILVER CREAM 1% TOPICAL 400GM JAR	Dermatological / Burn
BETAMETHASONE VALERATE LOTION USP 60ML PLASTIC BOTTLE	Dermatological / Corticosteriod
FLUOCINONIDE CREAM USP 0.05% 15GM TUBE	Dermatological / Corticosteriod
HYDROCORTISONE CREAM USP 1% 1 OZ (28.35 GM) TUBE	Dermatological / Corticosteriod
TRIAMCINOLONE ACETONIDE CREAM USP TOPICAL 0.1% 15 GM	Dermatological / Corticosteriod
NYSTATIN AND TRIAMCINOLONE ACETONIDE CREAM 15GM COLLAPSIBLE TUBE	Dermatological / Corticosteroid and Antifungal Combination
ZINC OXIDE OINTMENT USP 1 OZ (28.35 GM)	Dermatological / Protectants / Topical
CLIOQUINOL AND HYDROCORTISONE CREAM USP 20GM TUBE	Dermatological / Pseudo Foliculitis Barbae
PERMETHRIN CREAM 60GM TUBE	Dermatological / Scabicides / Pediculicides
PERMETHRIN CREAM RINSE 0.100% 2FL OZ PLASTIC SQUEEZE BOTTLE	Dermatological / Scabicides / Pediculicides
SUNSCREEN PREPARATION SPF-30 8 HOUR WATERPROOF 4OZ BOTTLE	Dermatological / Sunscreen
CALAMINE LOTION USP 4 OUNCES OR 118 MILLILITERS	Dermatological / Topical Astrigents
ENT	
CETYLPYRIDINIUM CHLORIDE AND BENZOCAINE LOZENGES 648 PER PACKAGE	ENT / Anesthetic / Throat
NYSTATIN ORAL SUSPENSION USP 100000 UNITS/ML 60ML BOTTLE	ENT / Antifungal Oral
PSEUDOEPHEDRINE HYDROCHLORIDE TABLETS USP 60MG 100S	ENT / Decongestant
TRIPROLIDINE AND PSEUDOEPHEDRINE HYDROCHLORIDES TABLETS USP 100S	ENT / Decongestant and Antihistamine

AMMAL Description	Drug Class
GUAIFENESIN AND PSEUDOEPHEDRINE HCL EXTENDED-RELEASE TABLETS100S	ENT / Expectorant / Decongestant
GUAIFENESIN AND DEXTROMETHORPHAN HYDROBROMIDE EXT-REL TABLETS100	ENT / Expectorants / Antitussive
FLUTICASONE PROPIONATE NASAL SPRAY 16GM 120 ACTUATIONS	ENT / Intranasal Steroid
OXYMETAZOLINE HYDROCHLORIDE NASAL SOLUTION 15ML SPRAY BOTTLE	ENT / Nasal Decongestants
PHENYLEPHRINE HCL NASAL SOLUTION USP .25% 15ML PLASTIC BOTTLE	ENT / Nasal Decongestants
BENZONATATE CAPSULES USP 100 MG 100S	ENT / NonNarcotic Antitussives
CARBAMIDE PEROXIDE OTIC SOLUTION 0.5FL OZ BOTTLE	ENT / Otic
HYDROCORTISONE AND ACETIC ACID OTIC SOLUTION USP 10ML BOTTLE3/PG	ENT / Otic
HYDROCORTISONE AND ACETIC ACID OTIC SOLUTION USP 10ML BOTTLE3/PG	ENT / Otic
ANTIPYRINE AND BENZOCAINE OTIC SOLUTION USP 10ML	ENT / Otic / Local Anesthesia
NEOMYCIN&POLYMYXIN B SULFATES&HYDROCORTISONE OTIC SUSP USP 10ML	ENT / Otic / Steroid and Antibiotic Combinations
Endocrine	
DEXTROAMPHETAMINE SULFATE TABLETS USP 5MG 100 TABLETS PER BOTTLE	Endocrine
MAGNESIUM SULFATE INJECTION USP 2ML AMPUL 25 AMPULS PER PACKAGE	Endocrine / Anticonvulsants
INSULIN HUMAN AND INSULIN HUMAN ISOPHANE SUSPENSION 10ML VIAL	Endocrine / Antidiabetics Agents / insulin
INSULIN HUMAN INJECTION MODIFIED 100UN/ML 10ML VIAL	Endocrine / Antidiabetics Agents / Insulin
METHYLPREDNISOLONE SOD SUCCINATE F/INJ USP 2GRAMS IN 50ML VIAL	Endocrine / Corticosteroids / IV
METHYLPREDNISOLONE SODIUM SUCCINATE FOR INJECTION USP 1000MG	Endocrine / Corticosteroids / IV

AMMAL Description	Drug Class
TRIAMCINOLONE ACETONIDE INJECTABLE SUSP USP 40MG/ML 5ML VIAL	Endocrine / Corticosteroids / IV
PREDNISONE TABLETS USP 10MG 500 TABLETS PER BOTTLE	Endocrine / Corticosteroids / Oral
GLUCAGON FOR INJECTION USP 1 MG UNIT FOR EMERGENCY USE	Endocrine / Diabetes related agent
POTASSIUM IODIDE TABLETS 130MG 14 TABLETS PER BOTTLE	Endocrine / Expectorants
CALCIUM CHLORIDE INJECTION USP 10% 10ML AMPUL 25 PER PACKAGE	Endocrine / Intravenous Nutritional Therapy / Electrolytes
DEXAMETHASONE SODIUM PHOSPHATE INJECTION USP 5CC	Endocrine / Corticosteroid / Parenteral
COLCHICINE TABLETS USP 0.6MG 100 TABLETS PER BOTTLE	Endocrine / Gout
ALLOPURINOL TABLETS USP 300MG 100 TABLETS PER BOTTLE	Endocrine / Gout
MULTIVITAMIN AND MINERAL TABLETS 100 TABLETS PER BOTTLE	Endocrine / Nutritional Combination Products
GLYBURIDE TABLETS 5MG 500S BT	Endocrine / Oral Hypoglycemic
METFORMIN HYDROCHLORIDE TABLETS 500MG 100S BT	Endocrine / Oral Hypoglycemic
LEVOTHYROXINE SODIUM TABLETS USP 0.1MG 100 TABLETS PER BOTTLE	Endocrine / Thyroid Drugs / Thyroid Hormones
FERROUS SULFATE TABLETS USP 324MG 1000 TABLETS PER BOTTLE	Endocrine / Trace Elements / Iron
THIAMINE HYDROCHLORIDE INJECTION USP 100MG/ML 2ML VIAL 25/PG	Endocrine / Vitamin/Endocrine and Metobolic
THIAMINE HYDROCHLORIDE TABLETS USP 50MG 100 TABLETS PER BOTTLE	Endocrine / Vitamin/Endocrine and Metobolic
PYRIDOXINE HYDROCHLORIDE TABLETS USP 50MG 100 TABLETS PER BOTTLE	Endocrine / Vitamins/Water-Soluble Vitamins
Gastrointestinal	
ALUMINA MAGNESIA AND SIMETHICONE ORAL SUSPENSION USP 5OZ BT 12S	Gastrointestinal / Antacid
ALUMINUM HYDROXIDE GEL DRIED MAGNESIUM TRISILICATE TABLETS 100S	Gastrointestinal / Antacid

AMMAL Description	Drug Class
ALUMINUM HYDROXIDE GEL DRIED MAGNESIUM TRISILICATE TABLETS 100S	Gastrointestinal / Antacid
ALUMINUM HYDROXIDE GEL USP 64MG/ML 12 OZ OR 355 ML BOTTLE	Gastrointestinal / Antacid
ALUMINUM MAGNESIUM SIMETHICONE TABLETS CHEWABLE 100 TABS/BOTTLE	Gastrointestinal / Antacid
BISMUTH SUBSALICYLATE TABLETS CHEWABLE SUGAR FREE I.S. 30S	Gastrointestinal / Anti Diarrheal, H. Pylori
GLYCOPYRROLATE INJECTION USP 0.2 MG PER ML 20 ML	Gastrointestinal / Anticholinergics / Antispasmodics
LOPERAMIDE HYDROCHLORIDE CAPSULES USP 2MG 100 CAPSULES/BOTTLE	Gastrointestinal / Antidiarrheals
METOCLOPRAMIDE INJECTION USP 5MG/ML 2ML VIAL 25S	Gastrointestinal / Antiemetic
PROCHLORPERAZINE MALEATE TABLETS USP 5MG 100 TABLETS PER BOTTLE	Gastrointestinal / Antiemetic
PROMETHAZINE HYDROCHLORIDE INJECTION USP 25MG/ML 1ML AMPUL 25/BX	Gastrointestinal / Antiemetic
PROMETHAZINE HYDROCHLORIDE TABLETS USP 25MG 100 TABLETS/BOTTLE	Gastrointestinal / Antiemetic
TRIMETHOBENZAMIDE HCL INJECTION USP 100MG/ML 2ML UNIT 10/PG	Gastrointestinal / Antiemetic
MECLIZINE HYDROCHLORIDE TABLETS USP CHEWABLE 25 MG 100S	Gastrointestinal / Antiemetic / Antivertigo
CHOLESTYRAMINE FOR ORAL SUSPENSION USP 210GM CAN	Gastrointestinal / Cardiovascular / Antihyperlipidemic
METHYLCELLULOSE USP 2GM POWDER FORM ORANGE FLAVOR 16OZ	Gastrointestinal / Dietary Fiber
METOCLOPRAMIDE INJECTION USP 5MG/ML 10ML VIAL 25 PER PACKAGE	Gastrointestinal / GI Stimulants
METOCLOPRAMIDE TABLETS USP 10MG 500 TABLETS PER BOTTLE	Gastrointestinal / GI Stimulants
HYDROCORTISONE ACETATE AND PRAMOXINE HYDROCHLORIDE CREAM 1OZ	Gastrointestinal / Hemorrhoidal Preparation

AMMAL Description	Drug Class
RANITIDINE INJECTION USP 25MG/ML 6ML VIAL	Gastrointestinal / Histamine H2 Antagonists
RANITIDINE TABLETS USP 150MG 60 TABLETS PER BOTTLE	Gastrointestinal / Histamine H2 Antagonists
SODIUM PHOSPHATES ENEMA USP DISP ENEMA UNIT 4-1/2 FL OZ (133 ML)	Gastrointestinal / Laxative
BISACODYL TABLETS USP 5MG I.S. 100 TABLETS PER BOX	Gastrointestinal / Laxatives / irritant or stimulant Laxative
CALCIUM CARBONATE TABLETS USP 600 MG CHEWABLE 45 TABS/PACKAGE	Gastrointestinal / Mineral and Electrolytes
RABEPRAZOLE SODIUM TABLETS 20 MG 90S	Gastrointestinal / Proton Pump Inhibitor
BARIUM SULFATE FOR SUSPENSION USP POWDER 25LB OR 11.340KG	Gastrointestinal / Radiopaque agents / Gi Contrast Agents
DOCUSATE SODIUM CAPSULES USP 100MG I.S. 100S	Gastrointestinal / Stool Softener
SUCRALFATE TABLETS 1GM 500 TABLETS PER BOTTLE	Gastrointestinal / Sucralfate
Immunizations	
GLOBULIN HEPATITIS B IMMUNE USP 5 ml Bottle	Immunization
GLOBULIN RABIES IMMUNE USP 10 DOSES 150UNITS PER Ml	Immunization
GLOBULIN RHO (D) IMMUNE USP	Immunization
HEPATITIS A VIRUS VACCINE INACTIVATED 50UN/1ML ADULT 1ML VIAL	Immunization
HEPATITIS B VIRUS VACCINE INACTIVATED MODIFIED 10MCG/ML 1ML VIAL	Immunization
TETANUS AND DIPHTHERIA TOXOIDS FOR ADULT USE ADSORBED USP 5ML	Immunization
TUBERCULIN PURIFIED PROTEIN DERIVATIVE 5 UNITS PER 0.1ML 50DOSES	Immunization
TYPHOID VACCINE MODIFIED 10ML VIAL 20 DOSES	Immunization
YELLOW FEVER VACCINE USP 5 SINGLE DOSE VIALS	Immunization
RABIES VACCINE HUMAN DIPLOID CELL STRAIN SYRINGE-NEEDLE UNIT	Immunization

AMMAL Description	Drug Class
Intravenous Fluids	
POTASSIUM CHLORIDE CONCENTRATE FOR INJECTION USP 20ML VIAL 25/PG	Intravenous / Electrolytes
SODIUM BICARBONATE INJ USP 8.4% SYRINGE-NEEDLE UNIT 50ML 10S	Intravenous / Electrolytes
SODIUM BICARBONATE INJECTION USP 50ML BOTTLE 10 PER PACKAGE	Intravenous / Electrolytes
DEXTROSE 5% AND .45% SODIUM CHLORIDE 1000 ML BAG 12S	Intravenous / Fluid
DEXTROSE AND SODIUM	Intravenous / Fluid
DEXTROSE AND SODIUM CHLORIDE INJECTION USP 1000 ML BAG 12/PG	Intravenous / Fluid
DEXTROSE AND SODIUM CHLORIDE INJECTION USP 500 ML BAG 24/PACKAGE	Intravenous / Fluid
DEXTROSE INJECTION USP 5% 1000 ML BAG 12 BAGS PER PACKAGE	Intravenous / Fluid
RINGER'S INJECTION LACTATED USP 1000 ML BAG 12 PER PACKAGE	Intravenous / Fluid
SODIUM CHLORIDE INJECTION USP 0.45% 1000 ML BAG 12 PER PACKAGE	Intravenous / Fluid
SODIUM CHLORIDE INJECTION USP 0.9% 1000 ML BAG 12 PER PACKAGE	Intravenous / Fluid
SODIUM CHLORIDE INJECTION USP 0.9% 500 ML BAG 24 PER PACKAGE	Intravenous / Fluid
DEXTROSE INJECTION USP 50 ML CARTRIDGE NEEDLE UNIT 50/PACKAGE	Intravenous Fluid / Diabetes Related
DEXTROSE INJECTION USP 3ML AMPUL 100 PER PACKAGE	Intravenous Fluid / Diluents
SODIUM CHLORIDE INJECTION USP 0.900% 10ML VIAL 25 VIALS/PACKAGE	Intravenous Fluid / Diluents
WATER FOR INJECTION STERILE USP 5ML AMPUL 25 AMPULS PER BOX	Intravenous Fluid / Diluents
SODIUM CHLORIDE IRRIGATION USP 0.9% 1000 ML BOTTLE 12/PACKAGE	Intravenous Fluid / Irrigation Fluid

