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COMSUBLANT/COMSUBPACINST 6000.2E  
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25 Aug 16

COMSUBLANT/COMSUBPAC INSTRUCTION 6000.2E

From: Commander, Submarine Force, U.S. Atlantic  
Commander Submarine Force, U.S. Pacific Fleet

Subj: STANDARD SUBMARINE MEDICAL PROCEDURES MANUAL

Ref: (a) Manual of the Medical Department (NAVMED P-117)  
(b) OPNAVINST 6400.1 (Series)  
(c) TB MED 530/NAVMED P-5010-1/AFMAN 48-147-IP  
(d) NAVSEA S9510-AB-ATM-010 (Volumes 1 & 2)  
(e) NAVSEA S9086-CH-STM-030/CH-074) (series)  
(f) Naval Ships Technical Manual (NSTM) 533  
(g) COMSUBLANT/COMSUBPACINST 6320.6 (Series)

1. Purpose. To promulgate a consolidated guide for Submarine Medical Departments within the U.S. Atlantic and Pacific Fleets.

2. Cancellation. COMSUBLANT/COMSUBPACINST 6000.2D

3. Revisions. This is a complete revision and should be reviewed in its entirety.

4. Discussion. The primary mission of the Medical Department is to maintain the health, safety, and readiness of the crew by means of a comprehensive program of prevention and treatment of illness and injury. This manual is a complete rewrite and consolidation of Standard Submarine Medical Procedures Manual for the Submarine Force. This manual is issued to minimize individual ship's efforts in implementing the provisions of reference (a) and other directives from higher authority, which concern command responsibilities in Medical Department administration.

5. Scope. While the directives and the information in this instruction are not all encompassing, they address most of the common medical administrative situations and issues encountered

by Medical Officers and Medical Department Representatives of the Submarine Forces. Medical Department personnel will use this instruction as their basic shipboard procedure manual. This joint instruction represents a significant change from previous medical guides and should be reviewed in its entirety.

6. Applicability. The provisions of this manual apply to the administration of Submarine Medical Departments.

7. Action. Unit Commanders and Commanding Officers will implement the provisions of this instruction within their commands. It is designed to replace many ship-specific instructions and may be adopted verbatim, with a minimum of additions, to compensate for varied ship types by execution of the letter of promulgation on page 1.

8. Certification. This publication has been reviewed and approved per SECNAVINST 5600.16.

9. Changes to the Manual

a. The practice of medicine onboard submarines is dynamic. Changes and additions to this manual are anticipated and encouraged. While the contents of this manual cover a wide variety of practices and procedures, there are, and will continue to be, directives from higher authority, which outline procedures to afloat commands concerning Medical Department functions. Nothing in this instruction should be construed as countermanding those directives.

b. To maintain uniformity, all recommended changes to this manual shall be forwarded via the ISIC to the respective TYCOM. Local changes are not authorized and will not be issued.



E. J. BOYLE  
Chief of Staff



D. G. PERRY  
Chief of Staff

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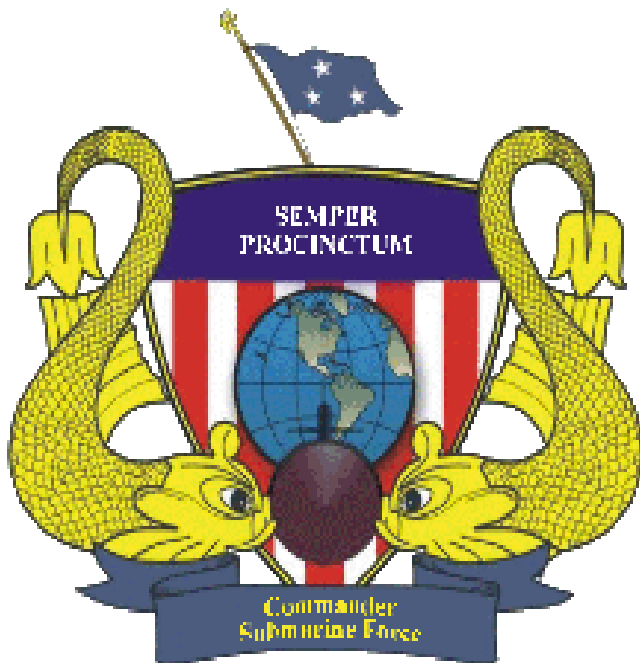
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# STANDARD SUBMARINE MEDICAL PROCEDURES MANUAL



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## **CHAPTER 1 RESPONSIBILITIES**

**1.1. General Information.** The administration of the submarine Medical Department is an assigned tasking for an Independent Duty Hospital Corpsman (IDC) assigned to the submarines of the United States Atlantic and Pacific Fleets. Reference (a) outlines the general responsibilities for Medical Departments of the United States Navy. Additionally, Chapter 9 of reference (a) discusses duties specific for the Independent Duty Corpsman. Due to the unique nature of an Independent Duty Corpsman assigned to submarines, specific guidance in some areas will be provided in other references listed herein.

**1.2. Commanding Officer.** The Commanding Officer is responsible for the health and well-being of all personnel assigned to his command. His authority and responsibility are established in United States Navy Regulations. Additionally, the Commanding Officer shall:

a. Ensure that the procedures outlined in this manual are implemented within his command.

b. Establish internal procedures, which will require the Medical Department Representative (MDR) to keep him informed of all health and habitability situations, which may affect the readiness of the ship's personnel.

c. Approve all internal Medical Department instructions.

d. Comply with OPNAVINST 6400.1 (series) concerning the training, certification, supervision and Continuing Medical Education (CME) requirements of the Independent Duty Corpsman.

e. Review all Medical Readiness Inspection Reports and submit root causes and corrective actions to ISIC with a copy to the cognizant NSSC within 30 days of receipt of formal report.

f. Countersign all prescriptions for controlled substances written underway.

g. Appoint, in writing, members to the Controlled Substances Inventory and Audit Board. The collateral duty list meets this requirement. Appointment letters are not required.

h. Review all reports submitted by the Controlled Substances Inventory and Audit Board.

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i. Review all Sanitation Inspection Reports per reference (c).

j. Ensure proper sanitation in the ship's potable water system.

k. Direct implementation of all required Safety and Occupational Health (SOH) Medical Surveillance Programs.

l. Ensure the utilization of the approved electronic medical database. (SAMS, TMIP etc.)

m. Ensure that all significant medical issues include consultation with the IDC's physician supervisor (typically the local NSSC/ISIC/SUBGRU Undersea Medical Officer).

**1.3. Executive Officer.** The Executive Officer (XO) shall keep himself informed about the readiness status of the ship's Medical Department. He shall specifically have the following responsibilities in the administration of the ship's Medical Department:

a. Keep the Commanding Officer informed regarding discrepancies discovered, corrective actions taken, and the overall readiness of the department to support at-sea operations.

b. Supervise the activities of the Medical Department Representative in his capacity overseeing the administrative functions of the ship's Medical Department.

c. The Executive Officer or an officer designated by the Executive Officer, will conduct a monthly internal monitor to review the administrative and material readiness of the ship's Medical Department, including the turnover log. These monitors shall be completed using selected portion(s) of the Medical Readiness Inspection Checklist, in APPENDIX I. This is an internal tool to help ensure the Medical Department is healthy. To aid in the oversight, a suggested MDR tickler is provided in APPENDIX K. An updated list may be available from the NSSC/ISIC Medical Department.

d. Ensure that the Medical Department Representative trains the Emergency Medical Assistance Team (EMAT) in the execution of their duties per approved submarine training program, and that their functions are fully incorporated into shipboard casualty response.

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e. Ensure that the Medical Department Representative relief letter (see APPENDIX A for a sample format) is submitted to the Commanding Officer upon permanent relief of the ship's Medical Department Representative.

#### **1.4. Medical Department Representative (MDR)**

a. The Medical Department Representative is responsible to the Commanding Officer via the Executive Officer for the overall status of the Medical Department. He shall be familiar with the responsibilities of this position as described in MANMED, Chapter 9. Additionally, he shall be guided by specific instructions in this manual and those of higher authority.

b. The Medical Department Representative will maintain current certifications per reference (b). In addition, TWO BLS Instructors shall be trained and maintained onboard to assist the Medical Department Representative in BLS training of the crew.

c. The MDR will provide a Problem Summary List to NSSC/ISIC Medical Department no less than monthly, via the chain of command. The physician supervisor may mandate a more frequent reporting periodicity. (see APPENDIX J for minimum requirements and recommended format). This report may be submitted electronically or via hard copy.

d. Conduct training for EMAT personnel and the crew per Chapter 3 of this manual.

e. Per OPNAVINST 6000.1(series), provide written notification to Commanding Officer upon confirmation of service member's pregnancy.

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**CHAPTER 2**  
**MEDICAL DEPARTMENT**

**SECTION 1- ORGANIZATION**

**2.1.1. Medical Department.** This instruction serves as the sole Medical Department Organization Manual. A thorough knowledge of this manual by all personnel assigned to the Medical Department is essential to ensure that the proper health and welfare of the crew is maintained.

**2.1.2. Medical Department Representative (MDR).** The Medical Department Representative serves as the Department Head of the Medical Department and will keep the Commanding Officer and the Chain of Command informed of conditions that affect the health, safety, and readiness of all command personnel. MDR shall have completed the formal NUMI curriculum.

a. As a Department Head, the MDR will routinely report status of medical readiness, training, occupational health programs and materiel via the Executive Officer and the Chief of the Boat (COB).

b. As the Commanding Officer's Medical Advisor, the MDR must have direct access to the Commanding Officer when briefing the medical status of crew members (e.g., medical evacuation recommendations). This unfiltered access is necessary in order to allow the Commanding Officer to fulfill his health and welfare responsibilities per Article 0820 of U.S. Navy Regulations and is consistent with MDR responsibilities per reference (a), Article 9-16. This does not preclude the MDR from ensuring that the Executive Officer and COB remains fully informed of shipboard medical events, consistent with Privacy Act and Health Information Portability and Accountability Act (HIPAA) requirements.

c. Duty and watchstanding requirements. The MDR may qualify but shall not be assigned to the inport watchbill. Senior in Rate qualifications (COW/Co-Pilot & DOOW/Pilot) are encouraged and can provide additional flexibility to the ships watch rotation. However, the ship should limit the amount of at sea watchstanding assigned to the MDR to ensure adequate emergency response, patient care and program management.

**2.1.3. Signature Authority.** All appropriate health record entries made by the Medical Department Representative will be signed and indicate name, rate, title and National Provider

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Identifier (NPI). MDR signatures on consultation requests (SF 513/CHCS/AHLTA) are normally accepted by the consultant activity; however, this policy will often vary depending upon local policies concerning such referrals. All medical correspondence and reports submitted externally from the command (PSL's are exempt) will only be released from the command over the signature of the Commanding Officer. Those reports, whose format requires the signature of the MDR, shall bear his signature as well.

**2.1.4. Emergency Detachment of the MDR.** The Medical Department shall be maintained in such a manner that, in the event of an emergency detachment of the MDR, a relieving corpsman would be able to make a smooth transition to continue all the duties and responsibilities assigned. All passwords for Medical Department programs (SAMS, TMIP, Prime Vendor, and SLEP) and safe combinations will be recorded on combination change envelopes and kept with the CMS Custodian.

a. During a non-contact relief, the relieving corpsman shall request the combination to the narcotic safe from the CMS Custodian. NSSC/ISIC Corpsmen who act as interim MDR, are qualified Medical Department Representatives and therefore, do not require a radiation health acceptance board and all qualifications are considered valid. Interim MDR's will be certified per reference (b). It is imperative that the Independent Duty Corpsman assigned maintains an up-to-date Turnover Log to help facilitate a smooth and accurate turnover of MDR's. The NSSC/ISIC Medical Department will review this log as part of the QA process.

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**CHAPTER 2**  
**MEDICAL DEPARTMENT**

**SECTION 2- ADMINISTRATION**

**2.2.1. Medical Department Administration.** Most of the duties and responsibilities of the Medical Department are adequately covered in this manual. Specific instructions may be issued as Medical Department instructions; however, directive pyramiding shall be avoided.

**2.2.2. Ship's Medical Directives.** Ship's medical directives will use the Standard Subject Identification Codes (SSIC) per SECNAVINST 5210.11. All shipboard directives submitted by the Medical Department Representative will be routed via the chain of command for review, subject to final approval of the Commanding Officer.

**2.2.3. Health Records**

a. The health and dental records provide a chronological record of examinations, treatments, immunizations, and health care rendered to a Sailor. These records shall be secured in a locked drawer, cabinet, or office. Custody will be maintained in such a manner as to protect its personal nature. In the MDR's absence, arrangements shall be made to allow the ship's company to have access to their records via the Executive Officer or the ship's Duty Officer/Leading Yeoman. The information contained therein shall be regarded as sensitive and shall not be divulged except as authorized in MANMED.

b. General administration and management of health records shall be per MANMED and other current instructions. Management of the health records are the responsibility of the MDR. Health record verifications are accomplished per MANMED, Chapter 16. Submarines may file health records alphabetically vice by terminal digit.

c. Each time an individual has a clinical encounter, approved electronic health record will be used to properly document all clinical encounters and follow-up encounters. Preventive Health Assessments (PHA's) will be entered into the approved electronic medical database and be documented on the NAVMED 6120/4 (available Navy Medicine Online at <https://nmo.med.navy.mil/>).

d. The DD Form 2766 (Adult Preventive and Chronic Care Flow sheet) shall be reviewed and updated during the receipt audit of the Health Record. The DD2766 provides immediate visibility of current health status and future screening requirements and will be maintained in the member's outpatient medical record.

**2.2.4. Privacy Act.** Details concerning general requirements and applicability of the Privacy Act within the naval establishment are contained in MANMED and SECNAVINST 5211 series. While the detailed administration of this program is complex and requires extensive study and understanding of these directives for complete compliance, the purpose of this program is to prevent the disclosure of personal information without their knowledge or consent.

**2.2.5. Correspondence.** All official correspondence related to the Medical Department shall meet the requirements of the Navy Correspondence Manual.

**2.2.6. Record Retirement.** Each Medical Department Representative shall establish an annual review of record retirement. Detailed procedures for implementing a record retirement program are contained in SECNAVINST 5212.5 series.

**2.2.7. Books and Publications.** Books and publications required for all ships are outlined in the COMFLTFORCOM Instruction 6820.1 series. Other reference material may be optionally carried in either text or CD-ROM format. Changes to instructions and directives will be updated by the MDR upon receipt.

**2.2.8. Logs to be maintained**

- a. Sick Call Log
- b. Potable Water Log (SAMS/TMIP)
- c. Controlled Medicinals Log. This log shall be maintained per Chapter 5 of this manual and chapter 21 of reference (a). See APPENDIX C for sample page.
- d. Medical Department Representative Turnover Log
- e. Gas Free Engineering Log



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**2.2.9. Medical Department Representative Turnover Log.** The Medical Department Representative will maintain a turnover log. This log will be reviewed monthly during the Executive Officer's internal periodic monitoring and by the NSSC/ISIC Medical Department during Quality Assurance reviews. This log will be updated at least monthly, or more often as necessary. The log will contain the following four sections:

- a. Current Problem Summary List (APPENDIX J)
- b. Medical Tickler File Section (Article 2.2.11)
- c. Medical Supply Section
  - (1) Locations of all medical lockers and stowage locations
  - (2) MOV (Material Obligation Validation - obtained from the Supply Department and will include Prime Vendor orders)
  - (3) Warning/Requisition List
  - (4) Current Expiring Medication List (projected 3 months out)
- d. Medical Administration Section
  - (1) Battle Bill
  - (2) TRICARE ISOS information (Fleet specific)

**2.2.10. Memorandum for the Record.** A Memorandum for the Record will be prepared by the MDR to document any occurrence of historical, legal, or general interest in which good judgment dictates that the event(s) should be recorded. Memorandums will be submitted through the MDR's chain of command.

**2.2.11. Tickler File.** Each Medical Department Representative shall establish a tickler file to serve as a reminder of periodic and/or recurrent medical requirements. Approved electronic medical database (e.g., SAMS/TMIP) will generate all of the requested Tickler File information. At a minimum, the following reports shall indicate overdue items and those that will be coming due in the next 3 months (for IMR purposes, project to the end of deployment/patrol cycle):

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- a. Physical examination status
- b. Preventive Health Assessment (PHA)
- c. Immunizations tracking status
- d. HIV, DNA, G6PD, Sickle Cell tracking status
- e. Hearing Conservation Program
- f. Dental roster with annual exam dates
- g. Allergies
- h. Personnel Requiring Long-term Medications
- i. List of Personnel onboard with Waivers

**2.2.12. Problem Summary List (PSL).** MDR's are required to maintain a PSL in order to assist with tracking medical care and other important items.

a. APPENDIX J outlines the minimum requirements for inclusion on the PSL. MDR's may add additional items as they deem necessary.

b. PSL shall be routed on a monthly basis through the chain of command and submitted to the physician supervisor. The physician supervisor may mandate a more frequent reporting periodicity.

c. PSL shall be retained for 6 months.

**2.2.13. Battle Bill.** All shipboard Medical Departments shall have a Medical Department Battle Bill addressing specific triage and routing of casualties for Damage Control Central. Mass casualty receiving area will be the crews mess. A copy of the Medical Department Battle Bill will be maintained in the Medical Department Representative Turnover Log and in Damage Control Central.

**2.2.14. ADP.** The MDR's workspace shall be equipped with access to the ship's classified and unclassified networks. The MDR shall have two separate computers, one for the classified network and one for the unclassified network with CAC access. The approved electronic medical database shall be installed on the unclassified system.

a. Password Maintenance: The medical database system will have password maintenance conducted every 90 days (Unless otherwise directed).

b. These computers are for MDR use only!

c. Two crew submarines shall have one computer per crew for the electronic medical database. These computers will be removable to take to off-crew.

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**CHAPTER 2**  
**MEDICAL DEPARTMENT**

**SECTION 3 - MEDICAL EVALUATION AND TREATMENT**

**2.3.1. Treatment at Non-Federal Facilities.** Refer all claims for treatment at non-federal facilities to the servicing TRICARE facility for payment of claims for medical care furnished to military personnel by all non-federal sources.

**2.3.2. International SOS.** TRICARE Management Activity (TMA) has partnered with International SOS Assistance, Inc., (ISOS) to deliver TRICARE Overseas Program (TOP) prime benefits to active duty service members operating worldwide. APPENDIX (B) outlines the use of this program for Pacific, European, African and Central theatres.

**2.3.3. Injuries.** All injuries to personnel, whether incurred during duty or while on liberty / leave, shall be reported and entered into the ship's Deck Log. SSBN/SSGN crews in off crew status are exempt from entering the accident report in the ship's Deck Log. The Injury Report (Appendix L) shall be used to report all accidents and injuries. OPNAVINST 5100.19 (Series), Navy Safety and Occupational Health Program Manual for Forces Afloat provides additional guidance in this area. Ensure OPREP 3 Personnel Casualty Reports are submitted per fleet guidelines.

**2.3.4. Medical Consultations**

a. Medical treatment of individuals shall be provided and followed by the ship's Medical Department Representative. Any injury/illness outside the MDRs scope of practice, should be referred to the next echelon of care. Use local policy for outside consultations. Those patients being initially referred for suicidal thoughts will be escorted to the place of consultation. Escorts will be (at the commands discretion) at least E-5 or above and appropriate to the patients rank. The Medical Department Representative shall not act as the command escort but may accompany the patient during treatment.

b. No patient shall be referred for routine treatment which can be accomplished by the IDC or the ISIC Medical Department. Additionally, no patient shall attend referral appointments without his or her health record and appropriate documentation concerning the MDR's opinion of the current complaint.

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c. The NSSC/ISIC Medical Officer will be informed when the Medical Department Representative, prior to the referral, refers a patient to a Medical Treatment Facility (MTF). The Medical Department Representative will take all necessary steps to keep himself, the command and NSSC/ISIC Medical Officer informed regarding the patient's status and progress, and to ensure that follow-up studies and appointments are kept. Any treatment recommendations which could impact special duty status must be identified immediately and reported to the physician supervisor.

d. Three months prior to the ship's deployment (in conjunction with POM certification) and SSBN's/SSGN's one month prior to patrol, the Medical Department Representative, Executive Officer, NSSC/ISIC Corpsman and Medical Officer will review the entire crew's medical/dental status, with particular attention to the Problem Summary List (PSL). Every effort will be made to identify any conditions which, if not properly addressed, could result in an avoidable MEDEVAC.

e. Referrals outside homeport will be conducted on an urgent basis only. Coordinate with local NSSC/ISIC for support.