AMMAL Description	Drug Class
WATER FOR IRRIGATION STERILE USP 1500 ML PLASTIC BOTTLE 9/PG	Intravenous Fluid / Irrigation Fluid
DEXTROSE INJECTION USP 5% 250 ML BAG 36 BAGS PER PACKAGE	Intravenous Fluid / Piggybac
SODIUM CHLORIDE INJECTION USP 0.9% 100 ML BAG 96	Intravenous Fluid / Piggybac
SODIUM CHLORIDE INJECTION USP 0.9% 250 ML BAG 36 PER PACKAGE	Intravenous Fluid / Piggybac
HETASTARCH IN LACTATED ELECTROLYE INJECTION 500ML CONTAINER 12S	Intravenous Fluid / Volume expander
Neurologicals	
NEOSTIGMINE METHYLSULFATE INJ USP 1MG/ML 10ML VIAL 10/PACKAGE	Neurological / Anticholinesterase Muscle Stimulants
PHENYTOIN SODIUM CAPSULES EXTENDED USP 100MG 100 CAPS PER BOTTLE	Neurological / Anticonvulsants
PHENYTOIN SODIUM INJECTION USP 50MG/ML VIAL 5ML 25S	Neurological / Anticonvulsants
LORAZEPAM INJECTION USP 2MG/ML 1ML SYRINGE 10 PER PACKAGE	Neurological / Benzodiazepines
LORZAEPAM TABLETS 1 MG 100 TABLETS PER BOTTLE	Neurological / Benzodiazepines
SUMATRIPTAN SUCCINATE INJECTION 6MG/0.5ML 2ML VIAL 5S	Neurological / Migraine
ERGOTAMINE TARTRATE AND CAFFEINE TABLETS USP 100 TABLETS/BOTTLE	Neurological / Migraine Combinations
ISOMETHEPTENE MUCATE ACETAMINOPHEN&DICHLORALPHENAZONE CAPS 100S	Neurological / Migraine Combinations
MANNITOL INJECTION USP 25% 50ML SINGLE DOSE VIALS 25 VIALS/PG	Neurological / Other
OB/GYN	
FLUCONAZOLE TABLETS 150MG 12S	OB/GYN / Antifungal / Oral
CLOTRIMAZOLE VAGINAL CREAM USP 1% 45GM TUBE WITH APPLICATOR	OB/GYN / Antifungal / Vaginal

AMMAL Description	Drug Class
TERCONAZOLE VAGINAL CREAM 0.4% 45GM TUBE W/DOSE APPLICATOR	OB/GYN / Antifungal / Vaginal
TIOCONAZOLE VAGINAL OINTMENT 65MG/GM 4.6GM APPLICATOR	OB/GYN / Antifungal / Vaginal
IMIQUIMOD CREAM MED 5% 250MG PACKET 12S PG	OB/GYN / Anti-Viral Topical
MEDROXYPROGESTERONE ACETATE INJECTABLE SUSP 150MG/ML 1ML VIAL	OB/GYN / Contraceptive / Injectable
CONTRACEPTIVE PATCHES NORELGESTROMIN 6MG ETHINYL ESTRADIOL 0,75MG 6 PATCHES BY 3	OB/GYN / Contraceptive / Patch / Ortho Evra
LEVONORGESTREL AND ETHINYL ESTRADIOL TABLETS 84S PG	OB/GYN / Contraceptive / Pill / Alesse-28
ETHYNODIOL DIACETATE AND ETHINYL ESTRADIOL TABS USP 126S	OB/GYN / Contraceptive / Pill / Demulen 1/35-21
NORGESTREL AND ETHINYL ESTRADIOL TABLETS USP 168 TABS/PACKAGE	OB/GYN / Contraceptive / Pill / LoOvral-28
NORETHINDRONE AND ETHINYL ESTRADIOL TABLETS USP 84 TABS/PACKAGE	OB/GYN / Contraceptive / Pill / Norinyl 1/35-28
NORGESTIMATE AND ETHINYL ESTRADIOL TABLETS 4032S PG	OB/GYN / Contraceptive / Pill / Ortho-Tricyclen-28
LEVONORGESTREL AND ETHINYL ESTRADIOL TABLETS 84S	OB/GYN / Contraceptive / Pill / Tri-Levlen-28
LEVONORGESTREL TABLETS 0.75 MG (2) PER PACKAGE	OB/GYN / Contraceptive / Post Coital / Plan B
MEDROXYPROGESTERONE ACETATE TABLETS USP 2.5MG 100 TABLETS/BOTTLE	OB/GYN / Hormone Replacement / Provera
FLUCONAZOLE TABLETS 150MG 12S	OB/GYN / Antifungal / Oral
Ophthalmics	
BACITRACIN ZINC&POLYMYXIN B SULFATE OPHTHALMIC OINT USP 3.5GM12S	Ophthalmic / Antibiotic
CIPROFLOXACIN HYDROCHLORIDE OPHTHALMIC SOLUTION 5ML BOTTLE	Ophthalmic / Antibiotic
ERYTHROMYCIN OPHTHALMIC OINTMENT USP 5MG/GM 3.5GM TUBE	Ophthalmic / Antibiotic
SULFACETAMIDE SOD OPHTHALMIC OINTMENT USP 10% 1/8 OZ (3.5 GM)	Ophthalmic / Antibiotic

AMMAL Description	Drug Class
SULFACETAMIDE SODIUM OPHTHALMIC SOLUTION USP 10% 15ML BOTTLE	Ophthalmic / Antibiotic
TRIMETHOPRIM AND POLYMIXIN B SULFATES OPHTHALMIC SOLUTION 10ML	Ophthalmic / Antibiotic
TRIFLURIDINE OPHTHALMIC SOLUTION 1% 7.5ML BOTTLE	Ophthalmic / Antiviral
PREDNISOLONE ACETATE OPHTHALMIC SUSPENSION 1% 5 ML	Ophthalmic / Corticosteroids
CYCLOPENTOLATE HYDROCHLORIDE OPHTHALMIC SOLUTION USP 5ML BOTTLE	Ophthalmic / Cycloplegic Mydriatics
TROPICAMIDE OPHTHALMIC SOLUTION USP 1% 15 ML	Ophthalmic / Cycloplegic Mydriatics
NAPHAZOLINE HCL&ANTAZOLINE PHOSPHATE OPHTHALMIC SOLUTION 15 ML	Ophthalmic / Decongestant Antihistamine
FLUORESCEIN SODIUM OPHTHALMIC STRIPS USP 1MG STERILE 100S	Ophthalmic / Flourescein
PILOCARPINE HYDROCHLORIDE OPHTHALMIC SOLUTION USP 2% 15 ML	Ophthalmic / Glaucoma
TIMOLOL MALEATE OPHTHALMIC SOLUTION USP 5ML BOTTLE	Ophthalmic / Glaucoma
ARTIFICIAL TEARS SOLUTION 15 ML DROPPER BOTTLE	Ophthalmic / Irrigation
HYDROXYPROPYL METHYLCELLULOSE OPHTHALMIC SOLUTION 0.5% 15ML BT	Ophthalmic / Irrigation
PROPARACAINE HYDROCHLORIDE OPHTHALMIC SOLUTION USP 0.5% 15 ML	Ophthalmic / Local Anesthetics
TETRACAINE HYDROCHLORIDE OPHTHALMIC SOLUTION 0.5% 15 ML	Ophthalmic / Local Anesthetics
TETRAHYDROZOLINE HYDROCHLORIDE OPHTHALMIC SOLUTION USP 0.05%15ML	Ophthalmic / Vasoconstrictors
Other	
GLUCOSE TEST SOLUTION 100GM 12 FL OZ BOTTLE 12 BOTTLES/PACKAGE	Diabetes Testing
SODA LIME NF 2.5LB CARTRIDGE 12 PER PACKAGE	
Psychiatric	

AMMAL Description	Drug Class
HALOPERIDOL INJECTION USP 5MG/ML 1ML AMPUL 10 AMPULES/PACKAGE	Psychiatric / Antipsychotic agents
HALOPERIDOL TABLETS USP 2MG 1000 TABLETS PER BOTTLE	Psychiatric / Antipsychotic agents
ZOLPIDEM TARTRATE TABLETS 5 MG 100 TABLETS PER BOTTLE	Psychiatric / Benzodiazepine
TEMAZEPAM CAPSULES 15 MG 500 CAPSULES PER BOTTLE	Psychiatric / Benzodiazepine
BENZTROPINE MESYLATE INJECTION USP 1MG/ML 2ML AMPUL 6S PG	Psychiatric / Extrapyramidal reactions
BUPROPION HYDROCHLORIDE SUSTAINED RELEASE TABLETS 150MG 60S	Psychiatric / Smoking Cessation
CITALOPRAM HYDROBROMIDE (CELEXA) TABLETS 20MG 100'S	Psychiatric / SSRI
FLUOXETINE HYDROCHLORIDE CAPSULES 10MG 100 CAPSULES PER BOTTLE	Psychiatric / SSRI
PAROXETINE HYDROCHLORIDE TABLETS 20MG 100S BT	Psychiatric / SSRI
SERTRALINE HYDROCHLORIDE TABLETS 100MG 100 TABLETS PER PACKAGE	Psychiatric / SSRI
Pulmonary	
CARBON DIOXIDE USP CYLINDER TYPE E	Pulmonary
NEDOCROMIL SODIUM INHALATION AEROSOL 16.2 GM 112 METERED DOSES	Pulmonary
IPRATROPIUM BROMIDE INHALATION AEROSOL 14GM VIAL 200 INHALATIONS	Pulmonary / Anticholinergics
ALBUTEROL INHALATION AEROSOL 17GM CONTAINER 200 METERED SPRAYS	Pulmonary / Beta Agonists
ALBUTEROL SULFATE INHALATION SOLUTION 3ML BOTTLE 25 BOTTLES/PG	Pulmonary / Beta Agonists
SALMETEROL DISKUS INHALER POWDER 50MCG W/DEVICE 60 BLISTERS	Pulmonary / Beta Agonists
TERBUTALINE SULFATE INJECTION USP 1MG/ML 1ML AMPUL 10/PACKAGE	Pulmonary / Beta Agonists

AMMAL Description	Drug Class
BECLOMETHASONE DIPROPIONATE INHALATION AEROSOL 16.8GM OR 5.88OZ	Pulmonary / Corticosteroid
TRIAMCINOLONE ACETONIDE INHALATION AEROSOL 20GM CONTAINER	Pulmonary / Corticosteroid
OXYGEN USP 99% CYLINDER TYPE D 95GL	Pulmonary / Oxygen
OXYGEN USP 99% CYLINDER TYPE H 1650 GALLON	Pulmonary / Oxygen
Urology	
PHENAZOPYRIDINE HYDROCHLORIDE TABLETS USP 100MG 100 TABLETS/BT	Urology / Interstitial Cystitis Agents
SODIUM CITRATE AND CITRIC ACID ORAL SOLUTION USP 473ML BOTTLE	Urology / Urinary Alkalinizers
METHYLERGONOVINE MALEATE INJECTION USP 0.2MG/CC 1ML AMPUL 20/BX	Urology / Uterine-Active Agents/Oxytocicis
METHYLERGONOVINE MALEATE TABLETS USP 0.2MG 100 TABLETS/BOTTLE	Urology / Uterine-Active Agents/Oxytocicis
OXYTOCIN INJECTION USP 10 UNITS/ML 1ML AMPUL 25 PER PACKAGE	Urology / Uterine-Active Agents/Oxytocics
OXYBUTININ CHLORIDE TABLETS USP 5MG 100S BT	Urology / Anti-Spasmotic

APPENDIX L

AMMAL Change Request Form

CURRENT NSN:
NOMENCLATURE:
CHECK ONE: ☐ **Add** ☐ **Replace** ☐ **Delete with Replacement** ☐ **Delete W/O Replacement**
NEW OR REPLACEMENT NSN:
NEW OR REPLACEMENT NOMENCLATURE:
(If this item is a piece of equipment, provide the information below. If available, a copy of the company catalog/item sheet should be forwarded with the ACR)
MANUFACTURER NAME:
ADDRESS:
PHONE:
MODEL #: **PART #:** **CAT #:**
JUSTIFICATION FOR CHANGE:
AMMAL(S) AFFECTED:

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APPENDIX M

Authorized Minimal Medical Allowance Lists

1. The following AMMALs will be carried aboard NAVAIRFOR aircraft carriers:

TITLE	OSI	REQD
First Aid Box	0927	90
BMET Afloat	0937	1
Junior Emergency Response Kit	0944	5
Battle Dressing Station	0955	6
Mass Casualty Box	0963	7
Level III X-ray	1011	1
Optician Allowance	1012	1
CVN Core	1013	1
CVN Supplemental	1014	1
CVN Laboratory Core	1015	1
CVN Laboratory Supplemental	1016	1
Women At Sea	1017	1
Physical Therapy	1028	1
CBR (Force Protection Block)	1031	1

TITLE	SRI	REQD
Level III X-ray	2011	1
Optician Allowance	2012	1
Core	2013	1
Supplemental	2014	1
Lab Core	2015	1
Lab Supplemental	2016	1
Women At Sea	2017	1
Physical Therapy Block	2028	1