### **2.3.5. Request for Medical Assistance**

a. If a serious medical problem arises onboard, the Commanding Officer will be advised as fully as possible of the situation and of the potential risk to the patient. If the Medical Department Representative considers it necessary, he will recommend to the Commanding Officer that a request for medical assistance (e.g., MEDADVICE or MEDEVAC message) be sent. While the MDR may first brief the Executive Officer and/or COB as to the recommended action, a negative endorsement upon their part shall not impede the MDR from fulfilling his duties as the Commanding Officer's medical advisor. Any decision to not send a medical assistance request, when recommended by the MDR, resides solely with the Commanding Officer. In these cases, a Memorandum for the Record shall be completed by the MDR.

b. The message format will be per current AOR OPORD (see APPENDIX D for a sample format). The action addressee is the operational commander at the time the message is sent. In all cases TYCOM (when not OPCOM), parent NSSC/ISIC and Naval Undersea Medical Institute (PLAD: NAVOPMEDINST DET NAVUSEAMEDINSTITUTE GROTON CT), Naval Submarine Medical Research Lab (PLAD: NAVSUBMEDRSCHLAB NEW LONDON CT) and local Military Treatment Facilities (MTF) will be included as info addressees. The decision to request a MEDEVAC is made by the Commanding

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Officer. The Medical Department Representative's recommendation to the Commanding Officer shall be documented in the patient's health record. The following measures are essential to provide continuity of care, permit timely MTF support and allow quality assurance review of the medical evacuation process:

(1) If another, non-record, form of communication (e.g., SAT Phone, Chat, E-mail) is used, the MEDADVICE/MEDEVAC message is still required and must reference said communications.

(2) COMSUBLANT and COMSUBPAC will coordinate with non-TYCOM SUBOPAUTHs (CTF 54/74 and CTF 69) to ensure that TYCOMs are info addressees on all OPCOM responses to MEDADVICE/MEDEVAC messages.

(3) MEDADVICE/MEDEVAC messages are intended to be UNCLAS documents as to allow expeditious review and action by supporting MTFs, which typically have limited SIPR access and classified handling capabilities. Classified position and coordinating details should be passed by separate message.

(4) Copies of the initial message and all follow-up messages will be maintained for three years in the Medical Department files.

c. The Medical Department Representative shall request Medical Advice or Evacuation for those conditions that meet the following criteria:

(1) Any medical condition threatening loss of life or limb.

(2) Any potentially serious working diagnosis, which, with treatment, is worsening or failing to respond within 24 hours.

(3) If a UMO has been consulted by a prior Medical Advice message and the recommended intervention does not result in expected resolution of patient symptoms, a follow-up medical update message shall be sent within 24 to 48 hours.

(4) Any working diagnosis for which proper treatment cannot be provided for one of the following reasons:

(a) The Medical Department Representative is unsure of the treatment protocol.

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(b) Treatment is outside the skill of the Medical Department Representative.

(c) Medication, equipment, supplies, or other necessary support is not available to the Medical Department Representative.

(5) Any suspected or confirmed outbreak of infectious disease (e.g., infectious diarrhea, influenza, severe URI, etc).

(6) Sexual Assault is sufficient reason for emergent medical evacuation of the victim to a facility with complete SAPR environment. The algorithm for MDR actions in these cases can be found in APPENDIX M. Should time to MEDEVAC be delayed, MDR shall perform necessary care, within his/her scope of practice, per current BUMED guidelines.

d. For reporting purposes the definition of a MEDEVAC shall be any medical or dental referral for examination or treatment of an individual from any ship at sea or away from homeport. This includes BSP of convenience into the home port.

e. The responsible NSSC/ISIC shall coordinate follow on care immediately on disembarking from ship. The NSSC/ISIC shall track all MEDEVAC's and provide status reports to the Type Commander and unit as requested.

f. All medical evacuations to locations other than U.S. medical facilities must follow guidance promulgated by cognizant Operational Commander for the theater of operations.

g. Per OPNAVINST 6000.1(series), medical evacuation (MEDEVAC) will not be used for pregnant servicewomen, *solely due to their pregnancy*, unless directed by a medical officer.

#### **2.3.6. Dispensing of Medications**

a. All medications shall be dispensed per MANMED, Chapter 21.

b. The Medical Department Representative will record all medications dispensed on the SF-600 in the individual's health record. Written prescriptions shall be completed for all controlled medicinals. Personnel will only be authorized to get underway with an active prescription for controlled substances with the concurrence of the UMO and Commanding Officer.



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c. Medicinals shall be maintained under lock and key at all times. It is not permissible to leave prescription strength medication or any quantities of over the counter medications out for crews use at any time.

### **2.3.7. Physical Examinations**

a. Examinations, will be performed in a manner which ensures clinical adequacy while maximizing patient comfort and privacy. This generally means in designated medical spaces, but may vary based on the chief complaint and ship configuration.

b. Policy on standby personnel (chaperones) for physical examinations is guided by BUMEDINST 6320.83 (series). For the Submarine Force:

(1) Standbys, in general, are recommended for any potentially compromising physical exam, should be routinely offered, and shall be provided upon request. Additionally, the patient or provider may request a standby.

(2) Standbys are absolutely required when genitalia or female breast are exposed or examined by a provider. This is regardless of the respective genders of the provider and the patient. This requirement is waived to provide emergent critical care, when delaying for a standby would, in the opinion of the provider, jeopardize the patient.

(3) Visualization of the examined body part by the standby is not desired, and given the peculiar configuration of submarine medical department spaces, line of sight contact with the patient may be impossible. Standbys will, as a minimum, remain in close physical proximity and verbal contact with the provider and the patient throughout the exam.

(4) The MDR will ensure that standbys are familiar with requirements for patient confidentiality. The standby's name should be entered into the medical record. The standby's gender is immaterial, but patient wishes should be acceded to whenever possible.

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**CHAPTER 2**  
**MEDICAL DEPARTMENT**

**SECTION 4 - SPECIAL MEDICAL CATEGORIES**

**2.4.1 Prolonged Absence and Post-Hospitalization Physical Examination**

a. All members who have had surgery, been hospitalized or prolonged illness shall have their health records screened by an Undersea Medical Officer (UMO) prior to returning to submarine duty.

b. Upon review, if potential physical defects or disqualifying factors are noted, the patient will be referred to the NSSC/ISIC Undersea Medical Officer for final determination. A UMO clearance notation of the screening will be documented in the health record.

**2.4.2. Personnel Reliability Program (PRP)**

a. The Medical Department Representative (MDR) shall medically screen members for inclusion in the PRP and as a part of the continuous monitoring. SECNAVINST 5510.35 (series) and COMSUBLANT/COMSUBPACINST 8120.2 (series) contain specific guidance.

b. Screening conducted by the MDR will consist of reviewing the member's medication profile, medical (including hard copy, HAIMS, AHLTA or any other Electronic Health Record available) and dental records. The member should complete a DD Form 2807 and the MDR shall review the DD Form 2807 with the member during the interview. Specific attention shall be given to any substance misuse or abuse, mental health history, chronic illness, medication use or other condition that may have an impact on reliability or cause sudden or subtle incapacitation. All significant history and conditions shall be documented on the SF600, Chronological Record of Medical Care, and provided immediately to the Certifying Official for timely suitability determinations.

c. If any concerning information is identified during the record review and interview process, the MDR shall inform the Certifying Official and the member shall be referred to the Competent Medical Authority (CMA) for further evaluation. If available health records are not sufficiently comprehensive or current, the CMA shall conduct a medical examination or consult

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with the appropriate medical specialist without delay to determine medical qualification under PRP standards. Examination and/or consultation results, including all significant physical or mental conditions, shall be documented in the member's health record via an SF600 entry and the findings provided immediately to the Certifying Official.

d. After entry into the PRP, the health/dental record shall be annotated to identify the individual as being in the PRP per SECNAVINST 5510 series. This annotation includes activation of all PRP flags in any electronic health record system. The MDR must review all medical and dental encounters to determine if there is any concerning information. All records should be reviewed and annotated to reflect the MDR's determination of concerning information and state the patient's PRP status. All encounters shall be reported to the Certifying Official with the MDR's recommendation for PRP status.

**2.4.3. Casts.** Patients with casts are not normally allowed onboard submarines. The NSSC/ISIC Medical Officer will be consulted for exceptions to this guidance, and UMO clearance will be documented in the patient's health record when appropriate.

**CHAPTER 2  
MEDICAL DEPARTMENT**

**SECTION 5 - SUBMARINE/DIVING PHYSICAL DISQUALIFICATIONS AND  
WAIVER REQUESTS**

**2.5.1. General Information**

a. The complete procedure for the administrative management of submarine disqualification cases is contained in the Submarine Personnel Manual 1306.1 series.

b. Guidelines for all cases being submitted for a waiver of physical standards are contained in the COMSUBLANT/COMSUBPACINST 6000.1 (series) and MANMED Chapter 15, Section IV.

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**CHAPTER 3**  
**TRAINING**

**3.1. Responsibility.** The Medical Department Representative is responsible for maintaining an effective medical training program for the crew and the Emergency Medical Assistant Team (EMAT).

**3.2. Minimum Training Requirements**

a. Each member of the crew will receive indoctrination and annual instruction on required subjects from OPNAVINST 5100.19 (series) and other applicable directives.

b. Emergency Medical Assistant Team (EMAT) continuing training will be conducted per current submarine qualification instructions.

c. The governing philosophy for all emergency medical training is that it represents a continuous process; it will never be complete but is a process and skill which requires ongoing commitment. Specifically regarding EMAT training:

(1) The EMAT will consist of at least six trained personnel to allow for flexibility in schedules and watchbills. The entire crew shall be eligible for EMAT selection. Stretcher bearers are extra personnel whose sole responsibility during casualties is to assist EMAT personnel in transporting patients.

(2) Local MTFs, NSSC's, clinics, and civilian training institutions will be consulted for availability of additional medical training (i.e., EMT, TCCC, and First Responder courses). Such established courses are an extremely effective source of training which give EMAT members basic building blocks to manage emergencies.

(3) Of those personnel trained, one trained EMAT member per watch section shall be identified by name or designation on the Ship's Watch, Quarter and Station Bill.

d. Casualty Drills (Team Training). Realistic training for the EMAT must be optimized by including personnel casualty scenarios in regular ship's drills. The ship's MDR will monitor the EMAT and stretcher-bearers for effectiveness during ship's drills and evolutions while underway. An evaluation of the effectiveness of the EMAT will be conducted by the NSSC/ISIC Medical Department and reported directly to the ships chain of command. This evaluation may include practical exams if

desired, and will be accomplished during Pre-overseas Movement Certifications (POMCERT), Submarine Operational Assessment's (SOA) or whenever an NSSC/ISIC/TYCOM medical personnel are embarked underway during drills.

(1) In conjunction with the ship's Medical Readiness Inspection, a medical emergency drill assessing both the IDC and EMAT, will be run by the cognizant Physician Supervisor or ISIC Undersea Medical Officer. Documentation of the drill will be placed in the IDC's training record and annotated on Medical Department Tickler.

e. Additional requirements. All ships force divers, command fitness leaders (CFL's) and "wire-rated" crewmembers (as required) will have current BLS provider certifications.

### **3.3. Training for Independent Duty Hospital Corpsman (IDC).**

The NSSC/ISIC Medical Department will implement a certification and training program for subordinate Independent Duty Corpsmen per OPNAVINST 6400.1 (series) and applicable directives. The MDR shall attend scheduled training at the NSSC/ISIC Medical Department when inport. The NSSC/ISIC Medical Department will maintain the training record for each Independent Duty Corpsman.

**3.4. Continuing Medical Education.** Medical Department Representatives are required to obtain formalized continuing medical education. A minimum of 15 hours Continuing Medical Education (CME's) are required each year. Annually, BUMED may sponsor shipboard Independent Duty Corpsmen to attend an annual Independent Duty Corpsman Conference. To obtain the required CME's; Independent Duty Corpsmen are encouraged to attend the conference. Commands are also urged to seek out the assistance from MTFs, Dental Centers, Naval Branch Health Clinics, and NSSC/ISIC Medical Staff in achieving required and approved CME's. Participation in the NSSC/ISIC weekly training program can count towards CME credit.

**3.5. Remediation.** The need for Level of Knowledge (LOK) or clinical skills remediation may be identified by the physician supervisor during monthly/quarterly chart reviews. The remediation plan will be generated by the physician supervisor, per OPNAVINST 6400.1 (series) and be endorsed by the Medical Department Representative's parent command. A copy of the completed remediation will be retained in the training record. NOTE: Letters of Instruction are generated by the parent command and are generally reserved for programmatic or performance deficiencies.



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**CHAPTER 4**  
**MEDICAL READINESS**

**SECTION 1 - GENERAL INFORMATION**

**4.1.1. Material Preparedness**

a. The Medical Department Representative will maintain the Authorized Medical Allowance List (AMAL) requirement of supplies and equipment onboard at all times. Deficiencies in the AMAL will be equal to the outstanding requisitions for re-supply. AMAL's will be maintained at >90 percent onboard with the remaining 10% on order with the exception of the Emergency Response Kit, First Aid Boxes and Decontamination Kit which will be 100 percent at all times. Any defective equipment or supplies found during the annual inventory will be replaced immediately.

b. The MDR will maintain an accurate and up to date inventory of all medical supplies/material/equipment carried onboard. The results of an annual supply inventory will be retained in Medical Department files. Pre-deployment cycles shall be utilized to ensure all Medical Department supplies and equipment are present for the entire deployment/patrol.

c. First Aid Boxes and Decontamination Kit are considered Damage Control equipment, and as such, shall not be modified in any way unless directed by higher authority. First Aid Boxes shall be arranged 1 per compartment of the ship (SSN - 2, SSBN/SSGN -3).

d. All medical equipment associated with the Shipboard Equipment Replacement Program shall be entered in OHMS/NG.

**4.1.2. Security of Supplies.** Supplies in first aid boxes must be protected from dust, dirt, and pilferage. Emergency Response Kit, first aid kits and boxes will be sealed with a seal that can be broken with ease. Placement of seals shall not break the watertight integrity of the box. Each first aid kit and box will have a tag/label on its exterior indicating its most recent inventory and inspection. Their contents will be physically inventoried quarterly, immediately after use, and if the original seal is found compromised during the interim period.

#### **4.1.3. Markings**

- a. All medical supply lockers will be appropriately identified and kept locked.
- b. All emergency equipment/storage lockers will be marked or labeled with a Red Cross.
- c. The Emergency Response Kit will be clearly marked, **"EMERGENCY RESPONSE KIT."**
- d. All litter/stretchers locations will be marked **"STRETCHER."**

#### **4.1.4. Medical Readiness Inspection (MRI)**

- a. In order to ascertain that Medical Departments are materially and administratively ready to support the mission of the ship, Medical Readiness Inspections are required.
- b. The NSSC/ISIC Undersea Medical Officer and Medical Department Representative will perform a Medical Readiness Inspection annually. Based on units operational commitments MRI's shall not exceed 18 months. MRIs will be scheduled as close as possible to 90 days prior to a major deployment. The MRI must be completed early enough to allow the ship time to correct significant discrepancies prior to the ship getting underway. Additionally, MRIs will be accomplished 90 days prior to the completion of major shipyard overhaul (Phase II Crew Certification) and initial sea trials for new construction submarines.
- c. Medical Readiness Inspections are formal in nature and comprehensive in scope. APPENDIX I will be used for the MRI. Fleet input for the APPENDIX I are encouraged and should be submitted to TYCOM for inclusion. Deficient areas that are noted as significant by the inspector that would endanger the crew, ship's mission or impact individual medical/dental readiness is cause for failure of the complete section regardless of the overall "C" status of the specific section. Significant deficiencies will be defined by the inspecting authority and are items that are contrary to specific instructions and references that outline the day to day operations of a submarine Medical Department.

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d. Any Medical Readiness Inspection graded overall C-3 or C-4 will be reevaluated within 60 days of the original MRI or prior to deployment, whichever comes first.

e. Some areas of the Medical Readiness Inspection checklist will not be applicable when ships are being evaluated in the shipyard. Enter "N/A due to shipyard overhaul" on those items of the checklist that are not applicable. The grading matrix will be adjusted to exclude the items that are not applicable.

f. Medical Inspection reports and corrective actions will be maintained onboard for a period of 3 years.

#### **4.1.5. External Reporting of Medical Readiness Inspections**

a. The evaluating authority shall forward the original MRI report to the Commanding Officer of the ship. A copy of the cover letter will be sent to cognizant TYCOM.

b. If the MRI is graded overall as C-3 or C-4, forward a copy of the inspection report with all enclosures to the respective TYCOM via the chain of command.

**4.1.6. Turnover of the MDR.** The departing and relieving MDR's will conduct a turnover utilizing the MRI checklist in APPENDIX I. The checklist will be utilized and included as part of the relief letter (see APPENDIX A). If contact relief is not possible, the incumbent MDR and a representative of the NSSC/ISIC Medical Department will complete the checklist. In any case the checklist shall be submitted to the Commanding Officer. The NSSC/ISIC Medical Department will monitor the turnover.

**4.1.7. Individual Medical Readiness.** Individual Medical Readiness (IMR) percentages are a reflection of the command's ability to mobilize at any time for any contingency. Each command is expected to maintain the highest possible IMR, but remain no less than 90 percent fully ready at all times. To achieve this goal, MDR's must maintain the approved electronic medical database accurately and update it regularly. The MDR is required to upload medical database to NMO weekly.

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**CHAPTER 4**  
**MEDICAL READINESS**

**SECTION 2 - EMERGENCY SUPPLIES AND EQUIPMENT**

**4.2.1. Emergency Material**

a. Submarines should stow all emergency, essential and other medical supplies in such a manner as not to place the entire stock of any one given item in a single compartment of the ship.

b. All emergency supplies, litters and medical equipment will be maintained per shipboard 3M program. The date of inspection and initials of the inspector will be listed on an inspection tag affixed to the piece of emergency equipment.

c. Four Bag Valve Mask (BVM) resuscitators will be maintained onboard each submarine. One BVM resuscitator will be stowed with or near the Emergency Response Kit (ERK). One BVM resuscitator will be provided with an Emergency Air Breathing (EAB) hook-up.

d. All emergency material containing drug paraphernalia or medicines shall be locked when stowed outside of a lockable medical space (sick bay).

e. AEDs or comparable equipment shall be stowed in a location easily accessible to the crew (i.e., crews mess).

**4.2.2. Oxygen Cylinders**

a. Only oxygen cylinders that provide a cover for protection of the valve are authorized for use onboard submarines. If a cylinder without a valve cover is substituted, a report of item discrepancy (Standard Form 364) shall be submitted per NAVSUPINST 4440.128 (series).

b. Oxygen cylinders shall be checked for adequacy of charge immediately upon receipt and thereafter per PMS criterion. Bottles must be firmly secured in a vertical or horizontal position with their valves protected thus not creating a potential missile hazard. Medical Department Representatives should maintain one oxygen cylinder readily available for use, if storage and safety permits. On SSN submarines, with the exception of the VIRGINIA class, the yoke and regulator will be

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stowed in plastic near the vicinity of the oxygen cylinder stowage location. Oxygen regulators shall be readily available for use with cylinders stowed fore and aft.

c. The MDR and EMAT personnel shall become familiar with the location of the oxygen bank tap (688/726 class) or jumper connection (for 726/774 class) on their specific platform. When added to the Allowed Equipment List (AEL), MDR and EMAT shall be familiar with the operation/use restrictions of oxygen concentrators.

**4.2.3. Litters.** Four handling lines (1.5 inch, 3-strand nylon, NSN 4020-00-641-8900) will be made up for use with litters. With the exception of SSBN/SSGN, the lines should be long enough to lower the litter from the top of the sail to the Control Room Deck passing through a block or pad-eye at the top of the hatch with a final turn around a stanchion. The handling lines will be made with cargo handling clips at one end to facilitate attachment to a handling ring on the stretcher. Handling lines may be kept in a separate stowage locker or adjacent to the litter. Handling line weight testing will be performed by the IMA/Shipyard/Refit facility upon receipt and when found to be excessively worn or soiled. Weight testing will be performed per NSTM and shipboard 3M system. Training in the use of the stretcher shall be conducted annually by the MDR with members of the small boat handling and helo transfer party IAW shipboard casualty procedures.

**4.2.4. Dental Emergency Kit.** The Dental Emergency Kit will be ready for emergent use.

**4.2.5. Emergency Response Kit (ERK)**

a. The ERK will contain an inventory list and will be secured with a seal.

b. The ERK should be stowed in or near the primary treatment area of the ship. Any supplies consumed during an emergency will be replaced immediately.

c. The ERK will be maintained at 100% at all times.

**CHAPTER 5**  
**SHIPBOARD MEDICAL ACCOUNTING & SUPPLY**

**SECTION 1 - GENERAL INFORMATION**

**5.1.1 Discussion.** The Medical Department Representative onboard each ship is responsible and accountable for property and supplies within his department and will be required to sign for major items of equipment/equipage. He will act as his department's Repair Parts Petty Officer (RPPO) and will utilize the same procedures for requisitioning material as used by other department RPPOs.

**5.1.2. Quality Control of Medical Material**

a. Each ship of the Force will maintain a strict quality control program for all medical material onboard. Newly requisitioned supplies are to be rotated within the medical facilities and stowage lockers throughout the ship, replacing older stock that should be used first.

b. The Medical Department Representative will utilize the approved electronic medical database to manage medical supplies and ensure biologicals, medicinals and medical supplies are maintained within expiration dates.

c. NSSC/ISIC is responsible for ensuring each medical department utilizes Shelf Life Extension Program (SLEP) as required per BUMEDINST 6710.71.

**5.1.3. Authorized Medical/Dental Allowance Lists (AMALS/ADALS)**

a. Periodically the Naval Medical Logistics Command (NMLC) revises the AMALs/ADALs. Additions/deletions to the AMALs/ADALs are made via AMAL Change Requests (ACR). ACR's shall be submitted electronically and forwarded to the TYCOM via the NSSC/ISIC.

b. Special attention should be given to the acquisition codes that accompany AMAL changes. For example, many AMAL changes are coded to direct that the replaced item be used until it is no longer serviceable before the replacement item is ordered. AMAL changes can affect other TYCOMS. Consult with the TYCOM prior to ACR submission.

c. As needed, a supplemental medical allowance list (SMAL) will be submitted to the NSSC/ISIC Medical Department for approval. A SMAL is required any medication that is not carried on the AMAL/ADAL and is clinically indicated for a crewmember's specific diagnosis or is required by deploying units as chemoprophylaxis.

**5.1.4. Reporting of Defective/Unsatisfactory Medical Material.**

Upon receipt or discovery of defective or unsatisfactory medical material, ships will suspend all stocks involved from issue and use. Only items that are considered to be injurious or unsatisfactory due to inherent characteristics will be reported. Items involving idiosyncrasies or sensitivities of individual patients will not be reported.

**5.1.5. Survey of Supplies.** Detailed instructions for surveying missing, lost, stolen, or recovered government property are contained in NAVSUP P-485. Information on survey of controlled drugs is contained in MANMED, Chapter 21.

**5.1.6. OPTAR Medical Management.** AMAL Supplies are always considered number one in priority of the ship's consumable funds. If, at any time, the supply department relates to the Medical Department Representative that there are inadequate funds to procure needed medical supplies, the NSSC/ISIC Medical Department leadership will be notified. Medical supplies always receive first priority in OPTAR funds. OPTAR funding on all submarine medical items will be 100 percent, either onboard or on order. Items such as atmosphere control equipment or other non-medical material is not funded from medical OPTAR funds.

**5.1.7. Requisition Procedure.** A LOGREQ will be utilized to order AMAL/SMAL items, and DOD directed immunizations as required while on deployment. Only AMAL and approved SMAL items may be requisitioned. In the instance of a MEDEVAC which has consumed significant medical stores, a LOGREQ should be sent in sufficient time, if possible, to replenish critical items at the time of the personnel transfer.

**5.1.8. Special Items.** Safety glasses and prescription safety glasses will be ordered using non-medical OPTAR funds only per OPNAVINST 5100.19 (series).

**5.1.9. TOB and SERP Programs.** Initial outfitting of medical equipage and most new AMAL additions are purchased via Technical Operating Budget (TOB). The COMFLTFORCOM/COMPACFLT Medical Office via the Shipboard Equipment Replacement Program (SERP)



provides funding for replacement medical equipage. When directed by the TYCOM, a medical equipment inventory list, which is used to determine which equipment is purchased via SERP, will be submitted. Any high cost (>\$499) medical equipage will be replaced via CASREP if replacement is required outside of normal rotation periodicity. To assist in this process, all medical equipage requiring periodic maintenance shall be entered into the ships Organizational Maintenance Management System - Next Generation (OMMS/NG).

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**CHAPTER 5**  
**SHIPBOARD MEDICAL ACCOUNTING & SUPPLY**

**SECTION 2 - SUPPLY CONTROL**

**5.2.1. Medical Material Control Procedures**

a. Medical inventory management will be accomplished using approved electronic medical database. A physical inventory of all supplies, material, equipment, books and publications will be conducted at least every twelve (12) months. A memorandum to the Commanding Officer will document the results of this inventory. This inventory will compare inventory records with actual onboard quantities, and include verification of expiration/potency data. The Medical Department Representative will maintain results of the inventory on file until the CO reviews the next completed inventory.

b. Expendable medical materials, i.e., drugs, dressings, etc., with the exception of controlled medicinals, may be considered "expended" when the basic unit of issue (BT/PG) is opened to ease inventory management.

**5.2.2. Excess Material Turn-in.** Units having medical material in excess of their basic needs and expired medications will turn in such materials per local NSSC/ISIC Medical Department policy.

**5.2.3. Medical Equipment Maintenance.** In addition to the requirement of shipboard PMS, the MDR shall:

a. Prepare NAVMED 6700/3 (Medical/Dental Equipment Maintenance Record) for each equipment item currently onboard, or for subsequently acquired which require recurring maintenance. Entries of NAVMED 6700/3s will only be made for unplanned maintenance and repair of medical equipment.

b. When applicable, per shipboard PMS guidelines, a Biomedical Equipment Technician (BMET) will check medical equipment items. These checks, as well as equipment repair and maintenance beyond ship's fore capability, will be requested from the nearest BMET afloat, Military Treatment Facility (MTF) or medical equipment repair facility.

c. A current list of all medical equipment in the Shipboard Equipment Replacement Program (SERP) will be kept on file with the NAVMED 6700/3s.

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**5.2.4. Supply Replenishment During Overhaul**

a. It is imperative that a complete inventory of all medical supplies and equipment be accomplished during yard overhauls and outdated supplies replaced. This procedure will ensure that a complete AMAL is onboard at the completion of the overhaul period. However, in order to preclude medical items from approaching their expiration date as the ship nears overhaul completion, complete requisitioning of expiring medical supplies will be done six months prior to the completion of the overhaul period. Whenever possible, expiring medications and supplies may be transferred to other units that are in need. The NSSC/ISIC Medical Department shall be notified of AMAL requisitioning and transferring of medical supplies between units.

b. Replenishment of routine medical supplies used in support of patient care on a day-to-day basis is expected; however, these requisitions should be minimal, and the services available through the local shore based medical department or MTF will be used.

c. New construction ships will have AMAL/ADAL's delivered to them at no cost to the ship or TYCOM. NEWCON MDR's must closely track delivery of AMAL/ADAL against projected Sea Trials dates, particular when construction schedule changes. Early, forceful engagement with the SUPSHIP, NAVMEDLOGCOM and TYCOM to resolve delayed deliveries is required. For those ships undergoing scheduled shipyard availability, the MDR's will maintain normal AMAL/ADAL accountability and will order supplies through normal procedures. The MDR will ensure that all supplies are onboard prior to projected Sea Trials.

d. Shipboard Emergency Medical Equipment may be placed in a lay-up status when the ship enters a maintenance overhaul period. Units shall verify requirements with ISIC Medical Department prior to taking this action.

**5.2.5. Medical Department Inactivation.** APPENDIX F provides a checklist for submarines inactivating. It is imperative that command approval be given prior to any transfer, survey or destruction of medical supplies and/or records.

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**CHAPTER 5**  
**SHIPBOARD MEDICAL ACCOUNTING & SUPPLY**

**SECTION 3 - CONTROLLED SUBSTANCES**

**5.3.1. General Information.** Controlled Substances, as used herein, include those drug schedules outlined in Chapter 21, section II of reference (a). Additionally, Chapter 21, section IV of reference (a) provides specific guidance for the dispensing of controlled substances by Independent Duty Corpsman. The ships MDR is recognized as the ships Controlled Substance Custodian. As such, the ships MDR will maintain custody of all controlled substances that are authorized for shipboard use. Accountability of these controlled substances will be maintained in the form of a controlled substance log and periodic inventories as outlined in article 21-24 of reference (a). A sample controlled substance log and periodic inventory can be found in APPENDIX C. The Executive Officer, or other designated Officer, will require strict compliance with the receipt, custody and issue of controlled substances pursuant to Chapter 21 of reference (a).

a. During underway operations, treatment involving the use of controlled substances will be reserved for the relief of severe pain, seizure or the treatment and safety of emotionally disturbed personnel. The Commanding Officer will be notified and countersign the back of the DD 1289. In cases where prescribing authority is an embarked medical officer, the CO countersign is not required. Additionally, the patient will acknowledge receipt of the drug on the back of the DD 1289 unless incapacitated. In that instance the person administering the medication and a witness will sign the back of the DD 1289 stating that the recipient was incapable of signing.

b. Dispensing Controlled Substances

(1) Prescriptions for controlled substances will be documented on a properly prepared DD 1289. The prescription will be signed by the MDR and countersigned by the Commanding Officer.

(2) All prescriptions for controlled substances shall be numbered consecutively by calendar year (i.e., 07-13). Special letter prefixes are not required.

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(3) Upon dispensing the controlled substances the prescription is placed in sequential order on the left hand page opposite the expenditure entry of the working stock log.

(4) All controlled substances dispensed shall bear a label prepared per MANMED, Chapter 21.

(5) Except in extreme emergencies, controlled substances shall not be administered by Independent Duty Corpsmen while in port unless approved by a Medical Officer in writing.

c. Personnel receiving such medication will normally not be returned to duty for a period of eight hours after the last dose of medication. The Medical Officer/Medical Department Representative will make this decision after examination and evaluation. Exception may be granted when the recipient is deemed capable of performing duties that are non-critical to the safety of the submarine and the Sailor.

d. Only specific NSNs and quantities of Controlled Substances as published in AMALs will be requisitioned, or carried. NSNs will not be substituted. Force Medical Officer written approval will be obtained prior to ordering or carrying onboard any controlled substances not specifically authorized by AMAL. AMAL quantities may be exceeded for short periods when replacement items are received and prior to survey of expired items.

**5.3.2. Security.** Access to controlled substances will be limited to the MDR. Small safes with combination locks will be used for storage of controlled substances. Only those persons whose official duties demand access to the working stock safe will know the safe's combination. The combination will be changed upon assuming custody, on any suspicion that the combination has been compromised, or not less frequently than every 12 months. Records of combinations will be recorded on "Combination Change Envelope" OPNAV 5511/2 and placed in the custody of the Classified Material Control Officer.

**5.3.3. Appointment of Inventory/Audit Board and Procedures**

a. The members of the Controlled Substances Inventory and Audit Board will be appointed by the Commanding Officer on the Collateral Duty Listing. Requirements for membership to this board are outlined in MANMED, Chapter 21. The Medical Department Representative, Supply Officer and Controlled

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Substance Receipt Officer will not serve as members of the inventory/audit board.

b. The board will perform inventories and audits of all controlled substances per MANMED, Chapter 21, Article 21-24. The board will conduct audits in a manner that ensures that all controlled substances received onboard from any source are accounted for by inventory or expenditure records.

c. The board will perform inventory/audits of controlled substances according to the following schedule:

(1) At least quarterly (every 90 days) if there have been no transactions. For SSBNs/SSGNs the inventory conducted during crew turnover satisfies this requirement as long as it does not exceed 90 days.

(2) Within one month (30 days) of any transaction (prescription, receipt, survey, etc.) involving controlled substances.

(3) At the time of relief of the Commanding Officer or Medical Department Representative.

(4) At the request of the Commanding Officer.

(5) Upon direction from higher authority.

d. The board shall ensure that the records inspected constitute a complete audit trail and that they reflect all transactions which have occurred during the accounting period. The board should audit inventory records, requisitions, receipts and issue documentation, and should check supply department records as required to verify that all documents are accounted for. For this purpose, the supply department is required to provide a copy of all issue documents for controlled substances directly to the senior member of the board.

e. The senior member of the board will submit a written report of each inventory/audit to the Commanding Officer using the format contained in APPENDIX C.

**5.3.4. Loss.** Any loss of controlled substances must be reported immediately to the ships chain of command, cognizant NSSC/ISIC and TYCOM.

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**5.3.5. Disposal of Excess Quantities or Deteriorated Items**

a. Excess or deteriorated drugs requiring special custodial care will be disposed of per MANMED, Chapter 21. All survey/destruction of excess or deteriorated items will be done utilizing the current approved survey document. Survey of controlled substances will be in units of issue (i.e., tablets, capsules, etc.). Surveys will not be accomplished until authorized by the Commanding Officer on the survey form and all destruction will be in the presence of the Controlled Substances Inventory/Audit Board who will add to the form the date, method, and signature of witnesses following destruction.

b. Utilizing the DD Form 200, the following blocks apply:

1. Date prepared

2. Chronologically numbered survey

3. Not applicable (n/a)

4 - 8. Self-explanatory

9. Basis for destruction

10. n/a

11 - 12. MDR's information

13. n/a

14. Commanding Officer approval

15(a). This section will include the disposal method, lot number, manufacturer, and expiration date. Additionally, include the printed names and signatures of the board members.

15(b). - 16(h). n/a

17(b). - (f). Accountable (Supply) Officer information

**5.3.6. Records Retention.** All records, receipt/transfer documents, logs, prescriptions, and related records of controlled substances will be maintained for at least three years.



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**CHAPTER 6**  
**PREVENTIVE MEDICINE AND SANITATION AFLOAT**

**SECTION 1 - GENERAL INFORMATION**

**6.1.1 Discussion.** The Medical Department is charged with advising the Commanding Officer of conditions that may have an adverse effect on the health of personnel. The Medical Department is also charged with making appropriate recommendations for correction of such conditions. The Medical Department discharges these responsibilities primarily through the day-to-day pursuit of sanitation and preventive medicine measures and only secondarily by treatment rendered at sick call. Meticulous attention to disease prevention is a continuing program that must be accomplished through compliance with various directives. The occurrence of several infectious disease incidents makes it imperative to review shipboard sanitation and preventive health practices on a continuing basis, and to emphasize measures for eliminating potential sources from which disease may spread. Items included in this chapter are highlighted from existing directives and should not be construed as superseding techniques of preventive medicine contained in other publications.

**6.1.2. Sanitation Inspections**

a. The Medical Department Representative (MDR) and the leading CS will make a daily walk through sanitation inspection of living spaces (berthing), heads, washrooms, and mess facilities. The inspector will be concerned with practices and conditions, which may have an adverse effect upon the sanitation of the ship and the general health of the crew. The daily inspection will be in sufficient detail to discover an unsanitary practice in all areas inspected but is not intended to be formal or require extensive preparation, i.e., field days, clean ups, etc. The MDR will identify those conditions which are considered unsanitary or which degrade the habitability of a space, and will report his findings to the cognizant division officer and division leading petty officer. He will make provisions to follow-up on his recommendations and take appropriate action.

b. The MDR will conduct a formal sanitation inspection monthly, to include review of the Leading CS self-assessments. In no case will a formal sanitation inspection exceed 30 days in periodicity.

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c. The MDR will submit the formal report of inspection to the chain of command within 48 hours. The report will identify each discrepancy and list the recommended corrective action. Each inspection will make reference to any recurring discrepancies from previous inspections. The required daily inspections will serve as follow-up inspections to ensure that corrective action is being taken to remedy those items found on the formal inspection. If the galley is found non-compliant on formal inspection, a re-inspection will be conducted within five days.

d. Copies of all formal sanitation reports bearing evidence of the Commanding Officer's notation will be retained in Medical Department files for six months.

**6.1.3. Food Service Personnel.** Personnel involved in preparing or serving food will be subject to the following standards:

a. Physical Standards. All food service personnel will be given a physical evaluation per NAVMED P-5010, Chapter 1 and the Tri-service food code prior to assuming duties as a food handler. Results of the physical evaluation will be documented on a SF-600. Annual Preventive Health Assessment (PHA) will be utilized to verify physical standards for food service personnel.

b. Personal Grooming and Inspection. The leading CS will inspect each food handler daily prior to assuming the watch. In addition, the MDR will inspect food handlers daily to ensure their personal hygiene and grooming standards are acceptable and that they are free from lesions of the hands, face, or neck, and from other signs of communicable disease. "Hot Bunking" of MDR and food service personnel is prohibited.

c. Training. Food service personnel (CS) and food service attendants (FSA) will be trained per NAVMED P-5010, Chapter 1 and the Tri-service food code prior to assuming duties as a food handler.

**6.1.4. Areas Requiring Special Attention**

a. Trash Disposal Units (TDU). Trash should not be allowed to accumulate in or around the galley, TDU area or pantry. All trash cans will be washed with hot soapy water between uses.

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b. Garbage Storage. Periodically, storage of garbage will be required, either due to operational necessity or regulation. In those instances, the MDR will periodically evaluate those spaces to ensure compliance with NAVMED P-5010 and in keeping with the spirit of good health and hygiene.

c. Deck Drains. Deck drain gratings will be removed weekly in all food service areas for complete cleaning.

**6.1.5. Handling of Foreign Foods**. When it becomes necessary to procure fruits and vegetables produced in other than United States facilities, the following precautions should be observed prior to consumption: (see NAVMED P-5010 for additional guidance)

a. Chemical Fertilization. Purchase will be limited to those items, which are certified as having been grown under chemical fertilization. This certification, however, does not ensure that the produce is free of parasitic and bacteriological contamination since occasional laboratory examinations of such produce have revealed the presence of the eggs of whip-worms and tapeworms; nevertheless, such produce, when properly prepared, is safe for human consumption.

b. Disinfecting Produce. Prior to cooking, the produce should be washed thoroughly under running water using a vegetable brush to remove dirt and debris. If the produce is to be eaten raw, the following must be observed:

(1) Remove all deteriorated portions.

(2) Break head vegetables apart to allow contact of the disinfectant with all surfaces.

(3) Wash thoroughly in clear water to remove soil.

(4) All vegetables and fruits will be disinfected by immersion in approved commercial chemical treatment according to the product information sheet. See NAVMED P-5010 for additional disinfecting instructions. Per the Federal Drug Administration (FDA), the use of Wescodyne is prohibited for the disinfection of fruits and vegetables. This applies to vegetables of uncertain origin and those purchased in foreign countries, as well as those suspected of being contaminated with pathogenic organisms.

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**6.1.6. Berthing Compartments.** A ship must provide berthing spaces that are clean, comfortable, and properly maintained to ensure health, welfare, and fighting efficiency.

a. Bedding Changes. All assigned bunks, when not actually in use, will be made up with sheets and a blanket. Pillowcases and sheets in use will be changed at least once a week. Blankets will be cleaned at least every six months. Upon transfer of personnel, blankets will be turned in for cleaning prior to reissue.

b. Mattresses and Covers. All mattresses will be kept covered at all times. This applies to mattresses assigned to personnel on leave or TAD as well as unassigned mattresses. Keep mattress cover closure strings tied on the under surface. Removable ticking on foam rubber mattresses is to be laundered once each quarter. Mattresses that are badly soiled or otherwise in an unsatisfactory condition will be cleaned and renovated, or surveyed and replaced.

c. Sleeping Bags. Due to the difficulty of cleaning sleeping bags onboard submarines and the generation of toxic combustion gases during fires, sleeping bags are not authorized aboard submarines.

d. Laundry Bags. Soiled clothing should be placed in laundry bags. Laundry bags that are used for soiled laundry should be stowed at the foot of the bunk. They should never be permitted to hang near the heads of bunks.

e. Insect Control. Berthing spaces will be inspected by the Medical Department Representative to ensure the compartment is free from insects. Absolutely no open food containers will be stowed in personal lockers, under bunks, or elsewhere in berthing compartments, working spaces, or offices.

**6.1.7. Heads, Washrooms, and Showers.** Heads, washrooms, and showers should be secured and thoroughly cleaned at least once daily (Sunday and holidays included) or more often as necessary to maintain proper sanitation. This cleaning should be staggered to ensure that a sufficient number of heads are kept open.

a. Preventive Maintenance. Vigorous scrubbing with soap and hot water is needed to keep washbowls, toilet seats, and decks sanitary. Thorough cleaning is also necessary to keep

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urinals, commodes, lower bulkheads, and decks of the shower stalls free of slime-mold growth. Wescodyne solution 75 ppm (3 oz/5 gal. water) is recommended for routine sanitization.

b. Use of Deodorants. The use of deodorizing agents in urinals, berthing areas, and commodes onboard submarines is not authorized due to atmosphere contamination considerations.

c. Powdered/Liquid Soap Dispensers and Hand Dryers. Powdered and liquid soap dispensers are recommended for installation in all heads and washroom spaces. Suitable facilities should also be provided for drying the hands. Air dryers are highly recommended but paper towel dispensers are authorized. Drying facilities should be provided in the ratio of one facility for every four washbasins. Hand washing signs will be posted per NAVMED P-5010, Chapter 1.

d. Waste Receptacles. Mounted waste receptacles, including those used to segregate used feminine hygiene products, will be emptied and thoroughly cleaned on a regular basis to preclude fomite transmission.

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**CHAPTER 6**  
**PREVENTIVE MEDICINE AND SANITATION AFLOAT**

**SECTION 2 - POTABLE WATER**

**6.2.1. General Information.** NAVMED P-5010, Chapter 6 excludes nuclear powered submarines from the requirement for routine chlorination of potable water distilled onboard. The procurement of potable water from external sources is usually from Navy approved sources where chlorine residual is within the required limits of NAVMED P-5010, Chapter 6; however, this must not be assumed, regardless of water source. In addition, the possibility exists that contamination of potable water systems may occur during system maintenance or repair. Therefore, specific guidelines concerning continuing sanitation of potable water and emergency chlorination procedures must be established. The hazardous properties of the most commonly used chlorinating agent (calcium hypochlorite) require strict precautions. This chemical is an active oxidizing agent, which may produce spontaneous combustion when allowed to come in contact with oils or grease. NAVMED P-5010, Chapter 6 continues to be the basic directive for water sanitation afloat. Additional information can be found within NAVSHIPS Technical Manual, Chapter 533.