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APPENDIX N

Medical Department Training

1. The following training courses are required based on the billet assigned.

BSN	TITLE	GRADE RATE RATING	PRI NOBC NEC	COURSE	COURSE	COURSE	COURSE
002010	SENIOR MED OFF	2102H	163	J-495-0412	B-300-0038	ATLS	ACLS
002020	NRS ANESTH	2900I	952	J-495-0412	ACLS	B-6H-3001	
002030	GEN SGN	2100I	214	J-495-0412	B-6A-2300	B-6H-3001 ACLS	B-6A-1013 ATLS
002040	NURSE	2900J	904	J-495-0412	B-6A-2301	B-6H-3001 TNCC	ACLS FSO1
002050	PHYS THERAPIST	2300J	873	J-495-0412	B-6A-2301	B-6H-3001	HP
002060	CLIN PSYCH	2300J	851	J-495-0412	B-6A-2301	B-6H-3001	
002070	MED ADMIN OFF	2300J	800	J-495-0412	B-6A-2301	B-6H-3001	SAMS SUPPLY
002080	PHYSICIAN ASST	2300J	113	J-495-0412	B-6A-2301	B-6H-3001	ACLS
002090	GEN MED OFF	2100J	102	J-495-0412	B-6A-2300	B-6H-3001	ACLS ATLS
	RAD HEALTH OFFICER	2300J	1825	J-495-0412	B-6A-2301	B-6H-3001	
002110	SARP COUNSELOR	CPO	9519	J-495-0412			
002120	SARP INTERN	PO1	9522	J-495-0412			
002130	HOSPCORPS-LCPO	HMCS		J-495-0412	B-300-1000	SAMS	
002140	HOSPCORPS-PMT	HMC	8432	J-495-0412	B-322-1075	B-322-2101	B-322-2130 SAMS
002150	HOSPCORPS-BMET	HM1	8478	J-495-0412			
002160	HOSPCORPS-PMT	HM1	8432	J-495-0412	B-322-1075	B-322-2101	B-322-2130 SAMS
002170	HOSPCORPS-IDC	HM1	8425	J-495-0412	FSO1	B-6H-3001	
002180	HOSPCORPS-RAD HLTH	HM1	8407	J-495-0412	SAMS		
002190	HOSPCORPS-AVT	HM1	8406	J-495-0412			
002200	HOSPCORPS-ADV LAB	HM2	8506	J-495-0412	B-311-0118		
002210	HOSPCORPS-PSYCH	HM2	8485	J-495-0412			
002220	HOSPCORPS-PT	HM2	8466	J-495-0412			
002230	HOSPCORPS-OPTIC	HM2	8463	J-495-0412			

002240	HOSPCORPS-PMT	HM2	8432	J-495-0412	B-322-1075	SAMS	B-322-2101
002250	HOSPCORPS-IDC	HM2	8425	J-495-0412	FSO1	B-6H-3001	
002260	HOSPCORPS-AVT	HM2	8406	J-495-0412			
002270	HOSPCORPS-GEN DUTY	HM2	0000	J-495-0412	B-300-1000	SAMS	SUPPLY
002280	HOSPCORPS-ADV LAB	HM3	8506	J-495-0412	B-311-0118		
002290	HOSPCORPS-SURG	HM3	8483	J-495-0412	FSO1		
002300	HOSPCORPS-PHARM	HM3	8482	J-495-0412	SAMS		
002310	HOSPCORPS-XRAY	HM3	8452	J-495-0412			
002320	HOSPCORPS-RAD HLTH	HM3	8407	J-495-0412	SAMS		
002330	HOSPCORPS-GEN DUTY	HM3	0000	J-495-0412	B-300-1000	PHTLS	
002340	HOSPCORPS-GEN DUTY	HM3	0000	J-495-0412	B-300-1000	PHTLS	
002350	HOSPCORPS-GEN DUTY	HM3	0000	J-495-0412	B-300-1000	PHTLS	
002360	HOSPCORPS-GEN DUTY	HM3	0000	J-495-0412	B-300-1000	PHTLS	
002370	HN-SURG TECH	HN	8483	J-495-0412	FSO1		
002380	HN-GEN DUTY	HN	0000	J-495-0412	PHTLS		
002390	HN-GEN DUTY	HN	0000	J-495-0412	PHTLS		
002400	HN-GEN DUTY	HN	0000	J-495-0412	PHTLS		
002410	HN-GEN DUTY	HN	0000	J-495-0412	PHTLS		
002420	HN-GEN DUTY	HN	0000	J-495-0412	PHTLS		
002430	HN-GEN DUTY	HN	0000	J-495-0412	PHTLS		

CIN	COURSES
J-495-0412	SHIPBD FIRE FIGHTING
B-322-1075	SHIPBD PEST MGMT
B-322-2101	FOOD SAFETY MGR
B-322-2130	MARINE SANITATION
FSO1	CPR INSTRUCTOR
B-6H-3001	FMCBC (NAVY CHEM, BIO, RAD & ENVIRON CASUALTY CARE MGMT COURSE)
B-300-0038	MED MGMT OF CHEM & BIO CASUALTIES
B-300-1000	SURFACE FORCE MEDICAL INDOCTRINATION (BABY DOC)
B-6A-2301	SURFACE WARFARE MED DEPT OFFICER INDOC COURSE (SWMDOIC)
B-6A-2300	SURFACE WARFARE MEDICAL OFFICER INDOCTRINATION COURSE (SWMOIC)
B-311-0118	
B-6A-1013	TRAUMA REFRESHER COURSE FOR SURGEONS (TRCS)
	SPAWAR SAMS COURSE (SAMS)
	SUPPLY MGMT COURSE (SUPPLY)
	ADV CARDIAC LIFE SUPPORT (ACLS)
	ADV TRAUMA LIFE SUPPORT (ATLS)
	AUDIOMETRIC TECH SCHOOL (AUDIO)
	HEALTH PROMOTION COURSE (HP)
	PRE-HOSPITAL TRAUMA LIFE SUPPORT (PHTLS)
	TRAUMA NURSING CORE COURSE (TNCC)

APPENDIX O

Sample Medical Department Battle Doctrine

USS NEVERSAIL INSTRUCTION 6101.1

Subj: Medical Department Battle Doctrine

Ref: (a) COMNAVAIRFORINST 6000.1
(d) Authorized Minimum Medical Allowance List

1. Purpose. To promulgate guidance on the facilities, functions, procedures, responsibilities and policies of the Medical Department and other departments for emergencies and battle per references (a) and (b).

2. Scope

a. Location of Battle Dressing Stations

(1) Six Battle Dressing Stations are maintained onboard this ship and are located as follows:

(a) Main (Sick Bay) 1-142-1-L

(b) Forward (FWD EDF) 1-114-1-L

(c) Aft (AFT EDF) 1-184-1-L

(d) Flight Deck 04-144-0-L

(e) Forward (Auxiliary) 03-44-0-L

(f) Aft (Auxiliary) 03-163-0-L

(2) Routing to all Battle Dressing Stations will be indicated on bulkheads and hatches by approved markings designated in General Specifications for ships of the United States Navy and reference (c).

b. Assignments of specific duties of Medical/Dental Department personnel and stretcher bearers assigned to the Battle Stations, shall be assigned by name to the Watch, Quarter and Station Bill:

(1) The Medical Department personnel shall not be assigned duties away from the ship or on any of the Ship's Bills except for extreme emergencies. Duties involving casualties away from the ship shall be assigned to Medical Department personnel only if directed by the Commanding Officer.

(2) The Medical Department shall be prepared for emergencies at all times. The Watch, Quarter and Station Bill shall be kept current and posted in sick bay. All personnel of the Medical Department shall be continually instructed and familiarized with his/her station and prescribed duties. This bill shall be kept current at all times.

(3) General Quarters: General Quarters are the assigned battle stations of the officers and crew for fire, collision, and battle.

(a) Condition ONE: Engagement with the enemy is imminent. Medical Department personnel will not leave assigned battle stations to treat casualties; all casualties will be brought to the nearest Battle Dressing Station for treatment.

(b) Condition TWO: Engagement with the enemy is probable. Medical Department personnel man battle stations in a condition of readiness.

(c) Condition THREE: Engagement with the enemy is possible. Medical Department personnel must be prepared to assume the responsibilities of Condition ONE, but carry out their daily routine until otherwise directed.

c. Preparation of the Medical Department for Emergencies or Battle.

(1) Each Battle Dressing Station will be equipped with the supplies and equipment as outlined in references (c) and (d).

(a) A list of medical supplies at each station will be posted in the Battle Dressing Station, and will be maintained, inspected, and inventoried every six months to ensure readiness.

(b) The supplies in Battle Dressing Stations shall be carried in the "on hand" column on the stock record cards. These items are reserve stock and should be rotated into the working stock prior to expiration date. When taken from reserve stock, these items are to be reordered and replaced.

(c) Deteriorated items shall be replaced as required.

(d) Controlled substances, narcotics, and barbiturates that are carried as reserve stock shall not be routinely stored in the Battle Dressing Stations, but under the custody of the Bulk Custodian until the need arises for their possible use as directed by the Commanding Officer. They shall be issued by the Bulk Custodian, and shall be returned to the Bulk Custodian when the need no longer exists.

(e) Sterile goods, if sealed in plastic in accordance with Event-Related Sterilization guidelines are subject to re-inspection

only upon damage to the outer packaging. The date of sterilization will be placed on each package. Steam, Pressure Sensitive Adhesive, 1" Wide (NSN 9L 6530-00-299-9821) shall be used. Pre-packaged sterile knife blades and suture materials can be placed in the plastic dust cover with the sterile packs. A piece of tape should be placed on the outside of the plastic cover indicating the expiration date of the suture material inside. A list of contents containing the NSN, nomenclature, and quantity shall also be attached to the outside of all sterile packs. A list of surgical instruments and supplies required for surgical kits is contained in reference (c).

(1) Mass Casualty Boxes shall be stocked per AMMAL 0963 and maintained in the same manner as Battle Dressing Stations. A list of supplies shall be posted inside of each Mass Casualty Box. The locations are as follows:

COMPARTMENT NUMBER	NAME OF SPACE

(1) (2) First Aid Boxes:

(a) There are 90 wall type, weather-proofed First Aid Boxes on the ship. Each box is located as follows:

COMPARTMENT NUMBER	NAME OF SPACE

(b) A list of the required contents of these boxes is outlined in reference (c). A list of the supplies shall be posted inside of each box.

(c) The First Aid boxes shall be maintained in the same manner as the Battle Dressing Stations and Mass Casualty Boxes. They shall, however, be sealed with single strand wire and the seals inspected routinely for pilferage.

(d) Inspection and inventory of these boxes shall be conducted quarterly to replace deteriorated items and replenish as necessary. In the event boxes are entered, they will be inventoried and replenished immediately.

(3) Junior Emergency Response Kits (JERK) shall be maintained as follows:

(a) A total of 10 kits will be maintained in medical spaces.

(b) Items shall be replaced immediately as used.

(c) Kits will contain an inventory list and will be inventoried at least semi-annually to replace deteriorated items and replenish as necessary.

(d) The surgical instrument set shall be sterilized and maintained in the same manner as the sterile packs.

(4) Gun Bags

(a) There are 16 gun bags located as follows:

COMPARTMENT NUMBER	NAME OF SPACE

(b) They shall be maintained in accordance with reference (a). These bags are not to be used routinely, but maintained for emergency use only. One gun bag will be in each repair locker and one in each Battle Dressing Station for use by the stretcher bearers.

(5) Stretchers

(a) 80 Stokes and 24 semi-rigid (Reeve’s Sleeve)stretchers shall be well dispersed about the ship. Their locations and use shall be an item of instruction to all members of the crew.

(b) Location of Stokes Litters are as follows:

COMPARTMENT NUMBER	NAME OF SPACE

(c) Location of Reeve’s Sleeves are as follows:

COMPARTMENT NUMBER	NAME OF SPACE

(6) Small Craft First Aid Kits.

(a) There are (NUMBER) Small Craft First Aid Kits (NSN 6545-01-459-1115), one located in each Small Craft: Rigid Inflatables, the Captain's Gig, and in the barge.

(c) The contents in the Small Craft First Aid Kits shall be enclosed in plastic bags; these kits shall be opened and inspected as required by PMS.

d. Order of First Aid and Treatment

(1) First aid treatment must be initiated by the crewmember(s) on the scene and assist injured personnel to treatment facilities whenever possible.

(2) Stretcher Bearers will relieve the crewmember(s), rendering necessary first aid on the scene of the casualty, return the minor injuries to duty, and transfer the more serious casualties to Battle Dressing Stations.

(3) Self-aid or Buddy aid. Use available aid supplies in kits, boxes, etc., to stop hemorrhage, prevent or treat shock, alleviate respiratory distress, and assist injured personnel to treatment facilities.

(4) Battle Dressing Stations:

(b) Primary duty: To return as many casualties to duty as quickly as possible.

(c) To separate casualties not immediately returnable to duty and provide for their continuous care.

e. Action During Battle

(1) Treatment of casualties in order of seriousness, temporarily treating the more serious, and interrupting this treatment to treat the less serious casualties for return to duty.

(2) Arranging for evacuation of more serious casualties and expired patients from the Battle Dressing Station, as time and circumstances allow.

f. Action Immediately After Battle

(1) Continue treatment of battle casualties.

(2) Restore Battle Dressing Stations and first aid facilities to battle readiness.

(3) Arrange for transfer of serious casualties to medical treatment facilities.

(4) Report to the Commanding Officer the number of casualties and their status.

(5) The dead should be collected, prepared and stored.

(a) The following locations have been designated for storage of the dead:

COMPARTMENT NUMBER	NAME OF SPACE

(b) If the dead are to be kept until arrival in port, they should be placed in cold storage.

(1) Cold storage spaces must contain no other items and must be cleaned and fumigated prior to reuse. Refer to Decedent Affairs Manual.

(2) Remains must be kept at a temperature of 36-40 degrees Fahrenheit to prevent decomposition.