**6.2.2. Procedures.** Commanding Officers will implement the following procedures:

a. Designate and train personnel for each aspect of potable water procurement and sanitation as required by NAVMED P-5010, Chapter 6.

b. All potable water hoses and potable water filling connections will be properly marked per NAVMED P-5010, Chapter 6. They will be protected from contamination by storing with the ends coupled or closed with screw-type caps and will be stowed in a locker clearly marked "POTABLE WATER ONLY." Under no circumstances will potable water hoses be used for any other purpose, except the conveyance of potable water. All submarines require the use of BLUE colored hoses.

c. Testing for Chlorine (OCONUS)

(1) Per current directives and NEPMU guidance, submarines inport (non-US managed ports) will conduct one Free Available Chlorine (FAC) test daily at a different point along the water distribution system over a one week period. In the event of 0 (zero) FAC, immediately perform a bacteriological sample at the 0 FAC point.

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(2) Daily residual testing is not mandatory while the ship is underway.

(3) Submarines are generally exempted from routinely halogenating potable water. However, some submarines have been retrofitted with an in-line brominator unit. If bacteriological testing indicates positive coliform bacteria then the potable water supply shall be treated with either calcium hypochlorite (65-70 percent) or bromine until residual of 0.2 ppm FAC or Total Bromine (TBR) as applicable is obtained with a minimum 30 minutes contact time. Halogen residual must be maintained until repeat bacteriological testing indicates water is safe.

(4) Testing is required before receiving any water from an unapproved or suspect source.

(5) Testing is required 30 minutes after chlorinating potable water tanks.

(6) All testing is done using the color comparator and test tablets listed in the AMAL.

(7) After treating, testing will be accomplished by monitoring a minimum of four sampling points that are representative of the ship's distribution system.

(8) All testing is documented using the approved electronic medical database environmental health module.

d. Bacteriological sampling of potable water and ice will be performed weekly per NAVMED P-5010, Chapter 6. The testing of samples collected may be performed onboard or at a shore facility while in port. The results of weekly bacteriological analysis of potable water will be reported to the Commanding Officer via the Engineer Officer. The samples will be taken at various points in the potable water system, i.e., sinks, scuttlebutts and various other outlets. Weekly, conduct bacteriological sample testing which will consist of a positive and negative control, three random samples, and one ice machine.

e. The MDR will conduct training semi-annually for all engineering personnel involved with the procurement of potable water or maintenance of the potable water system.

f. A weekly inspection of potable water associated equipment; i.e., hoses, hose caps, chemical storage, etc., will be made in conjunction with the bacteriological analysis. Potable



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water connections/equipment will be cleaned using Wescodyne solution, prior to use, as shown in APPENDIX G.

### **6.2.3. Calcium Hypochlorite (HTH) Use and Stowage**

a. Until an acceptable substitute for potable water chlorination becomes available, the following minimal amounts of HTH will be carried onboard submarines:

SSN - (9) six oz. bottles  
SSBN/SSGN - (12) six oz. bottles

**NOTE:** Units deploying OCONUS should consult their NSSC/ISIC or cognizant NEPMU and be prepared to carry more than the above amounts of HTH.

b. The general procedures for chlorinating potable water are discussed in NAVMED P-5010. The potable water system is designed to prevent contamination, and the addition of HTH may require development of local procedures to ensure proper addition without equipment disassembly. An acceptable method at sea is to prepare the chlorine solution per the table listed in NAVMED P-5010 and pour the clear liquid into the depressurized potable water tank through the liquid level indicator manifold. In port, pouring the chemical liquid into the potable water hose and then connecting the hose to the potable water system piping will accomplish chlorination. The chemical will then be flushed into the tank by pressure from the external source.

c. Because of the hazardous nature of HTH, it will be carried only in the required amounts, or in small increased quantities when recommended by an NEPMU or NSSC/ISIC for specific operations. The individual bottles of HTH will be sealed in plastic bags and stored only in a plastic, rigid medical first aid box. Three 1/4-inch vent holes will be drilled in the bottom of the box, and it will be painted white and distinctively labeled "HAZARDOUS MATERIAL - CALCIUM HYPOCHLORITE" in red letters. The HTH storage box and its contents will be stowed per NAVSHIPS Technical Manual, Article 670-5.5. HTH will be carried only in sealed or resealed bottles, except during the brief period when chlorinating solution is being prepared. Dry HTH can cause explosive fires when it comes in contact with oils and other flammables. Calcium hypochlorite will be stowed in a well ventilated, oil free space (NOT IN A SHIP'S FAN ROOM). Unused HTH will be discarded only as an aqueous solution.

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**CHAPTER 6**  
**PREVENTIVE MEDICINE AND SANITATION AFLOAT**

**SECTION 3 - PEST AND RODENT CONTROL**

**6.3.1. Submarine Pest Control.** NAVMED P-5010, Chapter 8 and NAVMED P-5052-26 (Shipboard Pest Management Manual) provide specific guidelines to Commanding Officers and Medical Departments regarding optimal methods of prevention and eradication of shipboard vectors. Medical Department Representatives will complete a formal course of instruction in Shipboard Pest Control Management. Medical Department Representatives must re-certify every four years. The cognizant NEPMU/PMT, NECE or NUMI may conduct this training. In the event of shipboard vector infestation, the MDR shall contact the local PMT or cognizant NEPMU.

**6.3.2. Cockroaches.** To avoid cockroach infestations the first step taken should be to prevent their entry by making careful pierside inspections of stores before loading. This may be accomplished through the use of two percent D-Phenothrin aerosol. Spraying of D-Phenothrin is authorized for pierside inspection of canned, bottled, and individually packaged stores. For the inspection of vegetables, fruits, and other items such as bagged onions, potatoes, etc., it is not authorized.

a. Keeping or eating food in spaces other than food services areas is prohibited. Spaces, which exist behind of between pieces of fixed equipment and cannot be properly cleaned, should be sealed or shielded to prevent food particles from falling into them. No open food packages (particularly sugar, cornstarch, and condiments in the galley or wardroom pantry) will be left uncovered. Cardboard cartons containing fresh provisions provide harborage for cockroaches; these cartons are ideal for the laying of cockroach eggs. These items will be inspected and unloaded/unpacked topside and the cartons discarded immediately.

b. Submarine tenders and other support activities will have adequate pest control equipment and appropriate insecticides available. NAVMED P-5010, Chapter 8, specifically authorizes several insecticides for use on submarines. Currently, two percent D-Phenothrin is considered the insecticide of choice for cockroach control on submarines, but only while pierside and able to ventilate overboard for 24 hours. This spray is limited to crack and crevice use. With the exception of Combat,

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insecticides and pest control equipment must not be stored on submarines.

c. Combat bait stations are the only authorized pest control device for use on submarines by the MDR. Sufficient quantities of this bait should be maintained to adequately control cockroaches in all food service areas; however, a maximum of 144 bait stations can be stored while underway. Approximately 4-6 bait stations are required per 100 square feet. Each bait station remains effective for approximately three months.

**6.3.3. Rodents.** A Ship Sanitation Control Certificate (SSCC) or Ship Sanitation Control Exemption Certificate (SSCEC) is required for all naval vessels entering foreign ports. MANMED, Chapter 22 and BUMEDINST 6250.14 provide the procedures for obtaining this certification and extension. The certification is valid for six months from date of issue; therefore, attention must be devoted to planning for renewal prior to extended deployments.

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**CHAPTER 6**  
**PREVENTIVE MEDICINE AND SANITATION AFLOAT**  
**SECTION 4 - EPIDEMIOLOGY AND IMMUNIZATIONS**

**6.4.1. Quarantine Regulations**

a. Detailed instructions relating to quarantine regulations are found in MANMED, Chapter 22. Upon arrival in a foreign port or for reentry at a U.S. port, local regulations should be reviewed for any special requirements.

b. For ships transiting the Panama Canal, Free pratique and Bill of Health are required in order to enter the City of Colon on the Atlantic, and Balboa on the Pacific, entrance to the Canal.

c. Routine radio pratique procedures have been discontinued at all U.S. ports. Only the following vessels will be subject to onboard public health inspections:

(1) Vessels which, in the 15 days prior to arrival in the U.S. port since the last U.S. port (whichever period is shorter), have or had any passengers or crew onboard with the following conditions or illnesses:

(a) Temperature of 100.4°F (38°C) or greater (1) which has persisted for two days or more, or (2) which was accompanied or followed by any one or all of the following: cough, sore throat, rash, jaundice, glandular swelling, or

(b) Vomiting or diarrhea severe enough to interfere with work or normal activity, or

(c) Death, due to illness other than battle casualties or physical injuries.

(2) Vessels that have been in a plague infected country within 60 days prior to arrival in the United States.

(3) Vessels will be selected randomly for quality control inspections. Approximately two percent of arriving vessels will be inspected.

d. For U.S. ports, arriving vessels are no longer required to complete a quarantine declaration, unless boarded under

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conditions of sub-paragraph (c) above. The boarding inspector will furnish the declaration.

e. Complete public health inspection means the examination of vessel logs, deratting, Ship Sanitation Control Exemption Certificates, interview of the Commanding Officer to obtain information to be entered on the declaration and the observation of passengers or crew only if there is illness as described above.

**6.4.2. HIV Testing.** All personnel will be tested for HIV antibodies as required by current directives. Those personnel who test positive will be administratively processed according to current directives. Test results will be entered into the health record and approved electronic medical database and handled in a confidential manner.

**6.4.3. Preventive Measures Against Hepatitis.** Guidelines for the prevention and control of Hepatitis infection among Navy personnel are provided by BUMEDINST 6230 (series). All new Navy recruits should be fully vaccinated for both Hepatitis A and B. Consult NMCPHC or cognizant NEPMU for further guidance on preventive measure actions against Hepatitis A and all other Hepatitis infections. Additional guidance includes the following:

a. Isolation and infection control precautions should stress adequate hand washing after contact with the patient or his body fluids (blood, urine, or feces). Disposal of body fluids should be accomplished in a sanitary manner. Standard precautions should be taken to avoid accidental needle-sticks. Normal laundering and dishwashing procedures are adequate to disinfect linens, clothing, and eating utensils used by the patient.

b. MEDEVAC is indicated for those cases where retention onboard is obviously detrimental to the individual's health, the health of the crew, and/or the mission of the ship.

**6.4.4. Malaria.** Detailed instructions for malaria prevention are contained in BUMEDINST 6230.15 (series) and the Navy Medical Department Guide to Malaria Prevention and Control (Yellow Book).

a. The cognizant NEPMU or fleet surgeon should be consulted for current malaria chemoprophylaxis recommendations for foreign ports.

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## b. Additional information sources include:

(1) Centers for Disease Control and Prevention (CDC) Guidance on choosing a drug to prevent Malaria available at <http://www.cdc.gov/malaria/travelers/drugs.html>.

(2) Navy and Marine Corps Public Health Center (NMCPHC) Pocket Guide to Malaria Prevention and Control, NMCPHC-TM 6250.1 (2011), available at

(3) Travax website: <http://www.travax.nhs.uk/>

(4) Global Health Travel Reports:  
<http://globalhealth.ucdavis.edu/travel/index.html>

**6.4.5. Influenza.** All submarine personnel will receive an annual influenza immunization. A message is normally sent in late summer each year from the Bureau of Medicine and Surgery (BUMED) or Naval Medical Logistics Command (NMLC) providing guidance for details on this program.

a. Submarine MDR's will coordinate ordering Influenza vaccine through their NSSC/ISIC Medical Department. TYCOM's will coordinate with NSSC/ISIC Medical Departments for the ordering of flu vaccines to ensure all units are vaccinated.

b. Attention must be given to ordering vaccine for units either in overhaul geographically remote from their ISIC, to avoid double orders and delivery to correct site.

c. For units deploying prior to the annual distribution of vaccine, in order to avoid cold chain losses, shipment will be deferred until such time as vaccine can be shipped to an OCONUS MTF adjacent to the unit's port visit.

**6.4.6. Other Diseases.** Advice and assistance in communicable disease control can be obtained from the nearest NEPMU. NAVMED P-5038 Control of Communicable Disease in Man (American Public Health Association) is an excellent reference for further guidance.

**6.4.7. Immunizations**

a. All immunizations will be entered into approved electronic medical database and the health records promptly.

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b. The prescribed intervals between immunizations will be adhered to as strictly as possible. Requirements and time intervals are set forth in BUMEDINST 6230.15 series and the BUMED note 6230. In the event that a vaccine series completion has been delayed, the series will be continued at the point of delay and not restarted.

c. Routine immunizations will not be given at sea. This restriction does not apply to clinical situations requiring immediate administration (if available), i.e., tetanus prophylaxis for wound management.

**6.4.8. Anaphylaxis.** All precautions will be taken to avoid injections into the blood stream and to be prepared for possible anaphylactic reactions by having on hand a syringe containing epinephrine solution 1:1000 (Adult dose 0.3mg/dose - EPIPEN is recommended). Additionally, emergency medical equipment including a Bag Valve Mask (BVM) resuscitator, oropharyngeal airway and tourniquet will be immediately available.



**CHAPTER 6**  
**PREVENTIVE MEDICINE AND SANITATION AFLOAT**

**SECTION 5 - SHIP TO SHORE SEWAGE CONNECTIONS**

**6.5.1. General Information.** Submarines use 50 foot lengths of 2.5 inch rubber hose for ship to ship and ship to shore sewage connection.

**6.5.2. Procedure**

a. When a ship arrives in port, the shore base Public Works hose handling crew will deliver the proper amount of clean sewage transfer hoses and connect the hoses to the pier risers. The ship's crew is responsible for making all shipboard connections. The ship's crew should ensure that no sewage transfer hose is connected in any way to the potable water system. Sewage risers, valve handles, and hose ends should be color-coded per NAVSHIPS Tech Manual S9086-RK-TM-010/CH-505, Piping Systems.

b. Prior to disconnection, the sewage transfer hoses should receive a salt-water flush for at least ten minutes in an effort to flush out all residual wastewater. When a ship does not have this capability, the shore crew must flush the hoses at the nearest salt water pier risers after the hoses have been disconnected. In addition, the hose couplings and exterior surfaces must be cleaned and the ends of the hoses capped prior to storage.

c. In the event of a sewage spill onto the deck of a ship or onto the pier, the area will be thoroughly flushed into the harbor. An approved disinfectant such as NSN 6840-00-526-1129 Disinfectant, General (Wescodyne G), may be used to eliminate odors caused by the spill.

**6.5.3. Sanitation and Safety**

a. Strict adherence to good personal hygiene and sanitary practices is essential to prevent the spread of fecal contamination and the resulting potential for the occurrence of diseases onboard ship. Personnel are required to wear protective clothing including overalls, rubber boots, rubber gloves, and hair covering as appropriate when contact with sewage waste is likely.

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b. Personnel who come in contact with sewage waste in the course of their duties should adhere to the following requirements to minimize the spread of contamination to other areas of the ship:

(1) Keep movement about the ship to an absolute minimum.

(2) Place contaminated clothing in a plastic bag at the conclusion of maintenance or clean-up operations for ultimate laundering. No other special laundering procedures are required. The presence of a ship to shore sewage transfer system onboard ship increases the risk of exposure to untreated sewage, which in turn, increases the potential for occurrences of diseases associated with human waste. The Medical Department Representative must take an active role to ensure the system is operated and maintained in a safe and sanitary manner. To do so, the MDR must become familiar with the Naval Ships Technical Manual, Chapter 593 and the Manual of Naval Preventive Medicine NAVMED P-5010, Chapter 7. The MDR's duties will include:

(a) Provide onsite advice when requested in the correct procedures for personal protection and the cleaning of sewage leaks or spills. The MDR must be present for clean-ups and disinfection of food service spaces, living areas, and medical spaces.

(b) Ensure that Contaminated Hard Tank (CHT) workers have a current CHT physical exam and that all of their immunizations are current.

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**CHAPTER 6**  
**PREVENTIVE MEDICINE AND SANITATION AFLOAT**

**SECTION 6 - MEDICAL WASTE**

**6.6.1. Retention of Medical Waste Onboard.** During short duration local operations, units will separate and retain onboard all medical waste until return to port. Sharps will be collected separately in Sharps containers. Used feminine hygiene products are not medical waste.

**6.6.2. Disposal of Medical Waste In Port.** Once in port, retained medical wastes will be delivered to the supporting tender or MTF (or to a SOPA designated receiving facility in the absence of a tender or medical treatment facility) for disposal per SOPA instructions. All medical waste disposals will be annotated in the Ship's Deck Log.

**6.6.3. Disposal of Medical Waste at Sea.** If necessary, discharge of medical waste at sea is approved using the following guidelines:

- a. The ship must be beyond 50 miles from shore.
- b. Medical waste will be discharged only in assembled and weighted TDU canisters.
- c. Sharps containers will be retained for disposal ashore.
- d. Such disposal will be approved by the Commanding Officer and a Ship's Deck Log entry will be made indicating the number of containers, time, and position of overboard disposal.

**6.6.4. Training.** Medical personnel will be instructed by the NSSC/ISIC Medical Department in proper handling and transfer of medical waste within their units upon reporting aboard and annually thereafter. Medical waste handling, transfer, and disposal practices will be audited during Medical Readiness Inspections.

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**CHAPTER 6**  
**PREVENTIVE MEDICINE AND SANITATION AFLOAT**

**SECTION 7 - INDUSTRIAL HEALTH**

**6.7.1. Introduction.** The Navy Safety and Occupational Health (SOH) program is divided into two major subspecialties, Occupational Safety and Occupational Health. Occupational Safety addresses the identification and elimination, or control, of hazards in the workplace. Occupational Health focuses on the medical surveillance of personnel potentially exposed to hazards identified during workplace inspections and surveys conducted per the Navy Safety and Occupational Health (SOH) Program Manual for Forces Afloat, OPNAVINST 5100 series. The Commanding Officer will appoint a ship's safety officer to manage the overall SOH program. The Medical Department Representative manages the health aspects of the SOH program and will not be assigned as the ship's safety officer.

**6.7.2. Medical Surveillance.** The medical surveillance program will be implemented per the SOH Manual for Forces Afloat based on the results of an Industrial Hygiene Survey. As far as practical, SOH related examinations should be incorporated within regularly scheduled physical examinations conducted per MANMED, Chapter 15. A medical surveillance examination guide is contained in the Naval Environmental Health Center Technical Manual, NEHC-TM91-5, Medical Surveillance Procedures Manual and Medical Matrix.

**6.7.3. Environmental Health Survey.** Submarines may have an Environmental Health Survey, which includes a comprehensive evaluation of preventive medicine and occupational health programs by the cognizant NEPMU. The survey report is provided directly to the Commanding Officer of the unit evaluated.

**6.7.4. Safety Surveys.** Naval Safety Center conducts the shipboard safety survey of one or two day's duration and the interval between surveys, shall not exceed 36 months. For SSN's, the safety survey will normally be done during the ship's pre-deployment cycle. For SSBN's and SSGN's the survey should be conducted during a refit/major maintenance when both crews are onboard.

**NOTE:** Like Industrial Hygiene (IH) surveys, it is not routinely recommended that Safety Surveys be conducted prior to the completion of an upkeep or an overhaul because that is not the normal working environment for the submarine.

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Certain equipment/machineries may not be completely installed or operational yet and therefore may not reflect the true operating procedures employed on the submarine.

**6.7.5. Industrial Hygiene Surveys.** Each submarine shall arrange for a baseline industrial hygiene survey. This survey may be scheduled and obtained through the supporting NEPMU/BUMED Medical Treatment Facility (MTF). An update of the baseline industrial hygiene survey is necessary as system, equipment, or load-out changes significantly affect the on-board hazard and/or risk. Deterioration of existing controls, modifications and additions to shipboard processes and equipment will occur over time. An update of the industrial hygiene survey is required at least every three years to address all changes that may have occurred.

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## **CHAPTER 7**

### **ATMOSPHERE CONTROL**

**7.1. General Principles.** NAVSEA S9510-AB-ATM-010/(U) Volume 1 and NAVSEA S9510-AB-ATM-010/(C) Volume 2, Nuclear Powered Submarine Atmosphere Control Manual (U), contain detailed information regarding the ship's atmosphere control and monitoring equipment and provides a list of prohibited and restricted items plus authorized substitutes. The SSORM describes proper routine and emergency action regarding air revitalization. With prolonged submergence, meticulous attention to the details of atmosphere control is critical to the health and safety of the crew. Knowledge of the fundamentals of atmosphere control must be impressed upon all hands. Ships force personnel assigned to the Navigation Electronic division will order and maintain atmosphere and associated equipment. The MDR will provide oversight for training and inventory.