(3) The following refrigerated spaces have been designated for storage of the dead (Note: Indicate a primary and secondary storage refrigerator):

COMPARTMENT NUMBER	NAME OF SPACE

(7) Casualties Requiring Surgical or Medical Care

(a) Minor surgical or medical cases shall be evacuated to the (DESIGNATED) Battle Dressing Station.

(b) Major surgical or medical cases shall be evacuated to the Main Battle Dressing Station, or designated alternate location.

(8) Spaces Assigned for Collection of Battle Casualties.

(a) Seriously injured: (LOCATION)

(b) Minor injuries: (LOCATION)

(c) Mental cases: (LOCATION)

(9) Disposition of Battle Fatalities (See Decedent Affairs Manual, BUMEDINST 5360.1 (series)).

(a) Transfer remains ashore. (Request assistance from SOPA).

(b) Burial at sea. (Refer Decedent Affairs Manual, Chapter 8-1).

(10) Disposition of Missing Battle Casualties

(a) When death has not been established, a SF 600 will be completed giving all particulars pertaining to the presumed disappearance of the individual. The health record shall be closed and handled per NAVMED P-117, Chapter 16.

(b) When death is proven conclusively, procedures shall be as directed by BUMEDINST 5360.1 (series).

g. CBR Medical Defense

(1) Location of Decontamination Stations

(a) Forward Decontamination Station: (LOCATION)

(b) After Decontamination Station: (LOCATION)

(2) Flow of personnel to Decontamination Stations shall be directed by the Commanding Officer and coordinated by Damage Control Central.

(3) Access hatches leading to all Decontamination Stations shall be clearly marked.

(4) Organization of Medical Care for Contaminated Personnel.

(a) No person shall be sent to a non-contaminated area until completely decontaminated and monitored to ensure decontamination.

(b) After decontamination, injured persons, or persons requiring other medical care, may be sent to the designated Battle Dressing Station.

(5) Medical Department personnel shall be thoroughly informed on medical aspects of CBR defense and treatment of casualties.

(a) The Senior Medical Officer shall advise the Commanding Officer concerning medical aspects of CBR defense, including treatment and handling of casualties.

(b) Duties of Medical Department personnel assigned to decontamination stations are to treat the injured and ensure, with the aid of qualified damage control personnel, that proper monitoring and decontamination procedures are carried out.

(6) The Senior Medical Officer shall insure the Decontamination Station medical supplies and equipment are readily available. Decontamination station medical supplies are located at:

COMPARTMENT NUMBER	NAME OF SPACE

(7) Life saving measures may be taken immediately, but personnel providing treatment should minimize the possibility of becoming contaminated. If first aid is not immediately indicated, decontamination shall be accomplished prior to medical treatment.

(8) Ionizing Radiation Casualties. Treatment and handling of radiation casualties will be per current instructions.

(9) Care of the Dead.

(a) Deceased personnel who have been exposed to ionizing radiation must be monitored before transfer from the ship.

(b) Radioactive human remains will have routine decontamination procedures completed.

3. Training of Crew, Stretcher Bearers, Food Handlers, and Assigned Medical Department Personnel. A long-range training schedule for the officers and crew must be prepared by the Medical Department and filed with the Training Officer. From this program, the Training Officer shall assign training periods by division and it shall be published weekly in the Plan of the Day.

a. A training log shall be maintained indicating date, subject matter, number present, division attending, and instructor's name. All training shall be recorded in the Medical Department Daily Journal.

b. Hospital Corpsmen and Strikers shall have on the job training, completed correspondence courses, and studied the Handbook of the Hospital Corps.

c. Instruction of stretcher bearers shall be more intense than for other crew members, and shall include familiarization and use of all medical material in the gun bags.

d. Movies and training aids for instruction shall be ordered through the Training Officer.

(Signature)

APPENDIX P

Surgical Instrument Set Requirements

PLATFORM	MAJ SURG	MIN SURG	TRACH	CHEST	FX/ AMP	LAP	CHEST TUBE	ENT	VASC	BURR HOLE
AE		2								
AGF	1	4	1							
AO	1	4	1							
AOE	1	4	1							
ARS		2								
CG		2								
DD		2								
DDG		2								
FFG		2								
LCC	1	4	1							
LHA	6	67	6	2	10	8	6	3	2	4
LHD	6	67	6	2	10	8	6	3	2	4
LPD	1	4	1							
LSD 36		2								
LSD 41/49	1	4	1							
LST		2								
MCM		2								
MCS	1	4	1							
MHC		2								
CV/CVN	**4**	**12**	**4**	**2**	**2**	**4**	**4**	**2**	**2**	**2**
AS	2	10	2		1	2				
SSN		10								
SSBN		10								
AFDM/AFDB/ARDM/ ARD		5								
AGSS-555		5								
BDS (ALL SHIPS)		**4**								

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MAJOR SURGERY SET				
NSN	**NOMENCLATURE**	**UI**	**UPRICE**	**QTY**
6515003204600	FORCEPS TOWEL BACKHAUS 5.25" LG OPPOSED PRONGS TOWEL CLAMP CRS	EA	12.67	6
6515003333100	FORCEPS DRESSING CUSHING 7" LG STR & SERRATED RD TIP SLENDER MDL	EA	1.44	1
6515003333600	FORCEPS DRESSING 5.50"LG STRAIGHT AND SERRATED JAW ROUND TIP CRS	EA	5.26	2
6515003343800	FORCEPS HEMO KELLY 5.25-5.75" LG SLIGHTLY CURVED JAW STR HDL CRS	EA	10.77	10
6515003344900	FORCEPS HEMO HALSTED DESIGN 4.75-5.25" LG SLIGHTLY CRVD SERR CRS	EA	8.24	4
6515003345600	FORCEPS HEMO HALSTED 5"LG 0.875"JAW STRAIGHT JAW CRS BOX LOCK	EA	8.87	10
6515003346800	FORCEPS HEMO KELLY 5.50" LG 1" LG STRAIGHT JAW BOX LOCK CRS	EA	8.87	4
6515003347400	FORCEPS HEMO ROCHESTER-OCHSNER 1.5-1.75" STR JAW 6.25-6.75" LG	EA	11.59	2
6515003351900	FORCEPS INTESTINAL DOYEN DESIGN 8.750" O/A LG BOX LOCK JOINT CRS	EA	18.31	4
6515003352800	FORCEPS INTESTINAL BABCOCK DESIGN 6.250" O/A LG STR BOX LOCK CRS	EA	14.34	2
6515003353200	FORCEPS INTESTINAL DOYEN STRAIGHT 8.75-9.25"O/A LG CRS BOX LOCK	EA	18.38	3
6515003373900	FORCEPS GAUZE PAD HOLDING FOERSTER 9-9.75" LG BOX LOCK JOINT CRS	EA	15.20	1
6515003377800	FORCEPS TISSUE ADSON 4.50" LG TWEEZER STRAIGHT & SMOOTH JAW CRS	EA	7.60	2
6515003380300	FORCEPS TISSUE ALLIS DSGN 6"LG PIVOTED STRAIGHT & SMOOTH JAW CRS	EA	15.84	2
6515003419200	HOLDER SUTURE NEEDLE HEGAR-MAYO 7" LG CENTRAL OVAL GROOVED JAWS	EA	8.75	2
6515003447800	HANDLE SURGICAL KNIFE DETACHABLE BLADE SIZE 3 NARROW NOSE	EA	1.98	2
6515003604910	RETRACTOR ABDOMINAL BALFORD SIX-BLADED SLIDING BAR LARGE SIZE	EA	148.81	1
6515003609200	RETRACTOR SET GENERAL OPERATING DOUBLE END 8.5 & 8.75" BLADES	SE	9.20	1
6515003610350	RETRACTOR GENERAL OPERATING VOLKMAN DESIGN 8.5" SIZE 4 PRONG CRS	EA	13.16	2
6515003631100	SAW AMPUTATING SATTERLEE 8"BLADE LG 2.25"WIDTH F/LGE BONE SAWING	EA	45.61	1
6515003640520	SCISSORS GEN SURG MAYO CRVD BLADE 6.50-7" LG BLADE POINTS BLUNT	EA	14.44	1
6515003640920	SCISSORS GEN SURG MAYO DSGN 6.50-7" LG BLUNT PTS 1.626" CUT LG	EA	14.13	1
6515003657100	SCISSORS TONSIL METZENBAUM 7" O/A LG CRVD BLADE BLUNT POINTS CRS	EA	11.47	1
6515003866600	CANNULA ABDOMINAL POOLE 23FR 8.75" LG FENESTRATED CURVED HUB	EA	12.67	1
6515006600008	BLADE SURG KNIFE DET NO.15 CARBON STEEL U/W 3 3L 7 9 HANDLE 6S	PG	1.25	2
6515006600010	BLADE SURG KNIFE DET NO.11 SMALL TANG U/W 3 3L 7 9 HANDLE CS 6S	PG	0.72	2
6515006600011	BLADE SURG KNIFE DET NO.10 SMALL TANG U/W 3 3L 7 9 HANDLE CS 6S	PG	1.31	2
6515006647853	RETRACTOR SET GENERAL OPERATING DOUBLE END 1.5X13" & 2X13"BLADES	SE	20.98	1
6515011151730	SCISSORS GEN SURGERY METZENBAUM DISSECTING 9" LG CRVD BLADE CRS	EA	52.16	1
6530007939570	TRAY INSTRUMENT CORROSION-RESISTING STEEL 19.25X12.75X.75 INCHES	EA	54.78	1
6530010324088	DRAPE SURGICAL NONWOVEN FABRIC DISPOSABLE 100IN LG 92IN WIDE 20S	PG	92.53	1
7210002999610	TOWEL HAND COTTON 36X17INCHES SOLID GREEN GRAY NONDISPOSABLE	EA	1.71	8
MINOR SURGERY SET				
NSN	**NOMENCLATURE**	**UI**	**UPRICE**	**QTY**
6515002998736	HOLDER, NEEDLE HAGAR-MAYO 6"	EA	16.04	1
6515003343800	FORCEPS HEMO KELLY 5.25-5.75" LG SLIGHTLY CURVED JAW STR HDL CRS	EA	10.77	2
6515003346800	FORCEPS HEMO KELLY 5.50" LG 1" LG STRAIGHT JAW BOX LOCK CRS	EA	8.87	2
6515003377800	FORCEPS TISSUE ADSON 4.50" LG TWEEZER STRAIGHT & SMOOTH JAW CRS	EA	7.60	1
6515003379800	FORCEPS TISSUE 5" LG TWEEZER STRAIGHT AND SMOOTH JAW SQ TIP CRS	EA	2.50	1
6515003417200	HOLDER SUTURE NEEDLE COLLIER 5" LG STRAIGHT JAW BOX LOCK CRS	EA	16.15	1
6515003447800	HANDLE SURGICAL KNIFE DETACHABLE BLADE SIZE 3 NARROW NOSE	EA	1.98	1
6515011190018	PROBE GEN OPER 5"LG .062" DIA CRS SPATULATE HANDLE BULBOUS TIP	EA	3.55	1
6515003651820	SCISSORS GEN SURG 5.50" LG ONE BLUNT AND ONE SHARP BLADE PT CRS	EA	10.33	1
6515006600010	BLADE SURG KNIFE DET NO.11 SMALL TANG U/W 3 3L 7 9 HANDLE CS 6S	PG	0.72	2
6515006600011	BLADE SURG KNIFE DET NO.10 SMALL TANG U/W 3 3L 7 9 HANDLE CS 6S	PG	1.31	2
6530002999608	DRAPE SURGICAL GENERAL SURGERY GREEN 24 X 24 INCHES	EA	5.35	1

6530007939945	TRAY INSTRUMENT CORROSION RESISTING STEEL 10-1/2 X 8 X 2 INCHES	EA	6.23	1

TRACHEOTOMY SET

NOMENCLATURE	UI	UPRICE	QTY
FORCEPS TOWEL BACKHAUS 3.5" LG OPPOSED PRONGS TOWEL CLAMP CRS	EA	10.26	4
DILATOR TRACHEAL TROUSSEAU 5.5"LG CURVED SMOOTH STRAIGHT HDL	EA	13.18	1
FORCEPS HEMO KELLY 5.25-5.75" LG SLIGHTLY CURVED JAW STR HDL CRS	EA	10.77	1
FORCEPS HEMO HALSTED 5"LG 0.875"JAW STRAIGHT JAW CRS BOX LOCK	EA	8.87	1
FORCEPS TISSUE 5" LG TWEEZER STRAIGHT AND SMOOTH JAW SQ TIP CRS	EA	2.50	1
FORCEPS TISSUE ALLIS DSGN 6"LG PIVOTED STRAIGHT & SMOOTH JAW CRS	EA	15.84	1
HANDLE SURGICAL KNIFE DETACHABLE BLADE SIZE 3 NARROW NOSE	EA	1.98	1
PROBE GEN OPER 5"LG .062" DIA CRS SPATULATE HANDLE BULBOUS TIP	EA	3.55	1
RETRACTOR TRACHEAL HUPP DESIGN CRS SHARP BLADE POINT STR HANDLE	EA	11.39	1
RETRACTOR TRACHEAL HUPP CRS SHARP BLADE POINT 3 PRONG QUANTITY	EA	5.27	1
SCISSORS IRIS 4-4.50" O/A LG CRVD BLADE SHARP POINTS FNGR RING	EA	12.04	1
SCISSORS GEN SURG 5.50" LG ONE BLUNT AND ONE SHARP BLADE PT CRS	EA	10.33	1
BLADE SURG KNIFE DET NO.11 SMALL TANG U/W 3 3L 7 9 HANDLE CS 6S	PG	0.72	2
BLADE SURG KNIFE DET NO.10 SMALL TANG U/W 3 3L 7 9 HANDLE CS 6S	PG	1.31	2
CANNULA TRACHEOSTOMY SZ 4 WITH INTEGRAL 15MM MALE ADAPTER NYLON	EA	17.55	1
CANNULA TRACHEOSTOMY SZ 6 WITH INTEGRAL 15MM MALE ADAPTER NYLON	EA	17.55	1
CANNULA TRACHEOSTOMY SZ 7 WITH INTEGRAL 15MM MALE ADAPTER NYLON	EA	14.87	1
CANNULA KIT TRACHEOSTOMY SIZE 8 NYLON PERM ATCH 15MM MALE ADAP	EA	18.83	1
TRAY INSTRUMENT CORROSION RESISTING STEEL 10-1/2 X 8 X 2 INCHES	EA	6.23	1
TOWEL HAND COTTON 36X17INCHES SOLID GREEN GRAY NONDISPOSABLE	EA	1.71	4

CHEST SET

NSN	NOMENCLATURE	UI	UPRICE	QTY
6515000653181	FORCEPS HEMO MIXTER HALF-CURVED 6.87-7.375"LG 1.625-1.875"JAW	EA	13.68	6
6515003204600	FORCEPS TOWEL BACKHAUS 5.25" LG OPPOSED PRONGS TOWEL CLAMP CRS	EA	12.67	6
6515003208500	CONTRACTOR RIB BAILEY DESIGN DOUBLE-RAKE TYPE CRS PRONGED BLADE	EA	51.63	6
6515003277900	ELEVATOR PERIOSTEAL LANGENBECK DESIGN 8.25" LONG BLUNT EDGE CRS	EA	16.84	1
6515003279400	ELEVATOR SET PERIOSTEAL DOYEN CURVED BLUNT EDGE LGE .25" W BLADE	EA	53.87	1
6515003280700	ELEVATOR PERIOSTEAL 7.75" LG CURVED BLADE .625" BLADE WIDTH CRS	EA	9.07	1
6515003311300	FORCEPS BONE CUTTING LISTON-STILLE 10.25" LG CURVED DOUBLE CRS	EA	107.40	1
6515003314800	RONGEUR STILLE CRS DBL-JOINTED CURVED 9"LG CRANIAL BONE FORCEPS	EA	214.41	1
6515003333100	FORCEPS DRESSING CUSHING 7" LG STR & SERRATED RD TIP SLENDER MDL	EA	1.44	2
6515003333700	FORCEPS DRESSING 10" LG STRAIGHT & SERRATED RD TIP HEAVY MDL CRS	EA	6.04	2
6515003341400	FORCEPS GALL DUCT LAHEY DESIGN 7.5"LG CRS BOX LOCK JOINT TYPE	EA	10.14	2
6515003359100	FORCEPS LUNG GRASPING COLLIN DESIGN TRIANGULAR JAW 8" O/A LG CRS	EA	9.24	6
6515003373900	FORCEPS GAUZE PAD HOLDING FOERSTER 9-9.75" LG BOX LOCK JOINT CRS	EA	15.20	2
6515003419800	HOLDER SUTURE NEEDLE MASSON 10.5" LG STRAIGHT JAW BOX LOCK CRS	EA	17.10	2
6515003553300	PERIOSTEOTOME ALEXANDER-FARABEUF 8.25" LG CURVED F/RIB SURGERY	EA	122.00	1
6515003617250	RETRACTOR RIB FINOCCHIETO DESIGN CRS FENESTRATED BLADE MEDIUM	EA	117.30	1
6515003640920	SCISSORS GEN SURG MAYO DSGN 6.50-7" LG BLUNT PTS 1.626" CUT LG	EA	14.13	2
6515003657100	SCISSORS TONSIL METZENBAUM 7" O/A LG CRVD BLADE BLUNT POINTS CRS	EA	11.47	2
6515003669200	FORCEPS BONE CUTTING BETHUNE 13.5" LG CUPPED SCREW LOCK CRS	EA	52.62	1
6515003746900	ELEVATOR PERIOSTEAL MATSON 9X.312" BOUBLE-ENDED BLUNT BLADE	EA	41.65	1
6515010457158	KNIFE STERNUM LEBSCHE DSGN 10" LG PASSIVATED NONGLARE FINISH CRS	EA	70.25	1
6515012340253	MALLET BONE SURGERY CRS 7.5-11"LG 3.125"HEAD LG 2 POUNDS	EA	40.11	1

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6530007940000	TRAY INSTRUMENT CORROSION-RESISTING STEEL 15-1/2X9-1/2X2 INCHES	EA	7.75	1
7210002999610	TOWEL HAND COTTON 36X17INCHES SOLID GREEN GRAY NONDISPOSABLE	EA	1.71	2

FRACTURE- AMPUTATION SET				
NSN	**NOMENCLATURE**	**UI**	**UPRICE**	**QTY**
6515003225550	CURETTE MASTOID SPRATT SIZE 2 SPOON SHAPE BLADE SOLID RIGID CRS	EA	18.59	1
6515003301300	FILE BONE 3.5" BLADE STRAIGHT SERRATED COARSE CUT RD BLUNT TIP	EA	22.21	1
6515003315400	RONGEUR STILLE-LUER DBL-JOINTED STR 9"LG RD END JAWS BONE SURG	EA	151.06	1
6515003343800	FORCEPS HEMO KELLY 5.25-5.75" LG SLIGHTLY CURVED JAW STR HDL CRS	EA	10.77	8
6515003435800	KNIFE AMPUTATING LISTON DESIGN 10.5"LG CURVED BICONCAVE HANDLE	EA	139.45	1
6515003631100	SAW AMPUTATING SATTERLEE 8"BLADE LG 2.25"WIDTH F/LGE BONE SAWING	EA	45.61	1
6515003632300	CONDUCTOR BONE CUTTING WIRE SAW BAILEY DESIGN STEEL OVERALL	EA	14.38	1
6515003632400	HANDLE BONE CUTTNG WIRE SAW RECTANULAR WITH ROUNDED ENDS CRS	EA	73.66	1
6515003632700	SAW BONE CUTTING WIRE 20" LONG .040" DIAMETER WITHOUT HANDLE CRS	EA	10.09	1
6515011398267	RASP BONE 3" BLADE LG PUTTI STYLE DOUBLE ENDED 10.50" O/A LG	EA	194.35	1
6530007940000	TRAY INSTRUMENT CORROSION-RESISTING STEEL 15-1/2X9-1/2X2 INCHES	EA	7.75	1
7210002999610	TOWEL HAND COTTON 36X17INCHES SOLID GREEN GRAY NONDISPOSABLE	EA	1.71	1
LAPAROTOMY SET				
NSN	**NOMENCLATURE**	**UI**	**UPRICE**	**QTY**
6515000653181	FORCEPS HEMO MIXTER HALF-CURVED 6.87-7.375"LG 1.625-1.875"JAW	EA	13.68	4
6515002998737	HOLDER SUTURE NEEDLE HEGAR-MAYO 7" LG SERRATED TUNGSTEN CARB JAW	EA	13.30	2
6515003204590	FORCEPS TOWEL BACKHAUS 3.5" LG OPPOSED PRONGS TOWEL CLAMP CRS	EA	10.26	6
6515003204600	FORCEPS TOWEL BACKHAUS 5.25" LG OPPOSED PRONGS TOWEL CLAMP CRS	EA	12.67	6
6515003333600	FORCEPS DRESSING 5.50"LG STRAIGHT AND SERRATED JAW ROUND TIP CRS	EA	5.26	2
6515003333700	FORCEPS DRESSING 10" LG STRAIGHT & SERRATED RD TIP HEAVY MDL CRS	EA	6.04	2
6515003341400	FORCEPS GALL DUCT LAHEY DESIGN 7.5"LG CRS BOX LOCK JOINT TYPE	EA	10.14	2
6515003343800	FORCEPS HEMO KELLY 5.25-5.75" LG SLIGHTLY CURVED JAW STR HDL CRS	EA	10.77	12
6515003344100	FORCEPS HEMO MAYO-CARMALT 7.750 MIN 8.250 MAX O/A LG CRS	EA	13.62	2
6515003344300	FORCEPS HEMO ROCHESTER-PEAN 6-6.50"LG 1.875" JAW LG QTR-CRVD CRS	EA	11.14	10
6515003344900	FORCEPS HEMO HALSTED DESIGN 4.75-5.25" LG SLIGHTLY CRVD SERR CRS	EA	8.24	6
6515003346800	FORCEPS HEMO KELLY 5.50" LG 1" LG STRAIGHT JAW BOX LOCK CRS	EA	8.87	12
6515003347500	FORCEPS HEMO ROCHESTER-OCHSNER 1.875"JAW LG STR 7.25"O/A LG SZ 2	EA	15.20	6
6515003349500	FORCEPS HEMO PEAN DESIGN SLIGHTLY CURVED JAW 9"O/A LG CRS	EA	15.90	6
6515003373900	FORCEPS GAUZE PAD HOLDING FOERSTER 9-9.75" LG BOX LOCK JOINT CRS	EA	15.20	4
6515003377800	FORCEPS TISSUE ADSON 4.50" LG TWEEZER STRAIGHT & SMOOTH JAW CRS	EA	7.60	2
6515003379900	FORCEPS TISSUE 5.5" LG TWEEZER STRAIGHT & SMOOTH JAW RD TIP CRS	EA	9.98	2
6515003380300	FORCEPS TISSUE ALLIS DSGN 6"LG PIVOTED STRAIGHT & SMOOTH JAW CRS	EA	15.84	4
6515003419800	HOLDER SUTURE NEEDLE MASSON 10.5" LG STRAIGHT JAW BOX LOCK CRS	EA	17.10	1
6515003447800	HANDLE SURGICAL KNIFE DETACHABLE BLADE SIZE 3 NARROW NOSE	EA	1.98	2
6515003447820	HANDLE SURGICAL KNIFE DETACHABLE BLADE SZ4 U/W BLADE NO.20 21 25	EA	2.89	1
6515003447880	HANDLE SURGICAL KNIFE DETACHABLE BLADE SIZE 7 NARROW NOSE	EA	5.14	1
6515003585500	RACK SUTURE NEEDLE 5X1X0.4222" C/O BASE TRACT & COIL WIRE SPRING	EA	5.95	1
6515003603490	RETRACTOR ABDOMINAL DEAVER DESIGN 1X12" SIZE CRS	EA	10.98	1
6515003603510	RETRACTOR ABDOMINAL DEAVER DESIGN CRS 1.5X12" SIZE	EA	23.43	1
6515003603530	RETRACTOR ABDOMINAL DEAVER DESIGN 2X12" SIZE CRS	EA	26.38	1
6515003603850	RETRACTOR SET ABDOMINAL RICHARDSON-EASTMAN CRS DOUBLE END TYPE2S	SE	22.17	2
6515003604910	RETRACTOR ABDOMINAL BALFORD SIX-BLADED SLIDING BAR LARGE SIZE	EA	148.81	1
6515003609200	RETRACTOR SET GENERAL OPERATING DOUBLE END 8.5 & 8.75" BLADES	SE	9.20	2