### **7.2. Gas Free Engineer and Services**

a. The Gas Free Engineering Manual, NAVSEA Technical Manual, Chapter 074, Volume 3 (S9086-CH-STM-030/CH-074) (series) outlines criteria for safety precautions and use of safety equipment associated with detection of explosive and noxious gases. Ships are to ensure that all detection equipment is available and functional and that qualified personnel are available for proper operation. Periodic checks with test gases serve as a valuable aid in determining proper function of the equipment and personnel qualification.

b. Entries into tanks and void spaces shall be conducted per the Gas Free Engineering Manual. Grated compartments are not considered sealed and therefore do not require gas free certification, i.e., Aux Tank Fwd. In port, shore based Gas Free Engineers, i.e., IMA/SIMA/IMF, shall provide gas free services to include work being performed by ships force personnel.

c. The Medical Department Representative (MDR) is designated as the Gas Free Engineer (GFE). Annual certification will be documented in the MDR's Service Record via page 13 entry and signed by the Commanding Officer.

d. The MDR's gas free engineering responsibility is limited to providing gas free engineering services for underway periods.

e. The MDR will maintain a gas free engineering test log as required by current directives.

**7.3. Central Atmosphere Monitoring System (CAMS) Failure.** In the event of CAMS failure the MDR will refer to the Atmosphere Control Manual for portable monitoring requirements.

**7.4. Trace Gas Analyzer (TGA) Failure.** In the event of TGA failure the MDR will refer to the Atmosphere Control Manual, Chapter 6, Article 6-7.4, for portable monitoring requirements.



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**CHAPTER 8**  
**DENTAL AND ORAL HEALTH**

**8.1. Program Responsibility**

a. The administration of a dental program for submarines shall be conducted under the guidelines as outlined in the Fleet Dental Procedures Manual COMFLTFORCOM 6600.1 (series).

b. The dental and oral health of personnel shall be maintained at a very high standard. The Submarine Force Standard for Dental Readiness is 100 percent. The TYCOM will be informed when Dental Readiness drops below 90 percent. The MDR is responsible for promoting and arranging necessary treatment to achieve the required high level of dental readiness.

c. Dental readiness will be at 100 percent prior to the ships deployment overseas. The MDR and local NSSC/ISIC will liaison with the local Dental clinic to ensure all dental care is completed prior to deployment. Every effort should be made to complete the majority or all the dental exams that will come due through the deployment. MDR's will report any problems with obtaining dental exams in support of extended underway operations to the cognizant NSSC/ISIC. Dental Health Index is encouraged to be maintained above 75%.

d. Class 3 and Class 4 personnel are not authorized to get underway without a Dental Officer and UMO's clearance by signature. A complete listing of all patients will be maintained in the Medical Department Representative Turnover Log and Class 3 and Class 4 personnel will be listed on the Problem Summary List.

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**CHAPTER 9**  
**APPROVED ELECTRONIC MEDICAL DATABASE (SAMS/TMIP) AND**  
**EXTERNAL REPORTING REQUIREMENTS**

**9.1. General.** Approved electronic medical database (SAMS/TMIP) is an automated data processing (ADP) system that was developed for the Navy Medical Department. It will assist the Medical Department Representative in reducing administrative duties through many of its functional modules. Simultaneously increasing the time requirements that it takes to maintain the new database.

**9.2. Utilization.** Utilization of the approved electronic medical database is required upon receipt and installation of current version or higher. Higher authority directives and reports relating to approved electronic medical database will take precedence over this manual where a procedure or requirement conflict. Completed documentation of tasks, reports, etc., within approved electronic medical database, shall be considered sufficient and need not be further reported to comply with documentation of this manual. Specific guidance regarding utilization of approved electronic medical database may be found elsewhere in this manual and in the approved electronic medical database Users Manual. All reports within approved electronic medical database are considered valid and shall be utilized at all times.

**9.3. Backup**

a. Daily system backups are required. In the event that the primary system fails, the backup will be utilized to restore data. Backups are required to prevent loss of data entries and to ensure continuity of a valid database. In conjunction with daily database backups, TMIP Suite backups must be conducted monthly.

b. The Radiation Health Protection Manual (NAVMED P-5055) requires a quarterly back-up of information contained in the Radiation Health module. This back-up will be retained for two quarters.

**9.4. External Data Submission Requirements**

a. The following external reports are required:

- (1) Individual Medical Readiness (IMR) - Weekly

b. All external medical reporting requirements shall be completed utilizing approved electronic medical database when applicable and per current directives. MDR's will maintain active accounts with NMO (Navy Medicine Online) and IMR (Individual Medical Readiness) enabling them to submit required reports electronically.

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**APPENDIX A**

**MEDICAL DEPARTMENT REPRESENTATIVE RELIEF LETTER**

6000

Date

From: Departing Medical Department Representative  
To: Commanding Officer  
Via: (1) Relieving Medical Department Representative  
(2) Executive Officer

Subj: RELIEF AND ASSUMPTION OF DUTIES OF THE MEDICAL DEPARTMENT REPRESENTATIVE

Ref: (a) Manual of the Medical Department  
(b) COMSUBLANT/COMSUBPACINST 6000.2 (Series)  
(c) COMSUBLANT/COMSUBPACINST 6470.5 (Series)

Encl: (1) Annotated Copy of Medical Readiness Inspection  
(2) Record of Radiation Health Officer Qualification  
(3) Controlled Medicinals Audit

1. Per references (a) and (b), **(relieving Medical Department Representative)** has made a personal inventory, utilizing enclosure (1), of all medical spaces, records, supplies, and equipment.

2. Enclosure (2) was used to familiarize **(relieving Medical Department Representative)** with the ship's Radiation Health Program.

2. Per reference (c), a qualification board was conducted and annotated on enclosure (3) prior to assigning **(relieving Medical Department Representative)** to the duties as Radiation Health Officer.

3. An inventory of controlled medicinals was conducted; enclosure (4) is submitted. Custodial accountability of controlled medicinals was transferred to **(relieving Medical Department Representative)**. The combination to the working stock safe was then changed.

4. Each crewmember's general health was reviewed with **(relieving Medical Department Representative)**, and any unusual medical condition requiring continuing treatment or consultation was noted. All chronic conditions and medical problem requiring follow up are noted on the Problem Summary List (PSL).

Subj: RELIEF AND ASSUMPTION OF DUTIES OF THE MEDICAL DEPARTMENT  
REPRESENTATIVE

5. The other general duties and responsibilities as Medical Department Representative have been reviewed with (**relieving Medical Department Representative**) and he understands and has accepted those duties.

---

(Departing MDR)

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-----  
**FIRST ENDORSEMENT**

From: Relieving Medical Department Representative  
To: Commanding Officer  
Via: Executive Officer

1. I have, on this date, relieved (**departing Medical Department Representative**), as Medical Department Representative.

---

(Relieving MDR)

---

-----  
SECOND ENDORSEMENT

From: Executive Officer  
To: Commanding Officer

1. Comments:

---

(Executive Officer)

---

-----  
THIRD ENDORSEMENT

From: Commanding Officer  
To: Relieving Medical Department Representative

1. Noted.

---

(Commanding Officer)

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**APPENDIX B****INTERNATIONAL SOS (ISOS)**

The TRICARE Overseas Program (TOP) is contracted to International SOS Assistance, Inc. (ISOS). Current TOP/ISOS information for specific countries is available at <http://www.tricare-overseas.com>. For the purposes of ISOS, the world is divided into four regions: United States, Latin American (and Canada), Europe/Middle East/Africa and Asia/Pacific.

In most cases, the responsible CTF or Numbered Fleet Surgeon's office will coordinate with ISOS to make arrangements..

Contact numbers:

<u>Region</u>	<u>Calling from CONUS</u>	<u>Calling from OCONUS</u>
EUROPE	44-20-8762-8384	1-877-678-1207
LATAM	1-215-942-839	1-877-451-8659
PAC (Singapore)	+65 6339 2676	1-877-678-1208
(Sydney)	61 9273 2710	1-877-678-1209
US (North)	1-877-TRICARE	
(South)	1-877-444-5445	
(West)	1-877-988-9378	

Not all locations have medical services already under agreement with TOP/ISOS. In those locations, the provider/facility may require immediate payment for services. Therefore, any Sailor being transferred off the unit (e.g., MEDEVAC) to pursue treatment should have a government travel credit card.

1. For accessing health care in areas without US MTFs::

a. Call the 24-hour Tricare Global Remote Overseas (TGRO) Call Center with the toll-free number for your country (collect calls are also accepted if necessary)

b. Once the patient or the IDC has made contact with the TGRO Call Center, they will fax a guarantee of payment letter to the provider or facility. You will not have to pay for these medical services up front. However, for cashless/claimless care, you must contact the TGRO Call Center to ensure they guaranteed payment or you may have to pay for the care and file the claim. If a provider expects advance payment, contact the TGRO Call Center to resolve the issue.

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**APPENDIX C**

**CONTROLLED MEDICINALS INVENTORY/AUDIT REPORT AND LOG**

From: Senior Member, Controlled Medicinals Inventory/Audit Board  
To: Commanding Officer  
Subj: CONTROLLED MEDICINALS INVENTORY AND AUDIT REPORT FOR THE PERIOD OF \_\_\_\_\_  
Ref: (a) Manual of the Medical Department, Chapter 21  
(b) COMSUBLANT/COMSUBPACINST 6000.2 (Series)  
(c) NAVMEDCOMINST 6710.9 (Series)  
Encl: (1) Inventory of Controlled Substances

1. Per references (a) and (b), a physical inventory and audit of all controlled medicinals was conducted on \_\_\_\_\_.

2. The inventory of controlled medicinals and audit of accounting records, which included the receipt and expenditure vouchers, the prescriptions, and the Working Stock Log, were completed. The following discrepancies were noted:

- a. discrepancy: \_\_\_\_\_
- b. description: \_\_\_\_\_
- c. corrective actions: \_\_\_\_\_

3. All prescribed accounting records, logs, and prescriptions for the subject items were dated, properly prepared, and signed except as noted:

- a. discrepancy: \_\_\_\_\_
- b. description: \_\_\_\_\_
- c. corrective actions: \_\_\_\_\_

4. Seals on the closures of vials, bottles, and other containers of subject items were inspected and there were no indications that the contents had been damaged or tampered with except as noted:

- a. discrepancy: \_\_\_\_\_
- b. description: \_\_\_\_\_
- c. corrective actions: \_\_\_\_\_

Subj: CONTROLLED MEDICINALS INVENTORY AND AUDIT REPORT FOR THE  
PERIOD OF \_\_\_\_\_

5. Security of spaces where subject items are stowed was inspected and the following action to enhance the security of subject items is recommended:

- a. recommendation: \_\_\_\_\_
- b. recommendation: \_\_\_\_\_

6. The following persons have the combination and a list of personnel with combo/or keys for the places where controlled medicinals are stowed. (Combinations of safes were last changed by:)

Working Stock Safe: \_\_\_\_\_  
(Rank and Name)

Date Working Stock Safe combination was changed: \_\_\_\_\_

7. Items listed below show signs of damage, expired expiration dates, or deterioration and the recommendations for each listed item are indicated.

- a. damaged: \_\_\_\_\_
- b. expired: \_\_\_\_\_
- c. deteriorated: \_\_\_\_\_

8. Enclosure (1) is submitted.

\_\_\_\_\_  
Senior Member

\_\_\_\_\_  
Member

\_\_\_\_\_  
Member

NOTED: \_\_\_\_\_  
Commanding Officer

Date: \_\_\_\_\_

Copy to:  
Medical Department Representative (Original)

**NARCOTICS AND CONTROLLED MEDICINALS LOGS (SAMPLE PAGE)**  
**(Use separate page for each medicinal carried)**

INVENTORY OF CONTROLLED SUBSTANCE LOG

Name of Drug: Diazepam, 5mg

Stock No.: 6505-01-098-5802

Unit of Issue: Tablet

Date	Bal. remaining last entry	Received	Receipt Doc. # & source	Amount issued	Pt's name & Rx #	Diagnosis	Balance on hand	MDR's signature
10Oct98	0	100	Transfer memo #6-98 from bulk stock	N/A	N/A	N/A	100	J.R. Peters HM1 (SS), USN
10Oct98	100	N/A	N/A	10	Jones, Jacob R. TM3, USN 4-98	Seizure	90	J.R. Peters HM1 (SS), USN

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**APPENDIX D**

**MESSAGE FORMAT FOR REQUESTING MEDICAL ADVICE (EVACUATION)**

FROM: USS \_\_\_\_\_  
TO: OPERATIONAL COMMANDER

INFO: TYCOM (if not Operational Commander)  
GROUP  
NSSC/ISIC  
NUMI (NAVOPMEDINST DET NAVUSEAMEDINSTITUTE GROTON CT)  
NSMRL (NAVSUBMEDRSCHLAB NEW LONDON CT)  
Regional Military Treatment Facility

CLASSIFICATION: FOR OFFICIAL USE ONLY (FOUO)

SUBJ: REQUEST FOR MEDICAL ADVICE (EVACUATION)

REF: FILLED IN WHEN REQUIRED (i.e., when referring to earlier patient status reports)

1. RANK/RATE, FIRST INITIAL OF FIRST AND LAST NAME FOLLOWED BY LAST 4 DIGITS OF SSN, AGE, RACE, HEIGHT AND WEIGHT OF PATIENT, ADD MEMBER'S NEC
2. PATIENT'S CHIEF COMPLAINT
3. IMMEDIATE HISTORY OF PROBLEM (Including date and time of onset; chronology of events with dates and times to and including the present)
4. ANY SIGNIFICANT CONTRIBUTING FAMILY, MEDICAL, OR PAST SURGICAL HISTORY (Include recent changes in activity, exposures and diet/ingestion, similar complaints/problems in the past, what makes it better/worse, allergies, taking any medication for any condition prior to onset of problem, OTC medications, performance supplements or energy drinks; history of past surgeries; any significant family history relevant to current problem; subjective pain on one to ten scale, prior Medevacs, existing waivers)
5. TEMPERATURE (Indicate whether Oral/Rectal/Axillary)
6. BLOOD PRESSURE (Indicate which arm and whether taken sitting, lying, or standing and always check for Orthostatic Hypotension if possible)

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SUBJ: REQUEST FOR MEDICAL ADVICE (EVACUATION)

7. PULSE RATE, RHYTHM, AND STRENGTH

8. RESPIRATORY RATE AND PATTERN

9. PHYSICAL EXAMINATION (Including date and time of examination and whole body exam, amplifying the area of concern). Summarize trend of serial exams.

10. LABORATORY TEST RESULTS (Including date and time done; identify the test [i.e. CBC/DIFF, UA, guiac, DEXTROSTIX - and any other test(s) performed)

11. DIAGNOSIS/ASSESSMENT

- a. MOST LIKELY DIAGNOSIS SUSPECTED
- b. MOST SERIOUS DIAGNOSIS SUSPECTED
- c. A SECOND POSSIBLE DIAGNOSIS IN THE DIFFERENTIAL
- d. A THIRD POSSIBLE DIAGNOSIS IN THE DIFFERENTIAL

12. TREATMENT/MONITORING INITIATED AND PLANNED. (If IV fluids given, report type, rate and total volume delivered. If patient NPO, also report urine output (ml/hr). If on antibiotics, state which, amount, route and schedule; report total doses given. Report any oxygen usage. Characterize response to treatment)

13. LOCAL LIMITING FACTORS IF APPLICABLE (i.e., proper medication(s) for the condition - not onboard or in short supply; diagnostic imaging necessary to establish the diagnosis - i.e., MICROSCOPE OOC, etc.)

14. CORPSMAN'S LIMITING FACTORS IF APPLICABLE (i.e., no x-ray capability, no cardiac enzyme testing available, etc.)

15. IS A MEDICAL EVACUATION REQUESTED AT THIS TIME OR ONLY MEDICAL OFFICER'S OPINION AND ADVICE CONCERNING DIAGNOSIS AND TREATMENT PLAN?

16. ASSESSMENT OF PATIENT'S FITNESS FOR MEDEVAC BY AIR, SMALL BOAT, OR PIERSIDE

17. SUPPLIES/EQUIPMENT EXPENDED DURING TREATMENT REQUIRING REPLACEMENT AT THE TIME OF MEDEVAC (Will a LOGREQ be submitted with the intention to restock critical medical supplies at the time of a possible MEDEVAC?)

SUBJ: REQUEST FOR MEDICAL ADVICE (EVACUATION)

18. ANY ADDITIONAL COMMENTS OR INFORMATION DESIRED. (Does the condition warrant medical update message in 24 to 48 hours?)

19. OPERATIONAL/NAVIGATIONAL DATA PER COMMANDING OFFICER AS APPLICABLE (If this data is classified, transmit by SEPCOR. Rationale: this message may need to be forwarded to a medical consultant at the nearest MTF and SIPR→NIPR transcription by SUBOPAUTH delays response and introduces possible data or interpretation errors.

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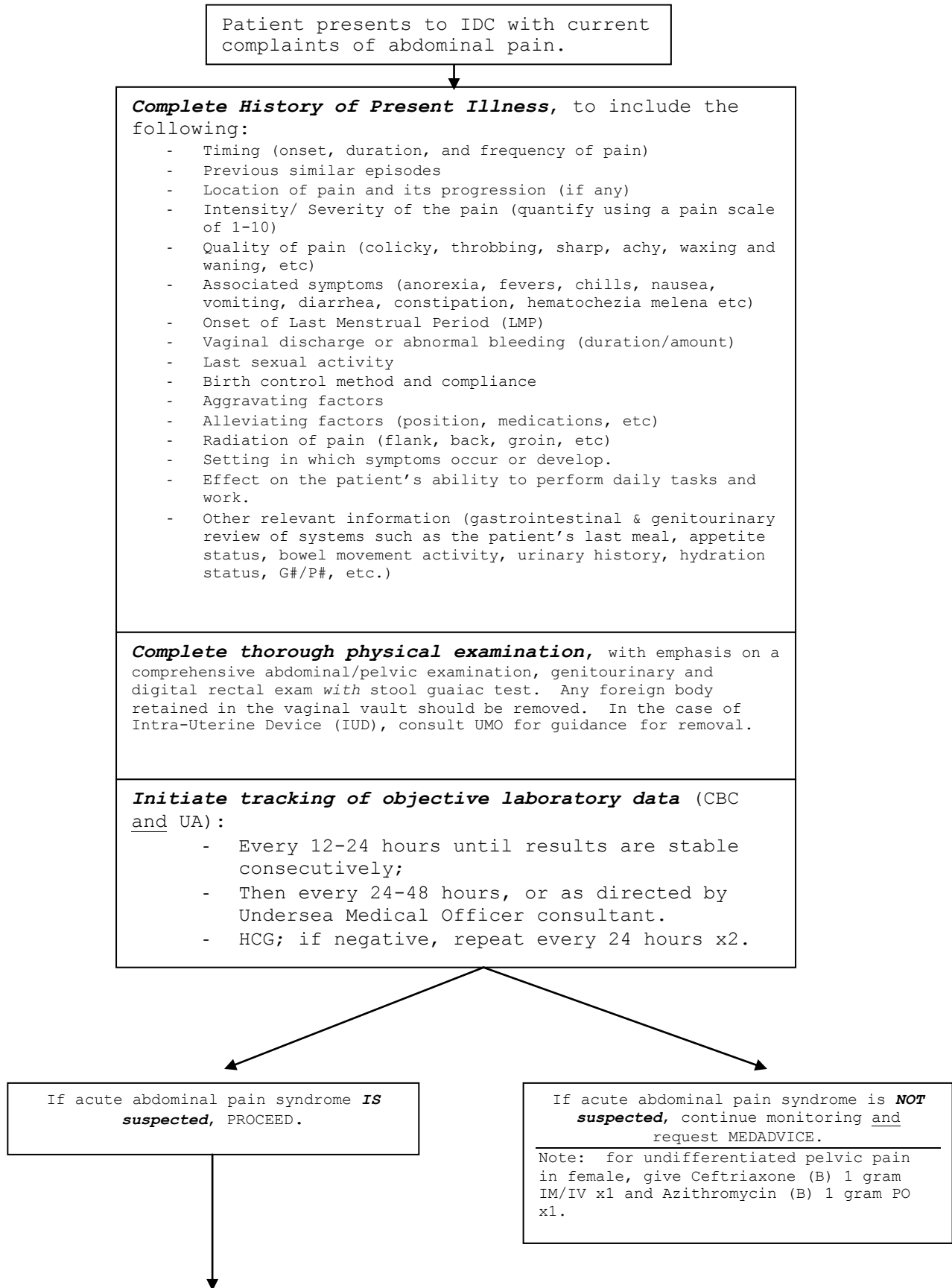
**APPENDIX E - TAB A****MEDICAL TREATMENT PROTOCOL FOR ABDOMINAL PAIN SYNDROME**

1. In the setting of a Sailor who presents with emergent abdominal or pelvic pain of unknown origin, the following diagnostic algorithm should be utilized for initial conservative management. The differential diagnosis for abdominal pain includes: appendicitis, diverticulitis, small bowel obstruction, ruptured ectopic pregnancy, peritonitis, pelvic inflammatory disease, endometriosis and other localized pain syndromes (e.g., colitis, mittelschmerz, adnexal torsion, ruptured ovarian cyst, tubo-ovarian abscess, cholecystitis, hepatitis and pancreatitis).

2. In recent years, the majority of submarine medical emergencies involving abdominal pain have been Sailors presenting with acute appendicitis, acute diverticulitis, and small bowel obstruction, with other, less frequently encountered, diagnoses such as hepatitis, acute cholecystitis, and pancreatitis. The integration of mixed gender crews has now expanded the differential diagnosis to include OB/GYN etiologies. Even though pathognomonic signs and symptoms can help differentiate one entity from another, the submarine environment does not lend itself to diagnostic confirmation underway due to the lack of imaging/laboratory capability and general surgical services. Furthermore, these diagnoses often present atypically, confounding the clinician's ability to assess the patient--the 'classic' presentation may occur only in a minority of cases. Despite the inherent difficulties, when approached with a detailed history, complete physical examination and thoughtful consideration of the potential diagnoses, conservative management and meticulous monitoring will result in successful outcomes for the majority of these cases. The following treatment protocol has been developed to help the Independent Duty Corpsman (IDC) manage submariners presenting with an acute abdominal pain syndrome.

3. The following protocol IS NOT offered as a substitute for Consultation via MEDADVICE and prudent medical judgment on the part of the IDC. The protocol is meant to offer a recommended course of action to ensure that when a patient presents with any type of abdominal/pelvic pain potentially requiring surgical intervention, that a complete work-up is initiated and a timely care plan is started--especially in the setting where no physician consultation is readily available.

4. Abdominal Pain Management Algorithm:



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**Immediately seek higher echelon medical support:**

- Transfer patient to an emergency room (if locally available). Consider use of ISOS if near foreign port and no local MTF capability. Do not delay definitive care!
- Contact ISIC medical authority via MEDEVAC or MEDADVICE message detailing ALL available clinical information.
- If patient is in extremis, utilize other on-board communications to notify higher-level medical authority, as indicated by circumstances.

Place patient on a STRICT NPO Status.

**Initiate IV Fluid Therapy** lactated Ringer's solution, or 0.9 Normal Saline) at 150-ml/hr and then titrate to assure a urinary output of greater than 1000 ml/day. Note: In suspected cases of Toxic Shock or other septic shock syndromes, significantly greater fluid (both bolus and rate) will be required. Only bolus with NS or LR.

**Monitor urinary input and output** and provide this data (if not already doing so) to the monitoring higher-level medical authority with each update report.

**Initiate one of the following antibiotic regimens\*** depending on the availability of medications, unless otherwise directed UMO:

## Regimen (1)--preferred:

Ampicillin-sulbactam (Unasyn) (B) 3 grams IV every 6 hrs  
 + Gentamicin (D) 5.0 mg/kg IV every 24 hours  
 + Metronidazole (Flagyl) (B) 15 mg/kg LOADING dose infused over one hour, followed by a maintenance dose of 7.5 mg/kg infused over one hour every 6 hrs.

OR

Regimen (2)--use if patient is HCG+ or has history of severe allergic rxn to PCN and/or cephalosporin:

Ciprofloxacin (C) 400 mg IV every 8 hours  
 + Metronidazole (Flagyl) (B) as above in treatment regimen (1)

OR

Regimen (3):

Gentamicin (D) 5.0 mg/kg IV every 24 hours  
 + Metronidazole (Flagyl) (B) as above in treatment regimen (1)

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**Pain control** should be achieved with Keterolac (C), Hydrocodone (C) or Morphine (C), as needed. Adequate pain control should be the goal. If pain control efforts require us of Narcotic analgesia, prepare for expeditious medevac. Always have Narcan (B) available for immediate use in the event of an overdose.

**If nausea and/or emesis is/are present**, utilize IV or IM Promethazine (C) 12.5-25 mg every 6 hours as needed to control emesis and/or nausea. Furthermore, if recurrent vomiting occurs, utilize intermittent nasogastric (NG) suctioning to prevent aspiration.

**NOTE:** Letter in parentheses after medication name signifies the medication's Pregnancy Risk Factor (PRF).

**Provide MEDEVAC/ MEDADVICE message** updates to ISIC medical authority at least every 24 hours until instructed to do otherwise by higher echelon medical authority.

**Transfer the patient to a medical facility** as soon as possible for definitive surgical treatment and management.

5. Medical Department personnel shall familiarize themselves with the prescribing and administration date that accompanies these medications prior to their use.

6. AMALs should be stocked with appropriate quantities of medications to ensure adequate and timely medical care.

**NOTE:** **Pregnancy Risk Factors represent the estimated risk of using that specific medication to the fetus. Because the number of drug studies which involve exposure to fetuses is very small, medications rarely have PRFs better than 'C'. This uncertainty regarding a drug's effect on the fetus should not preclude effective treatment of a pregnant patient, because best infant outcomes occur with a healthy mother. Rather, if two drugs are equally efficacious, the provider should choose that with the better PRF.**

**APPENDIX E - TAB B**

**MEDICAL TREATMENT PROTOCOL FOR SUSPECTED UROLITHIASIS**

1. The recommended treatment for suspected urolithiasis shall be as follows:

a. Hydration: Maintain oral hydration at a level high enough to have at least 1-2 L of urine output per 24 hour period. May start IV fluids if necessary (i.e., vomiting). Using Lactated Ringers or 0.9 percent normal saline at a rate of 150 ml/hr and adjust rate to maintain a urine of at least 2000 ml/24 hours.

b. Pain Control: This is often poorly addressed, and is a disservice to the patient. Ensure that the patient is kept comfortable. If two interventions to control pain are unsuccessful, urgent UMO consultation should be sought.

(1) Start patient on Ibuprofen (B/D) 800 mg orally every 8 hours or Naproxen (B/D) 500mg orally every 12 hours.

(2) Greater pain control, if necessary, can be achieved using Ketorolac (C) 30 mg IM/IV every 6 hours as needed. Do not exceed 120 mg IM/IV each day for a combined duration of 5 days.

(3) Oral narcotics, either Codeine (C) or Hydrocodone (C), should be used as an adjunct for breakthrough pain if the above course of NSAIDs is not sufficient to control pain.

2. Morphine (C) should be considered if pain is not controlled with the above alternatives.

a. If severe dysuria is present, utilize phenazopyridine (B) 100 mg PO every 8 hours for 2 days. (Be aware that this Medication may change the color of the urine and/or contact lenses orange.)

b. Nausea and Emesis: If nausea and emesis are present, Utilize Promethazine (C) 12.5-25 mg PO, PR or IV every 6 hours as needed for control. If using higher dosing of Promethazine, be aware of potential for dyskinetic reaction. Treatment for this is Diphenhydramine (B) 25 mg IV and discontinuation of Promethazine.

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c. Stone Expulsion: To increase the rate of spontaneous stone passage, in male patients only, start Alfuzosin (C) 10mg orally once daily with meal.

3. For signs of UTI/Pyelonephritis:

a. For uncomplicated UTI, start Ciprofloxacin (C) 500 mg orally every 12 hours for seven days, or Septra DS (C) orally every 12 hours for seven days. For +HCG patients, start Nitrofurantoin (B) 50-100 mg orally at bedtime for seven days.

b. For complicated UTI (fever >101 F, WBC >11,000, hemodynamic instability, flank pain), start Unasyn (B) three grams IV every six hours, or Ceftriaxone (B) one gram IV every 12 hours. For patients with confirmed PCN and cephalosporin allergies, use Ciprofloxacin (C) 500 mg orally every 12 hours.

c. Have patient strain urine and retain any stones for future chemical analysis. Passage of a stone does NOT negate the need for MEDEVAC (at next reasonable opportunity). The patient will be NPQ for submarine duty until a full evaluation can be completed.

d. Transfer to a medical treatment facility or clinic for evaluation at next earliest convenience. Complicated UTI requires an urgent MEDEVAC to an Urologist.

e. Provide 24-hour updates on the patient's medical status to the higher echelon medical authority, or sooner if directed. Updates should include complete interval history, physical exam, labs (CBC and U/A with Micro), pain control method and urine output status.

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**APPENDIX E - TAB C****MEDICAL TREATMENT PROTOCOL FOR SUICIDAL BEHAVIOR**

1. In the event of an embarked submariner presenting to his boat's IDC with suicidal ideation, gesture, and/or attempt, the following protocol is recommended for use by the IDC to assist with the management of the patient's acute situation and to assure his safety and that of the crew.
2. In recent years, sailors with suicidal ideation, gestures, and attempts have accounted for one of the largest groups that have required MEDEVAC from deployed submarines. These Sailors' conditions potentially posed a danger to themselves, their fellow crewmembers, and to the mission success of their submarines. Despite these inherent risks, close monitoring and regular communications with higher echelon medical support have helped to assure the safety and well-being of all concerned. The IDC represents the best source for information and reassurance to the crew and officers, so a working knowledge of basic psychiatry and how to perform a thorough mental status examination is imperative.
3. The mental status examination (MSE) represents a clinician's best tool for assessing psychiatric data and tracking a patient's symptoms over the course of time. This information, in conjunction with a physical examination, represents one of the vital elements of the "objective" data set for a clinician examining a psychiatric patient. Without this component of information, a full clinical assessment of the patient's situation is considered incomplete. When presented to a psychiatrist or medical officer, the MSE should paint a clear picture of the patient's current mental status at the time of the interview. The MSE is not intended as a history of present illness, but is often obtained concurrently. This information helps to differentiate and organize a patient's relevant psychiatric information for diagnostic and monitoring purposes.
4. The following protocol IS NOT offered as a substitute for prudent medical discretion on the part of the Independent Duty Corpsman (IDC). The protocol is meant to offer a recommended course of action for patients presenting with suspected signs and symptoms of suicidality, which when implemented, ensures that they receive a complete work-up and that a timely care plan is started and implemented while awaiting definitive psychiatric care at a medical treatment facility.

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## 5. Protocol:

a. Patient presents to the IDC with suspected suicidal ideation and/or complaints of depressive symptoms.

b. History: Obtain a complete history of present illness including the following:

- Timing (onset, duration, and frequency of symptoms)
- Depressive symptoms (depressed mood, diminished/increased sleep, anhedonia, guilt, feelings of worthlessness/hopelessness, avolition, fatigue, decreased concentration, diminished/increased appetite, suicidal/ homicidal thoughts; i.e., SIGECAPS)
- Anxiety symptoms
- Psychotic symptoms (audio-visual hallucinations, ideas of reference, delusions, disorganization, catatonia)
- Associated symptoms (fevers, chills, nausea, vomiting, diarrhea, constipation, pain, etc)
- Aggravating factors
- Alleviating factors (cutting behavior-past and present)
- Setting in which symptoms occur or develop.
- Effect on the patient's ability to perform daily tasks and work.
- Other relevant information (specifically a past psychiatric history, past medical and surgical history, social history, current medications, allergies, etc)
- Attempt to obtain additional information from witnesses or chain of command to verify or amplify patient's statements.

c. Physical Examination: Obtain a thorough physical examination, specifically noting any signs of self-mutilation, scarring, abnormal vital signs, or other evidence of self-harm.

d. Mental Status Examination: Following the AMSIT model briefly described below, obtain a complete MSE, with daily and regular monitoring and follow-up.

**A- Appearance/ Behavior/ Speech**

- General description of the patient's dress and behavior during the interview
- A description of the patient's manner of relating to the examiner
  - Behavioral evidence of emotion
  - Repetitious activities



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- Disturbance of attention (distractibility, self-absorption, etc)
- Speech volume, rate, rhythm, clarity, Spontaneity

**M- Mood and Affect**

- Mood: sustained emotional status (in the patient's own words: angry, sad, happy, etc)
- Affect: transient outward evidence of emotional state (range, intensity, lability, appropriateness of emotions to immediate thoughts)

**S- Sensorium**

- Orientation to person, place, time, situation
- Memory (recent and remote)
- Concentration
- Calculating Ability (as indicated)

**I- Intellectual Functioning**

- Estimate of current level of function Based on the patient's general fund of information, vocabulary, and complexity of concepts.

**T- Thought**

- Coherence of sentence structure and communication.
- Logic (are their thoughts plausible?)
- Goal directedness of thought (tangential Or circumstantial thoughts)
- Associations (blocking, flight of ideas, loose associations)
- Perceptions (evidence of current hallucinations, illusions, depersonalization, etc)
- Delusions (currently held)
- Content (noteworthy memories, feelings, suicidal or homicidal thoughts, past symptoms, etc)
- Judgment (making appropriate decisions)
- Insight (how the patient understands their current situation and the implications of their actions)

e. Contract for Safety: Assure a written contract for the patient's safety with an appropriate senior witness (CO, XO, etc.) to assure the patient's safety and well-being as well as the safety of the crew and the ship.

f. One-to-one Watch: If the patient expresses persisting thoughts of active suicidality (plan, expresses genuine intent, or has made an attempt), homicidal ideation, or refuses to contract for safety, immediately notify higher echelon medical authority and place the patient on a 24-hour one-to-one watch with a rotating watch section until the patient can be safely transferred to a medical treatment facility. This watch should be present for all of the patient's movements and activities (sleep, personal hygiene, meals, etc).

g. Monitoring: Given the confines and close-quarters relationships aboard a submarine, a patient who has expressed a history of suicidal ideation or has current symptoms poses a risk and a threat to the entire crew and should be immediately removed from watch-standing responsibilities and qualification expectations. Despite an effective and genuine contract for safety, the patient's chain-of-command and the IDC should be actively involved in monitoring the patient's status while the patient remains aboard pending transfer from the submarine to a medical treatment facility.

h. Medications: The patient should continue to take all previously prescribed medications as indicated, but should have these medications administered and controlled by the IDC. The patient should not have direct access to any medications (over-the-counter or prescription). No additional medications should be administered unless directed to do so by the higher echelon medical authority.

i. Notification: Seek higher echelon medical support via MEDEVAC or MEDADVICE message detailing ALL available clinical information.

j. Updates: Provide an update on the patient's medical status to the higher echelon medical authority, as needed, or sooner if directed, if the patient develops active signs of suicidality or becomes violent. Assure that the following information is included:

- Interval history
- Complete physical examination
- Vital signs

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- MSE
- Current treatment plan
- Fitness for MEDEVAC
- Availability of an appropriate escort

k. Definitive Care: The patient should be evaluated by a medical officer or physician as soon as feasible. An appropriate escort should be provided until the patient is transferred to a medical treatment facility and relieved by the local cognizant medical authority taking charge of the case.

l. Sitrep: Per OPNAVINST 3100.6H Special Incident Reporting Procedures, an OPREP-3 Unit SITREP must be submitted for all cases involving suicide, suicidal attempt, suicidal gestures, and suicidal ideations.

m. Physical qualification status: Any service member that exhibits suicidality (attempt, gesture or ideation) is considered Not Physically Qualified for submarine and nuclear field duty until evaluated by a UMO and a waiver of physical standards is granted by higher authority.

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**APPENDIX E TAB D****MEDICAL TREATMENT PROTOCOL FOR SUBMARINE SKIN/SOFT TISSUE INFECTIONS (SSTI)**

Ref: (a) Naval Environmental Health Command, "Guidelines for the Management of Community-Acquired Methicillin-Resistant Staphylococcus aureus (CA-MRSA) Infections in the US Navy and Marine Corps," AUG 2006

1. Background: Skin and soft tissue infections are a frequent cause of MEDEVACs from Naval Submarines, with CA-MRSA infections being of particular concern. That said, CA-MRSA outbreaks have yet to be documented on submarines.

2. Action: All Submarine Force health care professionals should be familiar with reference (a). Additionally, the following, submarine-specific guidance is provided.

a. Given the significant role for supervisors in addressing skin/soft tissue infection, engage your ship's COB and EDMC on the hygiene and cleanliness factors impacting this issue.

b. Assess your command for infection control measures. Are all Sailors showering daily? Do their LPO's enforce this? Does the ship's hot racking policy seek minimize the potential spread of infection? Is the laundry capacity sufficient that all hands have clean, dry clothes to wear and clean shower towels? Are crew heads wiped down? Does all exercise equipment have antimicrobial spray/wipes and is it used? Do the showers have soap dispensers? Are they routinely filled? These questions should be revisited upon being presented with a new skin/soft tissue infection.

c. Infectious disease. All wounds or infections treated in port should have wound cultures collected and the causative organism identified. Cultures are best collected prior to starting antibiotic treatment; treatment should not be unnecessarily delayed to obtain the culture.

d. Rash/lesion identification. CA-MRSA infections are typified by abscess formation, often deep-seated, erythematous, warm and flocculent. Commonly, the lesions occur on hair-bearing surfaces or sites where the skin's integrity has been compromised. A prodrome of burning or pain, vesicles (frequently excoriated) or a well-circumscribed location consistent with a nerve distribution should raised suspicions of a viral vice bacterial infection.

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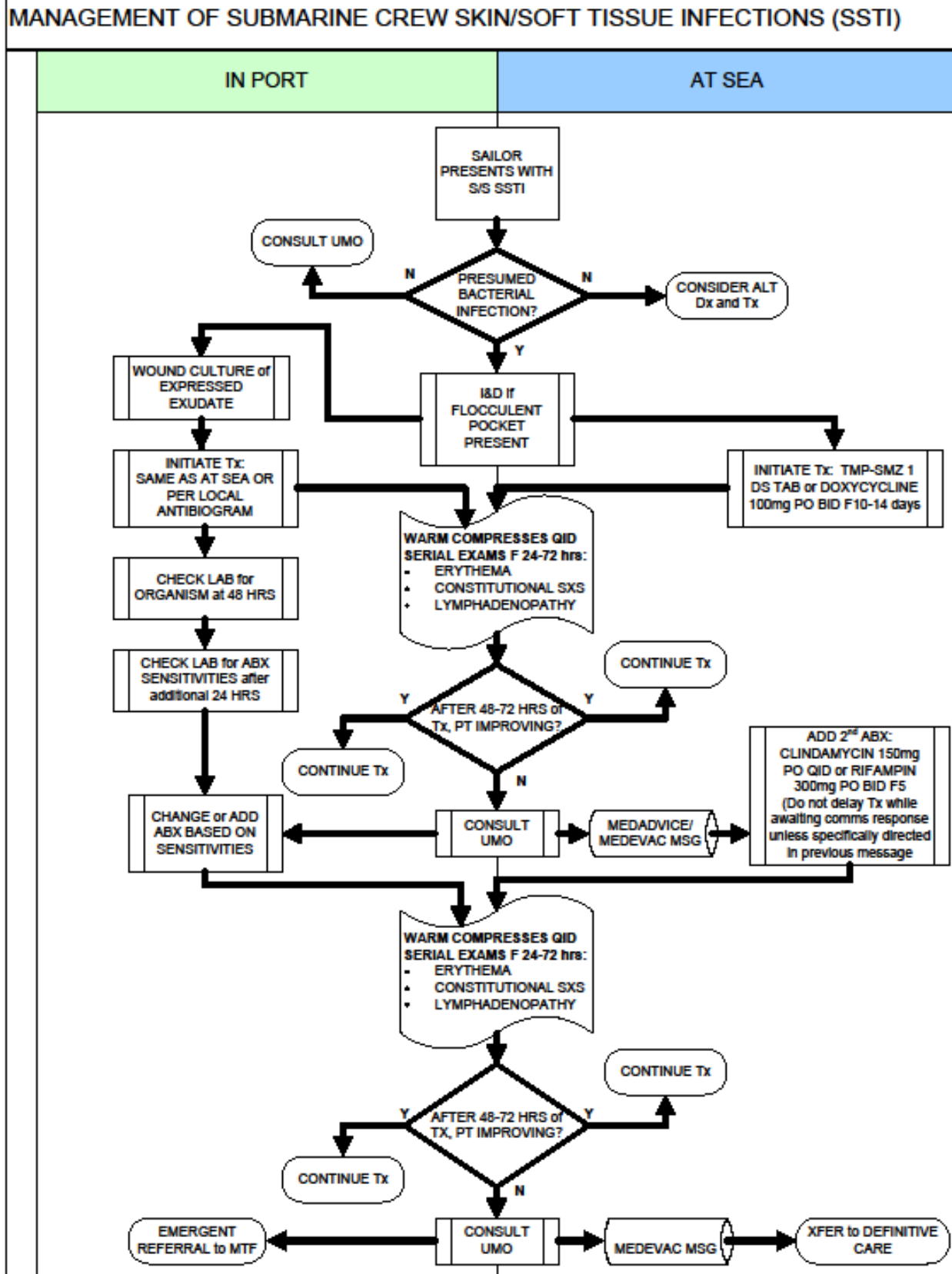
e. Index case. The History of Present Illness (HPI) should include close contacts and an assessment of the patient's personal hygiene. His living space should also be evaluated. Clothing and bedding should be laundered.

f. Treatment. Warm compresses at least QID. Limit movement of area. If a flocculent pocket exists, incise and drain. Monitor wound site for progression/resolution, check for constitutional symptoms and lymphadenopathy.

g. Antibiotics. Treatment of bacterial infections, whenever possible, should be guided by organism identification and sensitivities obtained by proper culture of wound material. A patient presenting with constitutional systems (fever, malaise) or the lack of access to lab facilities (at sea) may dictate empiric selection of antibiotics. Consistent with any existing drug allergies, initial treatment should be either TMP-SMZ "Septra" at 160mg/800mg (1 Double Tab) PO BID or Doxycycline at 100mg PO BID, for 10-14 days. If no response after 48 hours, add a second agent, either Rifampin at 300mg PO BID for five days or Clindamycin at 150mg PO QID to run concurrently with the first agent.

h. Notification. A skin/soft tissue infection requiring I&D inport should promptly be brought to the attention of the physician supervisor. Likewise for ANY skin/soft tissue infection occurring in the 60 day window preceding patrol or deployment. All efforts should be made to not have crew members with active MRSA infections/lesions to embark underway. Asymptomatic colonization alone should not prevent embarkation. At sea, if not already done, a MEDADVICE message should be sent if a second agent is started.

i. Physician supervisors are enjoined to ensure all skin/soft tissue infections are aggressively followed to resolution prior to patrol/deployment, and that appropriate preventive medicine measures are taken, to include, if clinically indicated, MRSA eradication.