6515003610350	RETRACTOR GENERAL OPERATING VOLKMAN DESIGN 8.5" SIZE 4 PRONG CRS	EA	13.16	2
6515003614850	RETRACTOR PERINEAL GELPI CRS HOOK UNIT TYPE 6.5" SELF RETAINING	EA	42.88	2
6515003620200	RETRACTOR VEIN CUSHING DESIGN 8.5" CORROSION RESISTING STEEL	EA	19.45	2
LAPAROTOMY SET- CONTINUED				
6515003640500	SCISSORS GEN SURG MAYO DSGN 5.25-5.75" LG CURVED BLADE BLUNT PTS	EA	12.23	2
6515003640920	SCISSORS GEN SURG MAYO DSGN 6.50-7" LG BLUNT PTS 1.626" CUT LG	EA	14.13	2
6515003651820	SCISSORS GEN SURG 5.50" LG ONE BLUNT AND ONE SHARP BLADE PT CRS	EA	10.33	1
6515003656200	SCISSORS TENOTOMY STEVENS 4-4.50" O/A LG CRVED BLADE BLUNT POINTS	EA	28.17	1
6515003657100	SCISSORS TONSIL METZENBAUM 7" O/A LG CRVD BLADE BLUNT POINTS CRS	EA	11.47	1
6515003866600	CANNULA ABDOMINAL POOLE 23FR 8.75" LG FENESTRATED CURVED HUB	EA	12.67	1
6515003867600	CANNULA LARYNGEAL ANGULAR YANKAUER 9"LG 0.234-0.266" DIA BRASS	EA	13.23	1
6515006903208	FORCEPS TISSUE DEBAKEY 7.75" LG TWEEZER STR & SERRATED JAW CRS	EA	15.20	2
6515006903223	SCISSORS GEN SURG POTTS SMITH 7.50" LG ANG TO HDL 60DEG BLUNT PT	EA	35.48	2
6515009269193	RETRACTOR MASTOID WEITLANER 6.5" HOOK UNIT TYPE 3 VS 4 PRONGS	EA	49.31	2
6515010489066	FORCEPS HEMOSTATIC STORZ DSGN R ANG JAW 8.75" LG 52MM JAW LG CRS	EA	81.95	2
6515010895668	SCISSORS GEN SURG METZENBAUM DELICATE DISSECTING 11" LG CRVD CRS	EA	50.68	1
6515011190018	PROBE GEN OPER 5"LG .062" DIA CRS SPATULATE HANDLE BULBOUS TIP	EA	3.55	1
6515011190787	PROBE GEN OPER 10" LG .062" DIA CRS SPATULATE HANDLE BULBOUS TIP	EA	6.04	1
6515011398195	RETRACTOR ABDOMINAL KELLY 3X3.50 INCH SERR TONGUE PASSIVATED CRS	EA	68.34	2
6515011398196	RETRACTOR GEN OPER HARRINGTON 13X2.25" CRVED RIGHT PASSIVATED CRS	EA	89.99	1
6515011398197	RETRACTOR VAGOTOMY WEINBERG 6.375X4" BLADE ONE SIZE HOLLOWED CRS	EA	96.40	1
6515011398407	RETRACTOR ABDOMINAL RICHARDSON DSGN 9 1/8" LG BLADE 1X0.75" CRS	EA	14.62	2
6515011398969	RETRACTOR ABDOMINAL CODMAN-SHURTLEFF SZ 2.50X3.25" TWO BLADE CRS	EA	175.37	2
6530007940300	TRAY, SURG INST 20 X 12 X 4"	EA	40.61	2
7210002999610	TOWEL HAND COTTON 36X17INCHES SOLID GREEN GRAY NONDISPOSABLE	EA	1.71	4
CHEST TUBE SET				
NSN	**NOMENCLATURE**	**UI**	**UPRICE**	**QTY**
6515003204590	FORCEPS TOWEL BACKHAUS 3.5" LG OPPOSED PRONGS TOWEL CLAMP CRS	EA	10.26	4
6515003343800	FORCEPS HEMO KELLY 5.25-5.75" LG SLIGHTLY CURVED JAW STR HDL CRS	EA	10.77	3
6515003344100	FORCEPS HEMO MAYO-CARMALT 7.750 MIN 8.250 MAX O/A LG CRS	EA	13.62	2
6515003349500	FORCEPS HEMO PEAN DESIGN SLIGHTLY CURVED JAW 9"O/A LG CRS	EA	15.90	2
6515003377800	FORCEPS TISSUE ADSON 4.50" LG TWEEZER STRAIGHT & SMOOTH JAW CRS	EA	7.60	1
6515003419200	HOLDER SUTURE NEEDLE HEGAR-MAYO 7" LG CENTRAL OVAL GROOVED JAWS	EA	8.75	1
6515003447800	HANDLE SURGICAL KNIFE DETACHABLE BLADE SIZE 3 NARROW NOSE	EA	1.98	1
6515003640520	SCISSORS GEN SURG MAYO CRVD BLADE 6.50-7" LG BLADE POINTS BLUNT	EA	14.44	1
6515003640920	SCISSORS GEN SURG MAYO DSGN 6.50-7" LG BLUNT PTS 1.626" CUT LG	EA	14.13	1
6515006600008	BLADE SURG KNIFE DET NO.15 CARBON STEEL U/W 3 3L 7 9 HANDLE 6S	PG	1.25	1
6530007939945	TRAY INSTRUMENT CORROSION RESISTING STEEL 10-1/2 X 8 X 2 INCHES	EA	6.23	1
7210002999610	TOWEL HAND COTTON 36X17INCHES SOLID GREEN GRAY NONDISPOSABLE	EA	1.71	4
ENT SET				
NSN	**NOMENCLATURE**	**UI**	**UPRICE**	**QTY**
6515012460182	DRILL TWIST BONE TWIST DRILL POINT 3" LENGTH 0.094" DIAMETER 6S	PG	122.72	1
6515003123500	DRILL HAND BONE SMEDBERG DESIGN JACOBS CHUCK DESIGN .156"DIA	EA	178.39	1
6515003417200	HOLDER SUTURE NEEDLE COLLIER 5" LG STRAIGHT JAW BOX LOCK CRS	EA	16.15	2
6515003573525	PROBE SET LACHRYMAL WILLIAMS STERLING SILVER SIZES 1-2 3-4 5-6	SE	68.25	1
6515003866800	CANNULA BRAIN FRAZIER 8 FRENCH 7.5"LG OPEN END TIP CRS	EA	11.83	2
6515011150416	FORCEPS BONE HOLDING CRVD DINGMAN 7.50" LG SERRATED JAW TYPE CRS	EA	54.36	2
6515012132679	RONGEUR LOVE-LERRISON STAINLESS STEEL OVERALL JAW SZ 3/16 IN	EA	346.24	1

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6520005196600	CURETTE ALVEOLAR MOLT CRES BLADE SZ 2 6.25-6.75" LG	EA	14.63	2
6520005196700	CURETTE ALVEOLAR MOLT CRES BLADE 2.125"L SZ 4 6.25 - 6.75"L	EA	15.52	2
6520005196740	CURETTE ALVEOLAR MOLT CRES BLADE 2.312"L BLADE SZ 5L	EA	13.97	1
6520005196770	CURETTE ALVEOLAR MOLT CRES BLADE 2.125"L BLADE SZ 6R	EA	12.40	1
ENT SET- CONTINUED				
6520005240050	ELEVATOR, MALAR IVY	EA	17.24	1
6520005242550	ELEVATOR, ROOT #34S	EA	21.19	2
6520005243050	ELEVATOR, ROOT #301	EA	20.58	2
6520005244550	ELEVATOR, ROOT #73 MILLER	EA	21.27	2
6520005245050	ELEVATOR, ROOT #74 MILLER	EA	20.63	2
6520005323990	FORCEPS TOOTH EXTRACTING #150 UPPER ANTERIORS BICUSPIDS & ROOTS	EA	57.72	1
6520005324990	FORCEPS, TOOTH EXTRACT #151	EA	71.91	1
6520005419350	HANDLE, MOUTH EXAM MIRROR	EA	1.41	2
6520005551150	SCISSORS, ORAL SURG 6.75"	EA	45.07	1
6520005630650	IMPRESSION TRAY, LOW MED	EA	6.06	1
6520005631150	IMPRESSION TRAY, LOW LARGE	EA	7.07	1
6520005631650	IMPRESSION TRAY, LOW SMALL	EA	5.29	1
6520005632650	IMPRESSION TRAY, UPPER MED	EA	7.07	1
6520005633150	IMPRESSION TRAY, UPPER LARGE	EA	7.07	1
6520005633650	IMPRESSION TRAY, UPPER SMALL	EA	7.07	1
6520005842699	ELEVATOR, PERIOS MOLT #9	EA	15.63	1
6520007822648	MIRROR, MOUTH EXAM #1	EA	1.21	4
6520009357257	PLUGGER, AMALG TANNER #71	EA	7.57	1
6520011378453	RETRACT, OBWEGESER CV SZ 168	EA	100.13	1
6520011378455	RETRACT, OBWEGESER CV DOWN	EA	63.01	1
6520012109532	AWL, ORAL SURG MAX #161	EA	103.03	1
6520012109533	AWL, ORAL SURG MAX #160	EA	41.54	1
6530007940000	TRAY INSTRUMENT CORROSION-RESISTING STEEL 15-1/2X9-1/2X2 INCHES	EA	7.75	1
7210002999610	TOWEL HAND COTTON 36X17INCHES SOLID GREEN GRAY NONDISPOSABLE	EA	1.71	2
VASCULAR SET				
NSN	**NOMENCLATURE**	**UI**	**UPRICE**	**QTY**
6515000653181	FORCEPS HEMO MIXTER HALF-CURVED 6.87-7.375"LG 1.625-1.875"JAW	EA	13.68	6
6515003204590	FORCEPS TOWEL BACKHAUS 3.5" LG OPPOSED PRONGS TOWEL CLAMP CRS	EA	10.26	2
6515003344900	FORCEPS HEMO HALSTED DESIGN 4.75-5.25" LG SLIGHTLY CRVD SERR CRS	EA	8.24	8
6515003347500	FORCEPS HEMO ROCHESTER-OCHSNER 1.875"JAW LG STR 7.25"O/A LG SZ 2	EA	15.20	6
6515003373900	FORCEPS GAUZE PAD HOLDING FOERSTER 9-9.75" LG BOX LOCK JOINT CRS	EA	15.20	2
6515006903198	HOLDER SUTURE NEEDLE DEBAKEY 7" LG SERRATED TUNGSTEN CARB JAWS	EA	19.45	2
6515006903200	HOLDER SUTURE NEEDLE DEBAKEY 9" LG SERRATED TUNGSTEN CARB JAWS	EA	34.84	2
6515006903208	FORCEPS TISSUE DEBAKEY 7.75" LG TWEEZER STR & SERRATED JAW CRS	EA	15.20	2
6515006903209	FORCEPS TISSUE DEBAKEY 9.5" LG TWEEZER STR & SERRATED JAW CRS	EA	17.74	2
6515006903212	CLAMP ARTERY DEBAKEY-BAHNSON CURVED & SERRATED 65MM JAW 10" O/A LG	EA	202.75	2
6515006903215	CLAMP ARTERY GLOVER 9CM LG SERRATED STRAIGHT 40MM JAW LG BULLDOG	EA	92.49	3
6515006903216	CLAMP ARTERY GLOVER 9CM LG CURVED SERRATED 40MM JAW LG ADJ SCREW	EA	34.04	3
6515008901682	CLAMP ARTERY GLOVER 6.5CM LG CURVED SERRATED 27MM JAW LG	EA	48.78	2
6515008901683	CLAMP VENA CAVA SATINSKY SERRATED RATCH-PAWL 10"LG LARGE CRS	EA	118.78	2
6530007940000	TRAY INSTRUMENT CORROSION-RESISTING STEEL 15-1/2X9-1/2X2 INCHES	EA	7.75	1
7210002999610	TOWEL HAND COTTON 36X17INCHES SOLID GREEN GRAY NONDISPOSABLE	EA	1.71	2

BURR HOLE SET				
NSN	**NOMENCLATURE**	**UI**	**UPRICE**	**QTY**
6515002998737	HOLDER SUTURE NEEDLE HEGAR-MAYO 7" LG SERRATED TUNGSTEN CARB JAW	EA	13.30	1
6515003124125	BUR CRANIAL HUDSON 14MM DIA 3.812" LG 6 FLUTE TRUNCATED CONE	EA	28.09	1
6515003124130	BUR CRANIAL HUDSON 20MM DIA 3.812" LG BALL HEAD 8 FLUTE CRS	EA	29.75	1
6515003345600	FORCEPS HEMO HALSTED 5"LG 0.875"JAW STRAIGHT JAW CRS BOX LOCK	EA	8.87	10
BURR HOLE SET- CONTINUED				
6515003447800	HANDLE SURGICAL KNIFE DETACHABLE BLADE SIZE 3 NARROW NOSE	EA	1.98	1
6515005152113	BRACE BIT BONE HUDSON 9.75" LG SNAP-LOCK PASSIVATED	EA	113.32	1
6515005152114	BUR CRANIAL HUDSON 9MM DIA 4.094" LG FLAME HEAD 6 FLUTE CRS	EA	28.17	1
6515005152115	BUR CRANIAL HUDSON 16MM DIA 3.812"LG BALL HEAD 8 FLUTE CRS	EA	25.94	1
6515005152116	DRILL FLAT CRANIAL 4X0.375" CUSHING DESIGN CRS	EA	47.98	1
6515006600011	BLADE SURG KNIFE DET NO.10 SMALL TANG U/W 3 3L 7 9 HANDLE CS 6S	PG	1.31	2

SURGICAL ATTIRE PACK			
NSN	**NOMENCLATURE**	**UI**	**QTY**
6532-00-299-8613	CAP, OPERATING, SURGICAL, LARGE	EA	3*
6532002999630	TROUSERS, OPERATING, SURGICAL, MENS MEDIUM	EA	3*
6532002999634	SHIRT, OPERATING, SURGICAL, MENS MEDIUM	EA	3*

STERILE LINEN PACK			
NSN	**NOMENCLATURE**	**UI**	**QTY**
6530-00-299-4905	WRAPPER, STERILIZATION, GREEN, 24"	EA	1
6532-00-083-6535	GOWN, OPERATING, SURG., GREEN, LARGE	EA	3*
7210-00-299-9610	TOWEL, HAND, GREEN	EA	3

STERILE SHEET PACK			
NSN	**NOMENCLATURE**	**UI**	**QTY**
6530009264905	WRAPPER, STERILIZATION, GREEN, 24"	EA	1
7210000811417	SHEET, BED, COTTON-POLYESTER WHITE	EA	2

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APPENDIX Q

RECOMMENDED LOCATIONS FOR FIRST AID BOXES AND LITTERS

1. The following locations are recommended for placement of First-Aid Boxes and Reeves Sleeve Litters. The compartment numbers are based on the USS RONALD REAGAN (CVN 76). Each ship must modify this listing to reflect the actual locations in their ship and include those locations in the ship's Battle Bill.

a. First Aid Boxes:

QTY	COMPARTMENT	NAME	FRAME	PORT /STBD
1	010-167-1-C	ECM EQUIPMENT RM		
1	01-0-1-Q	CAPSTAN MACH RM	0-1	STBD
1	01-13-0-Q	WINDLESS RM	13-27	CL
1	01-133-2-Q	ELECTRICAL SVC SHOP	133-138	PORT
1	01-175-2-Q	AIR FLITER CLEANING	175-180	PORT
1	01-230-4-Q	IC SHOP NO 3	230-235	STBD
1	02-118-5-Q	AVION SHOP NO 11		
1	02-121-1-L	AVION WORK SPACE		
1	02-92-1-Q	AIR FILTER CLEANING		
1	02-K-0-Q	FORECASTLE		
1	03-148-2-Q	FLAG GALLEY		
1	03-160-3-Q	CO GALLEY		
1	03-170-0-Q	CARRIER ATC CTR		
1	03-190-0-Q	ARRESTING GEAR		
1	03-195-0-Q	ARRESTING GEAR		
1	03-195-3-Q	AVIATION ARRESTING		
1	03-199-1-Q	AUTO STANCHION		
1	03-200-4-Q	AUTO STANCHION		
1	03-210-0-Q	ARRESTING GEAR		
1	03-84-0-Q	ELECTRIC SV EQUIPMENT		
1	03-84-13-Q	AVIATION LAUNCH		
1	07-160-3-Q	FLAG PLOT	160-165	STBD
1	07-167-3-Q	RADAR RM NO 3	167-170	STBD
1	08-175-1-Q	RADAR RM NO 4	175-180	STBD
1	1-127-0-Q	HANGER BAY NO 2	127-180	CL
1	1-179-0-Q	HANGER BAY NO 3	179-235	CL
1	1-230-1-Q	SUN WORK CENTER	230-237	STBD
1	1-235-01-Q	AVN JET ENGINE SHOP	235-255	CL
1	1-54-8-Q	PIPE SHOP	54-64	PORT
1	1-58-2-Q	AVN ORD	54-64	PORT
1	1-64-0-Q	HANGER BAY NO 1	64-127	CL
1	2-165--0-Q	CREW GALLEY	165-175	CL
1	2-172-0-Q	BAKERY	172-180	CL

1	2-175--2-Q	LOAD CTR SWBD RM NO 8	175-180	PORT
1	2-180-5Q	CAPSTAN MACH RM NO 2	180-185	STBD
1	2-190-1-Q	WR GALLEY NO 2	190-198	STBD
1	2-247-2-E	STEERING GEAR RAM NO 2	247-255	STBD
1	2-257-1-Q	CAPSTAN MACH RM	257-259	STBD
1	2-257-2-Q	CAPSTAN MACH RM	257-259	PORT
1	2-84-0-Q	CREW GALLEY	84-96	CL
1	3-101-2-Q	REACTOR INSTR & MAINT	101-107	PORT
1	3-133-0-Q	LS WPN ELEV NO 5	133-138	CL
1	3-133-1-Q	ACFT ELEV MACH RM NO 2	133-180	STBD
1	3-138--0-Q	LS WPN ELEV NO 6	138-143	CL
1	3-138-1-Q	AMIDS WPN ELEV HYD PUMP	138-141	CL
1	3-165-1-Q	METALSMITH MACH SHOP	165-180	CL
1	3-198-1-Q	ACFT ELEV MACH RM NO 3	200-225	STBD
1	3-200-0-Q	ACFT ELEV MACH RM NO 4	210-215	CL
1	3-210-0-Q	CPO GALLEY	210-215	CL
1	3-235-0-Q	LAUNDRY	235-245	CL
1	3-235-4-Q	DRY CLEANING	235-245	PORT
1	3-247-1-E	STEERING RM PWR RM NOl	247-255	STBD
1	3-247-2-E	STEERING RM PWR RM NO2	247-255	PORT
1	3-94-2-Q	MARINE PRESS SHOP	94-96	PORT
1	3-96-5-Q	AFT ELEVA MACH RM NO 1	96-123	STBD
1	4-1 80--2-O	PRINT SHOP	180-190	PORT
1	4-113--0-Q	FWD IC GYRO	113-118	STBD
1	4-113--3-E	REACTOR FILL PUMP RM	113-118	STBD
1	4-119--2-E	SWBD RM NO 1	119-128	PORT
1	4-128-0-M	UNIV ORD MAG	128-138	CL
1	4-138-0-M	UNIV ORD MAG	138-148	CL
1	4-148-0-E	REACTOR RM NO 2	148-150	CL
1	4-165-2-E	REACTOR FILL PUMP RM	165-170	PORT
1	4-171 -1-E	SWBD RM N0 2	171-180	STBD
1	4-171--0-Q	AFT TC GYRO RM	171-180	CL
1	4-174-2-Q	REACTOR PLANT PERS DECON	173-180	PORT
1	4-235--0-Q	LAUNDRY	235-245	CL
1	4-247-1-E	STEERING GEAR RAM NO 1	247-255	PORT
1	4-64-0-M	UNIV ORD MAG	54-74	CL
1	4-74-0-M	UNIV ORD MAG	74-84	CL
1	4-84-0-M	UNIV ORD MAG	84-96	CL
1	4-I 65-1-Q	DECONTAMINATION LAUNDRY		
1	5-128-0-M	UNIV WPNS MAG	138-148	CL.
1	5-54-0-M	UNIV WPNS MAG	55-63	CL
1	5-84-0-M	UNIV WPNS MAG READY SVC	84-98	CL
1	6-54-0-M	UNIV WPNS MAG	54-64	CL
1	6-84-0-M	UNIV WPNS MAG	84-96	CL
1	7-113-0-E	MAIN MACH RM NO 1	113-128	CL
1	7-128-0-M	UNIV WPNS MAG	128-138	CL
1	7-148-1-E	COOLANT TURB GEN RM NO 2	148-165	STBD
1	7-148-4-E	REACTOR AUX RM NO 2	148-165	PORT

1	7-165-0-E	MAIN MACH RM NO 2	165-180	CL
1	7-190-0-E	PUMP RM	192-200	CL
1	7-25-0-E	AIR CONDITIONING MACH RM		
1	7-44-0-E	PUMP ROOM NO 1	44-62	CL
1	7-64-0-E	PUMP ROOM NO 2	64-74	CL
1	7-74-0-M	UNIV WPNS MAG	74-84	CL
1	7-84-0-M	UNIV WPNS ASSY AREA	84-96	CL
1	7-96-1-E	COOLANT TUR GEN NO 1	96-113	STBD
1	7-96-4-E	REACTOR AUX RM NO 1	96-113	PORT

b. Reeves Sleeve Stretchers:

QTY	COMPARTMENT NAME	
1	03-10-2-Q	REPAIR 7F
1	03-175-13-Q	REPAIR 7B
2	03-18-2-L	FWD AUX BDS
1	03-220-9-Q	REPAIR 7A
2	03-225-4-L	AFT AUX BDS
2	04-165-3-L	FLIGHT DECK BDS
1	1-143-2-L	REPAIR 1B
1	1-225-5-L	REPAIR 1A
1	1-69-2-L	REPAIR 1F
2	2-109-1-L	MAIN BDS
1	2-160-2-Q	REPAIR 5
1	2-213-1-L	AFT BDS
1	2-220-2-L	REPAIR 3
1	2-34-2-L	REPAIR 2
1	2-89-1-L	FWD BDS
1	2-99-2-Q	REPAIR 4
1	3-122-0-L	DENTAL
1		HANGER BAY 1
1		HANGER BAY 2
1		HANGER BAY 3

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APPENDIX R

PRE-DEPLOYMENT CHECKLIST

PRE-DEPLOYMENT CHECKLIST	
SIX MONTHS PRIOR TO SCHEDULED DEPLOYMENT	**COMPLETED**
Check levels of supplies & equipment & initiate procurement action to bring levels up to AMMAL or Usage Rate, whichever is greater. Specific requirements for the area of deployment should be identified & requisitioned.	[ ]
Formulate plans for accelerated in-service training programs with specific emphasis upon needs for deployment such as Pharmacy, Laboratory, Operating Room, X-ray & Preventive Medicine, Ward Procedures, Intensive Care, etc. Specifically designate instructor subject areas & accumulate updated lesson plans, training films & tests.	[ ]
Formulate a training program in first aid emergency procedures for crew.	[ ]
Request quotas, as required, for the following schools: 1) Shipboard Water Sanitation (Medical & Engineering) 2) Food Sanitation, Basic and Refresher (Supply) 3) Food Sanitation, Supervisor level (Medical & Supply) 4) Shipboard Pest Control Training/Certification (Medical & Supply) 5) Understanding and Controlling Sound and Noise (Medical) 6) Audiometric Certification	 [ ] [ ] [ ] [ ] [ ] [ ]
Ensure all pest control operations are certified.	[ ]
FIVE MONTHS PRIOR TO DEPLOYMENT	**COMPLETED**
Commence accelerated in-service training programs for medical personnel.	[ ]
Commence accelerated first aid training for ship's crew; ensure that squadrons are doing the same for their personnel.	[ ]
FOUR MONTHS PRIOR TO DEPLOYMENT	**COMPLETED**
Systematically review each assignment and department functional responsibility to ensure that an individual is specifically identified and trained to do each job. Identify and give on-the-job training.	[ ]
Ascertain name and qualifications of squadron medical personnel deploying and establish means of direct communications.	[ ]
Monitor supplies ordered and received. All immunization materials, bulk and staple items should be on board and stored. Follow-up on non-receipted supplies, upping priorities as necessary.	[ ]
Obtain a roster of all Battle Group medical personnel and conduct initial meeting for planning deployment.	[ ]
THREE MONTHS PRIOR TO DEPLOYMENT	**COMPLETED**
Order spectacles as required for crew. Each crewmember wearing glasses shall have two pairs prior to deployment and one pair of gas mask inserts for required personnel. Ideally, shipboard optical supplies should be reserved for use during extended deployments or emergencies.	[ ]

Obtain an inventory of chronic medication requirements and coordinate with supporting MTF pharmacy.	[ ]
Monitor minimum standard inventories for Battle Dressing Stations, Mass Casualty Boxes, Decontamination Stations, First Aid Boxes, etc.	[ ]
Check all health records and ship's company personnel for blood type, Rh factor, tuberculin skin testing, current physical examinations, immunizations, and G6PD deficiency as required.	[ ]
Concentrate on food handlers training program as required by SECNAVINST 4061.1 (series).	[ ]
Have surveys conducted on all anesthesia and intensive care equipment.	[ ]
Have supporting MTF Anesthesia Dept. inventory and review anesthesia equipment and supplies.	
Have assigned surgeon inventory and review surgical suite.	[ ]
The medical repair technician should contact the nearest shore Bio-Med repair facility, as required, for support to assure all equipment is functional, replacement parts are on board, and calibrations are accurate.	[ ]
Impose on squadron Commanding Officers the written requirement that their Medical Officer and/or Medical Department representative review all squadron health records and bring them up-to-date in the following areas: 1) Annual physical examinations 2) Skin tests 3) Immunizations 4) Assure each member requiring glasses has two pairs 5) Audiometric testing 6) G6PD testing as needed 7) HIV tests	 [ ] [ ] [ ] [ ] [ ] [ ] [ ]
TWO MONTHS PRIOR TO DEPLOYMENT	**COMPLETED**
Monitor supplies ordered and received. All bulk and staple items should be on board and stored. Follow up on non-receipted supplies and update priorities as necessary.	[ ]
Obtain medical endemic, epidemic, logistic and intelligence information on all forthcoming port visits and operating areas from a Navy Environmental and Preventive Medicine Unit.	[ ]
Establish firm contact with Squadron Flight Surgeons scheduled to deploy to determine area of medical specialty.	[ ]
Contact a Navy Environmental and Preventive Medicine Unit for pre-deployment brief.	[ ]
ONE MONTH PRIOR TO DEPLOYMENT	**COMPLETED**
Ensure current certificate of deratization exemption is on board.	[ ]
Procure sundry medical supplies as required, resorting to high priorities, personal visits to SERVMARTs and Open Purchase.	[ ]
Procure, on emergency basis, items and services required to put all medical equipment in reliable operational condition.	[ ]

APPENDIX S

POST EXPOSURE PROPHYLAXIS PROTOCOL

1. For urgent consultation, call the Post Exposure Prophylaxis (PEP) Hotline at 888-448-4911.

2. Provide immediate care to the exposure site.
   - ❑ Wash wounds and skin with soap and water.
   - ❑ Flush mucous membranes with water.

3. Determine risk associated with exposure by
   - ❑ Type of fluid
     - ➢ Examples: blood, visibly bloody fluid, other potentially infectious fluid or tissue, concentrated virus
   - ❑ Type of exposure
     - ➢ Examples: percutaneous injury, mucous membrane or nonintact skin exposure, bites resulting in blood exposure

4. Evaluate exposure source.
   - ❑ Test known sources for HbsAg, anti-HCV, and HIV antibody (consider using rapid testing).
   - ❑ For unknown sources, assess risk of exposure to HBV, HCV, or HIV infection.
   - ❑ Do not test discarded needles or syringes for virus contamination.

5. Evaluate the exposed person.
   - ❑ Assess immune status for HBV infection (i.e., by history of hepatitis B vaccination and vaccine response.)

6. Give PEP for exposures posing risk of infection transmission.
   - ❑ HBV: See Table 1.
   - ❑ HCV: PEP not recommended.
   - ❑ HIV: See Tables 2 through 4.
     - ❑ Initiate PEP as soon as possible, preferably within hours of exposure.
     - ❑ Prepare person for transfer off ship (Medevac if underway) to Military Treatment Facility for follow-up care.
     - ❑ The PEP Protocol should be continued until transfer off ship is complete.
     - ❑ Offer pregnancy testing to all women of childbearing age not known to be pregnant.
     - ❑ Seek expert consultation if viral resistance is suspected.

7. Perform follow-up testing and provide counseling.
   - Advise exposed persons to seek medical evaluation for any acute illness occurring during follow-up.

   - HBV exposures
     - Perform follow-up anti-HBs testing in persons who receive Hepatitis B vaccine.
       - Test for anti-HBs 1-2 months after last dose of vaccine.
       - Anti-HBs response to vaccine cannot be ascertained if HBIG was received in the previous 3-4 months.

   - HCV exposure
     - Perform baseline and follow-up testing for anti-HCV and alanine aminotransferase (ALT) 4-6 months after exposures.
     - Perform HCV RNA at 4-6 weeks if earlier diagnosis of HCV infection desired.
     - Confirm repeatedly reactive anti-HCV enzyme immunoassays (EIAs) with supplemental tests.

   - HIV exposures
     - Perform HIV-antibody testing periodically for at least 6 months post exposure.
       - Examples: at baseline, 6 weeks, 3 months, 6 months
     - Perform HIV antibody testing if illness compatible with an acute retroviral syndrome occurs.
     - Advise exposed persons to use precautions to prevent secondary transmission during the follow-up period.
     - Evaluate exposed persons taking PEP within 72 hours after exposure and monitor for drug toxicity for at least 2 weeks.

8. References:
   - "PEP STEPS: A Quick Guide to Postexposure Prophylaxis in the Health Care Setting", Mountain Plains AIDS Education and Training Center in consultation with National Clinicians' Post Exposure Prophylaxis (PEP) Hotline.
   - NAVMEDCENPTSVAINST 6260.5C, Bloodborne Pathogen Exposure Control Plan, dated 06JUN2002
   - U.S. Department of Health and Human Services. (2001). Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HBV, HCV, and HIV and Recommendations for Postexposure Prophylaxis, MMWR: Morbidity and Mortality Weekly Report, 50(RR-11).