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**APPENDIX F**

**MEDICAL DEPARTMENT INACTIVATION CHECKLIST**

1. Turn in all non-controlled medicinals to cognizant NSSC/ISIC Medical Department for redistribution/guaranteed returns program.
2. Turn the following equipment into NSSC/ISIC Medical for transfer & redistribution:
  - a. Emergency medical equipment
  - b. Medical oxygen equipment
  - c. Medical laboratory equipment
  - d. Heat stress analysis equipment
3. Turn into the NSSC/ISIC Medical Department SAMS/TMIP computer equipment. (The TYCOM will be provided with a copy of the transfer document)
4. Survey/destroy all controlled medicinals.
5. Transfer bio-hazardous waste to hospital/clinic.
6. Forward 3M/PMS records to ships 3M Coordinator.
7. Turn in/transfer to NSSC/ISIC: medical books, manuals, and publications.
8. Forward Dose Investigation/Estimates to Chief, Bureau of Medicine and Surgery (M3) per RadCon Manual.
9. Forward Annual and Situational Reports (6470/1) to Federal Records Center, Seattle, WA, per SECNAVINST 5212.5 series.
10. Forward Radiation Health records with retention period of three years or less to NSSC/ISIC for retention/disposition per SECNAVINST 5212.5 series.
11. Destroy training records.
12. Destroy instruction/notices when no longer needed on decommissioning.

13. Ensure all personnel are medically qualified for transfer.
14. Ensure separation physicals are complete for those personnel separating.
15. Submit final Monthly Dosimetry Report.
16. Submit final Exposure Summary Report to NAVSEA 08.
17. Submit final Report of Personnel Exposure, 6470/1, to the Naval Dosimetry Center.
18. Turn over to NSSC/ISIC Medical any pending medical matters upon crew release.

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**APPENDIX G****STEP-BY-STEP PROCEDURE FOR SANITIZING SHIPBOARD  
POTABLE WATER CONNECTIONS WITH WESCODYNE<sup>1</sup>**1. Required Equipment:

a. Stock bottle of disinfectant-detergent, general purpose, 6840-00-526-1129, 1 gallon bottle or stock bottle of disinfectant-detergent, general purpose, 6840-00-292-9698, when the ship is deployed to an overseas location.

b. Measuring flask/beaker graduated in milliliters (ml)

c. Container(s) for diluted solution, e.g., 5 gallon container, 1 gallon container, 1 quart container

d. Clean sponges, e.g. disposable towel, 4 x 4 or 4 x 8 surgical sponges (if connections are to be wiped, rather than sprayed)

e. Spray bottle (if connections are to be sprayed, rather than wiped)

f. Goggles, industrial, chemical splash, 4240-00-190-6432

g. Apron, utility, rubber, full length, 8415-00-082-6108

h. Gloves, chemical oil protective (green nitrile), various NSN's depending on size

2. Dilution Procedure:

a. Wear goggles, gloves, and an apron.

b. Determine the amount of diluted working solution to be made and mix with cool or cold water; DO NOT use hot water.

(1) To make 5 gallons of finished solution, pour 30 ml concentrated solution into the measuring flask and add to 5 gallons of water.

(2) To make one gallon of finished solution, pour 6 ml concentrated solution into the measuring flask and add to 1 gallon of water.

<sup>1</sup>The trade name used in this procedure is solely for the purpose of product information and does not imply endorsement of the specific product named or criticism of similar ones not mentioned

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(3) To make 1 quart of finished solution, pour 1.5 ml concentrated solution into the measuring flask and add to 1 quart of water.

c. Store the diluted container until ready for use (when diluted, Wescodyne retains germicidal activity as long as the rich amber color is present).

### 3. Procedure to Sanitize Potable Water Connections (Shore to Ship):

a. Wear gloves to wipe solution. Wear gloves and splash proof goggles if the solution is to be sprayed.

b. Deliver a clean disinfected potable water hose to the shore potable water outlet.

c. Remove the caps from the shore/pier potable water connection and the ship's potable water riser. Remove the hose caps or uncouple the hose ends (do not place the uncapped or uncoupled hose ends on the deck or pier - hang them over a structure).

d. Sanitize the hose ends and riser connections by submerging into the solution, wiping with a sponge moistened with the solution or by spraying the solution on couplings. The solution must be in contact with surfaces for one minute to be sanitized. Wetting the surfaces is sufficient - do not apply an amount which results in dripping.

e. Open the valve of the pierside potable water outlet and flush for 15 - 30 seconds; then, close the valve.

f. Connect the potable water hose to the pierside potable water outlet, open the valve and flush the hose for 15 - 30 seconds and then close the valve.

g. Connect the other end of the potable water hose to the shipboard riser, open the pierside valve and deliver the potable water.

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**APPENDIX H****EMAT CORE KNOWLEDGE QUALIFICATION STANDARD**

1. Purpose. Emergency Medical Assistance Team (EMAT) personnel are key to maintaining medical and mission readiness for all submarine crews. EMAT members are health care extenders who provide additional hands, eyes, and distant capability to the ship's Medical Department Representative (MDR), and act as a potent medical force multiplier. It is essential that all EMAT members be similarly trained in the recognition and management of medical emergencies. Establishing a required level of core training ensures a more uniform medical response capability for all Squadron units, including those receiving previously trained EMAT members. This outline details those skills and capabilities that should be common to all EMAT personnel and provides an outline for all MDR's to follow in establishing ongoing unit EMAT training. This core knowledge baseline will be the standard tested to by the ship's MDR and Squadron/Group medical reviewers.

2. Basic Medical Skills and Capabilities. All EMAT personnel are required to have the following basic training and skills:

- a. Current Heartsaver and AED training (or equivalent)
- b. Have up-to-date Hepatitis A and B immunization
- c. Be trained in Basic First Aid to include:
  - (1) Hemorrhage control
  - (2) Basic fracture management
  - (3) Airway maintenance techniques
  - (4) Recognition and management of shock
  - (5) Theory and technique of management of known or potential cervical spine injuries, including use of the cervical collar
  - (6) Theory and use of Universal Precautions for infection control
  - (7) Technique and meaning of basic vital signs monitoring

d. Demonstrate adequate capability in basic assessment and emergency treatment of the following conditions:

- (1) Smoke inhalation
- (2) Sucking chest wound
- (3) Compound and simple fractures
- (4) Amputated limb/digit
- (5) Electrical shock (including Heartsaver AED knowledge)
- (6) Lacerations, including facial wounds
- (7) Basic management of thermal and chemical burns
- (8) Choking victim
- (9) Eye injury
- (10) Location and use of CBR equipment and medications
- (11) Severe allergic reactions (anaphylaxis), recognition and basic Treatment
- (12) Extremity and pelvic fractures

e. Be capable and successfully demonstrate both primary and secondary patient surveys of a simulated emergent victim.

5. Knowledge and proficiencies. Know the location of and be suitably proficient in the use of:

- a. Contents of First Aid Box
- b. Contents of basic equipment in EMAT bag
- c. Other emergency equipment:
  - (1) Reeves Sleeve
  - (2) Spine Board
  - (3) SAR stretcher and handling lines

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- (4) AED's, Vital Signs monitors
  - (5) All airway adjuncts and oxygen equipment
  - (6) Oxygen cylinders, regulators, Set up supplemental oxygen supply
  - (7) Nasal oxygen cannula, masks, and bag-valve mask system
  - (8) Equipment and supplies for intravenous fluid administration
  - (9) Traction splint
6. Be familiar with and be able to discuss preparations for and conduct of a mass casualty situation, including how EMAT personnel would specifically assist the MDR.
  7. Have sufficient working knowledge and familiarity with RADCON procedures and care of potentially contaminated victims, including:
    - a. Concept of priority of medical injuries over radiological contamination.
    - b. Know location of RADCON gear and be able to set up the decontamination station.
    - c. Know basic decontamination and isolation techniques.
  8. Demonstrate familiarity with indications and use of intravenous fluid therapy, including being able to assist the MDR in setting up for this procedure.
  9. Understand and be able to demonstrate basic medical documentation/log keeping, including log keeping for a major medical casualty.
  10. Properly assist in and direct multi-level transport of a non-ambulatory patient (with MDR supervision).
  11. Demonstrate proficiency as an EMAT member in shipboard casualty drills.
  12. Successfully pass an oral and written examination prepared and supervised by the unit MDR.

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**APPENDIX I  
MEDICAL READINESS AUDIT GUIDE**

Command: \_\_\_\_\_ MDR: \_\_\_\_\_ Date: \_\_\_\_\_

Senior Inspector: \_\_\_\_\_ Inspectors: \_\_\_\_\_

NOTE: The reporting capabilities of approved electronic medical database should be fully utilized during the inspection process to assist the inspector to verify that reports, logs, supply inventories, tickler files, etc., are being completed as required.

ART. #	A. GENERAL ADMINISTRATION	Y	N
1.1.1.	Are corrective actions for MRI's reported to the ISIC with a copy to the NSSC within 30 days of receipt of inspection report?		
1.1.2.	Has the Executive Officer, or an officer designated by the Executive Officer, conducted a monthly internal monitor using Appendix I? <b>(to include review of the Turnover Log)</b>		
1.1.2.	Is the MDR relief letter submitted to the CO in writing?		
1.1.3.	Is the MDR providing an updated Problem Summary List monthly to the NSSC/ISIC Medical Department via the chain of command?		
2.1.2.	Are all appropriate health record entries signed by the MDR?		
2.1.3.	Are all passwords and combinations recorded on a combination change envelope & kept with the CMS Custodian?		
2.1.3.	Is the MDR's turnover log being reviewed by the NSSC/ISIC in conjunction with the QA process?		
2.2.1.	Per SECNAVINST 5210.11 series, do the ship's medical directives use the Standard Subject Identification Codes (SSIC)?		
2.2.2.	Are health & dental records stored in a locked drawer, cabinet, or office?		
2.2.2.	Are health & dental records maintained IAW MANMED to include health record verifications?		
2.2.2.	Are PHA's being documented on the NAVMED 6120/4 and entered into the approved electronic medical database?		
2.2.2.	Is there a hard copy or approved electronic medical database generated DD2766 located in crew member medical records?		
2.2.6.	Has the MDR established & completed annual reviews of record retirement per SECNAVINST 5212.5 series?		
2.2.7.	Are all required books & publications onboard IAW current instructions?		
2.2.7.	Is the approved electronic medical database utilized to maintain the Sickcall Log?		
2.2.7.	Is the approved electronic medical database utilized to maintain the Potable Water Log?		
2.2.8.	Is the Medical Department Representative Turnover log Tickler File complete?		
2.2.8.	Is the Medical Department Representative Turnover log Medical Administration Section complete?		
2.2.9.	Is the MDR preparing Memorandums for the Record and are they routed through the appropriate chain of command? (As necessary)		
2.2.11.	Does the PSL contain all required items per Appendix J?		
2.2.11.	Is the MDR retaining PSLs for 6 months?		
2.2.12.	Is there a Medical Department Battle Bill?		
2.2.12.	Is the Medical Department Battle Bill maintained in the MDR's Turnover Log and DC Central?		
2.2.13.	Does the MDR have two computers (classified/unclassified) with CAC access?		

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2.2.13.	Is the approved electronic medical database installed on the unclassified computer?		
2.3.2.	Are all accidents & injuries properly reported per OPNAVINST 5100.19 series?		
2.3.2.	Are all accidents & injuries annotated in the ship's Deck Log?		
2.3.3.	When individuals were referred for Medical Consultation, was the UMO informed?		
2.3.3.	When individuals were referred for Medical Consultation, were they cleared to return to duty as necessary?		
2.3.3.	If performing a pre-deployment MRI, did the Executive Officer, Cognizant NSSC/ISIC, and MDR review the crew's medical/dental status? (within 3 months for SSN's/SSGN's and 1 month for SSBN's)		
2.3.4.	Are the appropriate info addressees being included on MEDEVAC/MEDADVICE messages? (i.e, NUMI, NSMRL, TYCOM, NSSC/ISIC)		
2.3.5.	Are medicinals maintained under lock and key?		
2.4.1.	Have all personnel in the PRP had their health & dental records annotated to identify them as being in the program?		
2.4.1.	Have all personnel in the PRP been annotated in CHCS to identify them as being in the program?		
2.5.	Are there personnel onboard that have a disqualifying medical condition without an interim waiver from BUMED or completed waiver from NPC? (SHOULD BE NO)		
CSL/CSP 6000.1	Are appropriate serial blood pressure checks performed on hypertensive personnel to include all required health record documentation & follow-ups by an Undersea Medical Officer?		
CSL/CSP 6000.1	Are annual UMO evaluations completed for personnel with GERD?		
CSL/CSP 6000.1	Are patients with Diabetes Mellitus have an annual physician follow up?		
CSL/CSP 6000.1	Has the MDR conducted and documented annual follow up for patients with kidney stone waivers?		
CSL/CSP 6000.1	Are other chronic medical conditions being specifically commented on by the MDR during annual PHAs?		
<b>Notes:</b>			
<b>Art. #</b>	<b>B. TRAINING</b>	<b>Y</b>	<b>N</b>
1.1.3.	Is the MDR's BLS Instructor cert. current & does he have a card?		
1.1.3.	Are at least two BLS Instructors trained & maintained onboard other than the MDR?		
1.1.3.	Is the MDR's ACLS cert. current & does he have a card?		
3.1.1.	Is the MDR executing EMAT and crew training per current SUBFOR training directives?		
3.1.1.	Is there evidence that each crew member is receiving initial and annual training on NAVOSH topics?		
3.1.1.	Are the required amount of personnel certified in CPR onboard (EMAT, CFL's, wire rates, Divers, etc)?		
3.1.1.	Are there at least 6 trained EMAT personnel?		
3.1.1.	Is the EMAT identified in the Ship's Watch, Quarter, & Station Bill & on the Collateral Duty Listing?		

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3.1.1.	Is the Ship's MDR evaluating the effectiveness of EMAT training by monitoring EMAT and stretcher bearers during shipboard drills?		
3.1.1.	Was a medical emergency drill conducted by the cognizant Physician Supervisor or ISIC Undersea Medical Officer?		
3.1.3.	Is the MDR obtaining CME's to meet the minimum required for the year?		
3.1.3.	Is the MDR attending physician supervisor training as required by reference (b) and IAW local ISIC training schedule?		
4.2.2.	Is the MDR training the small boat handling team and helo transfer team in stretcher handling annually?		
6.2.1.	Is the MDR conducting semi-annual training for all personnel involved with potable water and potable water systems?		
6.3.	Has the MDR re-certified in Shipboard Pest Control Mgt. (Every 4 years)?		
<b>Notes:</b>			
<b>Art. #</b>	<b>C. MEDICAL READINESS</b>	<b>Y</b>	<b>N</b>
	<b>Overall AMAL Percentage (&gt; 90% Satisfactory)</b>		
	2200: GENERAL MEDICINE _____%		
	2205: FORCE HEALTH PROTECTION _____%		
	2219: WOMEN AT SEA _____%		
	2232: LABORATORY _____%		
	2242: EMAT RESPONSE BAG _____%		
	2250: FIRST AID BOX (must be maintained at 100%) _____%		
	2256: IDC KIT (must be maintained at 100%) _____%		
	2277: DENTAL EMERGENCY _____%		
	2250: FIRST AID BOX _____%		
4.1.1.	Are all first aid kits sealed with an easily breakable seal?		
4.1.1.	Does each first aid kit & box have a tag/label on its exterior indicating its most recent inventory & inspection?		
4.1.1.	Are first aid kits inventoried as required?		
4.1.2.	Are all medical supply lockers appropriately identified & locked?		
4.1.2.	Are all emergency equipment/storage lockers marked or labeled with a red cross?		
4.1.2.	Is the ERK clearly marked "EMERGENCY RESPONSE KIT"?		
4.1.2.	Are all litter/stretcher locations marked "STRETCHER"?		
4.1.3.	Are Medical Readiness Inspections being conducted as required?		
4.1.3.	Are Medical Readiness Inspection reports and corrective actions maintained onboard for 3 years?		
4.1.5.	Is the Medical Readiness Inspection checklist accomplished during turnover & submitted with the MDR's relief letter?		
4.2.	Are medical supplies stored throughout the ship vice all in one compartment?		
4.2.	Are all emergency supplies, litters, & medical equipment inspected quarterly for readiness and include date and inspectors initials?		
4.2.	Are there four BVM resuscitators onboard to include one stored with or near the ERK & at least one provided with an EAB hook-up?		
4.2.	Is the AED or approved comparable equipment stowed in a location easily accessible to the crew?		
4.2.1.	Are only oxygen cylinders with valve covers maintained onboard?		

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4.2.1.	Is one oxygen cylinder readily available for use or are regulators readily available for use with cylinders stored fore & aft?		
4.2.1.	Is the MDR and EMAT personnel familiar with the location of the oxygen bank tap-in or oxygen connection on their specific platform?		
4.2.2.	Are all required litters onboard including the SAR MEDEVAC Litter?		
4.2.2.	Have all handling line requirements been met?		
4.2.4.	Does the ERK contain an inventory sheet and is it secured with an easily broken seal?		
<b>Notes:</b>			
<b>Art. #</b>	<b>D. SHIPBOARD MEDICAL ACCOUNTING &amp; SUPPLY</b>	<b>Y</b>	<b>N</b>
5.1.1.	Are biologicals, medicinals, & medical supplies maintained within expiration dates?		
5.1.1.	Are expired medications being issued? (Should be NO)		
5.1.1.	Is approved electronic medical database utilized to manage medical supplies?		
5.1.2.	Is the AMAL/ADAL current with the most recent update?		
5.1.2.	Is there a SMAL onboard?		
5.1.2.	Has the SMAL been approved by the NSSC/ISIC Medical Department? (as applicable)		
5.2.	Has a physical inventory of all supplies, materials, equipment, books and publications been conducted at least annually?		
5.2	Were the results of the annual physical inventory of supplies, and materials, equipment and books and publications retained in the Medical Department files until superseded?		
5.2.2.	Are NAVMED 6700/3's prepared for all medical equipment onboard?		
5.1.8.	Is there a current list of equipment in the SERP program entered in OMMS/NG filed with the NAVMED 6700/3's?		
5.3.	Does the MDR maintain custody of all controlled substances onboard?		
5.3.	Is the controlled substance log up-to-date & completed properly per APPENDIX C & MANMED Chap 21		
5.3.	Are DD 1289 prescription forms properly prepared IAW MANMED?		
5.3.	Has the CO countersigned the DD 1289 when controlled substances are prescribed underway?		
5.3.	Did the patient acknowledge receipt of the controlled substance on the back of the DD 1289, unless incapacitated?		
5.3.	Are there any controlled substances onboard which are not specifically authorized by the AMAL? If so, was the Force Medical Officer's written approval obtained prior to ordering or carrying on board?		
5.3.1.	Is a small safe with combination lock being used for controlled substances?		
5.3.1.	Has the safe's combination been changed, & recorded, as required?		
5.3.2.	Has the CO appointed the members of the Controlled Substances Inventory & Audit Board in writing & have the requirements for membership, per MANMED, been met?		
5.3.2.	Has the CSIAB conducted audits every 90-days, or within 30-days within transaction.		
5.3.2.	Has the board ensured that the records inspected constitute a complete audit trail & that they reflect all transactions?		
5.3.2.	Has the supply department provided a copy of all issue documents for controlled substances directly to the senior board member?		

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5.3.2.	Has the CSIAB submitted written reports of each inventory/audit to the CO using the format contained in APPENDIX C?		
5.3.3.	Has there been any loss or theft of any controlled substances? If so, was it reported appropriately?		
5.3.4.	Was a DD Form 200 utilized & completed correctly for survey of any controlled substances?		
5.3.4.	Was the CO's authorization obtained prior to the survey of any controlled substances & was the CSIAB present during destruction?		
5.3.5.	Are all records for controlled substances retained for 3 years?		
<b>Notes:</b>			
<b>Art. #</b>	<b>E. PREVENTIVE MEDICINE &amp; SANITATION AFLOAT</b>	<b>Y</b>	<b>N</b>
6.1.1.	Is the MDR making daily walk through sanitation inspections of heads, washrooms, & mess facilities?		
6.1.1.	Is the MDR conducting a formal sanitation inspection monthly?		
6.1.1.	Does the MDR submit the formal report of the sanitation inspection to the chain of command within 48 hours?		
6.1.1.	Are formal sanitation reports being maintained for 6 months?		
6.1.1.	Do sanitation inspections over the last 6 months indicate chronic or unresolved sanitation discrepancies?		
6.1.2.	Are food service personnel (FSA & CS's) given a physical evaluation and training per the Tri-Service Food Code?		
6.1.2.	Are the food service physical evaluations documented on a SF 600?		
6.1.5.	Are all mattresses onboard well kept and covered onboard?		
6.1.5.	Are sleeping bags being used onboard? (SHOULD BE NO)		
6.1.6.	Do all heads & washroom spaces have soap dispensers?		
6.1.6.	Do all heads & washroom spaces have hand washing signs posted?		
6.2.1.	Have daily FAC tests been conducted in port?		
6.2.1.	Are all potable water hoses properly marked & blue in color?		
6.2.1.	Are potable water hoses stored in a locker clearly marked "POTABLE WATER ONLY" & is the locker maintained properly?		
6.2.1.	Are potable water filling connections color-coded blue?		
6.2.1.	Was potable water FAC and bacteriological testing completed prior to the ship receiving any water from an unapproved or suspect source?		
6.2.1.	Has weekly bacteriological testing of potable water been conducted on at least 4 samples? (3 random samples and 1 ice machine)		
6.2.1.	Are the results of weekly bacteriological analysis of potable water reported to the CO via the Engineer?		
6.2.1.	Is a weekly inspection of potable water associated equipment being performed in conjunction with the bacteriological analysis?		
6.2.2.	Is the required amount of HTH carried onboard?		
6.2.2.	Are the individual bottles of HTH sealed in plastic bags & stored properly?		
6.2.2.	Does the storage box have three ¼" vent holes drilled in the bottom of the box & is it painted white & distinctly labeled "HAZARDOUS MATERIAL - CALCIUM HYPOCHLORITE" in red letters?		
6.2.2.	Is each bottle of HTH inspected at required periodicities?		
6.3.1.	Has all insecticide or pest control equipment, other than COMBAT Bait Stations, been removed from the ship?		
6.3.1.	Are there sufficient quantities of COMBAT Bait Stations maintained onboard to adequately control cockroaches in all food service areas?		

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6.3.2.	Is there a valid Ship Sanitation Control Certificate (SSCC) or Ship Sanitation Control Exemption Certificate (SSCEC) onboard? Date issued:		
6.4.1.	Has a current HIV test been properly documented in the health records and the approved electronic medical database?		
6.4.4.	If pre-deployment, does the ship have necessary malaria chemoprophylaxis onboard?		
6.4.5.	Did all personnel receive an annual influenza immunization?		
6.4.7.	Are all immunizations entered into the approved electronic medical database and health records promptly?		
6.4.8.	Does the MDR have an EPIPEN onboard per the AMAL?		
6.5.2.	Do all CHT workers have a current CHT physical exam documented on a SF 600 in their health records & are their immunizations current?		
6.6.2.	Are all medical waste disposals annotated in the Ship's Deck Log?		
6.6.2.	If conducted, did the ship meet all of the requirements for disposal of medical waste at sea?		
6.7.	Is someone other than the MDR assigned as the ship's Safety Officer?		
6.7.3.	Has the ships safety survey been completed within 36 months?		
6.7.4.	Has an update to the baseline IH survey been completed every three years?		
<b>Notes:</b>			
<b>Art. #</b>	<b>F. ATMOSPHERE CONTROL</b>	<b>Y</b>	<b>N</b>
7.1.	Is the MDR maintaining atmosphere control equipment? (SHOULD BE NO)		
7.1.1.	Does the MDR maintain records concerning atmosphere readings taken prior to tank / void entry?		
7.1.1.	Is a GFE test log maintained IAW current directives?		
7.1.1.	Is the MDR's annual GFE certification up-to-date and is the MDR assigned as the GFE by the CO?		
<b>Notes:</b>			
<b>Art. #</b>	<b>G. DENTAL &amp; ORAL HEALTH</b>	<b>Y</b>	<b>N</b>
8.1.	Is the Dental Program onboard conducted under the guidelines of the Fleet Dental Procedures Manual?		
8.1.	Is the dental readiness (ODR) onboard maintained > 90%? For Pre-Deployment MRI's, is the dental readiness (ODR) at 100%?		
8.1.	Have dental class 3 &/or 4 personnel gotten underway without Dental Officer and UMO clearance? (SHOULD BE NO)		
8.1.	When applicable, are class 3 and 4 dental personnel listed on the PSL and maintained in the turnover binder?		
<b>Notes:</b>			
<b>Art. #</b>	<b>H. APPROVED ELECTRONIC MEDICAL DATABASE and EXTERNAL REPORTING REQUIREMENTS</b>	<b>Y</b>	<b>N</b>
9.1.2.	Are approved electronic medical database backups being conducted as required?		
9.1.2.	Are two quarters of Radiation Health back-ups retained?		
9.1.3. and 4.1.6	Is the Medical Department submitting monthly IMR Reports via NMO and ORis TMIP transmitting automatically when connected?		
9.1.3.	Is the Medical Department submitting DEERS reports as required?		
<b>Notes:</b>			

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Art. #	I. MISCELLANEOUS	Y	N
NAVSEAINST 4790.8b	Has the MDR met all requirements of the 3M system for all medical equipment?		
NAVSEAINST 4790.8b	Does the MDR's 3M (SKED) reflect the most recent PMS Force Revision?		
<b>Notes:</b>			
	J. HEALTH MAINTENANCE (APPROVED ELECTRONIC MEDICAL DATABASE VS. H/R SCREENING) (>90%)	Y	N
	TYPHOID: [ %] as applicable		
	TETANUS: [ %]		
	YELLOW FEVER: [ %] as applicable		
	INFLUENZA: [ %]		
	HEPATITIS A: [ %]		
	HEPATITIS B: [ %]		
	MMR OR TITER: [ %]		
	ANTHRAX: [ %] as applicable		
	HIV: [ %]		
	Physicals: [ %]		
	PHA's: [ %]		
	Audiograms: [ %] (Annual for those enrolled)		
	DNA Verification: [ %]		
	Blood Type: [ %]		
	G6PD: [ %]		
	Sickle Cell: [ %]		

**Medical Readiness Inspection Grading Matrix**

Section	Grade
A. General Administration	%
B. Training	%
C. Medical Readiness	%
D. Shipboard Medical Accounting & Supply	%
E. Preventive Medicine & Sanitation Afloat	%
F. Atmosphere Control, Dental Health, SAMS/TMIP, & Miscellaneous	%
G. Health Maintenance	%
Overall Grade	_____ %
Overall C- status	C-

An overall grade of 80% must be achieved to receive a satisfactory grade on the audit. In addition, the activity must pass at least six of seven sections to receive a satisfactory grade on the audit.

**C-1** [ $\geq 90\%$ ] is considered fully ready, **C-2** [ $\geq 80\%$ ] is considered substantially ready, **C-3** [ $\geq 65\%$ ] is considered marginally ready, **C-4** [ $< 65\%$ ] is considered not ready.

**a. General Administration**

Audit Guide Items	<b>40</b>
Applicable Audit Guide Items	
SAT Audit Guide Items	
SAT Audit Guide Item divided By Applicable Audit Guide Items	<u>          </u> %

**b. Training**

Audit Guide Items	<b>15</b>
Applicable Audit Guide Items	
SAT Audit Guide Items	
SAT Audit Guide Item divided By Applicable Audit Guide Items	<u>          </u> %

**c. Medical Readiness**

Audit Guide Items	<b>29</b>
Applicable Audit Guide Items	
SAT Audit Guide Items	
SAT Audit Guide Item divided By Applicable Audit Guide Items	<u>          </u> %

**d. Shipboard Medical Accounting and Supply**

Audit Guide Items	<b>27</b>
Applicable Audit Guide Items	
SAT Audit Guide Items	
SAT Audit Guide Item divided By Applicable Audit Guide Items	<u>          </u> %

**e. Preventive Medicine and Sanitation Afloat**

Audit Guide Items	<b>37</b>
Applicable Audit Guide Items	
SAT Audit Guide Items	
SAT Audit Guide Item divided By Applicable Audit Guide Items	<u>          </u> %

**f. Atmosphere Control, Dental Health, SAMS/TMIP, and Miscellaneous**

Audit Guide Items	<b>14</b>
Applicable Audit Guide Items	
SAT Audit Guide Items	
SAT Audit Guide Item divided By Applicable Audit Guide Items	<u>          </u> %

**g. Health Maintenance**

Audit Guide Items	<b>16</b>
Applicable Audit Guide Items	
SAT Audit Guide Items	
SAT Audit Guide Item divided By Applicable Audit Guide Items	<u>          </u> %



**PERSONAL DATA - PROTECT IAW PRIVACY ACT OF 1974**

**APPENDIX J  
PROBLEM SUMMARY LIST (PSL)**

6000  
Date

From: Medical Department Representative, USS YOUR BOAT (SSN 700)  
To: Commanding Officer, USS YOUR BOAT (SSN 700)  
Via: (1) Chief of the Boat  
(2) Executive Officer

Subj: CREW MEDICAL PROBLEM SUMMARY LIST

Ref: (a) COMSUBLANT/COMSUBPACINST 6000.2 (series)

1. Current medical issues and sickcall visits.

	NAME	Last 4	DIAGNOSIS	NEXT APPT	DEPLOYABLE /IRWstatus
			Eczema	Derm: LIMDU	NO / PQ
			Umbilical Hernia	LLD x 21 days (15Apr)	YES / PQ
			Migraines	Propanolol LA 80mg Magnesium 400mg Riboflavin 400mg Cleared by Neuro & UMO	YES

2. Outstanding Consultation/Unresolved Medical Conditions.

			Parsonage-Turner syndrome	Ongoing HEP PT and TENS therapy	YES
PRP			Vasectomy	C/S Vas:	YES

3. Personnel with Durable Medical Equipment

	NAME	Last 4	SUPPLIER	ISSUE DATE	RENEWAL REQD
a.			EMIS	Apr13	Apr14
d.			CPAP: Mr. Breathe	In progress	
g.			CPAP: Mr. Breathe	Nov13	Nov14

**PERSONAL DATA - PROTECT IAW PRIVACY ACT OF 1974**

Subj: CREW MEDICAL PROBLEM SUMMARY LIST

4. Personnel Requiring Routine Follow Ups. Personnel on Long-Term Medications are maintained in MDR Turnover Binder.

NAME, Last 4	Diagnosis	Tx	IDC F/U	UMO F/U
	ELEVATED TSH	MONITOR TSH BIANNUALLY	Last: MAR15	Next: MAR17
	HYPERLIPIDEMIA	LIFESTYLE/DIET MODIFICATION -F/u labs 1YR	15 DEC 15	N/A
	GERD	NEXIUM 40MG - Requires annual UMO f/u (Schedule EGD(for Barrett's Esophagitis) & Colonoscopy at 45yo Feb16)	Last: 07MAR14	Next: 16MAR15
	HYPERLIPIDEMIA	LIFESTYLE/DIET MODIFICATION -F/u FBS&Lipids 6MOS	15 SEP 15	N/A
	HYPERLIPIDEMIA / HYPERGLYCEMIA	LIFESTYLE/DIET MODIFICATION -F/u labs 1YR	15 NOV 15	N/A
	HTN	Re-eval in QTR2&3 and UMO f/u required after P55	N/A	JUL15

5. All personnel requiring waivers onboard that are complete are maintained in the MDR Turnover Binder. This list is of pending and interim waivers.

	NAME	Last 4	DIAGNOSIS	INTERIM INFO	DEPLOYABLE
a.			Syncopal Episode	PENDING	NO

6. Dental Readiness: 100% as of 26 Mar 15  
Dental Health: 98.27% as of 26 Mar 15

- a. Class 2: 2
- b. Class 3: 0
- c. Class 4: 0

7. Physical exams pending through end of JUL15: NONE

8. Qualifications (Expiration Date)

- a. Shipboard Pest Management: Expires Jan16
- b. Food Safety Supervisor/Manager Course: Expires Jan16
- c. BLS Instructor: Expires Jun16
- d. ACLS: Expires May16
- e. CME's 2015: 6

9. Overall AMAL percentage of total quantity onboard: 98.53%

D. WAY

Copy to:  
NSSC/ISIC Medical

25 Aug 16

**APPENDIX K****Chapter 1 - MDR TICKLER  
FOR THE WEEK OF 2 APR 09 - 6 APR 09****1. SICK CALL:**

a. Number of personnel seen:	<u>6</u>
b. Number placed on sick list:	<u>1</u>
c. Number of injuries/accidents:	<u>0</u>
d. Number of records reviewed by UMO:	<u>2</u>

**2. PMS**

a. PMS completed this week: None  
 b. PMS Due next week: Oxygen Bottles

**3. INSPECTIONS/AUDITS/TESTS/SURVEYS/REPORTS:**LAST PERFORMED

a. SAMS/TMIP backup all files:(D)	<u>4 Apr 09</u>
b. Sanitation/Habitability inspection:(W)	<u>30 Mar 09</u>
c. Potable water equipment inspected:(W)	<u>28 Mar 09</u>
d. Bacteriological Testing of potable water:(W)	<u>28 Mar 09</u>
f. DEERS Immunizations (W)	<u>27 Mar 09</u>
g. Chronic Meds/Outstanding Consults to UMO (M)	<u>26 Mar 09</u>
h. IMR upload to NMO (M)	<u>16 Mar 09</u>
j. HTH bottles/locker inspected:(M)	<u>02 Mar 09</u>
k. Executive Officer Internal Monitoring (M)	<u>22 May 09</u>
l. BUMED situational report: (M)	<u>23 Mar 09</u>
m. Narcotics inventory:(Q)	<u>22 Feb 09</u>
n. SAMS/TMIP backup Radiation Health:(Q)	<u>01 Mar 09</u>
o. PMS schedule reviewed by XO:(Q)	<u>26 Mar 09</u>
p. Emergency first aid equipment inspected:(Q)	<u>16 Jan 09</u>
q. SSCEC certificate:(Q6M)	<u>31 Mar 09</u>
r. External radiation health audit:(A)	<u>22 Jan 09</u>
s. Internal radiation health audit:(A)	<u>07 Jul 09</u>
t. BUMED annual exposure report:(A)	<u>26 Feb 09</u>
u. NAVSEA-08 report:(A/preliminary due 1/31)	<u>11 Feb 09</u>
v. Supply bulkhead inventory and report to CO:(A)	<u>18 Dec 09</u>
w. HIV testing:(2 yrs)	
x. PPD testing and report to CO:(A) <u>100</u> %	<u>02/10/09</u>
y. External MRI:(Q 12-18M/predeployment)	<u>Upon end of DMP</u>
z. MDR "C" level CPR instructor certification:(Q2Y)	<u>13 Sep 08</u> (New card pending)
aa. CBR annual inventory with SLEP validation (A)	<u>18 Dec 08</u>

**4. IMMUNIZATIONS: Outstanding:**

a. Tetanus:\_\_\_(Q10Y), Typhoid:\_\_\_(Q2Y), Y/F:\_\_\_(Q10Y)  
 Hep A \_\_\_(2 series) Anthrax (if required) N/A  
 (Typhoid / YF required if deploying to endemic areas)

**5. DENTAL:**

a. Class - 1: 28, 2: 129, 3: 6 4: 0 %Readiness: 94.21%  
 All class 3 have appt pending.

**6. DOSIMETRY:**

a. LIF TLD's were issued: N/A Collection due: N/A Will reissue on \_\_\_\_\_.

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**APPENDIX L**

**ACCIDENT/INJURY REPORT**

Date

From: Medical Department Representative  
To: Commanding Officer  
Via: (1) Executive Officer  
(2) Chief of the Boat  
(3) Safety Officer

Subj: ACCIDENT/INJURY REPORT

Ref: (a) OPNAVINST 5100.19 (Series)

1. Rank/Name of injured:

a. MM3 Doe, John

2. Date, Time and location of incident:

a. 30 Dec 14 at 1815, MCUL underneath MC Logistics Escape Trunk(LET)

3. Alleged circumstances initially reported:

a. Member was cutting zip ties while assembling the "bath tub" under MC LET when his knife slipped and cut the palm of his right hand.

4. Witness(es):

a. None

5. Condition of individual at time of examination:

a. Normal, not under the influence of any substances.

6. Assessment:

a. Hand Laceration

7. Treatment:

a. Thorough physical assessment

b. Member received 3 sutures

Subj: ACCIDENT/INJURY REPORT

8. Safety hazard indicated:

a. None

9. Based on the above, the following findings are recommended:

a. In line of duty, not misconduct

10. Estimated loss of time from duty as a result of injury:

a. No time lost from duty as a result of this incident

11. Disposition:

a. Member is directed to limit use of his right hand while watch standing.

12. Accident entered into ship's deck log on 30 December 2014.

D. WAY

**APPENDIX M**

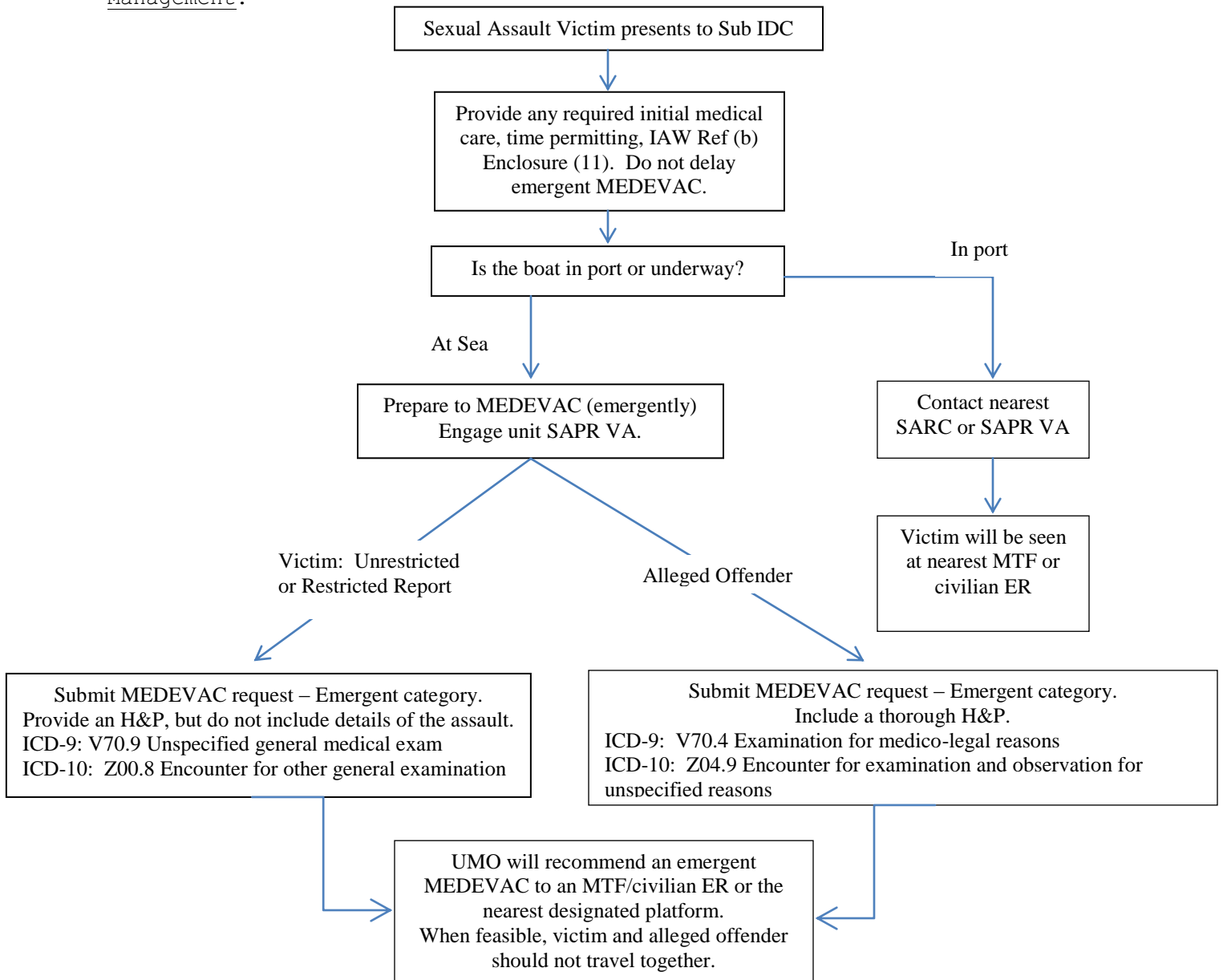
**SEXUAL ASSAULT VICTIM RESPONSE**

- Ref: (a) SECNAVINST 1752.4B  
(b) BUMEDINST 6310.11A  
(c) COMFLTFORCOM/COMPACFLTINST 6310.2

Policy. Victims of sexual assault shall be treated as emergent cases. They shall be provided victim-centric, gender responsive, culturally competent, recovery oriented medical care, SAPR services and sexual assault medical forensic exams. This care cannot be provided on a submarine. Therefore, victims shall be MEDEVACed to the nearest MTF/civilian ER or designated platform (LHA/LHD, CVN or AS).

Victims retain the right to choose to file a restricted or an unrestricted report per reference (a).

Management.



COMSUBLANT/COMSUBPACINST 6000.2E  
25 Aug 16

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