TABLE 1. RECOMMENDED POST EXPOSURE PROPHYLAXIS (PEP) FOR EXPOSURE TO HEPATITIS B VIRUS			
Vaccination & Antibody Response Status of Exposed Personnel *	**Treatment**		
	Source HBsAg Positive	**Source HBsAg Negative**	**Source Unknown or Not Available for Testing**
Unvaccinated	HBIG X 1 and initiate HB vaccine series	Initiate HB vaccine series	Initiate HB vaccine series
Previously Vaccinated			
Known responder **	No treatment	No treatment	No treatment
Known nonresponder ***	HBIG X 1 and initiate revaccination or HBIG X 2 ****	No treatment	If known high risk source, treat as if source were HbsAg positive
Antibody response unknown	Test exposed person for anti-HBs ➢ If adequate, no treatment is necessary ➢ If inadequate, administer HBIG X 1 and vaccine booster	No treatment	Test exposed person for anti-HBs ➢ If adequate, no treatment is necessary ➢ If inadequate, administer vaccine booster and recheck titer in 1-2 months

* Persons who have previously been infected with HBV are immune to reinfection & do not require PEP.
** A responder is a person with adequate levels of serum antibody to HbsAg
*** A nonresponder is a person with inadequate response to vaccination.
**** The option of giving one dose of HBIG and initiating the vaccine series is preferred for nonresponders who have not completed a second 3-dose vaccine series. For persons who previously completed a second vaccine series but failed to respond, two doses of HBIG are preferred.
HbsAg = Hepatitis B surface antigen
HBIG = Hepatitis B immune globulin; dose is 0.06 mL/kg intramuscularly
Anti-HBs = Antibody to HbsAg.

TABLE 2. RECOMMENDED HIV POST EXPOSURE PROPHYLAXIS (PEP) FOR PERCUTANEOUS INJURIES

	Infection Status of Source				
Exposure Type	**HIV-Positive Class 1***	**HIV-Positive Class 2***	**Source of Unknown HIV Status**	**Unknown Source**	**HIV-Neg.**
Less Severe	Recommend basic 2-drug PEP	Recommend expanded 3-drug PEP	Generally, no PEP warranted; however, consider basic 2-drug PEP** for source with HIV risk factors***	Generally, no PEP warranted; however, consider basic 2-drug PEP** in settings where exposure to HIV-infected persons is likely	No PEP
More Severe	Recommend expanded 3-drug PEP	Recommend expanded 3-drug PEP	Generally, no PEP warranted; however, consider basic 2-drug PEP** for source with HIV risk factors***	Generally, no PEP warranted; however, consider basic 2-drug PEP** in settings where exposure to HIV-infected persons is likely	No PEP

* HIV-positive, Class 1- Asymptomatic HIV infection or known low viral load. HIV-Positive, Class 2- Symptomatic HIV infection, AIDS, acute seroconversion, or known high viral load. If drug resistance is a concern, obtain expert consultation. Initiation of PEP should not be delayed pending expert consultation, and, because expert consultation alone cannot substitute for face-to-face counseling, resources should be available to provide immediate evaluation and follow-up care for all exposures.
** The designation “consider PEP” indicates that PEP is optional and should be based on an individualized decision between the exposed person and the treating clinician.
*** If PEP is offered and taken and the source is later determined to be HIV-negative, PEP should be discontinued.
An example of a “sources of unknown HIV status” is a deceased source person with no samples available for HIV testing.
An example of an “unknown source” is a needle from a sharps disposal container.
“Less Severe” refers to solid needle and superficial injury.
“More Severe” refers to large-bore hollow needle, deep puncture, visible blood on device, or needle used in patient’s artery or vein.

TABLE 3. RECOMMENDED HIV POST EXPOSURE PROPHYLAXIS (PEP) FOR MUCOUS MEMBRANE EXPOSURES AND NONINTACT SKIN* EXPOSURES

	Infection Status of Source				
Exposure Type	**HIV-Positive Class 1****	**HIV-Positive Class 2****	**Source of Unknown HIV Status**	**Unknown Source**	**HIV-Neg.**
Small Volume	Consider basic 2-drug PEP	Recommend basic 2-drug PEP	Generally, no PEP warranted; however, consider basic 2-drug PEP*** for source with HIV risk factors****	Generally, no PEP warranted; however, consider basic 2-drug PEP*** in settings where exposure to HIV-infected persons is likely	No PEP
Large Volume	Recommend basic 2-drug PEP	Recommend expanded 3-drug PEP	Generally, no PEP warranted; however, consider basic 2-drug PEP*** for source with HIV risk factors****	Generally, no PEP warranted; however, consider basic 2-drug PEP*** in settings where exposure to HIV-infected persons is likely	No PEP

* For skin exposures, follow-up is indicated only if there is evidence of compromised skin integrity as in dermatitis, abrasion, or open wound.
** HIV-Positive, Class 1- Asymptomatic HIV infection or known low viral load. HIV-Positive, Class 2- Symptomatic HIV infection, AIDS acute seroconversion, or known high viral load. If drug resistance is a concern, obtain expert consultation. Initiation of PEP should not be delayed pending expert consultation, and, because expert consultation alone cannot substitute for face-to-face counseling, resources should be available to provide immediate evaluation and follow-up care for all exposures.
*** The designation, “consider PEP,” indicates that PEP is optional and should be based on an individualized decision between the exposed person and the treating clinician.
**** If PEP is offered and taken and the source is later determined to be HIV-negative, PEP should be discontinued.
An example of a “source of unknown HIV status” is a deceased source person with no samples available for HIV testing.
An example of an “unknown source” is a splash from inappropriately disposed blood.
“Small volume” refers to a few drops.
“Large volume” refers to a major blood splash.

TABLE 4. BASIC AND EXPANDED HIV POST EXPOSURE PROPHYLAXIS (PEP) REGIMENS	
BASIC REGIMEN	
Zidovudine (RETROVIR; ZDV; AZT) + Lamivudine (EPIVIR; 3TC): available as COMBIVIR • ZDV 300 mg twice daily, and • 3TC 150 mg twice daily	
ADVANTAGES	**DISADVANTAGES**
ZDV is associated with decreased risk of HIV transmission in the CDC case-control study of occupational HIV infection.	Side effects are common and might result in low adherence.
ZDV has been used more than the other drugs for PEP in HCP.	Source patient virus might have resistance to this regimen.
Serious toxicity is rare when used for PEP.	Potential for delayed toxicity (oncogenic/teratogenic) is unknown.
Side effects are predictable and manageable with antimotility and antiemetic agents.	
Probably a safe regimen for pregnant HCP.	
Can be given as a single tablet (COMBIVIR) twice daily.	
EXPANDED REGIMEN = BASIC REGIMEN PLUS:	
Lopinavir/Ritonavir (KALETRA)-400/100 mg twice daily **(available dose 133.3mg/33.3mg-give 3 tabs BID)**	
ADVANTAGES	**DISADVANTAGES**
Potent HIV inhibitor.	Concomitant use of flecainide, propafenone, astemizole, terfenadine, dihydroergotamine, ergotamine, ergonovine, methylergonovine, rifampin, St. John's Wort, lovastatin, simvastatin, pimozide, midazolam, or triazolam is not recommended. Inhibition of the metabolism of these drugs could cause serious life-threatening adverse events (e.g. cardiac arrhythmias, prolonged sedation, or respiratory depression).
Well tolerated in patients with HIV infection.	May accelerate the clearance of certain drugs, including oral contraceptives (requiring alternative or additional contraceptive measures for women taking these drugs).
	Potential for delayed toxicity (oncogenic/teratogenic) is unknown.

APPENDIX T

Inpatient Record Review Form

USS (AIRCRAFT CARRIER) CV(N) XX INPATIENT RECORD REVIEW					
PROVIDER:	**PERIOD COVERED:**				
Last 4 SSN of Record					
	Y = YES **N** = NO **NA** = NOT APPLICABLE				
Addressograph Information On All Pages					
Privacy Act Statement is Present					
All Entries are Legible					
The Following are Completed, Dated, Timed & Signed:					
NAVMED 6300/5, Inpatient Admission/Disposition Record					
SF 502, Clinical Record- Narrative Summary					
SF 539, Abbreviated Medical Record **or** SF 504, Clinical Record- Privileged History (Part I) **and** SF 505, Clinical Record- History (Parts II & III) **and** SF 506, Clinical Record-Physical Examination					
SF 508, Doctor's Orders					
SF 509, Progress Notes					
NAVMED 6320/16, Recovery Room Record					
SF 516, Operation Report					
SF 517, Anesthesia					
SF 522, Request for Administration of Anesthesia and for Performance of Patient, Operational, and Other Procedures and Witness					
SF 510, Nursing Notes					
The Documentation is Appropriate for the Following:					
NAVMED 6550/12, Patient Profile					
NAVMED 6550/8 Medication Administration Record					
Doctor's Orders Noted & Verified by RN					
Hospital Corpsman Notes Co-signed by RN					
Discharge Orders & Patient Education Noted					

Record Review Summary

Comments:

Reviewer: _____Name/Signature/Date

❑ Documentation is Appropriate **If Checked, Return Form to QAC**	❑ Documentation Needs Improvement **If Checked, Review with Appropriate Individual**

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APPENDIX U

OUTPATIENT RECORD REVIEW FORMS

USS (AIRCRAFT CARRIER) CV(N) XX OUTPATIENT RECORD REVIEW					
PROVIDER:	**PERIOD COVERED:**				
Last 4 SSN of Records					
	Y = YES	**N** = NO	**NA** = NOT APPLICABLE		
The Following are Documented:					
Date & Time of Entry					
Provider's Printed Name, Rank & Corps					
Provider's Signature					
Chief Complaint or Purpose of Visit					
Objective Findings					
Diagnosis or Medical Impression					
Studies Ordered & Results, i.e., labs, x-rays					
Therapies Administered					
Disposition					
Patient Education & Instructions					
All Entries are Legible					
The Following are Appropriately Addressed:					
Vital Signs					
History & Physical					
Diagnostic Modalities					
Diagnosis & Therapy					
Consultations					

Record Review Summary

Comments:

Reviewer: _____Name/Signature/Date

❑ Care Well Documented and Legible ❑ Care Appropriate and Within Standards **If Boxes Checked, Return to QAC**	❑ Documentation Needs Improvement ❑ Care Varies from Established Practice **If Boxes Checked, Submit to SMO for Review**

Senior Medical Officer Review

❑ No Action Needed → Return Form to QAC	❑ Action Needed → Review with Provider

Comments:

SMO _____Name/Signature/Date

Provider _____Name/Signature/Date

OCT 21 2005

USS (AIRCRAFT CARRIER) CV(N) XX CLINICAL PSYCHOLOGIST RECORD REVIEW						
PROVIDER:	**PERIOD COVERED:**					
Last 4 SSN of Record						
						Y = YES **N** = NO **N/A** = NOT APPLICABLE
INITIAL REPORT						
Sufficient Identifying Data						
Inclusion of the Following:	Referral Question					
	History					
	Mental Status					
	Diagnosis					
	Treatment Plan					
Adequate History to Include Drug & Alcohol Use						
Mental Status Includes Suicide & Homicide Status						
If Suicidal, Assessment Includes Past Attempts & Determination of Current Risk						
Sufficient Documentation to Support Diagnosis						
History Consistent with Diagnosis						
Treatment Plan Consistent with Diagnosis						
Treatment Plan Meets Standard of Care						
Referral Question Appropriately Answered						
Safety Issues Adequately Addressed (Harm to Self or Others, Domestic Abuse)						
Physical Pain Assessment Documented						
PROGRESS NOTES						
Significant Events are Documented						
Changes in Symptoms are Documented						
Changes in Diagnosis are Consistent with Documentation						
Mental Status & Diagnosis are Documented or Statement of No Change						
Treatment Plan Meets Standard of Care						
TERMINATION NOTE						
Course of Treatment is Adequately Documented						
Initial & Termination Diagnosis are Stated						
Termination of Case was Appropriate						
Trainee Involvement Appropriately Documented						

Record Review Summary

Comments:

Reviewer: _____ Name/Signature/Date

❑ Care Well Documented and Legible	❑ Documentation Needs Improvement
❑ Care Appropriate and Within Standards	❑ Care Varies from Established Practice
If Boxes Checked, Return Form to QAC	**If Boxes Checked, Submit to SMO for Review**

Senior Medical Officer Review

❑ No Action Needed → Return Form to QAC	❑ Action Needed → Review with Provider

Comments:

SMO _____ Name/Signature/Date

Provider _____ Name/Signature/Date

USS (AIRCRAFT CARRIER) CV(N) XX PHYSICAL THERAPIST RECORD REVIEW						
PROVIDER:	**PERIOD COVERED:**					
Last 4 SSN of Record						
	Y = YES **N** = NO **N/A** = NOT APPLICABLE					
Date & Time of Entry						
Subjective Information (Including Age & Gender)						
DOI/DOS or Onset of Symptoms						
Chief Complaint or Purpose of Visit						
What Aggravates or Eases Symptoms						
Patient's Goals/Functional Limitations						
Tests & Measures Performed						
Assessment Appropriate to History & Objective Exam						
Plan Appropriate to Assessment/Goals? -Interventions including but not limited to these core privileges (refer patients to other practitioners, authorize light duty- 30 days, SIQ-24 hours, apply manual therapy including to spinal joints…)						
Goals in Measurable Terms with Time Frames						
At Least 1 Goal Written in Functional Terms						
Plan for Follow-up or Discharge Written						
Pain Level Noted on Each Note						
Patient Education Noted						
All Entries Legible						
Provider Signature & Stamp Present						

Record Review Summary

Comments:

Reviewer: _____Name/Signature/Date

❑ Care Well Documented and Legible ❑ Care Appropriate and Within Standards **If Boxes Checked, Return Form to QAC**	❑ Documentation Needs Improvement ❑ Care Varies from Established Practice **If Boxes Checked, Submit to SMO for Review**

Senior Medical Officer Review

❑ No Action Needed → Return Form to QAC	❑ Action Needed → Review with Provider

Comments:

SMO _____Name/Signature/Date

Provider _____Name/Signature/Date

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